

004170 - 2016/07

Office of Medicaid Cost Reimbursement Planning and Finance

2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| Kindred Hospi | tal The Pal | m Beaches | | | Provider Number: (| 0004170-00 |
|----------------|----------------|--------------------------|---------------|---------------|----------------------|-----------------------|
| 5555 W. Blue | | | | | Date: | 7/29/2016 |
| Riviera Beach | | | | | Fiscal Year End: 8 | 8/31/2015 |
| Tiviora Boasi. | , 00 0 | 7.0.0 | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | /pe: | | | | _ | |
| | _HOSI | PITAL | Current R | late | New Rate | Effective Date |
| | | Inpatient | DRG | | DRG | 7/1/2016 |
| | (| Outpatient | 11.65 | - | 12.52 | 7/1/2016 |
| Inpatie | | ty Billing Rate | | - | | 7/1/2016 |
| Rate Type: | | | | | | |
| rtate Type. | <u>Interim</u> | | Х | <u>Prospe</u> | ctive | |
| | _ | Total Interim | | x | | ve |
| | | — Settlement Based of | on Cost | | | |
| | | | | | | |
| | | | BAS | SIS: | | |
| | | | Budget | | | |
| | | X | Unaudited Co | sts | | |
| | | | Field Audited | | | |
| | | | Revised Field | | | |
| | | | Cost Report L | ate Test | | |
| | | | | | | TR OL |
| | | | W. | Rydell Sam | uel or Chanda Farcas | M |
| | | | Me | edicaid Cost | Reimbursement Analy | sis |
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009496 - 2016/07

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

| | <u>Medicaid I</u> | <u>Reimburseme</u> | <u>nt Rate Change F</u> | <u>orm</u> | |
|-------------------------------|----------------------|--------------------|-------------------------|------------------------|-----------------------|
| | al at Connerton Long | | | Provider Number: | |
| Term Acute Ca | · | | | Date: | 7/29/2016 |
| 9441 Health C | | | | Fiscal Year End: | 12/31/2014 |
| Land O' Lakes | , FL 34637- | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | |
| - | <u>HOSPITAL</u> | <u>Cı</u> | urrent Rate | New Rate | Effective Date |
| | Inpatient | | DRG | DRG | 7/1/2016 |
| | Outpatient | | 11.65 | 12.52 | 7/1/2016 |
| Inpatient County Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | |
| | <u>Interim</u> | | X Pros | <u>pective</u> | |
| | Total Interim | | | X Total Prospec | tive |
| | Settlement Bas | sed on Cost | | | |
| | | | BASIS: | | |
| | | Budg | et | | |
| | | X Unau | dited Costs | | |
| | | Field | Audited Costs | | |
| | | Revis | ed Field Audit | | |
| | | Cost | Report Late Test | | |
| | | | | | |
| | | | W. Rydell Sa | amuel or Chanda Farcas | FG |
| | | | Medicaid Co | st Reimbursement Anal | ysis |

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016815 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Kindred Hospital Melbouri | ne | | | Provider Number: | 0016815-00 |
|---------------------------|---------------------|---------------------|-------------|--------------------|-------------------------|
| 765 W Nasa Blvd | | | | Date: | 7/29/2016 |
| Melbourne, FL 32901- | | | | Fiscal Year End: | 8/31/2015 |
| · | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSP</u> | <u>PITAL</u> | Current Rate | <u>!</u> | New Rate | Effective Date |
| 1 | Inpatient | DRG | | DRG | 7/1/2016 |
| C | Outpatient | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient Count | ty Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Χ | Prospectiv | <u>ve</u> | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based or | n Cost | | | |
| | | | | | |
| | | BASIS: | <u>!</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Cos | | | |
| | | Revised Field Au | | | |
| | | Cost Report Late — | e rest | | |
| | | W. Ry | dell Samuel | or Chanda Farcas | F G |
| | | Medica | aid Cost Re | imbursement Anal | ysis |
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020127 - 2016/07

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

| Coored Heart I | Hoopital on t | the Culf | | | | | Pr | ovider Number: | 0020127- | -00 |
|-----------------|----------------|------------|-------------|-----------|----------|--------------|------------|----------------------|-------------|-----------------|
| Sacred Heart I | • | irie Guii | | | | | | | 7/29/2010 | |
| 3801 E Hwy 98 | | | | | | | F | iscal Year End: | | |
| Port St. Joe, F | L 32456- | | | | | | | | | d Cost Report |
| Danishan To | | | | | | | | | | |
| Provider Ty | _ | | | 0 | (D - (| _ | | Name Date | - | Tita athaa Bata |
| | HOSP. | | | Curre | | <u>e</u> | | New Rate | | Effective Date |
| | | npatient | | | RG | | | DRG | | 7/1/2016 |
| | | utpatient | | 140 | 6.06 | | | 160.53 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | Χ | Prospe | ective | | | |
| | _ | Total Inte | erim | | | > | < | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | _ | | |
| | | | | | | | | | | |
| | | _ | | <u>B</u> | ASIS | <u>):</u> | | | | |
| | | | | Budget | | | | | | |
| | | · | Χ | Unaudited | d Costs | 8 | | | | |
| | | - | | Field Aud | ited Co | osts | | | | |
| | | - | | Revised F | ield A | udit | | | | |
| | | - | | Cost Rep | ort Late | e Test | | | | |
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| | | | | | W/ R | ıdell Sam | nuel or | Chanda Farcas | . A | \ (\f |
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Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| nt Rate | Fiscal Year End: Audit Status: | 7/29/2016 |
|---|---|--|
| | Fiscal Year End: Audit Status: | 12/31/2014 |
| | Audit Status: | |
| | | · |
| | New Bete | |
| | | Effective Date |
| | | _ |
| | | 7/1/2016 |
| 1.12 | 409.77 | 7/1/2016 |
| | | 7/1/2016 |
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| X | C Total Prospec | tive |
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| I Costs ited Costs Field Audit ort Late Test W. Rydell Sam | | |
| Medicaid Cost | Reimbursement Anal | ysis |
| | | nly - No Change in rate |
| 3 | X Prosper X Prosper BASIS: d Costs ited Costs Field Audit ort Late Test W. Rydell Sam | A Prospective X Prospective X Total Prospective A Costs ited Costs ited Costs ited Audit ort Late Test W. Rydell Samuel or Chanda Farcas Medicaid Cost Reimbursement Anal |



031588 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Viora Hagnital | | | | Provider Number: 0 | 0031588-00 |
|-------------------------|---------------|---------------------|-----------|----------------------|------------------------|
| Viera Hospital | | | | _ | 7/29/2016 |
| 8745 Wickham Rd | | | | Fiscal Year End: 9 | |
| Melbourne, FL 32940- | | | | _ | Jnaudited Cost Report |
| | | | | Audit Status. C | Triadulted Cost Report |
| <u>Provider Type:</u> | | | | | |
| <u>HOSPITAL</u> | | Current Rate | _ | New Rate | Effective Date |
| Inpatier | nt | DRG | | DRG | 7/1/2016 |
| Outpatie | nt | 98.77 | | 106.18 | 7/1/2016 |
| Inpatient County Billin | ng Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X <u>P</u> ı | rospectiv | ve | |
| Total Ir | nterim | | X | Total Prospectiv | /e |
| | nent Based on | Cost | | | |
| | | | | | |
| | | BASIS: | | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Costs | | | |
| | | Revised Field Audit | | | |
| | | Cost Report Late Te | | | |
| | | - | 551 | | |
| | | W. Rydel | ll Samuel | or Chanda Farcas | # If |
| | | Medicaid | Cost Re | imbursement Analys | sis |
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032265 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| West Kendall Baptist Hospital | | _ | Provider Number: | 0032265-00 |
|-------------------------------|------------------|---------------------|-------------------------|-------------------------|
| | | | | 7/29/2016 |
| 9555 S.W. 162nd Court | | | Fiscal Year End: | |
| Miami, FL 33196-4930 | | | | Unaudited Cost Report |
| | | | , idali Otalao. | |
| Provider Type: | | | | - |
| <u>HOSPITAL</u> | | Current Rate | New Rate | Effective Date |
| Inpatient | | DRG | DRG | 7/1/2016 |
| Outpatien | ıt | 142.04 | 152.70 | 7/1/2016 |
| Inpatient County Billing | g Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | | X Pro | <u>spective</u> | |
| Total Int | erim | | X Total Prospec | tive |
| Settleme | ent Based on Cos | t | | |
| | | | | |
| | | BASIS: | | |
| | Bud | dget | | |
| | X Una | audited Costs | | |
| | Fie | ld Audited Costs | | |
| | Rev | vised Field Audit | | |
| | Cos | st Report Late Test | İ | |
| | | | | |
| | | W. Rydell S | Samuel or Chanda Farcas | F G |
| | | Medicaid C | ost Reimbursement Anal | ysis |
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032975 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Palm Bay Hosp | ital | | | | | Provider Number: | 0032975-00 |
|----------------|----------------|---------------|------------|----------------|-------------|----------------------|-------------------------|
| 1425 Malabar R | Road N.E. | | | | | Date: | 7/29/2016 |
| Palm Bay, FL 3 | 32907- | | | | | Fiscal Year End: | 9/30/2015 |
| , | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Typ | oe: | | | | | | |
| | HOSP | <u> ITAL</u> | | Current Rat | <u>te</u> | New Rate | Effective Date |
| | I | npatient | _ | DRG | | DRG | 7/1/2016 |
| | C | Outpatient | _ | 55.44 | | 59.60 | 7/1/2016 |
| Inpatie | nt Count | y Billing Rat | te | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| | <u>Interim</u> | | | Х | Prospec | <u>tive</u> | |
| | | Total Interim | | | _ x | Total Prospec | tive |
| | | Settlement Ba | ased on Co | st | | | |
| | | | | | | | |
| | | | | BASIS | <u>S:</u> | | |
| | | | | udget | | | |
| | | | | naudited Cost | | | |
| | | | | eld Audited C | | | |
| | | | | evised Field A | | | |
| | | | | ost Report Lat | e rest | | |
| | | | | W. R | ydell Samu | iel or Chanda Farcas | * FG |
| | | | | Medi | caid Cost F | Reimbursement Anal | ysis |
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040876 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Nemours Child | ren's Hospital | | | Provider Number: | 0040876-00 |
|---------------------|-------------------------------|------------------------|-------------|--------------------|-------------------------|
| 13535 Nemour | | | | Date: | 7/29/2016 |
| Orlando, FL 32 | - | | | Fiscal Year End: | 12/31/2014 |
| Offafido, FL 32 | 2021- | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | ne: | | | | |
| <u>i iovidei iy</u> | <u>pe.</u> <u>HOSPITAL</u> | Current Rate | <u>.</u> | New Rate | Effective Date |
| | Inpatient | DRG | | DRG | 7/1/2016 |
| | Outpatient | 372.49 | | 241.77 | 7/1/2016 |
| Innatio | nt County Billing Rate | 372.49 | | 241.77 | 7/1/2016 |
| | The County Dilling Nate | | | | |
| Rate Type: | | | | | |
| | <u>Interim</u> | X | Prospecti | | |
| | Total Interim | 1 0 1 | X | Total Prospec | tive |
| | Settlement Base | d on Cost | | | |
| | | DACIC | _ | | |
| | | BASIS | <u> </u> | | |
| | X | Budget Unaudited Costs | | | |
| | ^ | Field Audited Costs | | | |
| | | Revised Field Au | | | |
| | | Cost Report Late | | | |
| | | ——— Cost Report Late | : 1651 | | |
| | | W. Ry | dell Samue | l or Chanda Farcas | F |
| | | Medic | aid Cost Re | imbursement Anal | ysis |
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054568 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospita | al Weslev C | hapel | | | | - | Pro | ovider Number: | 005456 | 8-00 |
|-----------------|----------------|-------------|-------------|-----------------------------|---------|-----------|---------|---------------------|---------|-----------------|
| 2600 Bruce B | - | | | | | | | Date: | 7/29/20 |)16 |
| Wesley Chape | | _ | | | | | F | iscal Year End: | 12/31/2 | 2014 |
| Trooloy Chape | n, 11 000 11 | | | | | | | Audit Status: | Unaudi | ted Cost Report |
| Provider Ty | /pe: | | | | | | | | | |
| - | HOSP | <u>ITAL</u> | | Curre | nt Rate | <u>e</u> | | New Rate | | Effective Date |
| | I | npatient | | D | RG | | | DRG | | 7/1/2016 |
| | 0 | utpatient | | 75 | .36 | | | 81.02 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | | Total Inte | erim | | | > | Κ | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | | | |
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| | | _ | | Budget | d Cook | | | | | |
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| | | - | | Cost Rep | | | | | | |
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| | | | | | W. Ry | ydell San | nuel or | Chanda Farcas | g | |
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083692 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Healthsouth Rehabilitation Hospital Ocala | of | | Provider Number: | |
|---|----------------|-------------------|------------------------------|-------------------------|
| 3660 Grandview Parkway Suite 200 |) | | | 7/29/2016 |
| Birmingham, AL 35243- | | | Fiscal Year End: | |
| | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | | Current Rate | New Rate | Effective Date |
| Inpatient | t | DRG | DRG | 7/1/2016 |
| Outpatier | nt | 11.65 | 12.52 | 7/1/2016 |
| Inpatient County Billing | g Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | | Х | Prospective | |
| Total In | terim | | X Total Prospec | tive |
| Settlem | ent Based on (| Cost | | |
| | | | | |
| | | BASIS : | | |
| | | Budget | | |
| | X | Unaudited Costs | | |
| | | Field Audited Cos | sts | |
| | | Revised Field Au | dit | |
| | | Cost Report Late | Test | |
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| | | W. Ryo | dell Samuel or Chanda Farcas | F G |
| | | Medica | aid Cost Reimbursement Anal | ysis |
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092683 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Poinciana Medical Center | | | • | Provider Number: | 0092683-00 |
|--------------------------|--------------------|---------------|----------------|---------------------|-------------------------|
| | | | | Date: | 7/29/2016 |
| 325 Cyrpress Parkway | | | | Fiscal Year End: | |
| Kissimmee, FL 34758- | | | | | Unaudited Cost Report |
| . . | | | | | |
| Provider Type: | | 0 | 5 - 4 - | Name Bata | Effective Date |
| <u>HOSPITA</u> | | Current F | | New Rate | Effective Date |
| Inpa | | DRG | | DRG | 7/1/2016 |
| Outpa | | 59.29 | - _ | 63.74 | 7/1/2016 |
| Inpatient County Bi | Iling Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | Х | Prospec | <u>tive</u> | |
| Tot | al Interim | | X | Total Prospec | tive |
| Set | tlement Based on (| Cost | | | |
| | | | | | |
| | | BAS | SIS: | | |
| | | Budget | | | |
| | X | Unaudited Co | osts | | |
| | | Field Audited | Costs | | |
| | | Revised Field | d Audit | | |
| | | Cost Report l | Late Test | | |
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| | | W | . Rydell Samu | el or Chanda Farcas | F G |
| | | Me | edicaid Cost R | eimbursement Anal | ysis |
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095875 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Healthsouth Rehab of Martin | | | | Provider Number: | 0095875-00 |
|-----------------------------|---------------|------------------|--------------|--------------------|-------------------------|
| 5850 SE Community Drive | | | | Date: | 7/29/2016 |
| Stuart, FL 34997- | | | | Fiscal Year End: | 12/31/2014 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Rate | <u>e</u> | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatient | | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | Х | Prospecti | <u>ve</u> | |
| Total Inte | erim | | _ X | Total Prospec | tive |
| Settlemen | nt Based on (| Cost | | | |
| | | | | | |
| _ | | BASIS | <u>:</u> | | |
| _ | | Budget | | | |
| | Χ | Unaudited Costs | 3 | | |
| | | Field Audited Co | osts | | |
| | | Revised Field A | udit | | |
| _ | | Cost Report Late | e Test | | |
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| | | W. R | /dell Samue | l or Chanda Farcas | |
| | | Medic | caid Cost Re | eimbursement Anal | ysis |
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097013 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St. Vincents Clay County | | | - Provider Number: 0 | 0097013-00 |
|----------------------------|---------------|------------------|-------------------------|------------------------|
| • | | | _ | 7/29/2016 |
| 1670 St. Vincents Way | | | Fiscal Year End: 6 | |
| Middleburg, FL 32068- | | | _ | Jnaudited Cost Report |
| | | | Addit Otatus. C | Triadulted Gost Report |
| <u>Provider Type:</u> | | | | |
| <u>HOSPITAL</u> | <u>Cui</u> | rrent Rate | New Rate | Effective Date |
| Inpatient | | DRG | DRG | 7/1/2016 |
| Outpatient | | 92.84 | 99.81 | 7/1/2016 |
| Inpatient County Billing R | Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| Interim | | X <u>Prospec</u> | ctive | |
| Total Interio | m | X | | ve |
| | Based on Cost | | | |
| | | | | |
| | | BASIS: | | |
| _ | Budget | | | |
| | | ited Costs | | |
| | | udited Costs | | |
| | | d Field Audit | | |
| | | eport Late Test | | |
| | | ., | | |
| | | W. Rydell Samu | uel or Chanda Farcas | R G |
| | | Medicaid Cost F | Reimbursement Analys | sis |
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100030 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| UF Health Sha | ands Hospita | al | | | | - | Pro | ovider Number: | 0100030-00 | |
|-----------------|---------------------|------------|---------------|----------------|----------|------------|---------|---------------------|-----------------------|------|
| Box J-100336 | • | A1 | | | | | | Date: | 7/29/2016 | |
| Gainesville, Fl | | | | | | | F | iscal Year End: | 6/30/2015 | |
| Gamesvine, i i | 32010 | | | | | | | Audit Status: | Unaudited Cost Re | port |
| Provider Ty | ne. | | | | | | | | | |
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| | | npatient | | | RG | | | DRG | 7/1/20 ⁻ | |
| | | outpatient | | | 4.04 | | | 176.75 | 7/1/20 | |
| Inpatie | ent Count | - | | | | | | | 7/1/20 | |
| | | , <u> </u> | | | | | | | | |
| Rate Type: | luta vius | | | | V | Ducono | 4! | | | |
| | <u>Interim</u> - | Total Inte | vrim | | Х | Prospe | ctive | Total Prospec | tivo | |
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| | | - | | Budget | 7.0.0 | <u>=</u> | | | | |
| | | - | Х | _ Unaudited | d Costs | 3 | | | | |
| | | - | | - Field Aud | ited Co | sts | | | | |
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100030 - 2016/07

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

| UF Health Sha | ands Hospita | ıl | | | | | Provider Number: | : 0100030-01 |
|-----------------|----------------|-------------|-------------|--------------|-------------|-----------|--------------------------|-------------------------|
| Box J-100336 | • | | | | | | Date | 7/29/2016 |
| Gainesville, Fl | | | | | | | Fiscal Year End: | 6/30/2015 |
| , | | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | |
| | HOSPI | <u>ITAL</u> | | <u>Curre</u> | nt Rate | | New Rate | Effective Date |
| | lı | npatient | | D | RG | | DRG | 7/1/2016 |
| | 0 | utpatient | | 16 | 4.04 | | 176.75 | 7/1/2016 |
| Inpatie | ent County | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| rate Type. | <u>Interim</u> | | | | Х <u>Р</u> | rospecti | <u>ve</u> | |
| | _ | Total Inte | erim | _ | | Χ | Total Prospec | ctive |
| | | Settleme | nt Based on | Cost | _ | | | |
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| | | _ | | <u>E</u> | BASIS: | | | |
| | | _ | | Budget - | | | | |
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| | | _ | | _ | ited Costs | | | |
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100030 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| UF Health Sha | ands Hospita | al | | | | - | Pro | ovider Number: | 0100030-02 | |
|-----------------|---------------------|-------------|-------------|----------------|----------|-----------|---------|---------------------|------------------|------------|
| Box J-100336 | • | A1 | | | | | | Date: | 7/29/2016 | |
| Gainesville, Fl | | | | | | | F | iscal Year End: | 6/30/2015 | |
| Gamesvine, i i | 32010 | | | | | | | Audit Status: | Unaudited Co | ost Report |
| Provider Ty | ne. | | | | | | | | | |
| 1 TOVIGET TY | <u>HOSP</u> | ITAI | | Curre | nt Rate | e | | New Rate | Effe | ctive Date |
| | | npatient | | | RG | | | DRG | | /1/2016 |
| | | outpatient | | | 4.04 | | | 176.75 | | /1/2016 |
| Inpatie | ent Count | - | | | | | | | | 1/2016 |
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| Rate Type: | Intorim | | | | V | Droope | | | | |
| | <u>Interim</u> - | Total Inte | arim | | Х | Prospe | (| Total Prospec | tive | |
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| | | - | | - Field Aud | ited Co | sts | | | | |
| | | - | | - Revised F | ield Au | udit | | | | |
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100030 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| UF Health Sha | ande Hoenit | al | | | | | Prov | vider Number: | : 0100030 | 0-03 |
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| Box J-100336 | ilius i lospita | aı | | | | | | Date | 7/29/20 | 16 |
| Gainesville, FI | 22610 | | | | | | Fis | cal Year End: | 6/30/20 | 15 |
| Gairlesville, Fi | 32010- | | | | | | | Audit Status: | : Unaudit | ed Cost Report |
| Provider Ty | me. | | | | | | | | | |
| <u>i iovidei iy</u> | <u>HOSP</u> | ΙΤΔΙ | | Curre | nt Rate | | N | ew Rate | | Effective Date |
| | | npatient | | | RG | | | DRG | | 7/1/2016 |
| | | Outpatient | | | 1.04 | | | 176.75 | | 7/1/2016 |
| Inpatie | ent Count | - | | | | | | 170170 | | 7/1/2016 |
| | one ooune | .y Dg | rtato | | | | | | | 17172010 |
| Rate Type: | lt | | | | V | D | ·•··- | | | |
| | <u>Interim</u> - | Total Inte | rim | _ | X | Prospect X | | Total Proces | ativo. | |
| | | _ | nt Based on | Cost | | ^ | | Total Prospec | cuve | |
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| | | | | В | ASIS: | | | | | |
| | | - | | Budget | 7 (0.0. | • | | | | |
| | | - | X | - Unaudited | Costs | | | | | |
| | | - | | - Field Audi | ted Cos | sts | | | | |
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100030 - 2016/07

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

| UF Health Sha | ands Hospita | ıl | | | | | Provider Number: | : 0100030-04 |
|-----------------|----------------|------------|-------------|--------------|-------------|----------|-------------------------------|-------------------------|
| Box J-100336 | • | | | | | | Date | 7/29/2016 |
| Gainesville, Fl | | | | | | | Fiscal Year End: | 6/30/2015 |
| , | | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | |
| | HOSPI | ITAL | | <u>Curre</u> | nt Rate | | New Rate | Effective Date |
| | lı | npatient | | D | RG | _ | DRG | 7/1/2016 |
| | 0 | utpatient | | 16 | 4.04 | _ | 176.75 | 7/1/2016 |
| Inpatie | ent County | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| rate Type. | <u>Interim</u> | | | | Х <u>Р</u> | rospecti | <u>ve</u> | |
| | _ | Total Inte | erim | _ | | Χ | Total Prospec | ctive |
| | | Settleme | nt Based on | Cost | | | | |
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| | | _ | | <u>E</u> | BASIS: | | | |
| | | _ | | Budget - | | | | |
| | | _ | X | Unaudited | | | | |
| | | _ | | _ | ited Costs | | | |
| | | _ | | _ | Field Audit | | | |
| | | _ | | Cost Rep | ort Late Te | est | | |
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| | | | | | W. Ryde | ll Samue | l or Chanda Farca | s N |
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100048 - 2016/07

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

| Ed Fraser Memorial Hospital | | | | Provider Number: | 0100048-00 |
|-----------------------------|-------------|-----------------|--------------|--------------------------------|-------------------------|
| 159 North Third Street | | | | Date: | 7/29/2016 |
| MacClenney, FL 32063- | | | | Fiscal Year End: | 9/30/2015 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Ra | <u>te</u> | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatien | t | 107.51 | | 117.88 | 7/1/2016 |
| Inpatient County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | Х | Prospect | <u>tive</u> | |
| Total Inte | erim | | _ x | Total Prospec | etive |
| Settleme | ent Based o | n Cost | | | |
| | | | | | |
| | | BASIS | <u>S:</u> | | |
| | | Budget — | | | |
| | X | Unaudited Cost | is | | |
| | | Field Audited C | osts | | |
| | | Revised Field A | Nudit | | |
| | | Cost Report La | te Test | | |
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| Batch ID:J4VC6 | | | | — Printed on : 7/29/2016 4: | 56 PM |



100064 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Bay Medical C | enter Sacre | d Heart | | | | | Pro | ovider Number: | 01000 | 064-00 |
|----------------|----------------|-------------|-------------|--------------|----------|-----------|--------------|----------------------|----------|-------------------|
| Health System | | | | | | | | Date: | 7/29/2 | 2016 |
| P.O. Box 2515 | | | | | | | F | iscal Year End: | 12/31 | /2014 |
| Panama City, | FL 32402-2 | 515 | | | | | | Audit Status: | Unau | dited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | | <u>Curre</u> | nt Rate | <u>e</u> |] | New Rate | | Effective Date |
| | 1 | npatient | | D | RG | | | DRG | | 7/1/2016 |
| | 0 | utpatient | t | 88 | 3.14 | | | 94.76 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Х | Prospe | <u>ctive</u> | | | |
| | _ | Total Inte | erim | | | _ x | | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | - | | |
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| | | | | | SASIS | <u>:</u> | | | | |
| | | - | | Budget - | | | | | | |
| | | - | X | Unaudited | | | | | | |
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| | | - | | Cost Rep | ort Late | e l'est | | | | |
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100072 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Observato Otservato | - Danianal M | | | | | | Provider Number: | · 0100072-00 |
|----------------------|----------------------------|-----------|----------------|-----------|----------|-------------|--------------------|-------------------------|
| Shands Starke Center | e Regional IVI | edicai | | | | | | 7/29/2016 |
| Post Office Bo | x 100336 | | | | | | Fiscal Year End: | |
| Gainesville, Fl | L 32610-033 | 6 | | | | | | : Unaudited Cost Report |
| Provider Ty | mo: | | | | | | | |
| Provider Ty | <u>pe.</u> <u>HOSPI</u> | ΤΔΙ | | Curre | nt Rate | | New Rate | Effective Date |
| | | npatient | | | RG | | DRG | 7/1/2016 |
| | | utpatien | | | .46 | | 85.38 | 7/1/2016 |
| Innatio | | - | | | .40 | | 65.56 | 7/1/2016 |
| Шран | ent County | , Βιιιιιί | Rate | | | | | |
| Rate Type: | | | | | | | | |
| | Interim - | | | | X | Prospect | | |
| | | Total Int | | | | X | Total Prospec | ctive |
| | | Settleme | ent Based on (| Cost | | | | |
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| | | | | Budget | | | | |
| | | | X | Unaudited | | | | |
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| | | | | Cost Rep | ort Late | Test | | |
| | | | | | W. Ryd | dell Samue | el or Chanda Farca | s RG |
| | | | | | Medica | aid Cost Re | eimbursement Ana | lysis |
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100081 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Holmes Regional Medica | l Center | | | Provider Number: | 0100081-00 |
|------------------------|--------------------|--------------|------------------|---------------------------|-------------------------|
| 3300 Fiske Boulevard | | | | Date: | 7/29/2016 |
| Rockledge, FL 32955- | | | | Fiscal Year End: | 9/30/2015 |
| C , | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSE</u> | <u>PITAL</u> | Current | Rate | New Rate | Effective Date |
| | Inpatient | DR | | DRG | 7/1/2016 |
| (| Outpatient | 70.1 | 3 | 75.55 | 7/1/2016 |
| Inpatient Coun | ty Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | | X <u>Prospec</u> | <u>ctive</u> | |
| | Total Interim | | X | Total Prospec | etive |
| | Settlement Based o | n Cost | | | |
| | | | | | |
| | | | <u>SIS:</u> | | |
| | | Budget | | | |
| | X | Unaudited (| | | |
| | | Field Audite | | | |
| | | Revised Fie | | | |
| | | Cost Repor | t Late Test | | |
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| | | V | V. Rydell Samu | uel or Chanda Farcas | s // () |
| | | <u></u> | Medicaid Cost F | Reimbursement Anal | ysis |
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100099 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Cape Canaveral Hospital | | | | Provider Number: | 0100099-00 |
|--------------------------|----------------|------------------|--------------|---------------------|-------------------------|
| | | | | Date: | 7/29/2016 |
| 3300 Fiske Boulevard | | | | Fiscal Year End: | |
| Rockledge, FL 32955- | | | | | Unaudited Cost Report |
| | | | | radit Glatas. | - Chadaled Cost Report |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | | Current Rate | <u>e</u> | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatien | t | 65.86 | | 70.81 | 7/1/2016 |
| Inpatient County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospecti | ive | |
| Total Inte | erim | | - <u> </u> | — Total Prospec | tive |
| Settleme | ent Based on (| Cost | | <u> </u> | |
| | | | | | |
| | | BASIS |): | | |
| • | | Budget | _ | | |
| | | Unaudited Costs | 5 | | |
| | | Field Audited Co | osts | | |
| | | Revised Field A | udit | | |
| - | | Cost Report Late | | | |
| - | | | | | |
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| | | W. R | ydell Samue | el or Chanda Farcas | |
| | | Medic | caid Cost Re | eimbursement Anal | ysis |
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100102 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Parrish Medical | l Center | | | | | Provider Number: | 0100102-00 |
|--------------------|---------------------------|------------------|----------|-------------|----------|---------------------|-------------------------|
| | | 0122 | | | | Date: | 7/29/2016 |
| 951 N. Washing | - | e123 | | | | Fiscal Year End: | 9/30/2015 |
| Titusville, FL 3 | 2190- | | | | | Audit Status: | Unaudited Cost Report |
| Providor Tv | noi | | | | | | · · |
| <u>Provider Ty</u> | <u>pe.</u> <u>HOSP</u> | IΤΛΙ | Curre | ent Rate | | New Rate | Effective Date |
| | | npatient | | RG | | DRG | 7/1/2016 |
| | | • | | 7.49 | | 104.80 | 7/1/2016 |
| Innatio | | utpatient | | 7.49 | | 104.00 | 7/1/2016 |
| inpatie | nt Count | y Billing Rate | | | | | |
| Rate Type: | | | | | | | |
| | <u>Interim</u> | | _ | X <u>P</u> | rospect | | |
| - | | Total Interim | | _ | Х | Total Prospec | tive |
| _ | | Settlement Based | on Cost | | | | |
| | | | _ | | | | |
| | | | | BASIS: | | | |
| | | | Budget | | | | |
| | | X | Unaudite | | | | |
| | | | | dited Costs | | | |
| | | | | Field Audit | | | |
| | | | Cost Rep | ort Late To | est | | |
| | | | | W. Ryde | II Samue | el or Chanda Farcas | F F |
| | | | | Medicaio | Cost R | eimbursement Anal | ysis |
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100111 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Wuesthoff Med | dical Center | -Rockledae | | | | - | Pr | ovider Number: | : 0100111 | -00 |
|----------------|----------------|-------------|-------------|------------------------------|---------|-----------|----------------------------|---------------------|------------|----------------|
| 110 Longwood | | _ | | | | | | Date: | 7/29/201 | 6 |
| 565002 | Avenuer.C | J. BUX | | | | | Fiscal Year End: 9/30/2015 | | | |
| Rockledge, FL | 32956-500 |)2 | | | | | | Audit Status: | Unaudite | ed Cost Report |
| Provider Ty | /pe: | | | | | | | | | |
| <u></u> | HOSP | ITAL | | Curre | nt Rate | <u>e</u> | | New Rate | | Effective Date |
| | | npatient | | DI | RG | | | DRG | <u> </u> | 7/1/2016 |
| Outpatient | | | 60 | .74 | | 65.30 | | | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | _ | Total Inter | rim | | | _ > | Κ | Total Prospec | ctive | |
| | | Settlemen | nt Based on | Cost | | | | _ | | |
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| | | _ | | | ASIS | <u>:</u> | | | | |
| | | _ | | Budget - | | | | | | |
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| | | | | | W. Ry | /dell San | nuel or | Chanda Farcas | s 🛭 | |
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100111 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Wuesthoff Med | tical Cantar | Pocklodae | | | | - | Provider Number: | 0100111-01 | |
|-------------------------------|---------------------|------------|----------------|----------------|----------|------------------------|-------------------------|--------------------|--------|
| | | • | ; | | | | | 7/29/2016 | |
| 110 Longwood 565002 | AvenueP.O | . Box | | | | | Fiscal Year End: | | |
| Rockledge, FL | 32956-500 | 2 | | | | | Audit Status: | Unaudited Cost F | Report |
| Provider Ty | me: | | | | | | | | · |
| <u>FIOVICE TY</u> | <u>pe.</u> HOSPI | ΤΔΙ | | <u>Curre</u> ı | nt Rate | <u> </u> | New Rate | Effective | e Date |
| | · | npatient | | | ₹G | <u> </u> | DRG | | |
| | | utpatient | | | .74 | | 65.30 | - 7/1/2 7/1/2 | |
| Inpatient County Billing Rate | | | | ., - | | 00.00 | _ | 7/1/2016 | |
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| Rate Type: | land a select | | | | V | D | | | |
| | <u>Interim</u> - | Total Inte | rim | | Х | <u>Prospectiv</u> - | | tivo | |
| | | - | nt Based on (| Coet | | ^ | Total Prospec | uve | |
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| | | | | В | ASIS | <u>.</u> | | | |
| | | - | | Budget | 7.0.0 | <u>-</u> | | | |
| | | - | X | Unaudited | l Costs | i | | | |
| | | _ | | Field Audi | ted Co | sts | | | |
| | | _ | | Revised F | ield Au | ıdit | | | |
| | | _ | | Cost Repo | ort Late | e Test | | | |
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| | | | | | Medic | aid Cost Re | imbursement Anal | ysis | |
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100129 - 2016/07

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

| Broward Healt | h Medical (| Center | | | | I | Provider Number: 0100129-00 | | | | |
|-------------------------------|----------------|---------------|------------|-----------------|------------|-------------|-----------------------------|-------------------------|--|--|--|
| 1600 S. Andre | ws Avenue |) | | | | | Date: | 7/29/2016 | | | |
| Ft. Lauderdale | | | | | | | Fiscal Year End: | 6/30/2015 | | | |
| | , | | | | | | Audit Status: | Unaudited Cost Report | | | |
| Provider Ty | /pe: | | | | | | | | | | |
| - | HOSF | PITAL | | Curre | nt Rate | | New Rate | Effective Date | | | |
| | | Inpatient | | DI | RG | | DRG | 7/1/2016 | | | |
| Outpatient 10 | | | | | 3.99 | | 116.91 | 7/1/2016 | | | |
| Inpatient County Billing Rate | | | | | | | | 7/1/2016 | | | |
| Rate Type: | | | | | | | | | | | |
| rate Type. | <u>Interim</u> | | | | X <u>I</u> | Prospectiv | <u>e</u> | | | | |
| | - | Total Inter | im | | | X | Total Prospec | tive | | | |
| | | Settlemen | t Based on | Cost | _ | | | | | | |
| | | | | | | | | | | | |
| | | _ | | | ASIS: | | | | | | |
| | | _ | | Budget — | | | | | | | |
| | | | X | Unaudited — | | | | | | | |
| | | _ | | Field Audi - | | | | | | | |
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| | | _ | | Cost Repo | ort Late | Test | | | | | |
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| | | | | | W. Ryd | ell Samuel | or Chanda Farcas | s // | | | |
| | | | | | Medica | id Cost Rei | mbursement Anal | ysis | | | |
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100129 - 2016/07

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

| Broward Health Medical Center | | | | Provider Number: | 0100129-01 | |
|-------------------------------|-------------|--------------------|--------------|-------------------------------|-------------------------|--|
| 1600 S. Andrews Avenue | | | | Date: | 7/29/2016 | |
| Ft. Lauderdale, FL 33316- | | | | Fiscal Year End: 6/30/2015 | | |
| , | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| HOSPITAL | | Current Rat | <u>:e</u> | New Rate | Effective Date | |
| Inpatient | | DRG | | DRG | 7/1/2016 | |
| Outpatien | t | 108.99 | | 116.91 | 7/1/2016 | |
| Inpatient County Billing | , Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | |
| Interim | | X | Prospecti | <u>ive</u> | | |
| Total Int | erim | | _ x | Total Prospec | tive | |
| Settleme | ent Based o | n Cost | | | | |
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| | | BASIS | <u>S:</u> | | | |
| | | Budget — | | | | |
| | Х | Unaudited Cost | | | | |
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| | | W. R | ydell Samue | l or Chanda Farcas | s #1 | |
| | | Medi | caid Cost Re | eimbursement Anal | ysis | |
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100129 - 2016/07

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

| Broward Health | h Medical Ce | enter | | | | F | Provider Number: | 0100129-05 |
|----------------|----------------|------------|-------------|-------------|-------------|-------------|------------------------|-------------------------|
| 1600 S. Andrev | ws Avenue | | | | | | Date: | 7/29/2016 |
| Ft. Lauderdale | | | | | | | Fiscal Year End: | 6/30/2015 |
| T ti Education | , 000.0 | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | | | |
| | HOSPI | TAL_ | | Curre | nt Rate | | New Rate | Effective Date |
| | Ir | patient | | DI | RG | _ | DRG | 7/1/2016 |
| | Οι | utpatient | | 108 | 3.99 | | 116.91 | 7/1/2016 |
| Inpatie | ent County | / Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| <u></u> | <u>Interim</u> | | | | Х <u>Р</u> | rospective | <u>e</u> | |
| | - | Total Inte | rim | | | Х | Total Prospec | tive |
| | | Settlemer | nt Based or | n Cost | | | | |
| | | | | | | | | |
| | | _ | | | ASIS: | | | |
| | | _ | | Budget — | | | | |
| | | _ | Х | Unaudited | | | | |
| | | _ | | Field Audi | | | | |
| | | _ | | Revised F | | | | |
| | | _ | | Cost Repo | ort Late Te | est | | |
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| | | | | | | | | ROLL |
| | | | | | W. Rydel | ll Samuel o | or Chanda Farcas | |
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100188 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Holy Cross Hospital, Inc. | | | - | Provider Number: | 0100188-00 |
|---------------------------|-----------------------|---------------|----------------------|--------------------------------|-------------------------|
| P.O. Box 23460 | | | | Date: | 7/29/2016 |
| Ft. Lauderdale, FL 33307- | | | | Fiscal Year End: | 6/30/2015 |
| Tt. Lauderdale, TL 33307- | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITA | ΔI | Current R | ate | New Rate | Effective Date |
| | atient | DRG | <u> </u> | DRG | 7/1/2016 |
| • | patient | 75.77 | | 81.46 | 7/1/2016 |
| Inpatient County I | | | | | 7/1/2016 |
| | 3 | | | | |
| Rate Type: Interim | | Х | <u>Prospect</u> | ivo | |
| | otal Interim | | <u> Гтозрест</u> | Total Prospec | tive |
| | ettlement Based on | Cost | | | |
| | | | | | |
| | | BAS | IS: | | |
| | | Budget | | | |
| | X | Unaudited Co | sts | | |
| | | Field Audited | Costs | | |
| | | Revised Field | Audit | | |
| | - | Cost Report L | ate Test | | |
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| | | W. | Rydell Samue | el or Chanda Farcas | s A T |
| | | Me | dicaid Cost R | eimbursement Anal | ysis |
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100196 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Kindred Hospital-South Florida | a-Et | | | Provider Number: | 0100196-00 |
|--------------------------------|-----------------------|----------------|------------------|--------------------------------|-------------------------|
| Lauderdale | a-1 t | | | Date: | 7/29/2016 |
| 1516 E Las Olas Blvd. | | | | Fiscal Year End: | 8/31/2015 |
| Ft. Lauderdale, FL 33301- | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITA | J | Current Ra | ate | New Rate | Effective Date |
| | atient | DRG | <u> </u> | DRG | 7/1/2016 |
| • | atient | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient County B | | | | | 7/1/2016 |
| | | | | | _ |
| Rate Type: Interim | | X | <u>Prospecti</u> | ive | |
| | otal Interim | | — X | Total Prospec | tive |
| | ettlement Based on | Cost | | | |
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| | | BAS | <u> S:</u> | | |
| | | Budget | | | |
| | X | Unaudited Cos | sts | | |
| | | Field Audited | Costs | | |
| | | Revised Field | Audit | | |
| | | Cost Report La | ate Test | | |
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| | | W. | Rydell Samue | el or Chanda Farcas | s A |
| | | Med | dicaid Cost Re | eimbursement Anal | ysis |
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100200 - 2016/07

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

| Memorial Region | onal Hospita | al | | | | | Pr | ovider Number: | 0100200-00 |
|-----------------|----------------|----------------|-------------|------------------------------|-------------|----------|---------|---------------------|-------------------------|
| 3501 Johnson | - | - | | | | | | Date: | 7/29/2016 |
| Hollywood, FL | | | | | | | F | iscal Year End: | 4/30/2015 |
| riony wood, i E | 00021 | | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | | | | |
| | HOSP | ITAL | | Currer | nt Rate | <u>e</u> | | New Rate | Effective Date |
| | I | npatient | | DF | RG | | | DRG | 7/1/2016 |
| | 0 | outpatient | | 150 |).59 | | | 161.56 | 7/1/2016 |
| Inpatie | nt Count | y Billing | Rate | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | <u> </u> |
| <u></u> | <u>Interim</u> | | | | X | Prospe | ective | | |
| | • | Total Inte | rim | | | _ > | < | Total Prospec | tive |
| | | _ Settlemer | nt Based on | Cost | | | | _ | |
| | | | | | | | | | |
| | | _ | | | <u>ASIS</u> | <u>:</u> | | | |
| | | _ | | Budget | | | | | |
| | | _ | X | Unaudited | | | | | |
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| | | _ | | Cost Repo | | | | | |
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| | | | | | w. Ry | dell San | nuel or | Chanda Farcas | 5 N J |
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100218 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Broward Health North | | | | Provider Number: | 0100218-00 |
|---------------------------|------------------|------------------|-------------|---------------------|-------------------------|
| | | | | | 7/29/2016 |
| 303 South East 17th St. | | | | Fiscal Year End: | |
| Ft. Lauderdale, FL 33316- | | | | | Unaudited Cost Report |
| | | | | riddit Otatao. | - Chadalod Cool Ropolt |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | | Current Rate | | New Rate | Effective Date |
| Inpati | | DRG | | DRG | 7/1/2016 |
| Outpat | ient | 84.61 | | 90.45 | 7/1/2016 |
| Inpatient County Bill | ling Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | Prospect | <u>ive</u> | |
| Tota | l Interim | | _ X | Total Prospec | tive |
| Settl | ement Based on (| Cost | | | |
| | | | | | |
| | | <u>BASIS</u> | <u>:</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | ; | | |
| | | Field Audited Co | sts | | |
| | | Revised Field Αι | udit | | |
| | | Cost Report Late | e Test | | |
| | | - | | | |
| | | W. Ry | /dell Samue | el or Chanda Farcas | F G |
| | | Medic | aid Cost R | eimbursement Anal | ysis |
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100218 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Broward Health North | | | _ | Provider Number: | 0100218-03 |
|---------------------------|----------------|-----------------|--------------|---------------------|-------------------------|
| | | | | | 7/29/2016 |
| 303 South East 17th St. | | | | Fiscal Year End: | |
| Ft. Lauderdale, FL 33316- | | | | | Unaudited Cost Report |
| Descrides Tomas | | | | | |
| Provider Type: | | Current Ra | to | New Rate | Effective Date |
| HOSPITAL | 1 | | <u></u> – | | |
| Inpatien | | DRG | | DRG | 7/1/2016 |
| Outpatier | | 84.61 | | 90.45 | 7/1/2016 |
| Inpatient County Billin | g Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | Prospect | <u>iive</u> | |
| Total In | | | X | Total Prospec | tive |
| Settlem | ent Based on (| Cost | | | |
| | | | _ | | |
| | | BASI | <u>S:</u> | | |
| | | Budget | | | |
| | | Unaudited Cos | | | |
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| | | Revised Field A | | | |
| | | Cost Report La | te Test | | |
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100269 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Calhoun Liberty Hospital | | | - | Provider Number: | 0100269-00 |
|----------------------------|---------------------|------------------|-------------|---------------------|-------------------------|
| Post Office Box 419 | | | | Date: | 7/29/2016 |
| | | | | Fiscal Year End: | 12/31/2014 |
| Blountstown, FL 32424-0419 | | | | Audit Status: | Unaudited Cost Report |
| Dravidar Typa | | | | | |
| Provider Type: | 1 | Current Rate | • | New Rate | Effective Date |
| <u>HOSPITA</u> | | | <u> </u> | | |
| · | itient | DRG | | DRG | 7/1/2016 |
| | atient | 50.28 | | 54.79 | 7/1/2016 |
| Inpatient County B | illing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | Prospect | <u>ive</u> | |
| To | tal Interim | | X | Total Prospec | tive |
| Se | ttlement Based on 0 | Cost | | | |
| | | | | | |
| | | BASIS | <u>):</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | 5 | | |
| | | Field Audited Co | osts | | |
| | | Revised Field A | udit | | |
| | | Cost Report Late | e Test | | |
| | | | | | |
| | | W. R | ydell Samue | el or Chanda Farcas | F G |
| | | Medic | caid Cost R | eimbursement Anal | ysis |
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100277 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Bayfront Healt | h Punta Go | orda | | | | Provider Number: 0100277-00 | | | |
|-------------------------------|----------------|----------------|------------|-----------|-------------|-----------------------------|--------------------------|----------------|-------------|
| 809 E. Marion | | | | | | | Date | e: 7/29/2016 | |
| Punta Gorda, I | | 3898 | | | | | Fiscal Year End | d: 9/30/2015 | |
| | | | | | | | Audit Status | s: Unaudited C | ost Report |
| Provider Ty | pe: | | | | | | | | |
| | HOSF | PITAL | | Curre | nt Rate | | New Rate | Effe | ective Date |
| | | Inpatient | | D | RG | | DRG | 7 | 7/1/2016 |
| | | Dutpatient | | | .93 | | 55.83 | | 7/1/2016 |
| Inpatient County Billing Rate | | | | | | | | 7/1/2016 | |
| Rate Type: | | <u> </u> | | | | | | | |
| Nate Type. | <u>Interim</u> | | | | X <u>Pr</u> | rospectiv | /e | | |
| | - | Total Inter | im | _ | | Х | <u>-</u> Total Prospe | ctive | |
| | | — Settlemen | t Based on | Cost | _ | | | | |
| | | | | | | | | | |
| | | _ | | <u>E</u> | BASIS: | | | | |
| | | | | Budget | | | | | |
| | | | Х | Unaudite | d Costs | | | | |
| | | | | Field Aud | ited Costs | | | | |
| | | | | Revised F | Field Audit | | | | |
| | | _ | | Cost Rep | ort Late Te | est | | | |
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| | | | | | W. Rydell | l Samuel | or Chanda Farca | as 🕖 | J |
| | | | | | Medicaid | Cost Rei | mbursement Ana | alysis | |
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| Batch ID:J4VC6 | | | | | | Pri | nted on : 7/29/2016 4 | 4:56 PM | |



100277 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Bayfront Healt | ayfront Health Punta Gorda | | | | | | Provider Number: 0100277-02 | | | | |
|-------------------------------|----------------------------|--------------|-------------|---------------|-----------|------------|-------------------------------|-------------------------|--|--|--|
| 809 E. Marion | Ave. | | | | | | Date | 7/29/2016 | | | |
| Punta Gorda, I | FL 33950-38 | 398 | | | | | Fiscal Year End | 9/30/2015 | | | |
| , | | | | | | | Audit Status | Unaudited Cost Report | | | |
| Provider Ty | /pe: | | | | | | | | | | |
| | <u>HOSPI</u> | TAL | | Curr | ent Rate | <u>!</u> | New Rate | Effective Date | | | |
| | lr | npatient | | | DRG | | DRG | 7/1/2016 | | | |
| | 0 | utpatient | | 5 | 1.93 | | 55.83 | 7/1/2016 | | | |
| Inpatient County Billing Rate | | | | | | 7/1/2016 | | | | | |
| Rate Type: | | | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Χ | Prospect | <u>tive</u> | | | | |
| | - | Total Inte | rim | _ | | - X | Total Prospec | ctive | | | |
| | | Settleme | nt Based on | Cost | | | | | | | |
| | | - | | | | | | | | | |
| | | _ | | <u> </u> | BASIS: | <u>:</u> | | | | | |
| | | _ | | Budget - | | | | | | | |
| | | _ | X | Unaudite - | | | | | | | |
| | | _ | | Field Au | | | | | | | |
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| | | _ | | Cost Rep | port Late | Test | | | | | |
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| | | | | | W. Ry | dell Samue | el or Chanda Farca | s A | | | |
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100285 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Day frank I I a alt | la Dant Olaani | | | | <u> </u> | — Provider Number: | 0100285-00 | | |
|---------------------|----------------|--------------|------------|---------------|---------------|-----------------------|-------------------------|--|--|
| Bayfront Healt | | otte | | | | Date: 7/29/2016 | | | |
| 2500 Harbor B | | | | | | Fiscal Year End: | | | |
| Port Charlotte, | , FL 33952- | | | | | | Unaudited Cost Report | | |
| | | | | | | Addit Otatas. | - Chadated Cost Report | | |
| Provider Ty | | | | | | | - 66 .1 - 5 . | | |
| | <u>HOSP</u> | | | Current R | | New Rate | Effective Date | | |
| | | npatient | | DRG | | DRG | 7/1/2016 | | |
| | | utpatient | | 54.94 | | 64.12 | 7/1/2016 | | |
| Inpatie | ent Count | y Billing I | Rate | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | | | |
| | <u>Interim</u> | | | Х | <u>Prospe</u> | ctive | | | |
| | _ | Total Inter | m | | x | Total Prospec | tive | | |
| | | Settlemen | Based on (| Cost | | | | | |
| | | _ | | | | | | | |
| | | | | BAS | <u>IS:</u> | | | | |
| | | _ | | Budget | | | | | |
| | | | Χ | Unaudited Co | sts | | | | |
| | | | | Field Audited | Costs | | | | |
| | | | | Revised Field | Audit | | | | |
| | | _ | | Cost Report L | .ate Test | | | | |
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| | | | | W. | Rydell Sam | uel or Chanda Farcas | 3 A J | | |
| | | | | Me | dicaid Cost | Reimbursement Anal | ysis | | |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

100315 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Nodes Comment Heavited | | Provider Number: | 0100315-00 |
|-------------------------------|---------------------|-------------------------|--|
| Naples Community Hospital | | | 7/29/2016 |
| 350 7th Street North | | Fiscal Year End: | |
| Naples, FL 33941-3029 | | | Unaudited Cost Report |
| | | Audit Status. | —————————————————————————————————————— |
| <u>Provider Type:</u> | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 73.70 | 79.23 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
| Interim | X Pr | <u>ospective</u> | |
| Total Interim | | X Total Prospec | ctive |
| Settlement Based on 0 | Cost — | <u> </u> | |
| | | | |
| | BASIS: | | |
| | Budget | | |
| X | Unaudited Costs | | |
| | Field Audited Costs | | |
| | Revised Field Audit | | |
| | Cost Report Late Te | st | |
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| | W. Rydell | Samuel or Chanda Farcas | s F G |
| | Medicaid | Cost Reimbursement Anal | lysis |
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Florida Agency For Health Care Administration

100331 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Shands Lake S | Shore Regio | onal Medical | | | | Provider Number: | | |
|-----------------|----------------|-----------------|-----------------|------------------------|---------|--------------------|-----------------------|----------------|
| Center | 2000 | | | | | Date: | 7/29/20 | 16 |
| Post Office 100 | | | | | | Fiscal Year End: | 6/30/20 | 15 |
| Gainesville, FL | 32610-03 | 36 | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | <u>pe:</u> | | | | | | | |
| | <u>HOSP</u> | <u>PITAL</u> | Curre | ent Rate | | New Rate | _ | Effective Date |
| | I | Inpatient | D | RG | | DRG | 7/1/2016 | |
| | C | Outpatient | 86 | 86.04 | | 94.00 | | 7/1/2016 |
| Inpatie | nt Count | ty Billing Rate | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| | <u>Interim</u> | | | X Pros | spectiv | <u>/e</u> | | |
| | | Total Interim | | | Х | Total Prospec | tive | |
| | | Settlement Base | ed on Cost | | | | | |
| | | | - | | | | | |
| | | | | BASIS: | | | | |
| | | X | Budget Unaudite | d Costs | | | | |
| | | | | d Costs lited Costs | | | | |
| | | | | Field Audit | | | | |
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| | | | | W. Rydell S | Samuel | or Chanda Farcas | A | R G |
| | | | | Medicaid Co | ost Re | imbursement Anal | ysis | |
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100358 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| D (1.404M) | | | | Provider Number: | 0100358-00 |
|------------------|---------------------|---------------------|-------------|---------------------|-------------------------|
| Baptist Of Miami | | | | | 7/29/2016 |
| 8900 North Kend | | | | Fiscal Year End: | |
| Miami, FL 33176 | - | | | | Unaudited Cost Report |
| | | | | riddit Otatuo. | - Indudited Cool Report |
| Provider Type | | Comment Bata | | Now Date | Effective Date |
| | <u>HOSPITAL</u> | Current Rate | | New Rate | Effective Date |
| | Inpatient | DRG | | DRG | 7/1/2016 |
| | Outpatient | 149.14 | | 160.34 | 7/1/2016 |
| Inpatient | County Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>In</u> | <u>terim</u> | Х <u></u> | Prospect | <u>ive</u> | |
| | Total Interim | | Χ | Total Prospec | tive |
| | Settlement Based on | Cost | | | |
| | | | | | |
| | | BASIS: | | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Costs | s | | |
| | | Revised Field Audi | it | | |
| | | Cost Report Late T | est | | |
| | | _ | | | |
| | | W. Ryde | ell Samue | el or Chanda Farcas | of of |
| | | Medicai | d Cost R | eimbursement Anal | ysis |
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Office of Medicaid Cost Reimbursement Planning and Finance

2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

100366 - 2016/07

Medicaid Reimbursement Rate Change Form

| University of N | /liami Hospi | tal | | | Provider Number: 0100366-00 | | | |
|-------------------------------|----------------|----------------|-------------|-----------|-----------------------------|--------------|-------------------------------|-------------------------|
| 1475 NW 12th | n Avenue, H | ope Lodge | | | | | Date | 9/27/2016 |
| Suite #205 | | | | | | | Fiscal Year End | 5/31/2015 |
| Miami, FL 33 | 136- | | | | | | Audit Status | Unaudited Cost Report |
| Provider Ty | ype: | | | | | | | |
| - | HOSF | <u>PITAL</u> | | Curre | ent Rat | <u>e</u> | New Rate | Effective Date |
| | | Inpatient | | D | RG | | DRG | 7/1/2016 |
| | C | Outpatient | | 161.32 | | | 164.85 | 7/1/2016 |
| Inpatient County Billing Rate | | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | |
| itale Type. | <u>Interim</u> | | | | Х | Prospecti | ive | |
| | | Total Inter | rim | _ | | X | Total Prospec | ctive |
| | | – Settlemer | nt Based on | Cost | | - | <u> </u> | |
| | | | | | | | | |
| | | _ | | <u> </u> | BASIS | <u>):</u> | | |
| | | | | Budget | | | _ | |
| | | | Χ | Unaudite | d Costs | 5 | | |
| | | _ | | Field Auc | dited Co | osts | | |
| | | _ | | Revised I | Field A | udit | | |
| | | _ | | Cost Rep | ort Lat | e Test | | |
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| | | | | | W. R | ydell Samue | el or Chanda Farca | s A T |
| | | | | | Medi | caid Cost Re | eimbursement Ana | lysis |
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100366 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| University of M | liomi Hoonite | <u> </u> | | | | <u> </u> | — Pro | ovider Number: | 0100366-0 |)3 |
|--|---------------|---------------|------------|---------------|----------|---------------|-----------------|--------------------|-------------|---------------|
| • | - | | | | | | Date: 9/27/2016 | | | |
| 1475 NW 12th Suite #205 | Avenue, Ho | pe Loage | | | | | Fiscal Year End | | · 5/31/2015 | |
| Miami, FL 331 | 36- | | | | | | | Audit Status: | | |
| Dravidar Tu | | | | | | | | | | <u> </u> |
| <u>Provider Ty</u> | _ | T | | Curro | nt Rate | • | | New Rate | E | ffective Date |
| | <u>HOSPI</u> | | - | | | <u> </u> | | DRG | | 7/1/2016 |
| | | npatient | - | DRG 161.32 | | . | | 164.85 | | 7/1/2016 |
| Outpatient Inpatient County Billing Rate | | | 10 | 1.32 | | | 104.00 | | | |
| inpatie | ent County | / Billing Ra | ate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| | Interim - | | | _ | Х | Prospe | | | | |
| | | Total Interim | | | | X | (| Total Prospect | tive | |
| | | Settlement E | Based on C | Cost | | | | | | |
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| | | | | | BASIS | <u>5:</u> | | | | |
| | | | | Budget | | _ | | | | |
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| | | | | | W. Ry | ydell Sam | nuel or | Chanda Farcas | s py | |
| | | | | | Medio | caid Cost | Reimb | oursement Anal | ysis | |
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100412 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Hialeah Hospital | | | Provider Number: | 0100412-00 | | | |
|------------------------------|---------------|-----------------------|-------------------------|-------------------------|--|--|--|
| 651 E. 25th StreetDept. 7202 | | | Date: | 7/29/2016 | | | |
| Miami, FL 33013-3878 | | | Fiscal Year End: | 5/31/2015 | | | |
| Wildini, 1 E 00010 0070 | | | Audit Status: | Unaudited Cost Report | | | |
| Provider Type: | | | | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date | | | |
| Inpatie | nt | DRG | DRG | | | | |
| Outpatie | | 53.65 | 57.68 | 7/1/2016 | | | |
| Inpatient County Billin | | | _ | 7/1/2016 | | | |
| | | | - | _ | | | |
| Rate Type: Interim | | X <u>Pr</u> | <u>ospective</u> | | | | |
| Total I | nterim | `` | X Total Prospec | ctive | | | |
| Settler | ment Based on | Cost | <u> </u> | | | | |
| | | | | | | | |
| | | BASIS : | | | | | |
| | | Budget | | | | | |
| | Х | Unaudited Costs | | | | | |
| | | Field Audited Costs | | | | | |
| | | Revised Field Audit | | | | | |
| | | Cost Report Late Test | | | | | |
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| | | Medicaid | Cost Reimbursement Anal | lysis | | | |
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100421 - 2016/07

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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|---------------|----------------|-------------------|-------------------|---------------|------------------------|-------------------------|
| Jackson Memo | orial Hospital | | | | Provider Number: | |
| 1611 N.W. 12t | h Avenue | | | | | 7/29/2016 |
| Miami, FL 331 | 136- | | | | Fiscal Year End: | 9/30/2015 |
| | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | /pe: | | | | | |
| - | HOSPI | <u>TAL</u> | <u>Curre</u> | nt Rate | New Rate | Effective Date |
| | In | patient | D | RG | DRG | 7/1/2016 |
| | Οι | ıtpatient | 16 | 6.77 | 179.06 | 7/1/2016 |
| Inpatie | ent County | Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | _ |
| rate Type. | <u>Interim</u> | | | X Pro | <u>spective</u> | |
| | _ | Total Interim | | | X Total Prospec | tive |
| | | Settlement Based | on Cost | | <u> </u> | |
| | - | | | | | |
| | | | Е | BASIS: | | |
| | | | Budget | <u> </u> | | |
| | | X | Unaudited | d Costs | | |
| | | | Field Aud | ited Costs | | |
| | | | — Revised F | Field Audit | | |
| | | | Cost Rep | ort Late Test | t | |
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| | | | | Medicaid C | ost Reimbursement Ana | ysis |
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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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|---------------------|---------------------|-------------------|----------------|-------------------|-------------------------|
| Jackson Memorial Ho | spital | | Р | rovider Number: | 0100421-01 |
| 1611 N.W. 12th Aven | ue | | | Date: | 7/29/2016 |
| Miami, FL 33136- | | | | Fiscal Year End: | 9/30/2015 |
| , | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| | <u>OSPITAL</u> | Current Rate | <u>9</u> | New Rate | Effective Date |
| | Inpatient | DRG | | DRG | 7/1/2016 |
| | Outpatient | 166.77 | | 179.06 | 7/1/2016 |
| Inpatient Co | ounty Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interi | <u>n</u> | X | Prospective | <u>!</u> | |
| | Total Interim | | _ X | Total Prospec | ctive |
| | Settlement Based on | Cost | | | |
| | | | | | |
| | | <u>BASIS</u> | <u>:</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | 3 | | |
| | | Field Audited Co | osts | | |
| | | Revised Field Au | udit | | |
| | | Cost Report Late | e Test | | |
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| | | Medic | aid Cost Reim | nbursement Anal | ysis |
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100421 - 2016/07

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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|--------------------|--------------------------|---|----------------------|--------------------------|
| Jackson Memorial H | Hospital | | Provider Number | |
| 1611 N.W. 12th Ave | enue | | Date | : 7/29/2016 |
| Miami, FL 33136- | | | Fiscal Year End | : 9/30/2015 |
| | | | Audit Status | : Unaudited Cost Report |
| Provider Type: | | | | |
| | HOSPITAL | Current Rate | New Rate | Effective Date |
| | Inpatient | DRG | DRG | 7/1/2016 |
| | Outpatient | 166.77 | 179.06 | 7/1/2016 |
| Inpatient C | County Billing Rate | | _ | 7/1/2016 |
| | | · · · · · · · · · · · · · · · · · · · | - | |
| Rate Type: Inte | rim | X <u>Pros</u> r | <u>pective</u> | |
| <u>into</u> | Total Interim | | X Total Prospe | ctive |
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100421 - 2016/07

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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|--------------------|--------------------|----------------------|----------------------|----------|----------------------------|-------------------------|--|
| Jackson Memo | orial Hospital | | | | Provider Number: | | |
| 1611 N.W. 12tl | h Avenue | | | | Date: | 7/29/2016 | |
| Miami, FL 331 | 36- | | | | Fiscal Year End: 9/30/2015 | | |
| | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | |
| • | HOSPITAL | | Current Rate | | New Rate | Effective Date | |
| | Inpatient | | DRG | | DRG | 7/1/2016 | |
| | Outpatier | | 166.77 | | 179.06 | 7/1/2016 | |
| Inpatie | ent County Billing | | | | | 7/1/2016 | |
| Rate Type: | | - | | | | | |
| <u>itale Type.</u> | <u>Interim</u> | | X <u>Pro</u> | spectiv | /e | | |
| | - Total Int | erim | | Х | Total Prospec | tive | |
| | Settleme | ent Based on | Cost — | | <u> </u> | | |
| | | | | | | | |
| | | | BASIS : | | | | |
| | | | Budget | | | | |
| | | X | Unaudited Costs | | | | |
| | | | Field Audited Costs | | | | |
| | | | Revised Field Audit | | | | |
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Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| laakaan Mama | rial Haanita | 1 | | | | Provider Number: | 0100421-17 |
|--------------------|----------------|--------------------|-----------|-------------|----------|---------------------|-------------------------|
| Jackson Memo | - | I | | | | | 7/29/2016 |
| 1611 N.W. 12th | | | | | | Fiscal Year End: | |
| Miami, FL 331 | 36- | | | | | | Unaudited Cost Report |
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| <u>Provider Ty</u> | | I T A I | Curro | nt Rate | | New Rate | Effective Date |
| | HOSP | | | | | | |
| | | npatient | | RG | | DRG | 7/1/2016 |
| I | | utpatient | 16 | 6.77 | | 179.06 | 7/1/2016 |
| inpatie | ent County | y Billing Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| | <u>Interim</u> | | | Х <u>Р</u> | rospect | <u>ive</u> | |
| | | Total Interim | | _ | Х | Total Prospec | tive |
| | | Settlement Based o | on Cost | | | | |
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| | | | | BASIS: | | | |
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| | | X | Unaudite | d Costs | | | |
| | | | Field Aud | ited Costs | ; | | |
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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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|-------------------------------|------------------|------------------------------------|----------------------------|-------------------------|--|
| Jackson Memorial Hospital | | Pr | ovider Number: | | |
| 1611 N.W. 12th Avenue | | | | 7/29/2016 | |
| Miami, FL 33136- | | F | Fiscal Year End: 9/30/2015 | | |
| | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | |
| HOSPITAL | Current Rate | <u>e</u> | New Rate | Effective Date | |
| Inpatient | DRG | | DRG | 7/1/2016 | |
| Outpatient | 166.77 | | 179.06 | 7/1/2016 | |
| Inpatient County Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | |
| Interim | Χ | Prospective | | | |
| Total Interim | _ | X | Total Prospec | tive | |
| Settlement Based on 0 | Cost | | <u> </u> | | |
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| | BASIS | <u>:</u> | | | |
| | Budget | | | | |
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| | Field Audited Co | sts | | | |
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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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|---------------------------|----------------|---------------------|------------------|--------------------|-------------------------|
| Jackson Memorial Hospital | | | | Provider Number: | 0100421-19 |
| 1611 N.W. 12th Avenue | | | | Date: | 7/29/2016 |
| Miami, FL 33136- | | | | Fiscal Year End: | 9/30/2015 |
| · | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Rate | | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatient | t | 166.77 | | 179.06 | 7/1/2016 |
| Inpatient County Billing | | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X <u>Pr</u> | ospecti | ve | |
| Total Inte | erim | | Х | Total Prospec | tive |
| Settleme | ent Based on | Cost | | <u> </u> | |
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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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|-------------------------------|-----------------------|------------------------|-------------------------|
| Jackson Memorial Hospital | | Provider Number: | |
| 1611 N.W. 12th Avenue | | | 7/29/2016 |
| Miami, FL 33136- | | Fiscal Year End: | |
| | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 166.77 | 179.06 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
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| | Budget | | |
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| | Medicaid Co | st Reimbursement Anal | ysis |
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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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|---------------|--------------------|-----------------|----------------------|---------|--------------------|-------------------------|
| Jackson Memo | orial Hospital | | | | Provider Number: | 0100421-34 |
| 1611 N.W. 12t | h Avenue | | | | Date: | 7/29/2016 |
| Miami, FL 331 | 136- | | | | Fiscal Year End: | 9/30/2015 |
| | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | rpe: | | | | | |
| | HOSPITAL | | Current Rate | | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatient | t | 166.77 | | 179.06 | 7/1/2016 |
| Inpatie | ent County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | _ |
| itale Type. | <u>Interim</u> | | X <u>Pro</u> | specti | ve | |
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Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| Jackson Memorial Hospital | | | - | Provider Number: | 0100421-35 |
|---------------------------|--------------------|---------------|----------------|-------------------------|-------------------------|
| 1611 N.W. 12th Avenue | | | | Date: | 7/29/2016 |
| | | | | Fiscal Year End: | 9/30/2015 |
| Miami, FL 33136- | | | | | Unaudited Cost Report |
| Date Man Torre | | | | | |
| Provider Type: | | 0 |)_{ | Nam Data | Effective Date |
| <u>HOSPITAL</u> | | Current F | | New Rate | Effective Date |
| Inpat | | DRG | | DRG | 7/1/2016 |
| Outpa | | 166.7 | 7 | 179.06 | 7/1/2016 |
| Inpatient County Bi | Iling Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Х | <u>Prospec</u> | <u>tive</u> | |
| Tot | al Interim | | X | Total Prospec | tive |
| Set | tlement Based on (| Cost | | | |
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| | | Budget | | | |
| | X | Unaudited Co | osts | | |
| | | Field Audited | Costs | | |
| | | Revised Field | d Audit | | |
| | | Cost Report I | _ate Test | | |
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| | | Me | edicaid Cost R | eimbursement Anal | ysis |
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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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|---------------|---------------------------------|------------------|-------------------|---------------|---------------------------|-------------------------|
| Jackson Memo | orial Hospital | | | | Provider Number: | 0100421-36 |
| 1611 N.W. 12t | h Avenue | | | | Date: | 7/29/2016 |
| Miami, FL 331 | | | | | Fiscal Year End: | 9/30/2015 |
| , | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | rpe: | | | | | |
| <u></u> | HOSPITAL | | Current Rate | <u>e</u> | New Rate | Effective Date |
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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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| Jackson Memo | orial Hospital | | | | Provider Number: | 0100421-42 |
| 1611 N.W. 12t | h Avenue | | | | Date: | 7/29/2016 |
| Miami, FL 331 | 136- | | | | Fiscal Year End: | 9/30/2015 |
| | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | rpe: | | | | | |
| | HOSPITAL | | Current Rate | | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatient | t | 166.77 | | 179.06 | 7/1/2016 |
| Inpatie | ent County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
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Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| | | | | | Provider Number: | 0100421 46 | |
|--------------------|--------------------|----------------|------------------|------------------|--------------------|-------------------------|--|
| Jackson Memo | orial Hospital | | | | | - | |
| 1611 N.W. 12th | h Avenue | | | | Date: 7/29/2016 | | |
| Miami, FL 331 | 36- | | | | Fiscal Year End | | |
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| Provider Ty | pe: | | | | | | |
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Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| Jackson Memo | orial Hasnit | ol. | | | | Pro | ovider Number: | 0140422-00 | |
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| 1611 N.W. 12t | • | aı | | | | | | 7/29/2016 | |
| Miami, FL 331 | | | | | | Fiscal Year End | | | |
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| Provider Ty | me. | | | | | | | | |
| <u>i iovidei i</u> y | <u>HOSF</u> | ΡΙΤΔΙ | Curre | ent Rat | e | | New Rate | <u>Effectiv</u> | e Date |
| | | Inpatient | | DRG | | | DRG | 7/1/2016 | |
| Outpatient | | | | 166.77 | | | 179.06 | 7/1/2 | |
| Inpatient County Billing Rate | | | | | | | 170.00 | 7/1/2 | |
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| Rate Type: | luta uiua | | | V | D | 4 ! | | | |
| | <u>Interim</u> - | Total Interim | _ | X | Prospe | | Total Dragge | tiv ro | |
| | - | — Settlement Based o | n Cost | | | <u> </u> | Total Prospec - | live | |
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100439 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Mercy Hospital, Inc. | | | F | Provider Number: | 0100439-00 |
|----------------------|---------------------|---------------------|--------------|-------------------|-------------------------|
| 3663 S Miami Ave. | | | | Date: | 7/29/2016 |
| Miami, FL 33133- | | | | Fiscal Year End: | 12/31/2010 |
| , | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSPI</u> | <u>ITAL</u> | Current Rate | | New Rate | Effective Date |
| Ir | npatient | DRG | | DRG | 7/1/2016 |
| O | utpatient | 118.04 | | 126.90 | 7/1/2016 |
| Inpatient County | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | Χ | Prospective | <u>e</u> | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based on | Cost | | | |
| | | | | | |
| | | BASIS: | | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Cost | | | |
| | | Revised Field Aud | | | |
| | | Cost Report Late | rest | | |
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| | | Medica | id Cost Reir | mbursement Anal | ysis |
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Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| Mercy Hospital, Inc. | | | _ | Provider Number: | 0100439-03 |
|----------------------|-----------------------|-----------------|-----------------|---------------------|-------------------------|
| 3663 S Miami Ave. | | | | Date: | 7/29/2016 |
| Miami, FL 33133- | | | | Fiscal Year End: | 12/31/2010 |
| Midili, FL 33133- | | | | Audit Status: | Unaudited Cost Report |
| Dravidar Typa | | | | | · |
| Provider Type: | ٨١ | Current Ra | ato | New Rate | Effective Date |
| HOSPITA Inn | - | DRG | <u> </u> | | |
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| | patient | 118.04 | | 126.90 | 7/1/2016 |
| Inpatient County I | Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | <u>Prospect</u> | <u>ive</u> | |
| T | otal Interim | | X | Total Prospec | tive |
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| | | BASI | <u>S:</u> | | |
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| | | Field Audited (| Costs | | |
| | | Revised Field | Audit | | |
| | | Cost Report La | ate Test | | |
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| | | Med | dicaid Cost Ro | eimbursement Anal | ysis |
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Office of Medicaid Cost Reimbursement Planning and Finance 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

| Mercy Hospital, Inc. | | | Provider Number: | 0100439-04 | |
|--------------------------|----------------|-----------------------|------------------------|-------------------------|--|
| 3663 S Miami Ave. | | | Date: | 7/29/2016 | |
| Miami, FL 33133- | | | Fiscal Year End: | 12/31/2010 | |
| · | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date | |
| Inpatien | t | DRG | DRG | 7/1/2016 | |
| Outpatier | nt - | 118.04 | 126.90 | 7/1/2016 | |
| Inpatient County Billing | g Rate | | | 7/1/2016 | |
| Rate Type: | | | | | |
| <u>Interim</u> | | X <u>Pros</u> | <u>pective</u> | | |
| Total In | terim | | X Total Prospec | tive | |
| Settlem | ent Based on C | ost | | | |
| | | | | | |
| | | BASIS: | | | |
| | | Budget | | | |
| | X U | Jnaudited Costs | | | |
| | F | Field Audited Costs | | | |
| | F | Revised Field Audit | | | |
| | | Cost Report Late Test | | | |
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| | | W. Rydell Sa | amuel or Chanda Farcas | * FG | |
| | | Medicaid Co | st Reimbursement Anal | ysis | |
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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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|---------------|----------------|---------------|----------------|----------------|---------------|-----------------------|-------------------------|
| Mount Sinai M | ledical Cent | ter | | | | Provider Number | - |
| 4300 Alton Rd | I | | | | | Date | 7/29/2016 |
| Miami Beach, | FL 33140- | | | | | Fiscal Year End: | 12/31/2014 |
| | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | |
| - | HOSF | PITAL | | <u>Curre</u> | nt Rate | New Rate | Effective Date |
| | | Inpatient | | D | RG | DRG | 7/1/2016 |
| Outpatient | | t | 120 | 0.22 | 129.72 | 7/1/2016 | |
| Inpatie | ent Count | ty Billing | , Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| rate Type. | <u>Interim</u> | | | | X <u>Pros</u> | <u>pective</u> | |
| | | Total Int | erim | | | X Total Prospec | ctive |
| | | – Settleme | ent Based or | n Cost | | | |
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| | | | | <u>B</u> | BASIS: | | |
| | | | | Budget | | | |
| | | | Х | — Unaudited | d Costs | | |
| | | | | Field Aud | ited Costs | | |
| | | | | Revised F | Field Audit | | |
| | | | | Cost Rep | ort Late Test | | |
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| | | | | | W. Rydell Sa | amuel or Chanda Farca | s A G |
| | | | | | Medicaid Co | st Reimbursement Ana | lysis |
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100463 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Mount Sinai M | edical Cente | er | | | | ļ | Provider Number: | 0100463-22 |
|----------------|----------------|-------------|-------------|-----------------|-------------|-----------|------------------------|-------------------------|
| 4300 Alton Rd | | | | | | | Date: | 7/29/2016 |
| Miami Beach, | | | | | | | Fiscal Year End: | 12/31/2014 |
| | 000 | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | /pe: | | | | | | | |
| - | HOSPI | <u>ITAL</u> | | <u>Curre</u> | nt Rate | | New Rate | Effective Date |
| | lı | npatient | | DI | ₹G | _ | DRG | 7/1/2016 |
| | 0 | utpatient | | 120 |).22 | | 129.72 | 7/1/2016 |
| Inpatie | ent County | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| rtato Typo. | <u>Interim</u> | | | | Х <u>Р</u> | rospectiv | <u>e</u> | |
| | - | Total Inte | rim | | | X | Total Prospec | tive |
| | | Settleme | nt Based on | Cost | _ | | | |
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| | | _ | | <u>B</u> | ASIS: | | | |
| | | _ | | Budget – | | | | |
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| | | _ | | Cost Repo | ort Late To | est | | |
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100471 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| University of M | iami Hospita | al and | | | | | Pr | ovider Number: | 0100471-00 | |
|-------------------------------|----------------|------------|-------------|---------------|----------|-----------|---------|----------------------|---------------|-------------|
| Clinics | | | | | | | | Date: | 7/29/2016 | |
| P.O. Box 0162 | | | | | | | F | iscal Year End: | 5/31/2015 | |
| Miami, FL 331 | 01- | | | | | | | Audit Status: | Unaudited C | ost Report |
| Provider Ty | <u>ре:</u> | | | | | | | | | |
| | <u>HOSPI</u> | TAL | | Curr | ent Rat | <u>e</u> | | New Rate | Effe | ective Date |
| | Ir | npatient | | | RG | | | DRG | 7 | 7/1/2016 |
| | O | utpatient | | 27 | 75.24 | | 295.90 | | 7 | 7/1/2016 |
| Inpatient County Billing Rate | | Rate | | | | | | 7 | //1/2016 | |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | X | Prospe | ective | | | |
| | • | Total Inte | rim | | | _ > | < | Total Prospec | tive | |
| | | Settlemen | it Based on | Cost | | | | _ | | |
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| | | _ | | | BASIS | <u>}:</u> | | | | |
| | | _ | | Budget – | | | | | | |
| | | _ | X | Unaudite — | | | | | | |
| | | _ | | Field Au | | | | | | |
| | | _ | | Revised – | | | | | | |
| | | _ | | Cost Rep | port Lat | e Test | | | | |
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| | | | | | W. R | ydell San | nuel or | Chanda Farcas | A | () |
| | | | | | Medi | caid Cost | Reiml | oursement Anal | ysis | |
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100498 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Northshore Medical Center | | - | Provider Number: | 0100498-00 |
|-------------------------------|--------------------|---------------|-------------------|-------------------------|
| | | | Date: | 7/29/2016 |
| 1100 N.W. 95th Street | | | Fiscal Year End: | |
| Miami, FL 33150-2098 | | | | Unaudited Cost Report |
| | | | Addit Otatas. | — Chadaled Goot Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | Current Rate | | New Rate | Effective Date |
| Inpatient | DRG | | DRG | 7/1/2016 |
| Outpatient | 15.68 | | 54.00 | 7/1/2016 |
| Inpatient County Billing Rate | • | | | 7/1/2016 |
| Rate Type: | | | | |
| Interim | X | Prospective | ž | |
| Total Interim | | X | Total Prospec | tive |
| Settlement Bas | ed on Cost | | | |
| | | | | |
| | BASIS: | | | |
| | Budget | | | |
| | Unaudited Costs | | | |
| | Field Audited Cost | ts | | |
| | Revised Field Aud | | | |
| | Cost Report Late | | | |
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100498 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Northshore Medical Center | | | | Provider Number: | 0100498-07 |
|----------------------------|--------------|------------------|-------------|---------------------|-------------------------|
| | | | | Date: | 7/29/2016 |
| 1100 N.W. 95th Street | | | | Fiscal Year End: | |
| Miami, FL 33150-2098 | | | | | Unaudited Cost Report |
| | | | | , idali Ciatas. | |
| Provider Type: | | | | | - |
| <u>HOSPITAL</u> | - | Current Rate | <u> </u> | New Rate | Effective Date |
| Inpatient | - | DRG | | DRG | 7/1/2016 |
| Outpatient | <u>-</u> | 15.68 | | 54.00 | 7/1/2016 |
| Inpatient County Billing I | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospecti | <u>ive</u> | |
| Total Inter | im | | - X | — Total Prospec | tive |
| Settlemen | t Based on C | Cost | - | <u> </u> | |
| | | | | | |
| | | BASIS | : | | |
| _ | | Budget | | | |
| _ | | Unaudited Costs | | | |
| - | | Field Audited Co | sts | | |
| _ | | Revised Field Au | ıdit | | |
| _ | | Cost Report Late | | | |
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| | | W. Ry | dell Samue | el or Chanda Farcas | * FG |
| | | Medic | aid Cost Re | eimbursement Anal | ysis |
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| | | | | For Information or | nly - No Change in rate |



100536 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Palm Springs General Hospital | | | | Pr | ovider Number: | 0100536-00 | |
|-------------------------------|-------------|-------------------|-----------------|---------------|----------------------|-------------------------|--|
| 1475 West 49th Street | | | | | Date: | 7/29/2016 | |
| Hialeah, FL 33012- | | | | F | iscal Year End: | 12/31/2014 | |
| , | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | | |
| HOSPITAL | | <u>Current</u> | Rate | | New Rate | Effective Date | |
| Inpatien | t | DR | G | | DRG | 7/1/2016 | |
| Outpatier | nt | 34.2 | 27 | | 36.84 | 7/1/2016 | |
| Inpatient County Billing | g Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| Interim | | | X <u>Pros</u> p | <u>ective</u> | | | |
| Total In | terim | | | Χ | Total Prospec | tive | |
| Settlem | ent Based o | n Cost | | | _ | | |
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| | | BA | SIS: | | | | |
| | | Budget — | | | | | |
| | X | Unaudited (| | | | | |
| | | Field Audite — | | | | | |
| | | Revised Fie | | | | | |
| | | Cost Report | t Late Test | | | | |
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| | | V | V. Rydell Sa | muel or | Chanda Farcas | | |
| | | <u> </u> | Medicaid Cos | st Reiml | oursement Anal | ysis | |
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100544 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Metropolitan Hospital Miami | | | F | Provider Number: | 0100544-00 |
|-----------------------------|-----------------------|------------------|---------------|---------------------------|-------------------------|
| 5959 NW 7th Street | | | | Date: | 7/29/2016 |
| Miami, FL 33126- | | | | Fiscal Year End: | 4/29/2014 |
| Wildini, 1 E 33120 | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPIT | AL | Current Rate | <u>)</u> | New Rate | Effective Date |
| | oatient | DRG | | DRG | 7/1/2016 |
| • | tpatient | 56.39 | | 60.62 | 7/1/2016 |
| Inpatient County | | | | | 7/1/2016 |
| | | | | | |
| Rate Type: Interim | | X | Prospective | a | |
| | Total Interim | | - X | <u>u</u> Total Prospec | tive |
| | Settlement Based on (| Cost | | _ | |
| | | | | | |
| | | BASIS | <u>:</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | i | | |
| | | Field Audited Co | sts | | |
| | | Revised Field Au | ıdit | | |
| | | Cost Report Late | e Test | | |
| | | | | | |
| | | W. Ry | dell Samuel d | or Chanda Farcas | · FG |
| | | Medic | aid Cost Reir | nbursement Anal | ysis |
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100587 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | ivieuicaiu Keimi | dusement Rate Chan | ge Form | | | |
|-----------------------|------------------|---------------------|------------|--------------------|-------------------------|--|
| South Miami Hospital | | | | Provider Number: | 0100587-00 | |
| 6200 S.W. 73rd Street | | | | Date: | 7/29/2016 | |
| Miami, FL 33143- | | | | Fiscal Year End: | 9/30/2015 | |
| | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| <u>HOSPITAL</u> | | Current Rate | | New Rate | Effective Date | |
| Inpati | ent | DRG | | DRG | 7/1/2016 | |
| Outpa | tient | 95.28 | | 102.43 | 7/1/2016 | |
| Inpatient County Bil | ling Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | _ | |
| Interim | | X <u>•</u> | Prospectiv | <u>ve</u> | | |
| Tota | I Interim | | X | Total Prospec | etive | |
| Settl | lement Based o | n Cost | | | | |
| | | | | | | |
| | | BASIS: | | | | |
| | | Budget — | | | | |
| | X | Unaudited Costs | | | | |
| | | Field Audited Cost | | | | |
| | | Revised Field Audi | | | | |
| | | Cost Report Late T | est | | | |
| | | W. Ryde | ell Samuel | or Chanda Farcas | i F H | |
| | | Medicai | d Cost Re | imbursement Anal | ysis | |
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100609 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Nialdana Obild | | -1 | | | Provider Number: | 0100609-00 |
|--------------------|--------------|--------------------|----------------------|--------------|---------------------|-------------------------|
| Nicklaus Child | - | al | | | | 7/29/2016 |
| 3100 S.W. 62n | | | | | Fiscal Year End: | |
| Miami, FL 331 | 55-3009 | | | | | Amended Cost Report |
| Duarda Tr | | | | | | |
| <u>Provider Ty</u> | | I T A I | Current Ra | uto. | New Rate | Effective Date |
| | <u>HOSPI</u> | | DRG | <u></u> – | DRG | _ |
| | | npatient | | | | 7/1/2016 |
| Innotic | | utpatient | 204.03 | | 224.86 | 7/1/2016 |
| inpatie | ent County | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| | Interim - | | X | Prospect | | |
| | | Total Interim | _ | X | Total Prospec | tive |
| | | Settlement Based o | n Cost | | | |
| | | | D 4 01 | • | | |
| | | | BASI Dudget | <u>5:</u> | | |
| | | | Budget Unaudited Cos | t o | | |
| | | | — Field Audited Cos | | | |
| | | | Revised Field | | | |
| | | | Cost Report La | | | |
| | | | — Cost Nepolt La | ile Test | | |
| | | | W. F | ₹ydell Samu | el or Chanda Farcas | F G |
| | | | Med | icaid Cost R | eimbursement Anal | ysis |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

100625 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Westshooter C | Sanaral Haa | nital | | | | | Provider Number: | : 0100625-00 |
|--------------------|--------------|---------------|--------------|-----------|------------|------------------|--------------------|-------------------------|
| Westchester G | | pitai | | | | | | 7/29/2016 |
| 2500 SW 75th | | | | | | | Fiscal Year End | |
| Miami, FL 331 | 155- | | | | | | | Unaudited Cost Report |
| Dravidar Tv | | | | | | | | |
| <u>Provider Ty</u> | | NT A I | | Curro | nt Rate | | New Rate | Effective Date |
| | HOSP | | | | | | | _ |
| | | Inpatient | | | RG | | DRG | 7/1/2016 |
| lm.m.a.4!.a | | Outpatien | | | 3.10 | | 73.21 | 7/1/2016 |
| Inpatie | ent Count | ty Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| | Interim - | | | | X <u>I</u> | <u>Prospecti</u> | | |
| | | Total Int | | | _ | X | Total Prospec | ctive |
| | | Settleme – | ent Based on | Cost | | | | |
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| | | | | Budget | | | | |
| | | | X | Unaudited | | | | |
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| | | | | Revised F | | | | |
| | | | | Cost Rep | ort Late I | est | | |
| | | | | | W. Ryde | ell Samue | l or Chanda Farca | s # H |
| | | | | | Medicai | d Cost Re | eimbursement Ana | lysis |
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100641 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Dontiet Medica | d Conton lo | مالن مصناام | | | | _ | Pr | ovider Number: | : 0100641-0 | 00 |
|-----------------|----------------|-------------|-------------|-------------|----------|--------------|---------|---------------------|-------------|----------------|
| Baptist Medica | | CKSOTIVIIIE | | | | | | | 7/29/2016 | |
| 800 Prudential | | | | | | | F | iscal Year End: | | |
| Jacksonville, F | ·L 32207- | | | | | | · | | | Cost Report |
| D | | | | | | | | | | |
| Provider Ty | - | | | 0 | 4 D 4 | | | Naw Data | _ | Wasting Date |
| | HOSP | | | Curre | | <u>e</u> | | New Rate | | iffective Date |
| | | npatient | | | RG | | | DRG | | 7/1/2016 |
| | | utpatient | | 77 | .98 | | | 83.84 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | Χ | Prospe | ective | | | |
| | | Total Inte | rim | | | | < | Total Prospec | ctive | |
| | | Settlemei | nt Based on | Cost | | | | | | |
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| | | _ | | | ASIS | <u>}:</u> | | | | |
| | | _ | | Budget - | | | | | | |
| | | _ | Х | Unaudited | | | | | | |
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| | | _ | | Revised F | | | | | | |
| | | - | | Cost Rep | ort Late | e Test | | | | |
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| | | | | | W. Ry | ydell San | nuel or | Chanda Farcas | s 👭 | |
| | | | | | Medic | caid Cost | Reimb | oursement Anal | lysis | |
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| Batch ID:J4VC6 | | | | | | | Printe | d on : 7/29/2016 4: | :56 PM | |



100641 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Baptist Medica | ıl Center Tad | rksonville | | | | - | Pro | ovider Number: | 01006 | 641-02 |
|-----------------|----------------|--------------|-------------|----------------|---------|----------------------------|----------|--------------------|------------|-------------------|
| 800 Prudential | | ondonvine | | | | | | Date: | 7/29/2 | 2016 |
| Jacksonville, F | | | | | | | F | iscal Year End: | 9/30/2 | 2015 |
| Jacksonville, F | L 32201- | | | | | | | Audit Status: | Unau | dited Cost Report |
| Provider Ty | ne: | | | | | | | | | |
| 1 TOVIGET TY | HOSP | ITAI | | Curre | nt Rat | e | | New Rate | | Effective Date |
| | | npatient | | | RG | | | DRG | | 7/1/2016 |
| | | utpatient | t | | .98 | | | 83.84 | | 7/1/2016 |
| Inpatie | ent Count | - | | | | | | | | 7/1/2016 |
| | | <i>,</i> | | | | | | | | |
| Rate Type: | <u>Interim</u> | | | | Χ | Prospe | octivo | | | |
| | <u> </u> | Total Inte | rim | | | _ F105pe _ > | | Total Prospec | tive | |
| | - | _ | nt Based on | Cost | | | | - - | | |
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| | | | | В | BASIS |) : | | | | |
| | | - | | Budget | | _ | | | | |
| | | - | Х | - Unaudited | d Costs | 3 | | | | |
| | | - | | - Field Aud | ited Co | osts | | | | |
| | | - | | Revised F | Field A | udit | | | | |
| | | - | | Cost Rep | ort Lat | e Test | | | | |
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| | | | | | W. R | ydell Sam | nuel or | Chanda Farcas | , <i>f</i> | |
| | | | | | Modi | caid Cost | Poimh | oursement Anal | veie. | |
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100641 - 2016/07

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

| Baptist Medical Center Jacksonv | ille | | F | rovider Number: | 0100641-03 |
|---------------------------------|---------------|------------------|---------------|-----------------------|-------------------------|
| 800 Prudential Drive | | | | Date: | 7/29/2016 |
| Jacksonville, FL 32207- | | | | Fiscal Year End: | 9/30/2015 |
| , | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | | Current Rate | <u> </u> | New Rate | Effective Date |
| Inpatie | ent | DRG | | DRG | 7/1/2016 |
| Outpat | ient | 77.98 | | 83.84 | 7/1/2016 |
| Inpatient County Bill | ing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospective | <u>}</u> | |
| Total | Interim | | - X | Total Prospec | tive |
| Settle | ement Based o | n Cost | | _ | |
| | | | | | |
| | | BASIS | <u>:</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Co | | | |
| | | Revised Field Au | | | |
| | | Cost Report Late | e rest | | |
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100641 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | | Provider Number: | 0100641-04 |
|-------------------------------------|-----------------------|-----------------------|-------------------------|
| Baptist Medical Center Jacksonville | | | 7/29/2016 |
| 800 Prudential Drive | | Fiscal Year End: | |
| Jacksonville, FL 32207- | | | |
| | | Audit Status: | Unaudited Cost Report |
| <u>Provider Type:</u> | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 77.98 | 83.84 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
| Interim | X Prosp | <u>ective</u> | |
| Total Interim | | X Total Prospec | tive |
| Settlement Based on C | Cost | | |
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| | BASIS : | | |
| | Budget | | |
| X | Unaudited Costs | | |
| | Field Audited Costs | | |
| | Revised Field Audit | | |
| | Cost Report Late Test | | |
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| | W. Rydell Sa | muel or Chanda Farcas | F G |
| | Medicaid Cos | st Reimbursement Anal | ysis |
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100676 - 2016/07

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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|-------------------------|------------------------|---------------|---------------|--------------------|-------------------------|
| UF Health Jacksonville | | | | Provider Number: | 0100676-00 |
| 580 West 8th Street | | | | Date: | 7/29/2016 |
| Jacksonville, FL 32209- | | | | Fiscal Year End: | 6/30/2015 |
| | | | | Audit Status: | Amended Cost Report |
| Provider Type: | | | | | |
| HOSPITA | <u>L</u> | Current R | <u>ate</u> | New Rate | Effective Date |
| Inpa | tient | DRG | | DRG | 7/1/2016 |
| Outp | atient | 123.66 | | 140.12 | 7/1/2016 |
| Inpatient County B | illing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | Х | Prospec | tive | |
| | tal Interim | | | — Total Prospec | tive |
| Se | ttlement Based on (| Cost | | <u> </u> | |
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| | | BAS | IS: | | |
| | | Budget | | | |
| | _ | Unaudited Co | sts | | |
| | | Field Audited | Costs | | |
| | | Revised Field | Audit | | |
| | - | Cost Report L | ate Test | | |
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| | | W. | Rydell Samu | el or Chanda Farca | s F |
| | | Me | dicaid Cost R | eimbursement Anal | lysis |
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100676 - 2016/07

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

| UF Health Jacksonville | | | F | Provider Number: | 0100676-01 |
|------------------------|---------------------|---------------------|----------------|------------------------|-------------------------|
| 580 West 8th Street | | | | Date: | 7/29/2016 |
| Jacksonville, FL 32209 | - | | | Fiscal Year End: | 6/30/2015 |
| | | | | Audit Status: | Amended Cost Report |
| Provider Type: | | | | | |
| | <u>SPITAL</u> | Current Rate | <u>e</u> | New Rate | Effective Date |
| | Inpatient | DRG | | DRG | 7/1/2016 |
| | Outpatient | 123.66 | | 140.12 | 7/1/2016 |
| Inpatient Cou | nty Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospective | <u>a</u> | |
| | Total Interim | | _ X | Total Prospec | tive |
| | Settlement Based of | on Cost | | _ | |
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| | | BASIS | <u>:</u> | | |
| | | Budget — | | | |
| | | Unaudited Costs | 3 | | |
| | | Field Audited Co | sts | | |
| | | Revised Field Au | | | |
| | | Cost Report Late | e Test | | |
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| | | W. Ry | /dell Samuel o | or Chanda Farcas | |
| | | Medic | aid Cost Reir | nbursement Anal | ysis |
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100722 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Mayo Clinic | | | | Provider Number: | 0100722-00 |
|-------------------------|-----------------------|------------------|------------------|---------------------|-------------------------|
| 4500 San Pablo Road | | | | Date: | 7/29/2016 |
| Jacksonville, FL 32216- | | | | Fiscal Year End: | 12/31/2014 |
| Jacksonville, FL 32210- | | | | Audit Status: | Unaudited Cost Report |
| Dravidar Typa | | | | | · |
| Provider Type: | - ^ 1 | Current Rat | • | New Rate | Effective Date |
| <u>HOSPIT</u> | | | <u> </u> | | |
| · | patient | DRG | | DRG | 7/1/2016 |
| | tpatient | 108.80 | | 117.39 | 7/1/2016 |
| Inpatient County | Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | <u>Prospecti</u> | <u>ive</u> | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based on C | Cost | | | |
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| | | BASIS | <u>6:</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | S | | |
| | | Field Audited Co | osts | | |
| | | Revised Field A | udit | | |
| | | Cost Report Lat | e Test | | |
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| | | W. R | ydell Samue | el or Chanda Farcas | F G |
| | | Medi | caid Cost Re | eimbursement Anal | ysis |
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100731 - 2016/07

Office of Medicaid Cost Reimbursement Planning and Finance

2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

| St. Vincent's M | ledical Cente | r | | | Provider Number: | 0100731-00 | |
|------------------------|----------------|------------------|-----------|-----------------|---------------------------|-------------------------|--|
| Riverside | | _ | | | Date: | 7/29/2016 | |
| 1800 Barrs Str Hall | eet3rd Floor, | Seton | | | Fiscal Year End: | d: 6/30/2015 | |
| Jacksonville, F | L 32204- | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | |
| <u> </u> | HOSPI | ΓAL | Curre | nt Rate | New Rate | Effective Date | |
| | | patient | D | RG | DRG | 7/1/2016 | |
| | | Itpatient | 11: | 2.62 | 121.08 | 7/1/2016 | |
| Inpatie | | Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| itale Type. | <u>Interim</u> | | | X <u>Pros</u> r | <u>pective</u> | | |
| | _ | Total Interim | _ | | X Total Prospec | tive | |
| | | Settlement Based | on Cost | | <u> </u> | | |
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| | | | <u>E</u> | BASIS: | | | |
| | | | Budget | | | | |
| | | X | Unaudited | d Costs | | | |
| | | | Field Aud | ited Costs | | | |
| | | | Revised F | Field Audit | | | |
| | | | Cost Rep | ort Late Test | | | |
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Florida Agency For Health Care Administration

100749 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Baptist Hospital Inc | | | | Provider Number: | 0100749-00 |
|--------------------------|-------------------|-----------------|---------------|---------------------|--------------------------|
| | | | | | 7/29/2016 |
| P.O. Box 17500 | | | | Fiscal Year End: | |
| Pensacola, FL 32522-7500 | | | | | Unaudited Cost Report |
| | | | | , taali Giatas. | |
| Provider Type: | | 0 10 | | N 5 / | 5 % (! 5 (|
| <u>HOSPITAL</u> | | Current Ra | <u>ate</u> | New Rate | Effective Date |
| Inpati | | DRG | | DRG | 7/1/2016 |
| Outpa | | 254.91 | | 83.46 | 7/1/2016 |
| Inpatient County Bil | ling Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Х | Prospect | tive_ | |
| Tota | ıl Interim | | x | Total Prospec | tive |
| Sett | lement Based on C | Cost | | | |
| | | | | | |
| | | BAS | <u>IS:</u> | | |
| | | Budget | | | |
| | X | Unaudited Cos | sts | | |
| | | Field Audited (| Costs | | |
| | | Revised Field | Audit | | |
| | | Cost Report La | ate Test | | |
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| | | W. | Rydell Samu | el or Chanda Farcas | of of |
| | | Med | dicaid Cost R | eimbursement Anal | ysis |
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Florida Agency For Health Care Administration

100749 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Dontiet Heenite | ما امم | | | | | | Provider Number: | : 0100749-02 | |
|-----------------|----------------|----------------|----------------|------------|-------------|----------|--------------------|-------------------------|---|
| Baptist Hospita | | | | | | | | 7/29/2016 | _ |
| P.O. Box 1750 | | • | | | | | Fiscal Year End: | | _ |
| Pensacola, FL | . 32522-750 | 00 | | | | | | : Unaudited Cost Report | _ |
| Danish a To | | | | | | | | | _ |
| Provider Ty | | I T | | Curro | at Data | | Now Date | Effective Date | |
| | HOSP | | | | nt Rate | | New Rate | Effective Date | _ |
| | | npatient | | | RG | | DRG | 7/1/2016 | _ |
| | | utpatien | | 254 | 1.91 | | 83.46 | 7/1/2016 | _ |
| Inpatie | ent Count | y Billing | g Rate | | | | | 7/1/2016 | _ |
| Rate Type: | | | | | | | | | |
| | <u>Interim</u> | | | | Х <u>Р</u> | rospect | <u>ive</u> | | |
| | | Total Int | erim | | | Χ | Total Prospec | ctive | |
| | | Settleme | ent Based on (| Cost | _ | | | | |
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| | | | | Budget | | | | | |
| | | | Χ | Unaudited | Costs | | | | |
| | | | | Field Audi | ted Costs | | | | |
| | | | | Revised F | ield Audit | | | | |
| | | | | Cost Repo | ort Late Te | est | | | |
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100749 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| P.O. Box 17500 Date: 7/29/2016 Pensacola, FL 32522-7500 Fiscal Year End: 9/30/2015 Audit Status: Unaudited Cost Report Provider Type: MOSPITAL Surrent Rate New Rate Effective Date Inpatient Outpatient Outpatient Outpatient Pilling Rate DRG DRG 7/1/2016 7/1/2016 Rate Type: X Prospective Interim X Prospective X Total Prospective Settlement Based on Cost BASIS: Budget X Unaudited Costs Field Audited Costs Field Audited Costs Revised Field Audit Cost Report Late Test |
|---|
| Provider Type: HOSPITAL Current Rate New Rate Effective Date Inpatient DRG DRG 7/1/2016 Outpatient County Billing Rate Total Interim X Prospective Interim Total Interim X Total Prospective Settlement Based on Cost Settlement Based |
| Audit Status: Unaudited Cost Report Provider Type: HOSPITAL Current Rate New Rate Effective Date Inpatient Outpatient Outpatient County Billing Rate DRG 7/1/2016 Rate Type: X Prospective 7/1/2016 Interim X Prospective X Total Prospective Settlement Based on Cost X Total Prospective Budget X Unaudited Costs X Unaudited Costs Field Audited Costs Revised Field Audit Revised Field Audit |
| HOSPITAL Current Rate New Rate Effective Date |
| HOSPITAL Current Rate New Rate Effective Date |
| Outpatient |
| Interim X Prospective Total Interim X Total Prospective Settlement Based on Cost BASIS: Budget X Unaudited Costs Field Audited Costs Revised Field Audit |
| Rate Type: Interim Total Interim Settlement Based on Cost BASIS: Budget X Unaudited Costs Field Audited Costs Revised Field Audit |
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100765 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Sacred Heart Hospital | | | | Provider Number: | 0100765-00 |
|--------------------------|---------------------|---------------------|--------------|--------------------|-------------------------|
| Post Office Box 2728 | | | | Date: | 7/29/2016 |
| Pensacola, FL 32513-2728 | 8 | | | Fiscal Year End: | 6/30/2015 |
| , | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSPI</u> | <u>TAL</u> | Current Rate | | New Rate | Effective Date |
| Ir | npatient | DRG | | DRG | 7/1/2016 |
| Ou | utpatient | 88.98 | | 96.33 | 7/1/2016 |
| Inpatient County | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospectiv | <u>e</u> | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based on | Cost | | | |
| | | | | | |
| | | BASIS: | | | |
| | | Budget - | | | |
| | X | Unaudited Costs | | | |
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| | | Revised Field Au | | | |
| | | Cost Report Late | Test | | |
| | | W. Ryo | dell Samuel | or Chanda Farcas | F G |
| | | Medica | aid Cost Rei | mbursement Anal | ysis |
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100803 - 2016/07

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

| George E. We | aems Memo | orial Hospital | | | Provider Number: | 0100803-00 |
|-----------------|----------------|---|------------------|------------------|---------------------------|-------------------------|
| P.O. Drawer 6 | | mai i roopitai | | | Date: | 7/29/2016 |
| Apalachicola, | | | | Fiscal Year End: | 9/30/2015 | |
| Apaiaci licola, | 1 L 32320- | | | | Audit Status: | Amended Cost Report |
| Provider Ty | vne: | | | | | |
| <u> </u> | <u>HOSF</u> | PITAL | Current Rate | <u>e</u> | New Rate | Effective Date |
| | | Inpatient | DRG | | DRG | |
| | | Dutpatient | 553.17 | | 622.15 | 7/1/2016 |
| Inpatio | | ty Billing Rate | - | | | 7/1/2016 |
| - | | | | | | |
| Rate Type: | <u>Interim</u> | | X | Prospec | tive | |
| | _ | Total Interim | | – X | Total Prospec | tive |
| | | Settlement Based of | on Cost | | <u> </u> | |
| | <u> </u> | | | | | |
| | | | BASIS | <u>):</u> | | |
| | | | Budget | | | |
| | | - | Unaudited Costs | 5 | | |
| | | | Field Audited Co | osts | | |
| | | | Revised Field A | udit | | |
| | | | Cost Report Late | e Test | | |
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| | | | Medic | raid Cost F | Reimbursement Anal | veis |
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Florida Agency For Health Care Administration

100862 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | <u> </u> | Provider Number: | 0100862-00 |
|--------------------------------|--------------------------|------------------------|-------------------------|
| Hendry Regional Medical Center | | | 7/29/2016 |
| 524 W Sagamore Street | | Fiscal Year End: | |
| Clewiston, FL 33440 | | | Unaudited Cost Report |
| | | Audit Status. | |
| <u>Provider Type:</u> | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 117.06 | 127.45 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
| Interim | X <u>Pros</u> | pective | |
| Total Interim | | X Total Prospec | tive |
| Settlement Based o | n Cost | <u> </u> | |
| | | | |
| | BASIS: | | |
| | Budget | | |
| X | Unaudited Costs | | |
| | — Field Audited Costs | | |
| | — Revised Field Audit | | |
| | Cost Report Late Test | | |
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| | Medicaid Co | ost Reimbursement Anal | ysis |
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100871 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Bayfront Healt | h Brooksvill | e | | | Provider Number: | 0100871-00 |
|-----------------|----------------|-----------------|-----------|-----------------|-----------------------|-------------------------|
| Post Office Bo | x 37 | | | | Date: | 7/29/2016 |
| Brooksville, FL | 34605-00 | 37 | | | Fiscal Year End: | 9/30/2015 |
| | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | Curre | ent Rate | New Rate | Effective Date |
| | I | npatient | D | RG | DRG | 7/1/2016 |
| | С | Outpatient | 74 | 1.35 | 79.93 | 7/1/2016 |
| Inpatie | ent Count | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| | <u>Interim</u> | | | X <u>Pros</u> p | <u>ective</u> | |
| | - | Total Interim | _ | | X Total Prospec | tive |
| | | Settlement Base | d on Cost | | | |
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| | | | | BASIS: | | |
| | | | Budget | | | |
| | | X | Unaudite | | | |
| | | | | lited Costs | | |
| | | | | Field Audit | | |
| | | | Cost Rep | ort Late Test | | |
| | | | | W. Rydell Sa | muel or Chanda Farcas | F G |
| | | | | Medicaid Cos | st Reimbursement Anal | ysis |
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100871 - 2016/07

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

| Bayfront Healt | h Brooksville | e. | | | | | Pr | ovider Number: | : 0100871-01 | |
|------------------|----------------|-------------|-------------|-----------------------|---------|-----------------|---------------|----------------------|-------------------------|--|
| Post Office Bo | | | | | | | | Date: | 7/29/2016 | |
| Brooksville, FL | | R7 | | | F | iscal Year End: | 9/30/2015 | | | |
| Diooksville, i L | . 34003-000 | <i>,</i> | | | | | Audit Status | | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | | | | |
| • | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rat | <u>e</u> | | New Rate | Effective Date | |
| | 1 | npatient | | D | RG | | - | DRG | 7/1/2016 | |
| | 0 | utpatient | | 74 | 1.35 | | - | 79.93 | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Х | Prosp | <u>ective</u> | | | |
| | - | Total Inte | rim | _ | | | X | Total Prospec | ctive | |
| | | Settleme | nt Based on | Cost | | | | _ | | |
| | <u>-</u> | <u> </u> | | | | | | | | |
| | | _ | | | BASIS | <u>S:</u> | | | | |
| | | _ | | Budget | | | | | | |
| | | _ | X | Unaudited | | | | | | |
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| | | - | | Revised F Cost Rep | | | | | | |
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| | | | | | Medi | caid Cos | t Reiml | oursement Anal | lysis | |
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100897 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Highlands Reg | ional Madia | al Contor | | | Provider Number: | : 0100897-00 | |
|---------------------|---------------------|--------------------------------|---------------|---------------|--------------------|-------------------------|--|
| P.O. Drawer 20 | | ai Cerilei | | | | 7/29/2016 | |
| | | | | | Fiscal Year End: | 9/30/2015 | |
| Sebring, FL 33 | 3870- | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | me: | | | | | | |
| <u>i iovidei iy</u> | <u>pe.</u> HOSPI | ΙΤΔΙ | Current R | ate | New Rate | Effective Date | |
| | | npatient | DRG | | DRG | 7/1/2016 | |
| | | utpatient | 58.61 | | 63.01 | 7/1/2016 | |
| Innatie | | y Billing Rate | 30.01 | | 00.01 | 7/1/2016 | |
| | The Ocume | y Dinning Itale | | | | | |
| Rate Type: | | | ., | _ | | | |
| | <u>Interim</u> | Total Later Co. | X | — Prospec | | er - | |
| | | Total Interim Settlement Based | on Coot | X | Total Prospec | πive | |
| | | Settlement Based (| on Cost | | | | |
| | | | BAS | ıe. | | | |
| | | | BAS Budget | <u>13.</u> | | | |
| | | X | Unaudited Co | ete | | | |
| | | | Field Audited | | | | |
| | | | Revised Field | | | | |
| | | | Cost Report L | | | | |
| | | | | 410 1001 | | | |
| | | | W. | Rydell Samu | el or Chanda Farca | s A G | |
| | | | Me | dicaid Cost R | Reimbursement Ana | lysis | |
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Batch ID:J4VC6

Printed on: 7/29/2016 4:56 PM



100901 - 2016/07

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

| Florida Hospital Heartl | and Medical | | F | Provider Number: | 0100901-00 |
|-------------------------|--------------------|---------------|-------------------|------------------------|-------------------------|
| Center | | | | Date: | 7/29/2016 |
| Highway 27 North | | | | Fiscal Year End: | 12/31/2014 |
| Avon Park, FL 33825- | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>H0</u> | SPITAL | Current | <u>Rate</u> | New Rate | Effective Date |
| | Inpatient | DRG | | DRG | 7/1/2016 |
| | Outpatient | 59.1 | <u> </u> | 63.59 | 7/1/2016 |
| Inpatient Co | unty Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | <u>1</u> | > | Prospective | <u>e</u> | |
| | Total Interim | | X | Total Prospec | etive |
| | Settlement Based o | n Cost | | | |
| | | | | | |
| | | _ | SIS: | | |
| | | Budget | | | |
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| | | Cost Report | Late Test | | |
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| | | W | . Rydell Samuel | or Chanda Farcas | s // () |
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| Batch ID:J4VC6 | | | | nted on : 7/29/2016 4: | 56 PM |



100901 - 2016/07

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

| Florida Hospita Center | al Heartland | Medical | | | | F | Provider Number: | |
|---------------------------|----------------|---------------|-------------|-------------|------------|-------------|------------------------|-------------------------|
| Highway 27 No | orth | | | | | | | 7/29/2016 |
| | | | | | | | Fiscal Year End: | |
| Avon Park, FL | 33020- | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | | Curren | t Rate | | New Rate | Effective Date |
| | I | npatient | | DRG | | | DRG | 7/1/2016 |
| | 0 | utpatient | | 59. | 15 | | 63.59 | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| Nate Type. | <u>Interim</u> | | | | X <u>Р</u> | rospective | <u>9</u> | |
| | - | Total Inte | erim | | | X | Total Prospec | tive |
| | | - Settleme | nt Based on | Cost | _ | | | |
| | | | | | | | | |
| | | _ | | <u>B</u> , | ASIS: | | | |
| | | | | Budget | | | | |
| | | | Χ | Unaudited | Costs | | | |
| | | | | Field Audit | ed Costs | i | | |
| | | | | Revised Fi | eld Audit | | | |
| | | | | Cost Repo | rt Late Te | est | | |
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| | | | | | W. Ryde | ll Samuel d | or Chanda Farcas | |
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100943 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital Carrollwood | | | | Provider Number: | 0100943-00 |
|------------------------------|--|------------------|------------------------|---------------------|-------------------------|
| 3100 East Fletcher Avenue | | | | Date: | 7/29/2016 |
| Tampa, FL 33613- | | | | Fiscal Year End: | 12/31/2014 |
| Tampa, TE 30010 | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITA | AI | Current Rate | 9 | New Rate | Effective Date |
| | atient | DRG | | DRG | 7/1/2016 |
| • | patient | 68.03 | | 7/1/2016 | |
| Inpatient County B | | 00.00 | | 73.14 | 7/1/2016 |
| | The state of the s | | | | |
| Rate Type: | | V | Dunamanti | | |
| Interim | otal Interim | X | _ <u>Prospecti</u> | | tivo |
| | otal interim ettlement Based on C | Cost | X | Total Prospec | live |
| | ettierit based on C | | | | |
| | | BASIS | | | |
| | | Budget | <u>•</u> | | |
| | | Unaudited Costs | ; | | |
| | | Field Audited Co | | | |
| | | Revised Field Au | | | |
| | | Cost Report Late | | | |
| | | • | | | |
| | | W. Ry | rdell Samue | el or Chanda Farcas | F G |
| | | Medic | aid Cost Re | eimbursement Anal | ysis |
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100978 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St. Josephs H | ospital | | | | | _ | Pro | ovider Number: | 01009 | 78-00 |
|----------------|----------------|-------------|-------------|-----------|---------|-----------|---------|---------------------|-----------------------|------------------|
| 3001 W. ML K | - | st Office | | | | | | Date: | 7/29/2 | 016 |
| Box 4227 | g = | | | | | | F | iscal Year End: | 12/31/2 | 2014 |
| Tampa, FL 33 | 8677-4227 | | | | | | | Audit Status: | Unaud | ited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | | | |
| - | HOSP | <u>ITAL</u> | | Curre | nt Rate | <u>e</u> | | New Rate | Effective Date | |
| | 1 | npatient | | DI | RG | | DRG | | 7/1/2016 | |
| | 0 | utpatient | t | 10 | 1.96 | | | 110.03 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | _ | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | _ | Total Inte | erim | | | _ > | < | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | _ | | |
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| | | - | | | ASIS | <u>}:</u> | | | | |
| | | - | | Budget | | | | | | |
| | | - | X | Unaudited | | | | | | |
| | | - | | Field Aud | | | | | | |
| | | - | | Revised F | | | | | | |
| | | - | | Cost Repo | on Late | e rest | | | | |
| | | | | | | | | | | R Ol |
| | | | | | W. Ry | ydell Sam | nuel or | Chanda Farcas | P | |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | ysis | |
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| Batch ID:J4VC6 | | | | | | | Printe | d on : 7/29/2016 4: | 56 PM | |



100978 - 2016/07

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

| St. Josephs Ho | spital | | | | | F | Provider Number: | 0100978-02 | |
|----------------|----------------|------------|-------------|---------------------|------------|-------------|-----------------------|-------------------------|--|
| 3001 W. ML Kir | - | t Office | | | | | Date: | 7/29/2016 | |
| Box 4227 | | | | | | | Fiscal Year End: | 12/31/2014 | |
| Tampa, FL 336 | 677-4227 | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | | | |
| | HOSPI" | TAL_ | | Current Rate | | | New Rate | Effective Date | |
| | Ir | patient | | DF | RG | | DRG | 7/1/2016 | |
| | Οι | utpatient | | 101 | .96 | | 110.03 | 7/1/2016 | |
| Inpatie | nt County | / Billing | Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | |
| | <u>Interim</u> | | | | X <u>Р</u> | rospective | <u>e</u> | | |
| | | Total Inte | rim | | | Χ | Total Prospec | tive | |
| - | | Settlemer | nt Based on | Cost | | | | | |
| | | | | | | | | | |
| | | _ | | | ASIS: | | | | |
| | | _ | | Budget | | | | | |
| | | _ | X | Unaudited | | | | | |
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| | | _ | | Revised F | | | | | |
| | | _ | | Cost Repo | rt Late Te | est | | | |
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100978 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St. Josephs H | ospital | | | | | _ | Pro | ovider Number: | 010097 | 78-03 |
|----------------|----------------|-------------|-------------|-----------|---------|-----------|---------|---------------------|----------------|------------------|
| 3001 W. ML K | - | st Office | | | | | | Date: | 7/29/20 | 016 |
| Box 4227 | g =a | | | | | | F | iscal Year End: | d: 12/31/2014 | |
| Tampa, FL 33 | 8677-4227 | | | | | | | Audit Status: | Unaud | ited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | | | |
| - | HOSP | <u>ITAL</u> | | Curre | nt Rate | <u>e</u> | | New Rate | Effective Date | |
| | I | npatient | | DI | RG | | DRG | | 7/1/2016 | |
| | 0 | utpatient | t | 10 | 1.96 | | | 110.03 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | _ | Total Inte | erim | | | _ > | < | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | _ | | |
| | | | | | | | | | | |
| | | - | | | ASIS | <u>}:</u> | | | | |
| | | - | | Budget | | | | | | |
| | | - | X | Unaudited | | | | | | |
| | | - | | Field Aud | | | | | | |
| | | - | | Revised F | | | | | | |
| | | - | | Cost Repo | on Late | e rest | | | | |
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| | | | | | W. Ry | ydell Sam | nuel or | Chanda Farcas | P | |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | ysis | , |
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100978 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St. Josephs Ho | penital | | | | | | – Pro | ovider Number: | 01009 | 978-06 |
|---------------------|---------------------|------------|---------------|------------|----------|-----------------------|-----------|---------------------|----------------|-------------------|
| 3001 W. ML Ki | - | t Office | | | | | | Date: | 7/29/2 | 2016 |
| Box 4227 | ng biva.Pos | t Office | | | Fi | scal Year End: | 12/31 | /2014 | | |
| Tampa, FL 330 | 677-4227 | | | | | | | Audit Status: | Unaud | dited Cost Report |
| Provider Ty | no: | | | | | | | | | |
| <u>r rovider ry</u> | <u>pe.</u> HOSPI | ΤΔΙ | | Curre | nt Rate | 2 | New Rate | | Effective Date | |
| | | npatient | | | ₹G | | - | DRG | 7/1/2016 | |
| | | utpatient | | 101.96 | | | 110.03 | | 7/1/2016 | |
| Innatie | nt County | • | | | | | | 110.00 | | 7/1/2016 |
| | in oount | , Dilling | raic | | | | | | | 77172010 |
| Rate Type: | In the other | | | | V | D | - | | | |
| | <u>Interim</u> | Total Inte | rim | _ | Х | _ <u>Prospec</u> X | | Total Process | tivo | |
| | | _ | nt Based on (| Coet | | ^ | | Total Prospec - | uve | |
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| | | - | | Budget | 7 (0.0 | <u>•</u> | | | | |
| | | - | X | Unaudited | l Costs | ; | | | | |
| | | - | | Field Audi | ted Co | sts | | | | |
| | | - | | Revised F | ield Au | udit | | | | |
| | | - | | Cost Repo | ort Late | e Test | | | | |
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100986 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| South Florida Baptist | | Provider Number: | 0100986-00 |
|-------------------------------|---------------------|---------------------------|-------------------------|
| 301 N Alexander Street | | Date: | 7/29/2016 |
| | | Fiscal Year End: | 12/31/2014 |
| Plant City, FL 33566- | | Audit Status: | Unaudited Cost Report |
| Duaridae Trusa | | | |
| Provider Type: | Command Data | New Date | Effective Date |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 76.03 | 81.74 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
| <u>Interim</u> | X <u>Pr</u> | ospective | |
| Total Interim | | X Total Prospec | tive |
| Settlement Based on 0 | Cost | | |
| | | | |
| | BASIS: | | |
| | Budget | _ | |
| X | Unaudited Costs | | |
| | Field Audited Costs | | |
| | Revised Field Audit | | |
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100994 - 2016/07

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

| Tampa Genera | al Hospital | | | | | | Pro | ovider Number: | 0100994-00 | |
|----------------|----------------|----------------|-------------|------------------|-------------|-----------|---------|---------------------|-------------------------|--|
| P.O. Box 1289 | - | | | | | | | Date: | 7/29/2016 | |
| Tampa, FL 33 | | | | | | | F | iscal Year End: | 9/30/2015 | |
| rumpa, r E 00 | 001 | | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | | | | |
| · | HOSP | <u>ITAL</u> | | Currer | nt Rate | <u>e</u> | | New Rate | Effective Date | |
| | Inpatient | | | | DRG | | DRG | | 7/1/2016 | |
| | 0 | utpatient | | 131 | .58 | | 142.29 | | 7/1/2016 | |
| Inpatie | nt Count | y Billing | Rate | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | Χ | Prospe | ective | | | |
| | - | Total Inte | rim | | | _ × | < | Total Prospec | ctive | |
| | | _ Settlemer | nt Based on | Cost | | | | | | |
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| | | - | ^ | - Field Audit | | | | | | |
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| | | - | | Cost Repo | | | | | | |
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| | | | | | | | | Chanda Farcas | | |
| | | | | | Medic | aid Cost | Reimb | oursement Anal | lysis | |
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| Batch ID:J4VC6 | | | | | | | Printe | d on : 7/29/2016 4: | :56 PM | |



100994 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Tampa General Hospital | | | | Provider Number: | 0100994-01 |
|------------------------|-----------------------|-----------------|---------------------------|-------------------------|-------------------------|
| P.O. Box 1289 | | | | Date: | 7/29/2016 |
| Tampa, FL 33601- | | | | Fiscal Year End: | 9/30/2015 |
| Tampa, FL 33001- | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITA | ΔI | Current Ra | te | New Rate | Effective Date |
| | atient | DRG | _ | DRG | 7/1/2016 |
| · | patient | 131.58 | | 142.29 | 7/1/2016 |
| Inpatient County I | | | | - | 7/1/2016 |
| | 3 | | | | _ |
| Rate Type: Interim | | Х | <u>Prospectiv</u> | 10 | |
| | otal Interim | | _ гтозреси | Total Prospec | tive |
| | ettlement Based on | Cost | | | |
| | | | | | |
| | | BASIS | <u>S:</u> | | |
| | | Budget | | | |
| | X | Unaudited Cost | ts | | |
| | | Field Audited C | osts | | |
| | | Revised Field A | vudit | | |
| | | Cost Report La | te Test | | |
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| | | W. F | tydell Samuel | or Chanda Farcas | s A T |
| | | Med | icaid Cost Rei | mbursement Anal | ysis |
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100994 - 2016/07

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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|--------------------------|--------------------|------------------|-------------|---------------------|-------------------------|--|
| Tampa General Hospital | | | | Provider Number: | 0100994-12 | |
| P.O. Box 1289 | | | | Date: | 7/29/2016 | |
| Tampa, FL 33601- | | | | Fiscal Year End: | 9/30/2015 | |
| . , | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| HOSPITAL | | Current Rate | <u>e</u> | New Rate | Effective Date | |
| Inpatient | _ | DRG | | DRG | 7/1/2016 | |
| Outpatient | | 131.58 | | 142.29 | 7/1/2016 | |
| Inpatient County Billing | Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | |
| Interim | | Χ | Prospect | <u>ive</u> | | |
| Total Inte | erim | | _ X | Total Prospec | tive | |
| Settleme | nt Based on C | ost | | | | |
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| | | BASIS | <u>):</u> | | | |
| | E | Budget | | | | |
| | ΧU | Jnaudited Costs | 3 | | | |
| | · · | Field Audited Co | osts | | | |
| | - F | Revised Field A | udit | | | |
| | (| Cost Report Late | e Test | | | |
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| | | W. R | ydell Samue | el or Chanda Farcas | F F | |
| | | Medic | caid Cost R | eimbursement Anal | ysis | |
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100994 - 2016/07

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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|--------------------------|------------------|------------------------|-----------------|--------------------|-------------------------|
| Tampa General Hospital | | | | Provider Number: | |
| P.O. Box 1289 | | | | Date: | 7/29/2016 |
| Tampa, FL 33601- | | | | Fiscal Year End: | 9/30/2015 |
| · | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Ra | <u>te</u> | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatien | 131.58 | | 142.29 | 7/1/2016 | |
| Inpatient County Billing | | | | | 7/1/2016 |
| | | | | | _ |
| Rate Type: Interim | | Х | <u>Prospect</u> | ive | |
| Total Inte | tive | | | | |
| | ent Based on (| Cost | X | Total Prospec | |
| | | | | | |
| | | BASI | S: | | |
| | | Budget | <u></u> | | |
| | Х | Unaudited Cos | ts | | |
| | | Field Audited C | Costs | | |
| • | | Revised Field <i>I</i> | Audit | | |
| | | Cost Report La | te Test | | |
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| | | W. F | Rydell Samue | el or Chanda Farca | s F I |
| | | Med | icaid Cost R | eimbursement Anal | lysis |
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100994 - 2016/07

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

| Tampa Genera | al Hospital | | | | | | Pro | ovider Number: | 0100994-14 | |
|----------------|----------------|----------------|-------------|------------------|-------------|-----------|--------|---------------------|-------------------------|--|
| P.O. Box 1289 | - | | | | | | | Date: | 7/29/2016 | |
| Tampa, FL 33 | | | | | | | F | iscal Year End: | 9/30/2015 | |
| rumpa, r E 00 | 001 | | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | | | | |
| _ | HOSP | <u>ITAL</u> | | Currer | nt Rate | <u>e</u> | | New Rate | Effective Date | |
| | Inpatient | | | | RG | | DRG | | 7/1/2016 | |
| | 0 | utpatient | | 131 | .58 | | 142.29 | | 7/1/2016 | |
| Inpatie | nt Count | y Billing | Rate | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | X | Prospe | ctive | | | |
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| | | _ Settlemer | nt Based on | Cost | | | | _ | | |
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101028 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital Tampa | | | _ | Provider Number: | 0101028-00 |
|---------------------------------------|--|------------------|------------------------|---------------------|-------------------------|
| 3100 East Fletcher Avenue | | | | Date: | 7/29/2016 |
| Tampa, FL 33613- | | | | Fiscal Year End: | 12/31/2014 |
| Tampa, TE 30010 | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITA | ΔI | Current Rate | e | New Rate | Effective Date |
| · · · · · · · · · · · · · · · · · · · | atient | DRG | | DRG | 7/1/2016 |
| · | patient | 62.43 | | 67.11 | 7/1/2016 |
| Inpatient County B | | 021-10 | | 07111 | 7/1/2016 |
| | The state of the s | | | | |
| Rate Type: | | V | Dunnannati | | |
| Interim | otal Interim | X | _ <u>Prospecti</u> | | tivo |
| | otal interim ettlement Based on C | Cost | X | Total Prospec | live |
| | ettierit based on C | | | | |
| | | BASIS | \- | | |
| | | Budget | <u>'•</u> | | |
| | | Unaudited Costs | 6 | | |
| | | Field Audited Co | | | |
| | | Revised Field A | | | |
| | | Cost Report Late | | | |
| | | · | | | |
| | | W. R <u>y</u> | ydell Samue | el or Chanda Farcas | F G |
| | | Medic | caid Cost Re | eimbursement Anal | ysis |
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101028 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital Tampa | | | Provider Numb | er: 0101028-09 | | | | |
|--------------------------|---------------------|---------------------|--------------------------|-----------------------------|--|--|--|--|
| 3100 East Fletcher Avenu | ıe | | Da | ate: 7/29/2016 | | | | |
| Tampa, FL 33613- | | | Fiscal Year E | Fiscal Year End: 12/31/2014 | | | | |
| | | | Audit Stat | us: Unaudited Cost Report | | | | |
| Provider Type: | | | | | | | | |
| HOSF | <u>PITAL</u> | Current Rate | New Rate | Effective Date | | | | |
| | Inpatient | DRG | DRG | 7/1/2016 | | | | |
| C | Outpatient | 62.43 | 67.11 | 7/1/2016 | | | | |
| Inpatient Count | ty Billing Rate | | | 7/1/2016 | | | | |
| Rate Type: | | | | | | | | |
| Interim | | X | <u>Prospective</u> | | | | | |
| | Total Interim | | X Total Prosp | pective | | | | |
| | Settlement Based on | Cost | | | | | | |
| | | - | | | | | | |
| | | BASIS: | | | | | | |
| | Budget | | | | | | | |
| | X | Unaudited Costs | | | | | | |
| | | Field Audited Cos | | | | | | |
| | | Revised Field Aud | | | | | | |
| | | Cost Report Late | rest | | | | | |
| | | W. Ryd | ell Samuel or Chanda Far | cas F | | | | |
| | | Medica | id Cost Reimbursement A | nalysis | | | | |
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101036 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Doctors Memorial Hospital | | | | Provider Number: | 0101036-00 | |
|---------------------------|-----------------------|-----------------|----------------|------------------------|-------------------------|--|
| P.O. Box 188 | | | | Date: | 7/29/2016 | |
| Bonifay, FL 32425- | | | | Fiscal Year End: | 9/30/2015 | |
| Domay, 1 L 02423 | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| HOSPIT | AL | Current Ra | <u>te</u> | New Rate | Effective Date | |
| | patient | DRG | | DRG | 7/1/2016 | |
| • | tpatient | 121.57 | | 128.79 | 7/1/2016 | |
| Inpatient County | | | | | 7/1/2016 | |
| Rate Type: | | | | | | |
| Interim | | Х | Prospectiv | re | | |
| | Total Interim | | — X | Total Prospec | tive | |
| | Settlement Based on (| Cost | | <u> </u> | | |
| | | | | | | |
| | | BASI | <u>S:</u> | | | |
| | | Budget | | | | |
| | X | Unaudited Cos | ts | | | |
| | | Field Audited C | osts | | | |
| | | Revised Field A | Audit | | | |
| | | Cost Report La | te Test | | | |
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| | | W. F | Rydell Samuel | or Chanda Farcas | s N | |
| | | Med | icaid Cost Rei | mbursement Anal | ysis | |
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101044 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Indian River M | ledical Cente | er | | | | _ | Pro | ovider Number: | 01010 | 44-00 |
|----------------|----------------|---------------|-------------|-----------|----------|-----------|------------|---------------------|----------|-------------------|
| 1000 36th Stre | | | | | | | | Date: | 7/29/2 | 016 |
| Vero Beach, F | | | | | | | F | iscal Year End: | 9/30/2 | 015 |
| 70.0 2000., 1 | _ 0_00 | | | | | | | Audit Status: | Unaud | lited Cost Report |
| Provider Ty | /pe: | | | | | | | | | |
| | HOSP | ITAL | | Curre | nt Rate | <u>e</u> | | New Rate | | Effective Date |
| | | npatient | | DRG | | | DRG | | 7/1/2016 | |
| | 0 | utpatient | t | 81 | .60 | | | 87.73 | | 7/1/2016 |
| Inpatie | ent Count | - | | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| itale Type. | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | _ | Total Inte | erim | | | _ ` | < | Total Prospec | tive | |
| | | - Settleme | nt Based on | Cost | | | | _ | | |
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| | | _ | | <u>B</u> | ASIS | <u>):</u> | | | | |
| | | _ | | Budget | | | | | | |
| | | <u>-</u> | Х | Unaudited | d Costs | 6 | | | | |
| | | | | Field Aud | | | | | | |
| | | - | | Revised F | | | | | | |
| | | - | | Cost Rep | ort Late | e Test | | | | |
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| | | | | | W. Ry | ydell Sam | nuel or | Chanda Farcas | P | |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | ysis | |
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101061 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Jackson Hospital | | | | Provider Number: (|)101061-00 | |
|-------------------------|----------------|-------------------|------------------|----------------------------|-----------------------|--|
| · | | | | _ | 7/29/2016 | |
| 4250 Hospital Drive | | | | Fiscal Year End: 9/30/2015 | | |
| Marianna, FL 32446- | | | | _ | Jnaudited Cost Report | |
| | | | | Addit Otalds. (| Shaddica Gost Report | |
| Provider Type: | | | | | | |
| <u>HOSPITAL</u> | _ | Current Rate | | New Rate | Effective Date | |
| Inpatien | t _ | DRG | <u> </u> | DRG | 7/1/2016 | |
| Outpatier | nt _ | 88.93 | | 94.54 | 7/1/2016 | |
| Inpatient County Billin | | | | 7/1/2016 | | |
| Rate Type: | | | | | | |
| Interim | | X | <u>Prospecti</u> | ive | | |
| Total In | terim | | X | Total Prospectiv | ve | |
| Settlem | ent Based on C | Cost | | <u> </u> | | |
| | | | | | | |
| | | BASIS: | | | | |
| | | Budget | | | | |
| | X | Unaudited Costs | | | | |
| | | Field Audited Cos | ts | | | |
| | | Revised Field Aud | dit | | | |
| | | Cost Report Late | Test | | | |
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| | | W. Ryd | dell Samue | l or Chanda Farcas | R If | |
| | | Medica | id Cost Re | eimbursement Analys | sis | |
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101079 - 2016/07

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

| Leesburg Regi | ional Medica | al Center | | | | | Provider Number: | 0101079-00 | |
|----------------|----------------|---------------|-------------|--------------|----------|---------------|--------------------------------|-------------------------|--|
| 600 E Dixie Av | | | | | | | Date: | 7/29/2016 | |
| Leesburg, FL | | | | | | | Fiscal Year End: | 6/30/2015 | |
| Locoburg, 1 L | 027 40 | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | /pe: | | | | | | | | |
| | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | | New Rate | Effective Date | |
| | I | npatient | | D | RG | | DRG | 7/1/2016 | |
| | 0 | utpatient | | 64.77 | | | 69.63 | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | |
| rtate Type. | <u>Interim</u> | | | | Х | Prospect | ive | | |
| | _ | Total Inte | erim | _ | | X | Total Prospec | etive | |
| | | - Settleme | nt Based on | Cost | | | | | |
| | | _ | | | | | | | |
| | | _ | | <u>B</u> | ASIS: | 1 <u>-</u> | | | |
| | | | | Budget | | | _ | | |
| | | | Х | Unaudited | d Costs | | | | |
| | | | | Field Aud | ited Cos | sts | | | |
| | | _ | | Revised F | Field Au | dit | | | |
| | | _ | | Cost Rep | ort Late | Test | | | |
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101087 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| South Lake Memorial Hea | noital | | - | Provider Number: | 0101087-00 |
|-----------------------------------|---------------------|----------------------|----------------|--------------------------|-------------------------|
| South Lake Memorial Hos | spitai | | | | 7/29/2016 |
| 847 8th Street | | | | Fiscal Year End: | 9/30/2015 |
| Clermont, FL 32711- | | | | Audit Status: | Unaudited Cost Report |
| Providor Typo: | | | | | · · |
| <u>Provider Type:</u> <u>HOSF</u> | ΝΤΔΙ | Current Ra | ate | New Rate | Effective Date |
| | Inpatient | DRG | <u> </u> | DRG | 7/1/2016 |
| | Outpatient | 68.06 | | 73.17 | 7/1/2016 |
| Inpatient Coun | - | | | 73.17 | 7/1/2016 |
| | ty billing Kate | | | | |
| Rate Type: | | | | _ | |
| <u>Interim</u> | | X | Prospect | | |
| | Total Interim | . 0 | X | Total Prospec | tive |
| | Settlement Based or | n Cost | | | |
| | | DAG | 10- | | |
| | | BAS | <u> 15:</u> | | |
| | X | Budget Unaudited Cos | nto. | | |
| | | — Field Audited (| | | |
| | | Revised Field | | | |
| | | Cost Report L | | | |
| | | — Cost Report La | ale resi | | |
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| | | W. | Rydell Samue | el or Chanda Farcas | |
| | | Med | dicaid Cost Re | eimbursement Anal | ysis |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

101095 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospita | al Watermar | n | | | Provider Number: | 0101095-00 |
|-------------------------------|----------------|------------------|---------------|----------------|-----------------------|-------------------------|
| P.O. Box 333 | | | | | Date: | 7/29/2016 |
| Eustis, FL 327 | 727-0333 | | | | Fiscal Year End: | 12/31/2014 |
| | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | |
| | HOSP | <u>ITAL</u> | <u>Currer</u> | nt Rate | New Rate | Effective Date |
| | I | npatient | DF | RG | DRG | 7/1/2016 |
| Outpatient | | 52. | .95 | 56.92 | 7/1/2016 | |
| Inpatient County Billing Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | |
| <u></u> | <u>Interim</u> | | | X <u>Prosp</u> | <u>ective</u> | |
| | - | Total Interim | | | X Total Prospec | tive |
| | | Settlement Based | on Cost | - | | |
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| | | | Budget | _ | | |
| | | X | Unaudited | | | |
| | | | Field Audit | | | |
| | | | Revised F | | | |
| | | | — Cost Rept | ort Late Test | | |
| | | | | W. Rydell Sa | muel or Chanda Farcas | s A G |
| | | | , | Medicaid Cos | st Reimbursement Anal | ysis |
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101109 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Las Managarithan Sal | | <u> </u> | - Provider Number: | 0101109-00 |
|-----------------------------|---------------|------------------|-----------------------|-------------------------|
| Lee Memorial Hospital | | | | 7/29/2016 |
| PO Box 151247 | | | Fiscal Year End: | |
| Cape Coral, FL 33915- | | | | Unaudited Cost Report |
| | | | Audit Status. | — Chaudiled Cost Report |
| <u>Provider Type:</u> | | | | |
| <u>HOSPITAL</u> | Curren | t Rate | New Rate | Effective Date |
| Inpatient | DR | 'G | DRG | 7/1/2016 |
| Outpatient | 98. | 05 | 105.76 | 7/1/2016 |
| Inpatient County Billing Ra | nte | | | 7/1/2016 |
| Rate Type: | | | | |
| Interim | | X <u>Prospec</u> | tive | |
| | | X | Total Prospec | tive |
| Settlement E | sased on Cost | | <u> </u> | |
| | | | | |
| | B | ASIS: | | |
| | Budget | | | |
| _ | X Unaudited | Costs | | |
| _ | Field Audit | ed Costs | | |
| _ | Revised Fi | eld Audit | | |
| _ | Cost Repo | rt Late Test | | |
| | | | | |
| | | W. Rydell Samu | el or Chanda Farcas | s A G |
| | - | Medicaid Cost F | Reimbursement Anal | ysis |
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101109 - 2016/07

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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|-------------------------------|----------------|------------|--------------|---------------------------------|---------------------|----------------------|-------------------------|
| Lee Memorial | Hospital | | | | | Provider Number: | 0101109-11 |
| PO Box 15124 | 17 | | | | | Date: | 7/29/2016 |
| Cape Coral, F | L 33915- | | | | | Fiscal Year End: | 9/30/2015 |
| • • | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | /pe: | | | | | | |
| | HOSP | ITAL | | Current R | late_ | New Rate | Effective Date |
| | | npatient | | DRG | | DRG | 7/1/2016 |
| | | Outpatient | | 98.05 | - | 105.76 | 7/1/2016 |
| Inpatient County Billing Rate | | | | | | 7/1/2016 | |
| <u>-</u> | | | | | <u> </u> | | _ |
| Rate Type: | <u>Interim</u> | | | X | <u>Prospe</u> | ctive | |
| | <u> </u> | Total Inte | erim | | <u> ттозре</u> Х | | tive |
| | | _ | nt Based on | Cost | | 10.0011100000 | |
| | | | | | | | |
| | | | | BAS | SIS: | | |
| | | - | | Budget | | | |
| | | - | Х | Unaudited Co | sts | | |
| | | - | | Field Audited | Costs | | |
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| | | - | | – Cost Report L | ate Test | | |
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101109 - 2016/07

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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|---------------|----------------|------------|-------------|---------------------------------|--------------------|----------------------|-------------------------|--|
| Lee Memorial | Hospital | | | | | Provider Number: | 0101109-17 | |
| PO Box 15124 | 17 | | | | | Date: | 7/29/2016 | |
| Cape Coral, F | L 33915- | | | | | Fiscal Year End: | 9/30/2015 | |
| • • | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | /pe: | | | | | | | |
| <u> </u> | HOSP | ITAL | | Current R | ate | New Rate | Effective Date | |
| | | npatient | | DRG | | DRG | 7/1/2016 | |
| | | Outpatien | t | 98.05 | | 105.76 | 7/1/2016 | |
| Inpatie | ent Count | - | | | | | 7/1/2016 | |
| <u>-</u> | | | <u> </u> | | | | _ | |
| Rate Type: | <u>Interim</u> | | | Х | Prospec | rtivo | | |
| | <u> </u> | Total Inte | erim | | <u></u> | | tive | |
| | - | _ | nt Based on | Cost | | | | |
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| | | | | BAS | IS: | | | |
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| | | | | Me | dicaid Cost F | Reimbursement Anal | ysis | |
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101109 - 2016/07

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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|----------------|----------------|---------------|----------------|---------------------|-------------|--------------------|-------------------------|
| Lee Memorial | Hospital | | | | | Provider Number: | : 0101109-18 |
| PO Box 15124 | 17 | | | | | Date | 7/29/2016 |
| Cape Coral, FI | L 33915- | | | | | Fiscal Year End: | 9/30/2015 |
| • | | | | | | Audit Status: | : Unaudited Cost Report |
| Provider Ty | pe: | | | | | | |
| • | HOSF | PITAL | | Current Rate | | New Rate | Effective Date |
| | I | Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatient | | t | 98.05 | | 105.76 | 7/1/2016 | |
| Inpatie | ent Count | ty Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| itate Type. | <u>Interim</u> | | | Х | Prospect | tive | |
| | _ | Total Inte | erim | | X | Total Prospec | ctive |
| | | _ Settleme | nt Based on | Cost - | | | |
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101117 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Lehigh Region | al Madical | Contor | | | | Pro | ovider Number: | 01011 | 17-00 |
|-------------------------------|---------------------|---------------------|-------------|--------|--|------------------|---------------------|----------|-----------------|
| 1500 Lee Blvd | | Center | | | | | Date: | 7/29/2 | 016 |
| Lehigh Acres, | | | | | | Fiscal Year End: | | | 2014 |
| Lenigh Acres, | rL 33930- | | | | | | Audit Status: | Amend | ded Cost Report |
| Provider Ty | me. | | | | | | | | |
| <u>i iovidei iy</u> | <u>HOSF</u> | ΡΙΤΔΙ | Curre | nt Rat | æ | | New Rate | | Effective Date |
| | | Inpatient | | RG | | | DRG | | 7/1/2016 |
| Outpatient | | | 1.20 | | | 43.27 | | 7/1/2016 | |
| Inpatient County Billing Rate | | | 0 | | | 10121 | | 7/1/2016 | |
| | Jin Gouii | ty Dinning Italio | | | | | | | 17172010 |
| Rate Type: | lusta ulus | | | V | D | 4 ! | | | |
| | <u>Interim</u> - | Total Interim | _ | X | Prospe | | Total Dragge | tis co | |
| | | Settlement Based of | on Cost | | | <u> </u> | Total Prospec | uve | |
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| | | | Budget | | <u>, </u> | | | | |
| | | | — Unaudite | d Cost | s | | | | |
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| | | - | — Revised I | | | | | | |
| | | | Cost Rep | | | | | | |
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| | | | | W. R | ydell San | nuel or | Chanda Farcas | 1 | V |
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101133 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Tallahassee M | allahassee Memorial Regional M.C. | | | | | Provider Number: 0101133-00 | | | |
|-------------------------------|-----------------------------------|---------------|----------|---------------|---------------|-----------------------------|-------------------------|--|--|
| 1300 Miccousu | ukee | | | | | Date: | 7/29/2016 | | |
| Tallahassee, F | L 32308- | | | | | Fiscal Year End: | 9/30/2015 | | |
| | | | | | | Audit Status: | : Unaudited Cost Report | | |
| Provider Ty | <u>rpe:</u> | | | | | | | | |
| | <u>HOSPI</u> | <u>TAL</u> | | Current R | <u>ate</u> | New Rate | Effective Date | | |
| | lr | npatient | - | DRG | | DRG | 7/1/2016 | | |
| Outpatient | | - | 198.13 | 3 | 213.94 | 7/1/2016 | | | |
| Inpatient County Billing Rate | | :e | | | | 7/1/2016 | | | |
| Rate Type: | | | | | | | | | |
| rato Typo. | <u>Interim</u> | | | Х | <u>Prospe</u> | <u>ctive</u> | | | |
| | - | Total Interim | | | x | | ctive | | |
| | | Settlement Ba | sed on C | Cost | | | | | |
| | | - | | | | | | | |
| | | | | BAS | <u>IS:</u> | | | | |
| | | | | Budget | | | | | |
| | | | X | Unaudited Co | sts | | | | |
| | | | | Field Audited | | | | | |
| | | | | Revised Field | | | | | |
| | | | | Cost Report L | ate Test | | | | |
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101141 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Pagional Cond | ral Haanital | Williotop | | _ | Pro | vider Number: | 0101141-00 |) |
|--|--------------|--------------------|-----------------------------|-------------|-------------|----------------|---------------|-------------|
| Regional Gene | - | VVIIIISTOTI | | | | | 7/29/2016 | |
| P.O. Drawer 40 | | | | | Fis | scal Year End: | | |
| Williston, FL 3 | 32696- | | | | | Audit Status: | | Cost Report |
| Duarday Tr | | | | | | | | |
| <u>Provider Ty</u> | | IT A I | Current R | ato | | New Rate | E# | ective Date |
| | <u>HOSPI</u> | | DRG | <u> </u> | | DRG | | |
| | | npatient | 38.66 | | | 42.25 | 7/1/2016 | |
| Outpatient Inpatient County Billing Rate | | 30.00 | | | 42.23 | | 7/1/2016 | |
| праце | ent County | y billing Kate | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| | Interim - | | X | Prospe | | | | |
| | | Total Interim | | X | | Total Prospec | tive | |
| | | Settlement Based o | on Cost | | | | | |
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| | | | BAS | <u>15:</u> | | | | |
| | | | Budget | -1- | | | | |
| | | X | Unaudited Co | | | | | |
| | | | Field Audited Revised Field | | | | | |
| | | | Cost Report L | | | | | |
| | | | — Cost Neport L | ale Test | | | | |
| | | | W. | Rydell Sam | nuel or (| Chanda Farcas | F | Gf |
| | | | Me | dicaid Cost | Reimb | ursement Anal | ysis | |
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101150 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Madison Coun | ty Momorial | Hoopital | | | ı | Provider Number: | 0101150-00 | |
|---------------------|---------------------|------------------|--------------------|--------------|--------------|---------------------------|----------------|------------|
| | | Поѕрна | | | | | 7/29/2016 | |
| 224 NW Crane | | | | | | Fiscal Year End: | 9/30/2015 | |
| Madison, FL 3 | 62340- | | | | | Audit Status: | Amended Co | st Report |
| Provider Ty | ma: | | | | | | | |
| <u>i iovidei iy</u> | HOSP | ΙΤΑΙ | Current F | ₹ate | | New Rate | Effe | ctive Date |
| | | npatient | DRG | | | DRG | | /1/2016 |
| | | utpatient | 47.23 | | | 53.67 | | /1/2016 |
| Inpatie | | y Billing Rate | | | | | | /1/2016 |
| | | , 2g | | | | | | |
| Rate Type: | Intorim | | X | Dro | spostiv | • | | |
| | <u>Interim</u> - | Total Interim | ^ | — <u>F10</u> | spectiv X | <u>e</u> Total Prospec | tive | |
| | | Settlement Based | on Cost | | | | uve | |
| | | - | | | | | | |
| | | | BAS | SIS: | | | | |
| | | | Budget | <u></u> | | | | |
| | | | — Unaudited Co | osts | | | | |
| | | | — Field Audited | Costs | | | | |
| | | | — Revised Field | d Audit | | | | |
| | | | Cost Report | _ate Tes | t | | | |
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| | | | Me | edicaid C | Cost Rei | mbursement Anal | ysis | |
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101168 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | | — Provider Number: | 0101168-00 |
|-------------------------------|-----------------------|-----------------------|-------------------------|
| Manatee Memorial Hospital | | | 7/29/2016 |
| 206 Second Street East | | Fiscal Year End: | |
| Bradenton, FL 34208- | | | |
| | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 60.11 | 64.62 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
| Interim | X <u>Prosp</u> | ective | |
| Total Interim | | X Total Prospec | tive |
| Settlement Based | | 10.0111100000 | |
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| | BASIS: | | |
| | Budget | | |
| X | Unaudited Costs | | |
| | Field Audited Costs | | |
| | Revised Field Audit | | |
| | Cost Report Late Test | | |
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| | Medicaid Cos | t Reimbursement Anal | ysis |
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101176 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Munroe Regional Medical Center | | Pr | ovider Number: | 0101176-00 | |
|--------------------------------|---------------------|--|----------------------|-------------------------|--|
| Post Office Box 6000 | | | Date: | 7/29/2016 | |
| Ocala, FL 34478- | | F | iscal Year End: | 6/3/2015 | |
| | | | Audit Status: | Amended Cost Report | |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | Current Rate | <u>2</u> | New Rate | Effective Date | |
| Inpatient | DRG | | DRG | 7/1/2016 | |
| Outpatient | 56.45 | | 60.69 | 7/1/2016 | |
| Inpatient County Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | |
| Interim | X | Prospective | | | |
| Total Interim | | - X | Total Prospec | tive | |
| Settlement Based or | n Cost | | _ | | |
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101184 - 2016/07

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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|-----------------|-------------------|-------------------|---------------------|------------------|--------------------|-------------------------|
| Martin Medical | Center | | | | Provider Number: | 0101184-00 |
| P.O. Box 9033 | | | | | Date: | 7/29/2016 |
| Stuart, FL 3499 | 95-9033 | | | | Fiscal Year End: | 9/30/2015 |
| , | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | |
| | HOSPITAL | | Current Rate | | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatien | t | 72.42 | | 77.86 | 7/1/2016 |
| Inpatie | nt County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | _ |
| | <u>Interim</u> | | X <u>Pr</u> | ospecti | ve | |
| | Total Int | erim | | X | Total Prospec | tive |
| - | Settleme | ent Based on (| Cost — | | <u> </u> | |
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| | | | Field Audited Costs | | | |
| | | | Revised Field Audit | | | |
| | | | Cost Report Late Te | st | | |
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| | | | Medicaid | Cost Re | eimbursement Anal | ysis |
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101192 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Lower Keys Medical Cente | or. | | - | — Provider Number: | 0101192-00 |
|--|-----------------------|-----------------------------|-----------------|---------------------------|-------------------------|
| P.O. Box 9107 | 51 | | | Date: | 7/29/2016 |
| | | | | Fiscal Year End: | 9/30/2015 |
| Key West, FL 33401- | | | | Audit Status: | Amended Cost Report |
| Drovidor Typo | | | | | <u> </u> |
| Provider Type: | IΤΛΙ | Current | Rato | New Rate | Effective Date |
| <u>HOSP</u> | npatient | DR | | DRG | 7/1/2016 |
| | • | 58.0 | | 62.35 | 7/1/2016 |
| Outpatient Inpatient County Billing Rate | | 30.0 | | 02.33 | |
| Inpatient Count | y billing Kate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | | X <u>Prospe</u> | | |
| | Total Interim | _ | × | Total Prospec | tive |
| | Settlement Based on – | Cost | | | |
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| | | <u> </u> | Medicaid Cost | Reimbursement Anal | ysis |
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101192 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Lower Keys Medical Cente | | | _ | —— Рі | ovider Number: | 0101192-01 | |
|-------------------------------|---------------------|----------------|--------------|---------------------|----------------------|-------------------------|--|
| P.O. Box 9107 | 2 1 | | | | Date: | 7/29/2016 | |
| Key West, FL 33401- | | | | F | iscal Year End: | 9/30/2015 | |
| Rey West, FL 33401- | | | | | Audit Status: | Amended Cost Report | |
| Provider Type: | | | | | | · | |
| HOSP | ΙΤΔΙ | Curren | t Rate | | New Rate | Effective Date | |
| | npatient | DR | | | DRG | 7/1/2016 | |
| | utpatient | 58.0 | | | 62.35 | 7/1/2016 | |
| Inpatient County Billing Rate | | | | | <u> </u> | 7/1/2016 | |
| | ,g | | | | | | |
| Rate Type: | | | V Press | naativa | | | |
| <u>Interim</u> | Total Interim | | X Pros | <u>pective</u> X | Total Prospec | tive | |
| | Settlement Based or | n Cost | | | _ | divo | |
| | _ | | | | | | |
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| | | Budget | | | | | |
| | | _ Unaudited | Costs | | | | |
| | | Field Audite | ed Costs | | | | |
| | | Revised Fi | eld Audit | | | | |
| | | Cost Repo | rt Late Test | | | | |
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| | | , | W. Rydell Sa | amuel o | Chanda Farcas | s A T | |
| | | <u>-</u> | Medicaid Co | st Reim | bursement Anal | ysis | |
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101206 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Fishermen's Hospital | | | | Provider Number: | 0101206-00 |
|-------------------------------|----------------|------------------|--------------|---------------------|-------------------------|
| 3301 Overseas Highway | | | | Date: | 7/29/2016 |
| Marathon, FL 33050- | | | | Fiscal Year End: | 6/3/2015 |
| , | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | | Current Rat | <u>e</u> | New Rate | Effective Date |
| Inpatien | t | DRG | | DRG | 7/1/2016 |
| Outpatier | nt | 90.55 | | 98.31 | 7/1/2016 |
| Inpatient County Billing Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Χ | Prospect | <u>ive</u> | |
| Total In | terim | | _ x | Total Prospec | tive |
| Settlem | ent Based on (| Cost | | | |
| | | | | | |
| | | BASIS | <u>6:</u> | | |
| | | Budget | | | |
| | X | Unaudited Cost | S | | |
| | | Field Audited Co | osts | | |
| | | Revised Field A | udit | | |
| | | Cost Report Lat | e Test | | |
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| | | W. R | ydell Samue | el or Chanda Farcas | |
| | | Medi | caid Cost Re | eimbursement Anal | ysis |
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101214 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Marinara Haarital | | | | Provider Number: 0 | 0101214-00 | | |
|-------------------------------|----------------|--------------------|------------------|---------------------------|------------------------|--|--|
| Mariners Hospital | | | | _ | 7/29/2016 | | |
| 91500 Overseas Highway | | | | Fiscal Year End: 6/3/2015 | | | |
| Tavernier, FL 33070- | | | | _ | Jnaudited Cost Report | | |
| | | | | Audit Status. t | Driaudited Cost Report | | |
| <u>Provider Type:</u> | | | | | | | |
| <u>HOSPITAL</u> | _ | Current Rate | | New Rate | Effective Date | | |
| Inpatient | | DRG | | DRG | 7/1/2016 | | |
| Outpatient | t | 290.55 | | 317.38 | 7/1/2016 | | |
| Inpatient County Billing Rate | | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | |
| Interim | | X | <u>Prospecti</u> | ve | | | |
| Total Inte | erim | | X | Total Prospectiv | ve | | |
| | ent Based on C | - Cost | | | | | |
| | | | | | | | |
| | | BASIS: | | | | | |
| | | Budget | | | | | |
| | | Unaudited Costs | | | | | |
| | | Field Audited Cost | ts | | | | |
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| | | W. Ryd | ell Samue | l or Chanda Farcas | R G | | |
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101231 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Baptist Medica | al Center - N | 265211 | | | | | Pro | ovider Number: | 010123 | 31-00 |
|-------------------------------|---------------|------------|-------------|----------------|----------|-------------------------|----------|---------------------|-------------|-----------------|
| 1250 South 18 | | assau | | | | | | Date: | 7/29/20 |)16 |
| Fernandina Be | | N3/I- | | | | | F | iscal Year End: | 9/30/20 |)15 |
| i emanuma be | acii, i L 32 | 004- | | | | | | Audit Status: | Unaudi | ted Cost Report |
| Provider Ty | me. | | | | | | | | | |
| 1 TOVIGET TY | HOSP | ITAI | | <u>Curre</u> | nt Rate | е | | New Rate | | Effective Date |
| | | npatient | | | RG | - | | DRG | | 7/1/2016 |
| | | utpatient | | 83.30 | | | | 90.89 | | 7/1/2016 |
| Inpatient County Billing Rate | | | | | | | 7/1/2016 | | | |
| | | ,9 | | | | | | | | ., |
| Rate Type: | Intorim | | | | Х | Droope | otivo | | | |
| | Interim - | Total Inte | rim | | ^ | _ Prospe | | Total Prospec | tive | |
| | | _ | nt Based on | Cost | | | | - | uvo | |
| | | - | | | | | | | | |
| | | | | В | ASIS |): | | | | |
| | | _ | | Budget | | _ | | | | |
| | | _ | Х | – Unaudited | d Costs | 3 | | | | |
| | | _ | | - Field Aud | ited Co | osts | | | | |
| | | _ | | Revised F | Field A | udit | | | | |
| | | _ | | Cost Rep | ort Late | e Test | | | | |
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| | | | | | W. Ry | dell Sam | nuel or | Chanda Farcas | a | |
| | | | | | Modic | naid Cast | Poimh | oursement Anal | veie | <u> </u> |
| | | | | | Medic | Jaiu Cusi | Keimi | oursement Anar | ysis | |
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101257 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Twin Cities Hospital | | | Provider Number: | 0101257-00 | |
|-------------------------------|-----------------|----------------------|-------------------------|-------------------------|--|
| 2190 Hwy 85 North | | | Date: | 7/29/2016 | |
| Niceville, FL 32578- | | | Fiscal Year End: | 5/31/2015 | |
| | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date | |
| Inpati | ent | DRG | DRG | 7/1/2016 | |
| Outpa | tient | 64.49 | 69.33 | 7/1/2016 | |
| Inpatient County Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | |
| Interim | | X <u>Pro</u> | <u>ospective</u> | | |
| Tota | al Interim | | X Total Prospec | tive | |
| Sett | lement Based on | Cost | | | |
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| | | BASIS: | | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Costs | | | |
| | | Revised Field Audit | | | |
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| | | Medicaid | Cost Reimbursement Anal | ysis | |
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101265 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| North Okaloos | a Medical C | Senter | | | | Pro | ovider Number: | 0101265-0 | 0 |
|----------------|----------------|----------------------------------|------------------|----------|--------------------------|----------|---------------------|--------------|--------------|
| 151 Redstone | | | | | | | Date: | 7/29/2016 | |
| Crestview, FL | | | | | | F | iscal Year End: | 3/31/2015 | |
| 0.000.000, 1.2 | 02000 | | | | | | Audit Status: | Amended 0 | Cost Report |
| Provider Ty | rpe: | | | | | | | | |
| | HOSP | ITAL | Curre | nt Rat | <u>e</u> | <u> </u> | New Rate | <u>Ef</u> | fective Date |
| | | npatient | D | RG | | | DRG | | 7/1/2016 |
| | | Outpatient | 82 | 82.04 | | | 88.20 | - | 7/1/2016 |
| Inpatie | | y Billing Rate | 2 | | | | | 7/1/2016 | |
| | | | | | | | | | |
| Rate Type: | <u>Interim</u> | | | Х | Prospe | ctive | | | |
| | - | Total Interim | _ | | – 1100ро Х | | Total Prospec | tive | |
| | | Settlement Bas | sed on Cost | | | | _ ' | | |
| | | _ | | | | | | | |
| | | | <u>E</u> | BASIS | <u>s:</u> | | | | |
| | | | Budget | | | | | | |
| | | - | Unaudite | d Costs | 5 | | | | |
| | | | Field Aud | lited Co | osts | | | | |
| | | | Revised I | Field A | udit | | | | |
| | | | Cost Rep | ort Lat | e Test | | | | |
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| | | | | W. R | ydell Sam | uel or | Chanda Farcas | Ø | |
| | | | | Medi | caid Cost | Reimb | oursement Anal | ysis | |
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101290 - 2016/07

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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|-------------------------------|---------------------|-------------------------|-----------------------|-------------------------|
| Florida Hospital | | | Provider Number: | 0101290-00 |
| 500 East Rollins Street | | | Date: | 7/29/2016 |
| Orlando, FL 32803- | | | Fiscal Year End: | 6/3/2014 |
| · | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date |
| Inpati | ent | DRG | DRG | 7/1/2016 |
| Outpat | ient | 81.75 | 87.70 | 7/1/2016 |
| Inpatient County Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | |
| Interim | | X <u>Prosp</u> | <u>oective</u> | |
| | I Interim | | X Total Prospec | tive |
| | ement Based o | | | |
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| | | BASIS: | | |
| | | Budget | | |
| | X | Unaudited Costs | | |
| | | Field Audited Costs | | |
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| | | Cost Report Late Test | | |
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| | | Medicaid Cos | st Reimbursement Anal | ysis |
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101290 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital | | | • | Provider Number: | 0101290-01 |
|-------------------------------|--|-----------------|---------------|---------------------|-------------------------|
| 500 East Rollins Street | | | | Date: | 7/29/2016 |
| Orlando, FL 32803- | | | | Fiscal Year End: | 6/3/2014 |
| Onando, i E 32003- | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | · |
| HOSPIT | ΓΔΙ | Current Ra | ate | New Rate | Effective Date |
| | patient | DRG | | DRG | 7/1/2016 |
| | tpatient | 81.75 | | 87.70 | 7/1/2016 |
| Inpatient County Billing Rate | | 01.70 | | 01.10 | 7/1/2016 |
| | Billing Nate | | | | |
| Rate Type: | | V | | | |
| Interim | Total lutavius | X | — Prospect | | 41 |
| | Total Interim Settlement Based on C | Cont | X | Total Prospec | tive |
| | Settlement based on C | | | | |
| | | BASI | ç. | | |
| | | Budget | <u>o.</u> | | |
| | | Unaudited Cos | sts | | |
| | | Field Audited (| | | |
| | | Revised Field | | | |
| | | Cost Report La | | | |
| | | • | | | |
| | | W. I | Rydell Samue | el or Chanda Farcas | FG |
| | | Med | dicaid Cost R | eimbursement Anal | ysis |
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101290 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital | | | • | Provider Number: | 0101290-04 |
|-------------------------------|-----------------------|-----------------|----------------------|---------------------|-------------------------|
| 500 East Rollins Street | | | | Date: | 7/29/2016 |
| Orlando, FL 32803- | | | | Fiscal Year End: | 6/3/2014 |
| Onando, i E 32003- | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPI | ΤΑΙ | Current Ra | ıte | New Rate | Effective Date |
| | patient | DRG | | DRG | 7/1/2016 |
| | ıtpatient | 81.75 | | 87.70 | 7/1/2016 |
| Inpatient County Billing Rate | | | | 01110 | 7/1/2016 |
| | Dinning Ivaco | | | | |
| Rate Type: | | V | Duamant | : <u>.</u> | |
| Interim | Total Interim | X | <u>Prospect</u> X | Total Prospec | tivo |
| | Settlement Based on C | Cost | | | aive |
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| | | BASI | S: | | |
| | | Budget | | | |
| | X | Unaudited Cos | its | | |
| | | Field Audited C | Costs | | |
| | | Revised Field | Audit | | |
| | | Cost Report La | ate Test | | |
| | | | | | |
| | | W. F | Rydell Samue | el or Chanda Farcas | of of |
| | | Med | licaid Cost R | eimbursement Anal | ysis |
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101338 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Orlando Health | | | | Provider Number: (| 0101338-00 | | |
|--------------------------|----------------|---------------------|-----------|----------------------------|-----------------------|--|--|
| | | | | _ | 7/29/2016 | | |
| 1414 S. Kuhl Avenue | | | | Fiscal Year End: 9/30/2015 | | | |
| Orlando, FL 32806- | | | | _ | Jnaudited Cost Report | | |
| | | | | - Tadit Status. C | Shadanda Goot Roport | | |
| Provider Type: | | | | | | | |
| <u>HOSPITAL</u> | | <u>Current Rate</u> | | New Rate | Effective Date | | |
| Inpatient | | DRG | | DRG | 7/1/2016 | | |
| Outpatien | nt | 124.38 | | 134.15 | 7/1/2016 | | |
| Inpatient County Billing | g Rate | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | |
| <u>Interim</u> | | Х <u></u> | Prospecti | ve | | | |
| Total Int | erim | | X | Total Prospecti | ve | | |
| Settleme | ent Based on (| Cost | | | | | |
| | | | | | | | |
| | | BASIS : | | | | | |
| | | Budget | | | | | |
| | X | Unaudited Costs | | | | | |
| | | Field Audited Costs | 8 | | | | |
| | | Revised Field Audi | t | | | | |
| | | Cost Report Late T | est | | | | |
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| | | W. Ryde | ell Samue | l or Chanda Farcas | / | | |
| | | Medicai | d Cost Re | eimbursement Analys | sis | | |
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101354 - 2016/07

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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|-------------------------|----------------------|------------------------------|------------------------|-------------------------|
| Health Central | | | Provider Number: | 0101354-00 |
| 10000 West Colonial Dr. | | | Date: | 7/29/2016 |
| Ocoee, FL 34761- | | | Fiscal Year End: | 9/30/2015 |
| | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| HOSPITA | <u>4L</u> | Current Rate | New Rate | Effective Date |
| Inp | atient | DRG | DRG | 7/1/2016 |
| Out | patient | 72.35 | 77.78 | 7/1/2016 |
| Inpatient County I | Billing Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| Interim | | X <u>Pros</u> | <u>pective</u> | |
| | otal Interim | | X Total Prospec | tive |
| s | ettlement Based on | Cost | <u> </u> | |
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| | | BASIS : | | |
| | | Budget | | |
| | X | Unaudited Costs | | |
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| | | Cost Report Late Test | | |
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| | | Medicaid Co | st Reimbursement Anal | ysis |
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101389 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Osceola Regio | nal Medical | Center | | | | | Pr | ovider Number: | 010138 | 9-00 |
|-------------------|----------------|---------------|-------------|-----------|---------|-----------|--------------|----------------------|------------|-----------------|
| 700 West Oak | | Center | | | | | | Date: | 7/29/20 | 16 |
| Kissimmee, FL | | 80 | | | | | F | iscal Year End: | 12/31/2 | 014 |
| Nissiiiiiiee, i L | 2 32142-230 | 59 | | | | | | Audit Status: | Unaudi | ted Cost Report |
| Provider Ty | /ne: | | | | | | | | | |
| 11011401 19 | HOSP | ITAL | | Curre | nt Rat | <u>e</u> | | New Rate | | Effective Date |
| | | npatient | | D | RG | | | DRG | | 7/1/2016 |
| | | utpatient | t | 74 | .78 | | | 80.39 | | 7/1/2016 |
| Inpatie | ent Count | - | | | | | | | _ | 7/1/2016 |
| Rate Type: | | <u> </u> | | | | | | | | |
| ixale Type. | <u>Interim</u> | | | | Χ | Prospe | ective | | | |
| | | Total Inte | erim | | | _ | X | Total Prospec | tive | |
| | | - Settleme | nt Based on | Cost | | | | _ | | |
| | | _ | | | | | | | | |
| | | | | <u>B</u> | BASIS | <u>):</u> | | | | |
| | | _ | | Budget | | | | | | |
| | | | Х | Unaudited | d Costs | 3 | | | | |
| | | _ | | Field Aud | ited Co | osts | | | | |
| | | - | | Revised F | Field A | udit | | | | |
| | | - | | Cost Rep | ort Lat | e Test | | | | |
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| | | | | | W. R | ydell Sar | nuel or | Chanda Farca | s f(| |
| | | | | | Medic | caid Cos | t Reim | bursement Anal | ysis | |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

101401 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Pulled le Userial Foot | | Provider Number: | 0101401-00 |
|-------------------------------|-----------------------|-----------------------|-------------------------|
| Bethesda Hospital East | | | 7/29/2016 |
| 2815 S Seacrest Blvd. | | Fiscal Year End: | |
| Boynton Beach, FL 33435- | | | Unaudited Cost Report |
| | | Audit Status. | Unaudited Cost Report |
| <u>Provider Type:</u> | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 69.53 | 74.75 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
| Interim | X Prosp | <u>ective</u> | |
| Total Interim | | X Total Prospec | tive |
| Settlement Based | | | |
| | | | |
| | BASIS: | | |
| | Budget | | |
| X | Unaudited Costs | | |
| | Field Audited Costs | | |
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| | Cost Report Late Test | | |
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101419 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Page Paten Pagional Haspital | | | | Provider Number: | 0101419-00 |
|------------------------------|-----------------|-----------------|---------------|--------------------------------|-------------------------|
| Boca Raton Regional Hospital | | | | | 7/29/2016 |
| 800 Meadows Rd. | | | | Fiscal Year End: | |
| Boca Raton, FL 33486- | | | | | Unaudited Cost Report |
| Duna dalam Taman | | | | | |
| Provider Type: | | Current Be | 4.0 | New Pote | Effective Date |
| <u>HOSPITAL</u> | -1 | Current Ra | <u></u> — | New Rate | Effective Date |
| Inpatie | | DRG | | DRG | 7/1/2016 |
| Outpatie | | 62.44 | | 67.12 | 7/1/2016 |
| Inpatient County Billin | ng Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | Prospecti | <u>ive</u> | |
| | nterim | | X | Total Prospec | etive |
| Settler | ment Based on (| Cost | | | |
| | | | _ | | |
| | | BASI | <u>S:</u> | | |
| | | Budget | | | |
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| | | Revised Field / | | | |
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| | | W. F | Rydell Samue | el or Chanda Farcas | s // |
| | | Med | icaid Cost Re | eimbursement Anal | ysis |
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101443 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Lakasida Madis | ool Contor | | | y | — Provider Number: | 0101443-00 |
|-----------------|----------------|-----------------------|---------------|--------------|--------------------------|-------------------------|
| Lakeside Medic | | | | | | 7/29/2016 |
| 39200 Hooker I | - | | | | Fiscal Year End: | |
| Belle Glade, FL | . 33430- | | | | | Amended Cost Report |
| Duarday Tro | | | | | | |
| Provider Ty | _ | T | Current E | lata | Now Poto | Effoctivo Data |
| | <u>HOSPI</u> | | Current F | | New Rate | Effective Date |
| | | npatient | DRG | | DRG | 7/1/2016 |
| l | | utpatient | 78.56 | · | 85.50 | 7/1/2016 |
| Inpatie | nt County | / Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| | <u>Interim</u> | | X | Prospe | <u>ective</u> | |
| _ | | Total Interim | | X | Total Prospec | tive |
| _ | | Settlement Based on C | Cost | | | |
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| | | | BAS | SIS: | | |
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| | | | Revised Field | | | |
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| | | | Me | edicaid Cost | Reimbursement Anal | vsis |
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101460 - 2016/07

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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|----------------|--------------------|-----------------------|------------------|---------------|---------------|-------------------------|
| JFK Medical C | enter | | | Provid | der Number: | 0101460-00 |
| 5301 S. Congre | ess Ave. | | | | Date: | 7/29/2016 |
| Lake Worth, FL | L 33462-1149 | | | Fisc | al Year End: | 6/30/2015 |
| | | | | A | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | |
| • | <u>HOSPITAL</u> | <u>Cu</u> | rrent Rate | <u>Ne</u> | w Rate | Effective Date |
| | Inpatient | | DRG | | RG | 7/1/2016 |
| | Outpatient | | 85.30 | 9 | 1.70 | 7/1/2016 |
| Inpatie | ent County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| rato Typo. | Interim | | X <u>Prosp</u> | <u>ective</u> | | |
| | - Total Inte | rim | | | otal Prospect | tive |
| | Settlemer | t Based on Cost | | | | |
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| | | | BASIS: | | | |
| | _ | Budge | t | | | |
| | _ | X Unaud | ited Costs | | | |
| | _ | Field A | udited Costs | | | |
| | _ | Revise | d Field Audit | | | |
| | _ | Cost R | eport Late Test | | | |
| | | | W. Rydell Sa | muel or Ch | anda Farcas | F G |
| | | | Medicaid Cos | st Reimburs | sement Analy | ysis |
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101486 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St. Mary's Medical Center | | | P | rovider Number: | 0101486-00 |
|---------------------------|-----------------------|------------------|----------------|-------------------|-------------------------|
| • | | | | Date: | 7/29/2016 |
| 1300 N. Flagler Drive | 04 | | i | Fiscal Year End: | 5/31/2015 |
| West Palm Beach, FL 334 | 01- | | | Audit Status: | Unaudited Cost Report |
| Dravidar Typa | | | | | · · |
| Provider Type: | ΤΛΙ | Current Rate | 2 | New Rate | Effective Date |
| <u>HOSPI</u> | npatient | DRG | <u>-</u> | DRG | 7/1/2016 |
| | • | | | | 7/1/2016 |
| | utpatient | 67.51 | | 72.82 | _ |
| Inpatient County | Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | Prospective | | |
| | Total Interim | | X | Total Prospect | tive |
| | Settlement Based on 0 | Cost | | | |
| | | - 4 0 1 0 | | | |
| | | BASIS | <u>:</u> | | |
| | | Budget | | | |
| | | Unaudited Costs | | | |
| | | Field Audited Co | | | |
| | | Revised Field Au | | | |
| | | Cost Report Late | e Test | | |
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| | | W. Ry | /dell Samuel o | r Chanda Farcas | # G |
| | | Medic | aid Cost Reim | bursement Analy | ysis |
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101486 - 2016/07

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

| | <u>ivied</u> | <u>icaid Reimb</u> | ursement Rate Una | ange Form | | |
|----------------|--------------------|--------------------|-------------------|-------------|--------------------|-------------------------|
| St. Mary's Med | lical Center | | | | Provider Number: | 0101486-01 |
| 1300 N. Flagle | r Drive | | | | Date: | 7/29/2016 |
| = | ach, FL 33401- | | | | Fiscal Year End: | 5/31/2015 |
| | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | |
| • | _HOSPITAL | | Current Rate | <u>)</u> | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatient | | 67.51 | | 72.82 | 7/1/2016 |
| Inpatie | ent County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | _ |
| rate Type. | <u>Interim</u> | | X | Prospecti | ve | |
| | Total Inte | erim | | - X | Total Prospec | etive |
| | Settleme | nt Based on | Cost | | | |
| | | | | | | |
| | | | BASIS | <u>:</u> | | |
| | • | | Budget | | | |
| | | Х | Unaudited Costs | | | |
| | | | Field Audited Co | sts | | |
| | | | Revised Field Au | ıdit | | |
| | _ | | Cost Report Late | e Test | | |
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| | | | W. Ry | dell Samue | l or Chanda Farcas | s A G |
| | | | Medic | aid Cost Re | eimbursement Anal | lysis |
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101494 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital Zephyrhills | | | | Provider Number: | 0101494-00 |
|------------------------------|---------------------|-----------------|------------------|-------------------------------|-------------------------|
| 7050 Gall Blvd | | | | Date: | 7/29/2016 |
| Zephyrhills, FL 33541- | | | | Fiscal Year End: | 12/31/2014 |
| 20pHy1111110, 1 E 000+1 | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPIT | AL | Current Ra | ate | New Rate | Effective Date |
| | patient | DRG | | DRG | 7/1/2016 |
| Out | patient | 65.91 | | 70.86 | 7/1/2016 |
| Inpatient County | Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | Х | <u>Prospecti</u> | v <u>e</u> | |
| | otal Interim | | x | Total Prospec | tive |
| s | Settlement Based on | Cost | | | |
| | | | | | |
| | | BAS | <u>S:</u> | | |
| | | Budget - | | | |
| | X | Unaudited Cos | | | |
| | | Field Audited (| | | |
| | | Revised Field | | | |
| | | Cost Report La | ate Test | | |
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| | | W. | Rydell Samue | l or Chanda Farcas | |
| | | Med | dicaid Cost Re | imbursement Anal | ysis |
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101494 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital Zephyrhills Provider Numb | er: 0101494-01 |
|--|---------------------------|
| 7050 Gall Blvd | te: 7/29/2016 |
| Zephyrhills, FL 33541- Fiscal Year El | nd: 12/31/2014 |
| · · | us: Unaudited Cost Report |
| Provider Type: | |
| HOSPITAL Current Rate New Rate | Effective Date |
| Inpatient DRG DRG | 7/1/2016 |
| Outpatient 65.91 70.86 | 7/1/2016 |
| Inpatient County Billing Rate | 7/1/2016 |
| Rate Type: | |
| Interim X Prospective | |
| Total Interim X Total Prosp | pective |
| Settlement Based on Cost | |
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| BASIS: | |
| Budget | |
| X Unaudited Costs | |
| Field Audited Costs | |
| Revised Field Audit | |
| Cost Report Late Test | |
| W. Rydell Samuel or Chanda Far | cas F |
| Medicaid Cost Reimbursement A | nalysis |
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101508 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Morton Plant N | North Bay Ho | ospital | | | | | Provider Number: | 0101508-00 |
|----------------|----------------|----------------|-------------|----------------|----------|------------|--------------------------------|-------------------------|
| 16255 Bay Vis | - | · | | | | | Date: | 7/29/2016 |
| Clearwater, FL | | | | | | | Fiscal Year End: | 12/31/2014 |
| | - 00.00 | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | |
| - | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | <u>!</u> | New Rate | Effective Date |
| | I | npatient | | D | RG | _ | DRG | 7/1/2016 |
| | 0 | utpatient | | 73 | 3.06 | | 78.54 | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| rtato Typo. | <u>Interim</u> | | | | Χ | Prospect | ive | |
| | - | Total Inte | rim | _ | | - X | Total Prospec | etive |
| | | - Settlemei | nt Based on | Cost | | | | |
| | | | | | | | | |
| | | _ | | <u> </u> | BASIS: | <u>:</u> | | |
| | | _ | | Budget - | | | | |
| | | _ | Х | Unaudited — | | | | |
| | | _ | | Field Aud - | | | | |
| | | _ | | Revised F | | | | |
| | | _ | | Cost Rep | ort Late | Test | | |
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| | | | | | W. Ry | dell Samue | el or Chanda Farca | s M |
| | | | | | Medic | aid Cost R | eimbursement Anal | lysis |
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101516 - 2016/07

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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|---------------------------|-------------------|------------------|--------------|---------------------|-------------------------|
| All Children's Hospital | | | | Provider Number: | 0101516-00 |
| 501 6th Avenue S | | | | Date: | 7/29/2016 |
| St. Petersburg, FL 33701- | | | | Fiscal Year End: | 6/30/2015 |
| O . | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Ra | <u>te</u> | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatier | nt | 234.69 | | 258.68 | 7/1/2016 |
| Inpatient County Billing | g Rate | | | | 7/1/2016 |
| Rate Type: | | | | | _ |
| Interim | | Х | Prospect | ive | |
| Total Int | terim | | X | Total Prospec | tive |
| Settleme | ent Based on | Cost | | | |
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| | | BASI | <u>S:</u> | | |
| | | Budget | | | |
| | Х | Unaudited Cos | ts | | |
| | | Field Audited C | osts | | |
| | | Revised Field A | Audit | | |
| | | Cost Report La | te Test | | |
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| | | W. F | Rydell Samue | el or Chanda Farcas | F |
| | | Med | icaid Cost R | eimbursement Anal | ysis |
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101524 - 2016/07

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

| Good Samaritan Hospital | | | | Provider Number: | 0101524-00 |
|----------------------------|------------|-----------------|---------------|---------------------------------|-------------------------|
| 1300 N. Flagler Drive | | | | Date: | 7/29/2016 |
| West Palm Beach, FL 33401- | | | | Fiscal Year End: | 5/31/2015 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Ra | <u>ite</u> | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatient | t | 68.88 | | 74.05 | 7/1/2016 |
| Inpatient County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospec | ctive | |
| Total Inte | erim | | X | Total Prospec | tive |
| Settleme | nt Based o | n Cost | | | |
| | | | | | |
| | | BASI | <u>S:</u> | | |
| | | Budget — | | | |
| _ | X | Unaudited Cos | | | |
| | | Field Audited (| | | |
| - | | Revised Field | | | |
| - | | Cost Report La | ate Test | | |
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| | | Med | licaid Cost I | Reimbursement Anal | ysis |
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101541 - 2016/07

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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|-----------------------------|---------------------|---------------------|----------|---------------------|-------------------------|
| Mease Dunedin Hospital | | | | Provider Number: | 0101541-00 |
| Post Box 210Mailstation 102 | | | | Date: | 7/29/2016 |
| Clearwater, FL 33517- | | | | Fiscal Year End: | 12/31/2014 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Rate | | New Rate | Effective Date |
| Inpatient | _ | DRG | | DRG | 7/1/2016 |
| Outpatient | _ | 69.34 | | 74.55 | 7/1/2016 |
| Inpatient County Billing R | Rate - | | | | 7/1/2016 |
| | | | | | _ |
| Rate Type: Interim | | X <u>P</u> | rospect | ive | |
| Total Interin | im | <u>^</u> | X | Total Prospec | tive |
| | t Based on C | ost _ | | | arvo |
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| | | BASIS: | | | |
| | E | Budget | | | |
| | | Jnaudited Costs | | | |
| | F | Field Audited Costs | ; | | |
| _ | F | Revised Field Audit | | | |
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101567 - 2016/07

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

| Bayfront Health - St Petersburg | | Р | rovider Number: | 0101567-00 |
|---------------------------------|-----------------------------------|----------------|----------------------|-------------------------|
| 701 6th St. South | | | Date: | 7/29/2016 |
| St. Petersburg, FL 33701- | | F | Fiscal Year End: | 9/30/2015 |
| | | | Audit Status: | Amended Cost Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | Current Rate | | New Rate | Effective Date |
| Inpatient | DRG | | DRG | 7/1/2016 |
| Outpatient | 80.65 | | 90.09 | 7/1/2016 |
| Inpatient County Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | X | Prospective | | |
| Total Interim | | X | Total Prospec | tive |
| Settlement Based o | n Cost | | _ | |
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| | Budget | | | |
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101567 - 2016/07

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

| D. Contilled | l Ot Datas | L | | | Pi | ovider Number: | 0101567-07 |
|-----------------|----------------|---------------------|--------------|-----------|---------------|---------------------|-------------------------|
| Bayfront Health | | burg | | | | | 7/29/2016 |
| 701 6th St. So | | | | | F | iscal Year End: | |
| St. Petersburg | , FL 33701- | | | | | | Amended Cost Report |
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| Provider Ty | _ | | 0 | 1 D - 1 - | | Name Date | Effective Date |
| | <u>HOSPI</u> | | Curren | | <u> </u> | New Rate | Effective Date |
| | | npatient | DR | | | DRG | 7/1/2016 |
| | | utpatient | 80. | 65 | | 90.09 | 7/1/2016 |
| Inpatie | ent County | y Billing Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| | <u>Interim</u> | | | Χ | Prospective | | |
| | | Total Interim | | | X | _ Total Prospec | tive |
| | | Settlement Based on | Cost | | | | |
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101583 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | | Provider Number: (| 0101583-00 | |
|-------------------------------|-----------------------|-------------------------|-----------------------|--|
| Morton F. Plant Hospital | | _ | | |
| 16255 Bay Vista Dr, MS 100 | | Date: 7/29/2016 | | |
| Clearwater, FL 33760- | | Fiscal Year End: | | |
| | | Audit Status: I | Unaudited Cost Report | |
| Provider Type: | | | | |
| HOSPITAL | Current Rate | New Rate | Effective Date | |
| Inpatient | DRG | DRG | 7/1/2016 | |
| Outpatient | 90.63 | 97.44 | 7/1/2016 | |
| Inpatient County Billing Rate | | | 7/1/2016 | |
| | | | • | |
| Rate Type: Interim | X <u>Prosp</u> | <u>ective</u> | | |
| Total Interim | | X Total Prospecti | ve | |
| Settlement Base | | | | |
| | | | | |
| | BASIS: | | | |
| | Budget | | | |
| X | Unaudited Costs | | | |
| | Field Audited Costs | | | |
| | Revised Field Audit | | | |
| | Cost Report Late Test | | | |
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| | W. Rydell Sa | muel or Chanda Farcas | # G | |
| | Medicaid Cos | st Reimbursement Analys | sis | |
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101583 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | | Provider Number: (|)101583 ₋ 01 | |
|-------------------------------|-----------------------|-------------------------|-------------------------|--|
| Morton F. Plant Hospital | | _ | | |
| 16255 Bay Vista Dr, MS 100 | | Date: 7/29/2016 | | |
| Clearwater, FL 33760- | | Fiscal Year End: 1 | | |
| | | Audit Status: l | Jnaudited Cost Report | |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date | |
| Inpatient | DRG | DRG | 7/1/2016 | |
| Outpatient | 90.63 | 97.44 | 7/1/2016 | |
| Inpatient County Billing Rate | | | 7/1/2016 | |
| | | | · | |
| Rate Type: Interim | X <u>Prosp</u> | <u>pective</u> | | |
| Total Interim | | X Total Prospecti | ve | |
| Settlement Based | Lon Cost | | | |
| | | | | |
| | BASIS: | | | |
| | Budget | | | |
| X | Unaudited Costs | | | |
| | Field Audited Costs | | | |
| | Revised Field Audit | | | |
| | Cost Report Late Test | | | |
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| | W. Rydell Sa | muel or Chanda Farcas | R I | |
| | Medicaid Cos | st Reimbursement Analys | sis | |
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101613 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital North Pine | ellas | | F | Provider Number: | 0101613-00 |
|-----------------------------|---------------------|---------------------|--------------|-------------------|-------------------------|
| 1395 South Pinellas Ave. | | | | Date: | 7/29/2016 |
| Tarpon Springs, FL 34689 | 9-1487 | | | Fiscal Year End: | 12/31/2014 |
| , , | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSP</u> | <u>ITAL</u> | Current Rate | | New Rate | Effective Date |
| I | npatient | DRG | | DRG | 7/1/2016 |
| C | Outpatient | 71.87 | | 77.26 | 7/1/2016 |
| Inpatient Count | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospective | <u>)</u> | |
| | Total Interim | | Х | Total Prospec | tive |
| | Settlement Based or | n Cost | | | |
| | | | | | |
| | | BASIS: | | | |
| | | Budget — | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Cos | | | |
| | | Revised Field Aud | | | |
| | | Cost Report Late | Test | | |
| | | W. Ryd | ell Samuel d | or Chanda Farcas | F G |
| | | Medica | id Cost Rein | nbursement Anal | ysis |
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| | | | F | or Information or | nly - No Change in rate |
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101648 - 2016/07

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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|-----------------------------------|-----------------|------------------|------------------------|-------------------------|
| Lakeland Regional Medical Center | | | Provider Number: | 0101648-00 |
| 230 South Florida Ave, Reimb Dept | | | Date: | 7/29/2016 |
| 4th Floor | | | Fiscal Year End: | 9/30/2015 |
| Lakeland, FL 33801- | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | <u></u> | Current Rate | New Rate | Effective Date |
| Inpatient | | DRG | DRG | 7/1/2016 |
| Outpatient | | 75.12 | 81.00 | 7/1/2016 |
| Inpatient County Billing | Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| Interim | | X <u>Pro</u> | <u>spective</u> | |
| Total Inte | im | | X Total Prospec | etive |
| Settlemer | t Based on Cost | | | |
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| - | X Unau | udited Costs | | |
| _ | Field | Audited Costs | | |
| _ | Revi | sed Field Audit | | |
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| | | Medicaid C | ost Reimbursement Ana | lysis |
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101664 - 2016/07

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

| Lake Wales Hospital Association | | Provider Number: | 0101664-00 |
|---------------------------------|-----------------------|---------------------------|-------------------------|
| 410 South 11th St. | | Date: | 7/29/2016 |
| Lake Wales, FL 33853- | | Fiscal Year End: | 12/31/2014 |
| | | Audit Status: | Amended Cost Report |
| Provider Type: | | | |
| HOSPITAL | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 54.75 | 58.86 | 7/1/2016 |
| Inpatient County Billing Ra | nte | | 7/1/2016 |
| Rate Type: | | | |
| Interim | X Prosi | <u>pective</u> | |
| Total Interim | | X Total Prospec | tive |
| Settlement E | ased on Cost | | |
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| | BASIS: | | |
| | Budget | | |
| | Unaudited Costs | | |
| | Field Audited Costs | | |
| | Revised Field Audit | | |
| | Cost Report Late Test | | |
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| | W. Rydell Sa | ımuel or Chanda Farcas | |
| | Medicaid Co | st Reimbursement Anal | ysis |
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101699 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | | | | Provider Number: (| ∩1∩160Q₋∩∩ |
|--------------------------|---------------|---------------------|-------------------------|---------------------|-----------------------|
| Winter Haven Hospital | | | | _ | 7/29/2016 |
| 200 Avenue "F" Northeast | | | | _ | |
| Winter Haven, FL 33880- | | | | Fiscal Year End: | |
| | | | | Audit Status: I | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | | Current Rate | ! | New Rate | Effective Date |
| Inpatient | - | DRG | | DRG | 7/1/2016 |
| Outpatient | - | 68.35 | | 73.48 | 7/1/2016 |
| Inpatient County Billing | Rate | | | | 7/1/2016 |
| Pata Typo: | | | | | |
| Rate Type: Interim | | Х | <u>Prospecti</u> | ve | |
| Total Inte | rim | | - <u>1 100роон</u> Х | Total Prospecti | ve |
| | nt Based on C | cost | | | |
| | | | | | |
| | | BASIS: | ı | | |
| _ | | Budget | - | | |
| _ | | Unaudited Costs | | | |
| - | | Field Audited Cos | sts | | |
| _ | | Revised Field Au | dit | | |
| _ | | Cost Report Late | Test | | |
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| | | W. Rv | dell Samue | l or Chanda Farcas | of Of |
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| | | Medica | aid Cost Re | eimbursement Analy | SIS |
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101702 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| West Gables Rehabilitation | | | Pr | ovider Number: | 0101702-00 |
|----------------------------|-----------------------|------------------|----------------------|-------------------|-------------------------|
| 2525 Southwest 75th Av. | | | | Date: | 7/29/2016 |
| Miami, FL 33155- | | | F | iscal Year End: | 12/31/2014 |
| Wildrin, I L 00100 | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITA | AL. | Current Rate | <u>!</u> | New Rate | Effective Date |
| | atient | DRG | <u> </u> | DRG | 7/1/2016 |
| · | patient | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient County E | | | | | 7/1/2016 |
| | | | | | |
| Rate Type: Interim | | Х | Prospective | | |
| | otal Interim | | - X | Total Prospect | tive |
| | ettlement Based on (| Cost | | _ | |
| | | | | | |
| | | BASIS | <u>.</u> <u>.</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Co | sts | | |
| | | Revised Field Au | dit | | |
| | | Cost Report Late | Test | | |
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| | | W. Ry | dell Samuel or | · Chanda Farcas | F G |
| | | Medic | aid Cost Reim | bursement Analy | ysis |
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101711 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Flagler Hospita | al | | | | Provider Number: | 0101711-00 |
|-----------------|----------------|------------------------------------|-------------|----------------|------------------------|-------------------------|
| 400 Health Par | k Blvd. | | | | Date: | 7/29/2016 |
| St. Augustine, | FL 32086- | | | | Fiscal Year End: | 9/30/2015 |
| - | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | |
| | <u>HOSP</u> | <u> PITAL</u> | <u>Curr</u> | ent Rate | New Rate | Effective Date |
| | 1 | Inpatient | | DRG | DRG | 7/1/2016 |
| | C | Outpatient | 6 | 0.72 | 65.28 | 7/1/2016 |
| Inpatie | nt Count | y Billing Rate | • | | | 7/1/2016 |
| Rate Type: | | | | | | |
| rate Types | <u>Interim</u> | | | X <u>Pros</u> | <u>pective</u> | |
| | • | Total Interim | _ | | X Total Prospec | tive |
| | | Settlement Bas | sed on Cost | | | |
| | | . | | | | |
| | | | | BASIS: | | |
| | | | Budget | | | |
| | | | X Unaudit | ed Costs | | |
| | | | | idited Costs | | |
| | | | | Field Audit | | |
| | | | Cost Re | port Late Test | | |
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| | | | | W. Rydell Sa | amuel or Chanda Farcas | s A T |
| | | | | Medicaid Co | st Reimbursement Anal | ysis |
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101737 - 2016/07

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

| Jay Hospital | | Pi | ovider Number: | 0101737-00 | |
|-------------------------------|---------------------|--------------|----------------------|-------------------------|--|
| 221 South Alabama Street | | | Date: | 7/29/2016 | |
| Jay, FL 32565- | | F | iscal Year End: | 9/30/2015 | |
| • | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | Current Rate | | New Rate | Effective Date | |
| Inpatient | DRG | | DRG | 7/1/2016 | |
| Outpatient | 100.47 | _ | 107.19 | 7/1/2016 | |
| Inpatient County Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | |
| Interim | Х <u>і</u> | Prospective | | | |
| Total Interim | | X | Total Prospec | tive | |
| Settlement Based | on Cost | | _ | | |
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| | BASIS: | | | | |
| | Budget | | | | |
| X | Unaudited Costs | | | | |
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| | Revised Field Aud | | | | |
| | Cost Report Late 7 | 621 | | | |
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| | w. Rydo | eli Samuei o | Chanda Farcas | 5 M | |
| | Medicai | d Cost Reim | bursement Anal | ysis | |
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101745 - 2016/07

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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|----------------|----------------|-----------------------|-----------------------------|--------------|--------------------------|-------------------------|
| Santa Rosa Ho | ospital | | | | Provider Number: | |
| P.O. BOX 648 | | | | | | 7/29/2016 |
| Milton, FL 325 | 570- | | | | Fiscal Year End: | |
| | | | | | Audit Status: | Amended Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | |
| | HOSP | <u>ITAL</u> | Current Ra | <u>te</u> | New Rate | Effective Date |
| | I | npatient | DRG | | DRG | 7/1/2016 |
| | C | Outpatient | 55.07 | | 59.21 | 7/1/2016 |
| Inpatie | ent Count | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| Nate Type. | <u>Interim</u> | | Х | Prospec | tive | |
| | - <u></u> | Total Interim | | — X | Total Prospec | ctive |
| | | _ Settlement Based on | Cost | | | |
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| | | | BASI | s. | | |
| | | | Budget | <u>u.</u> | | |
| | | | _ Unaudited Cos | ts | | |
| | | | Field Audited C | | | |
| | | | – Revised Field <i>F</i> | | | |
| | | | _ Cost Report La | | | |
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| | | | W. F | Rydell Samu | iel or Chanda Farca | 5 N |
| | | | Med | icaid Cost F | Reimbursement Anal | ysis |
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Florida Agency For Health Care Administration

101753 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| HealthSouth R | ehahilitation | . Hospital (| of | | | | Provider Number: | 0101753-00 | |
|-------------------------------|----------------|----------------|-------------|-----------|------------|----------|--------------------|-------------------|----------------|
| Largo | Chabilitation | i i ioopitai v | O1 | | | | Date: | 7/29/2016 | |
| 901 Clearwate | r Largo Rd. | | | | | | Fiscal Year End: | 12/31/2014 | |
| Largo, FL 346 | 340- | | | | | | Audit Status: | Unaudited Cost | Report |
| Provider Ty | ne: | | | | | | | | |
| | HOSP | ITAL | | Curre | nt Rate | | New Rate | <u>Effectiv</u> | <u>/e Date</u> |
| | | npatient | | D | RG | | DRG | 7/1/2 | <u> </u> |
| | | utpatient | t | 11 | .65 | | 12.52 | 7/1/2 | |
| Inpatient County Billing Rate | | | | - | | | | 7/1/2 | 2016 |
| Rate Type: | | | | | | | | | |
| rato Typo. | <u>Interim</u> | | | | X <u>Р</u> | rospecti | <u>ve</u> | | |
| | - | Total Inte | erim | | | X | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | _ | | | | |
| | | _ | | | | | | | |
| | | | | <u>B</u> | ASIS: | | | | |
| | | | | Budget | | | | | |
| | | <u>-</u> | X | Unaudited | d Costs | | | | |
| | | _ | | Field Aud | ited Costs | ; | | | |
| | | • | | Revised F | ield Audit | • | | | |
| | | • | | Cost Rep | ort Late T | est | | | |
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| | | | | | W. Ryde | ll Samue | l or Chanda Farcas | | H |
| | | | | | Medicaio | Cost Re | eimbursement Anal | ysis | |
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101761 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Mamorial Hagnital | | | | Provider Number: (| 0101761-00 |
|--------------------------|-----------------|------------------|-------------|----------------------|-----------------------|
| Memorial Hospital | | | | _ | 7/29/2016 |
| 1901 Arlington St. | | | | Fiscal Year End: 9 | |
| Sarasota, FL 33579- | | | | _ | Jnaudited Cost Report |
| | | | | - Addit Status. | Shadanda Goot Hoport |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | _ | Current Rate | <u> </u> | New Rate | Effective Date |
| Inpatient | _ | DRG | | DRG | 7/1/2016 |
| Outpatien | ıt _ | 81.06 | | 87.14 | 7/1/2016 |
| Inpatient County Billing | g Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Х | Prospecti | ve | |
| Total Int | erim | | X | Total Prospecti | ve |
| Settleme | ent Based on Co | ost | | | |
| | | | | | |
| | | BASIS: | <u>!</u> | | |
| | В | udget | | | |
| | u | Inaudited Costs | | | |
| | F | ield Audited Cos | sts | | |
| | R | evised Field Au | dit | | |
| | | ost Report Late | Test | | |
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| | | Medica | aid Cost Re | eimbursement Analys | sis |
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101788 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Central Florida | Pegional I | Hospital | | | - | Pro | ovider Number: | 010178 | 38-00 | |
|---------------------|--------------|-------------------------------|----------------|----------|--------------------------|----------------------------|---------------------|----------|------------------|--|
| 1401 West Sei | _ | · | | | | | Date: | 7/29/20 | 016 | |
| Sanford, FL 3 | | | | | | Fiscal Year End: 5/31/2015 | | | | |
| Salliolu, FL 3. | 2771- | | | | | | Audit Status: | Unaudi | ited Cost Report | |
| Provider Ty | ne: | | | | | | | | | |
| <u>i iovidei iy</u> | <u>HOSF</u> | PITAI | Curre | ent Rat | е | | New Rate | | Effective Date | |
| | | Inpatient | | DRG | | | DRG | | 7/1/2016 | |
| | | 1.12 | | | 65.71 | 7/1/2016 | | | | |
| Inpatie | | Outpatient by Billing Rate | | | | | | 7/1/2016 | | |
| | | | | | | | | | | |
| Rate Type: | Intorim | | | V | Dranna | | | | | |
| | Interim - | Total Interim | _ | Х | _ Prospe _ | | Total Prospec | tive | | |
| | | _ Settlement Based o | n Cost | | | | - - | live | | |
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| | | | ı | BASIS | S : | | | | | |
| | | | Budget | | <u></u> | | | | | |
| | | X | — Unaudite | d Costs | S | | | | | |
| | | | — Field Aud | dited Co | osts | | | | | |
| | | | — Revised | Field A | udit | | | | | |
| | | | — Cost Rep | ort Lat | e Test | | | | | |
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101796 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Shands Live O Center | ak Regional | Medical | | Р | rovider Number: | | |
|-------------------------|----------------|------------------|---------------------|-------------|----------------------|-------------------------|--|
| Post Office Box | x 100336 | | | | | 7/29/2016 | |
| Gainesville, FL | | 36 | | | Fiscal Year End: | | |
| Camesvine, 1 L | . 02010 000 | | | | Audit Status: | Amended Cost Report | |
| Provider Ty | pe: | | | | | | |
| | <u>HOSPI</u> | TAL | Current Rate | | New Rate | Effective Date | |
| | lı | npatient | DRG | | DRG | 7/1/2016 7/1/2016 | |
| | 0 | utpatient | 69.71 | | 75.95 | | |
| Inpatie | ent County | y Billing Rate | | _ | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| rate Type. | <u>Interim</u> | | Х <u>Р</u> | rospective | ! | | |
| | • | Total Interim | | X | Total Prospec | tive | |
| | | Settlement Based | on Cost | | _ | | |
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| | | | BASIS: | | | | |
| | | | Budget | | | | |
| | | | Unaudited Costs | | | | |
| | | | Field Audited Costs | i | | | |
| | | | Revised Field Audit | | | | |
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| | | | W. Ryde | ll Samuel o | r Chanda Farcas | s THE ST | |
| | | | Medicaid | Cost Reim | bursement Anal | ysis | |
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Florida Agency For Health Care Administration

101800 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Doctors' Memorial Ho | ospital | | | | | Provider Number: | 0101800-00 |
|----------------------|----------------|----------------|-----------------|--------------|---------|--------------------|-------------------------|
| 407 East Ash Street | , op 1131 | | | | | Date: | 7/29/2016 |
| Perry, FL 32347- | | | | | | Fiscal Year End: | 5/31/2015 |
| relly, FL 32347- | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | | | · · · |
| Provider Type: | <u>OSPITAL</u> | | Currer | nt Rate | | New Rate | Effective Date |
| <u> 110</u> | | | | RG | | DRG | 7/1/2016 |
| | Inpatient | | | | | | |
| Innations Co | Outpatien | | 110 |).76 | _ | 119.99 | 7/1/2016 |
| Inpatient Co | ounty Billing | j Kate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| Interi | <u>m</u> | | | X Pro | specti | <u>ve</u> | |
| | Total Int | | | | Х | Total Prospec | tive |
| | Settleme | ent Based on (| Cost | | | | |
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| | | | | ASIS: | | | |
| | | | Budget - | | | | |
| | | X | Unaudited | | | | |
| | | | Field Audi - | | | | |
| | | | Revised F | | | | |
| | | | Cost Repo | ort Late Tes | st | | |
| | | | | W. Rydell S | Samue | l or Chanda Farca | F G |
| | | | | Medicaid C | Cost Re | eimbursement Anal | ysis |
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101826 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospita | al - Fish Mer | morial | | | | _ | Pro | ovider Number: | 0101826-00 | |
|-----------------|----------------|-------------|-------------|--------------|----------|-----------|---------|----------------------|-------------------|--------|
| 1055 Sax Boul | | | | | | | | Date: | 7/29/2016 | |
| Orange City, F | | | | | | | F | iscal Year End: | 12/31/2014 | |
| Crainge City, i | _ 000 | | | | | | | Audit Status: | Unaudited Cost F | Report |
| Provider Ty | pe: | | | | | | | | | |
| • | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | <u>e</u> | | New Rate | Effective | e Date |
| | 1 | npatient | | D | RG | | | DRG | 7/1/2 | 016 |
| Outpatient | | | | 58 | 3.10 | | | 62.46 | 7/1/2 | 016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | 7/1/2 | 016 |
| Rate Type: | | | | | | | | | | |
| rtato . ypo. | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | - | Total Inte | erim | | | _ > | < | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | - | | |
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| | | <u>-</u> | | Budget - | | | | | | |
| | | _ | Х | Unaudited | | | | | | |
| | | _ | | Field Aud | | | | | | |
| | | - | | Revised F | | | | | | |
| | | - | | Cost Rep | ort Late | e rest | | | | |
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| | | | | | W. Ry | ydell Sam | nuel or | Chanda Farcas | A C | 4 |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | /sis | |
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| Batch ID:J4VC6 | | | | | | | Printe | d on : 7/29/2016 4:5 | 56 PM | |



101834 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Bert Fish Memorial Hospita | I | | | Provider Number: | 0101834-00 |
|----------------------------|---------------------|---------------------|--------------|--------------------|-------------------------|
| 401 Palmetto Street | | | | Date: | 7/29/2016 |
| New Smyrna Beach, FL 32 | 2170- | | | Fiscal Year End: | 9/30/2015 |
| · | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPI ⁻ | <u>TAL</u> | Current Rate | | New Rate | Effective Date |
| In | patient | DRG | | DRG | 7/1/2016 |
| Οι | utpatient | 71.47 | | 76.83 | 7/1/2016 |
| Inpatient County | Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | Prospectiv | <u>′e</u> | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based on | n Cost | | | |
| | | | | | |
| | | BASIS: | <u>.</u> | | |
| | | Budget — | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Cos | | | |
| | | Revised Field Au | | | |
| | | Cost Report Late — | Test | | |
| | | W. Ry | dell Samuel | or Chanda Farcas | F G |
| | | Medica | aid Cost Rei | mbursement Analy | ysis |
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| | | | | For Information or | nly - No Change in rate |

Printed on: 7/29/2016 4:56 PM



101842 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Halifax Health | Medical Ce | nter | | | | - | Pr | ovider Number: | : 010184 | 2-00 | |
|----------------|----------------|----------------|-------------|--------------|----------|-----------|---------|---------------------|------------|----------------|--|
| P.O. Box 2830 | | inoi | | | | | | Date: | 7/29/20 | 16 | |
| Daytona Beacl | | 5-2830 | | | | | F | iscal Year End: | 9/30/20 | 15 | |
| Daytona Beach | 11,1 L 32110 | 2000 | | | | | | Audit Status: | Unaudit | ed Cost Report | |
| Provider Ty | vpe: | | | | | | | | | | |
| <u> ,</u> | HOSP | ITAL | | <u>Curre</u> | nt Rate | <u>e</u> | | New Rate | | Effective Date | |
| | | npatient | | DI | RG | | DRG | | 7/1/2016 | | |
| | 0 | outpatient | | 86 | .69 | | | 93.34 | | 7/1/2016 | |
| Inpatie | ent Count | - | | | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | | |
| rtate Type. | <u>Interim</u> | | | | Х | Prospe | ective | | | | |
| | _ | Total Inte | rim | | | _ | | Total Prospec | ctive | | |
| | | – Settlemer | nt Based on | Cost | | | | _ | | | |
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| | | _ | | <u>B</u> | ASIS | <u>:</u> | | | | | |
| | | _ | | Budget | | | | | | | |
| | | _ | Х | Unaudited | d Costs | 6 | | | | | |
| | | _ | | Field Aud | | | | | | | |
| | | _ | | Revised F | | | | | | | |
| | | _ | | Cost Rep | ort Late | e Test | | | | | |
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| | | | | | W. Ry | /dell San | nuel or | Chanda Farca | s 🍂 | | |
| | | | | | Medic | caid Cost | t Reimb | oursement Ana | lysis | | |
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101869 - 2016/07

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

| Florida Hospita | al Memorial I | Medical | | | | | Provider Number: | | | |
|-------------------------------|----------------|-------------|-------------|--------------|----------|-------------|-------------------------------|-------------------------|--|--|
| Center | A., | | | | | | Date: | 7/29/2016 | | |
| 875 Sterthaus | | | | | | | Fiscal Year End: 12/31/2014 | | | |
| Ormond Beach | h, FL 32174 | - | | | | | Audit Status: | Unaudited Cost Report | | |
| Provider Ty | <u>/pe:</u> | | | | | | | | | |
| | <u>HOSPI</u> | <u>ITAL</u> | | <u>Curre</u> | nt Rate | <u>!</u> | New Rate | Effective Date | | |
| | lr | npatient | | DRG | | | DRG | 7/1/2016 | | |
| | 0 | utpatient | | 54 | .90 | | 59.02 | 7/1/2016 | | |
| Inpatient County Billing Rate | | | | | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | | | | |
| rato Typo. | <u>Interim</u> | | | | Х | Prospecti | ve | | | |
| | _ | Total Inte | erim | _ | | X | Total Prospec | tive | | |
| | | Settleme | nt Based on | Cost | | | | | | |
| | | | | | | | | | | |
| | | _ | | <u>B</u> | ASIS: | <u>.</u> | | | | |
| | | _ | | Budget – | | | | | | |
| | | _ | Х | Unaudited | d Costs | | | | | |
| | | _ | | Field Aud | ited Cos | sts | | | | |
| | | _ | | Revised F | ield Au | dit | | | | |
| | | | | Cost Repo | ort Late | Test | | | | |
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| | | | | | W. Ry | dell Samue | l or Chanda Farca | s A | | |
| | | | | | Medica | aid Cost Re | eimbursement Anal | ysis | | |
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| Batch ID:J4VC6 | | | | | | P | - rinted on : 7/29/2016 4: | 56 PM | | |



101877 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital DeLand | | | Provider Number: | 0101877-00 |
|--------------------------|----------------|---------------------|-------------------------|-------------------------|
| 701 West Plymouth Avenue | | | Date: | 7/29/2016 |
| Deland, FL 32720- | | | Fiscal Year End: | 12/31/2014 |
| | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date |
| Inpati | ent | DRG | DRG | 7/1/2016 |
| Outpat | ient | 49.82 | 53.56 | 7/1/2016 |
| Inpatient County Bill | ling Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | | X <u>Pr</u> | <u>ospective</u> | |
| Tota | l Interim | | X Total Prospec | tive |
| Settl | ement Based or | Cost | | |
| | | | | |
| | | BASIS: | | |
| | | Budget — | | |
| | X | Unaudited Costs — | | |
| | | Field Audited Costs | | |
| | - | Revised Field Audit | | |
| | | Cost Report Late Te | st | |
| | | | | ~ 0 |
| | | W. Rydell | Samuel or Chanda Farcas | i A G |
| | | Medicaid | Cost Reimbursement Anal | ysis |
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| | | | For Information or | nly - No Change in rate |

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101885 - 2016/07

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

| Healthmark Re | egional Medi | ical Cente | r | | | - | Pr | ovider Number: | 0101885 | -00 |
|-----------------|-----------------|------------|-------------|----------------|----------|-------------------------|--------------|----------------------|-------------|----------------|
| PO Box 1326 | ogioriai ivicai | | ! | | | | | Date: | 7/29/2010 | 6 |
| Defuniak Sprin | oge El 224 | 22 | | | | | F | iscal Year End: | 9/30/201 | 5 |
| Delulilak Spili | igs, FL 324 | 33- | | | | | | Audit Status: | Unaudite | d Cost Report |
| Provider Ty | ne: | | | | | | | | | |
| 1 TOVIGET 19 | HOSP | ITAI | | Curre | nt Rate | e | | New Rate | ı | Effective Date |
| | | npatient | | | RG | | | DRG | | 7/1/2016 |
| | 0 | t | | 7.64 | | 304.43 | | 7/1/2016 | | |
| Inpatie | ent Count | | | | | | | | 7/1/2016 | |
| - | | | | | | | | | | |
| Rate Type: | <u>Interim</u> | | | | Χ | Prospe | otivo | | | |
| | <u> </u> | Total Inte | erim | _ | | _ F105pe | | Total Prospec | rtive | |
| | | _ | nt Based on | Cost | | | | _ | , iivo | |
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| | | | | В | SASIS |): | | | | |
| | | • | | Budget | | | | | | |
| | | • | Х | - Unaudited | d Costs | 8 | | | | |
| | | • | | - Field Aud | ited Co | osts | | | | |
| | | • | | - Revised F | ield A | udit | | | | |
| | | • | | Cost Rep | ort Late | e Test | | | | |
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| | | | | | W. Ry | ydell Sam | nuel or | Chanda Farcas | s A | |
| | | | | | Medic | caid Cost | Reim | bursement Anal | ysis | |
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101893 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida Hospital Flagler | | | Provider Number: | 0101893-00 |
|--------------------------|-----------------|----------------------|------------------------|-------------------------|
| 60 Memorial Medical Pkwy | | | Date: | 7/29/2016 |
| Palm Coast, FL 32164- | | | Fiscal Year End: | 12/31/2014 |
| | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | | Current Rate | New Rate | Effective Date |
| Inpatient | | DRG | DRG | 7/1/2016 |
| Outpatien | t | 67.99 | 74.12 | 7/1/2016 |
| Inpatient County Billing | g Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | | X <u>Pros</u> | <u>pective</u> | |
| Total Int | erim | | X Total Prospec | tive |
| Settleme | ent Based on Co | st | | |
| | | | | |
| | | BASIS: | | |
| | Bı | udget | | |
| | X Uı | naudited Costs | | |
| | Fi | eld Audited Costs | | |
| | R | evised Field Audit | | |
| | C | ost Report Late Test | | |
| | | | | |
| | | W. Rydell Sa | amuel or Chanda Farcas | * FG |
| | | Medicaid Co | st Reimbursement Anal | ysis |
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| | | | For Information or | nly - No Change in rate |

Batch ID:J4VC6 Printed on: 7/29/2016 4:56 PM



101907 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Northwest Flor | ida Cammu | nitre | | _ | — Provider Number: | 0101907-00 | |
|----------------------------|---------------------------|--|--------------------|-------------|---------------------------|-------------------------|--|
| Northwest Flor Hospital | ida Cominid | THLY | | | | 7/29/2016 | |
| Post Office Box | x 889 | | | | Fiscal Year End: | | |
| Chipley, FL 32 | 2428- | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | mo: | | | | | | |
| <u>FIOVILIED TY</u> | <u>pe.</u> <u>HOSP</u> | ΙΤΔΙ | Current R | ate | New Rate | Effective Date | |
| | | npatient | DRG | | DRG | 7/1/2016 | |
| | | outpatient | 232.46 | | 253.11 | 7/1/2016 | |
| Innatie | | y Billing Rate | | <u> </u> | 200.11 | 7/1/2016 | |
| | The Ooding | y Dinning Rate | | | | | |
| Rate Type: | | | | _ | | | |
| | <u>Interim</u> - | Total lateries | X | | | di ca | |
| | | _ Total Interim _ Settlement Based o | n Cost | × | Total Prospec | xive | |
| | | - Settlement based o | | | | | |
| | | | BAS | is: | | | |
| | | - | Budget | <u></u> | | | |
| | | X | — Unaudited Co | sts | | | |
| | | | — Field Audited | Costs | | | |
| | | | — Revised Field | Audit | | | |
| | | | Cost Report L | ate Test | | | |
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| | | | ١٨/ | Pydall Sam | nuel or Chanda Farcas | . 4 | |
| | | | | | | | |
| | | | Me | dicaid Cost | Reimbursement Anal | ysis | |
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| Batch ID:J4VC6 | | | | | Printed on : 7/29/2016 4: | 56 PM | |



101915 - 2016/07

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

| Kindred Hospita | al-South Fl | orida- | | | | | Pr | ovider Number: | 0101915-00 | |
|-------------------------------|----------------|---------------|-------------|--------------|---------|--------------|---------------|---------------------|----------------|-----------|
| Hollywood | | | | | | | | Date: | 7/29/2016 | |
| 1859 Van Bure | | | | | | | F | iscal Year End: | 8/31/2015 | |
| Hollywood, FL | 33022- | | | | | | | Audit Status: | Unaudited Co | st Report |
| Provider Ty | <u>pe:</u> | | | | | | | | | |
| | <u>HOSP</u> | <u> ITAL</u> | | <u>Curre</u> | nt Rat | <u>e</u> | | New Rate | Effec | tive Date |
| | I | npatient | | DI | RG | | | DRG | 7/1 | 1/2016 |
| | Outpatient | | | | .65 | | 12.52 | | 7/1 | 1/2016 |
| Inpatient County Billing Rate | | | | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| 1 | <u>Interim</u> | | | | X | Prosp | <u>ective</u> | | | |
| | | Total Inte | rim | | | - | X | Total Prospec | tive | |
| • | | _ Settleme | nt Based on | Cost | | | | _ | | |
| | | | | | | | | | | |
| | | _ | | | BASIS | <u>S:</u> | | | | |
| | | _ | | Budget | | | | | | |
| | | _ | Х | Unaudited | | | | | | |
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| | | _ | | Revised F | | | | | | |
| | | - | | Cost Repo | ort Lat | e Test | | | | |
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| | | | | | W. R | ydell Sar | muel or | Chanda Farcas | s py | |
| | | | | | Medi | caid Cos | t Reiml | oursement Anal | ysis | |
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101923 - 2016/07

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

| Desoto Memorial Hospita | al | | | Provider Number: | 0101923-00 | | | |
|-------------------------|--------------------|----------------|---------------|---------------------------|-------------------------|--|--|--|
| PO Box 2180 | | | | Date: 7/29/2016 | | | | |
| Arcadia, FL 33821- | | | | Fiscal Year End: | 9/30/2015 | | | |
| | | | | Audit Status: | Unaudited Cost Report | | | |
| Provider Type: | | | | | | | | |
| | <u>PITAL</u> | <u>Curren</u> | t Rate | New Rate | Effective Date | | | |
| | Inpatient | DR | G | DRG | 7/1/2016 | | | |
| (| Outpatient | 132 | .14 | 139.43 | 7/1/2016 | | | |
| Inpatient Cour | nty Billing Rate | | | | 7/1/2016 | | | |
| Rate Type: | | | | | | | | |
| Interim | | | X Prospe | <u>ective</u> | | | | |
| | Total Interim | | | X Total Prospec | etive | | | |
| | Settlement Based o | n Cost | | | | | | |
| | | | | | | | | |
| | | | ASIS: | | | | | |
| | | Budget — | _ | | | | | |
| | X | Unaudited — | | | | | | |
| | | Field Audite | | | | | | |
| | | Revised Fig | | | | | | |
| | | Cost Repor | rt Late Test | | | | | |
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| | | , | W. Rydell San | nuel or Chanda Farcas | s // | | | |
| | | Ī | Medicaid Cost | t Reimbursement Anal | lysis | | | |
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101931 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Memorial Hosp | nital lacksor | wille | | | | | Pro | ovider Number: | 01019 | 31-00 |
|-----------------|-------------------------------|--------------|-------------|----------------|----------|--------------------------|--------|---------------------|----------|-------------------|
| PO Box16325 | | IVIIIC | | | | | | Date: | 7/29/2 | 016 |
| Jacksonville, F | | | | | | | Fi | scal Year End: | 12/31/ | 2014 |
| Jacksonville, 1 | L 32210 | | | | | | | Audit Status: | Unauc | dited Cost Report |
| Provider Ty | ne. | | | | | | | | | |
| 1 TOVIGET 19 | HOSPI | ITAI | | Curre | nt Rate | е | 1 | New Rate | | Effective Date |
| | | npatient | | | RG | | | DRG | | 7/1/2016 |
| | | utpatient | | | .26 | | | 70.16 | | 7/1/2016 |
| Inpatie | Inpatient County Billing Rate | | | | | | | | 7/1/2016 | |
| | | , | | | | | | | | |
| Rate Type: | <u>Interim</u> | | | | Χ | Prospe | ctivo | | | |
| | <u> </u> | Total Inte | erim | _ | | _ F10Spe X | | Total Prospec | tive | |
| | | _ | nt Based on | Cost | | | • | - | | |
| | | - | | | | | | | | |
| | | | | <u>B</u> | ASIS | <u>):</u> | | | | |
| | | - | | Budget | | <u> </u> | | | | |
| | | - | Х | - Unaudited | d Costs | 8 | | | | |
| | | - | | Field Aud | ited Co | osts | | | | |
| | | _ | | Revised F | ield A | udit | | | | |
| | | - | | Cost Rep | ort Late | e Test | | | | |
| | | _ | | _ | | | | | | |
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| | | | | | W. Ry | ydell Sam | uel or | Chanda Farcas | P | |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | vsis | • 0 |
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101940 - 2016/07

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

| Campbellton-G | Graceville H | ospital | | | | | Pr | ovider Number: | : 0101940-00 | |
|----------------|----------------|----------------|-------------|----------------------------|--------|--------------|---------------|----------------------|-------------------------|--|
| 5429 College [| | | | | | | | Date: | 7/29/2016 | |
| Graceville, FL | | | | | | | F | iscal Year End: | 9/30/2014 | |
| Oracovino, i E | 02240 | | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | | | | |
| • | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rat | <u>e</u> | | New Rate | Effective Date | |
| | I | npatient | | D | RG | | | DRG | 7/1/2016 | |
| Outpatient | | | | 11.65 | | | 12.52 | | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | X | <u>Prosp</u> | <u>ective</u> | | | |
| | | Total Inte | rim | | | | X | Total Prospec | ctive | |
| | | _ Settlemer | nt Based on | Cost | | | | _ | | |
| | | | | | | | | | | |
| | | _ | | | BASIS | <u>S:</u> | | | | |
| | | _ | V | Budget | d Caat | | | | | |
| | | _ | X | Unaudite - Field Auc | | | | | | |
| | | _ | | Revised I | | | | | | |
| | | _ | | Cost Rep | | | | | | |
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| Batch ID:J4VC6 | | | | | | | Printe | ed on : 7/29/2016 4: | :56 PM | |



101991 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Wiregrass Hospital | | | | Provider Number: | 0101991-00 |
|--------------------------|----------------|------------------|-------------|---------------------|-------------------------|
| | | | | | 7/29/2016 |
| 1200 Maple Av. | | | | Fiscal Year End: | |
| Geneva, AL 36340- | | | | | Unaudited Cost Report |
| Date of Law Towns | | | | | |
| Provider Type: | | Occurred Dat | _ | Name Data | Effective Date |
| <u>HOSPITAL</u> | - | Current Rate | <u> </u> | New Rate | Effective Date |
| Inpatient | - | DRG | | DRG | 7/1/2016 |
| Outpatien | - | 78.67 | | 84.57 | 7/1/2016 |
| Inpatient County Billing | g Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Х | Prospecti | <u>ive</u> | |
| Total Int | erim | | - x | Total Prospec | tive |
| Settleme | ent Based on C | Cost | | | |
| | | | | | |
| | | BASIS | <u>:</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | 5 | | |
| | | Field Audited Co | sts | | |
| | | Revised Field Au | udit | | |
| | | Cost Report Late | e Test | | |
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| | | W. Ry | /dell Samue | el or Chanda Farcas | s F G |
| | | Medic | aid Cost Re | eimbursement Anal | ysis |
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Batch ID:J4VC6 Printed on: 7/29/2016 4:56 PM



102016 - 2016/07

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

| Florala Memorial Hospital | | | Provider Number: | 0102016-00 | | | |
|---------------------------|-------------------|----------------------|----------------------------|-------------------------|--|--|--|
| PO BOX 206 | | | Date: 7/29/2016 | | | | |
| Florala, AL 36442- | | | Fiscal Year End: 6/30/2013 | | | | |
| | | | Audit Status: | Unaudited Cost Report | | | |
| Provider Type: | | | | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date | | | |
| Inpatien | | DRG | DRG | 7/1/2016 | | | |
| Outpatie | | 11.65 | 12.52 | 7/1/2016 | | | |
| Inpatient County Billin | | _ | - | 7/1/2016 | | | |
| | | | | | | | |
| Rate Type: Interim | | X Pros | <u>pective</u> | | | | |
| Total Ir | nterim | | X Total Prospec | tive | | | |
| | nent Based on Cos | st | | 0 | | | |
| | | | | | | | |
| | | BASIS : | | | | | |
| | Bu | ıdget | | | | | |
| | X Ur | naudited Costs | | | | | |
| | Fie | eld Audited Costs | | | | | |
| | Re | evised Field Audit | | | | | |
| | Co | ost Report Late Test | | | | | |
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| | | W. Rydell Sa | amuel or Chanda Farcas | | | | |
| | | Medicaid Co | st Reimbursement Anal | ysis | | | |
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102024 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| D.W.Mcmillan Me | emorial | | | | Provider Number: | 0102024-00 |
|-----------------|---------------|-----------------|------------|----------------|-----------------------|-------------------------|
| PO BOX 908 | | | | | Date: | 7/29/2016 |
| Brewton, AL 364 | 127- | | | | Fiscal Year End: | 9/30/2004 |
| , | | | | | Audit Status: | Unaudited Cost Report |
| Provider Type | <u>e:</u> | | | | | |
| | HOSP | <u>ITAL</u> | Curre | ent Rate | New Rate | Effective Date |
| | I | npatient | | RG | DRG | 7/1/2016 |
| | С | Outpatient | 12 | 9.76 | 139.50 | 7/1/2016 |
| Inpatien | t Count | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| | <u>nterim</u> | | | X <u>Pros</u> | <u>pective</u> | |
| | | Total Interim | _ | | X Total Prospec | tive |
| _ | | Settlement Base | ed on Cost | | | |
| _ | | _ | | | | |
| | | | <u> </u> | BASIS: | | |
| | | | Budget | | | |
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| | | | Cost Rep | oort Late Test | | |
| | | | | W. Rydell Sa | amuel or Chanda Farca | s F G |
| | | | | Medicaid Co | st Reimbursement Anal | ysis |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

102041 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Analah alal Manaa | -::t- | -1 | | | | | Provider Number: | 0102041-00 |
|-------------------|----------------|---------------|--------------|----------------|----------|------------------|--------------------|-------------------------|
| Archbold Memor | · | aı | | | | | | 7/29/2016 |
| Post Office Box | | | | | | | Fiscal Year End: | |
| Thomasville, GA | 31799-1 | 018 | | | | | | Unaudited Cost Report |
| | | | | | | | Addit Status. | Ollaudited Cost Report |
| Provider Typ | <u>oe:</u> | | | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | | Curre | nt Rate | | New Rate | Effective Date |
| | I | npatient | | D | RG | | DRG | 7/1/2016 |
| | 0 | utpatien | t | 45 | .54 | | 48.96 | 7/1/2016 |
| Inpatier | nt Count | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| | <u>Interim</u> | | | | Χ | <u>Prospecti</u> | ve | |
| | | Total Inte | erim | | | X | — Total Prospec | ctive |
| _ | | – Settleme | ent Based on | Cost | | | <u> </u> | |
| | | _ | | | | | | |
| | | | | <u>B</u> | ASIS: | | | |
| | | | | Budget | | | | |
| | | | Х | - Unaudited | d Costs | | | |
| | | | | - Field Aud | ited Cos | sts | | |
| | | | | - Revised F | ield Aud | dit | | |
| | | | | - Cost Rep | ort Late | Test | | |
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| | | | | | Medica | aid Cost Re | imbursement Ana | lysis |
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102067 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Southeast Alaban | na General | | | Pi | rovider Number: | 0102067-00 | |
|------------------|-----------------------|-----------------|---------------------|--------------|----------------------|-------------------------|--|
| PO BOX 6987 | | | | | Date: | 7/29/2016 | |
| Dothan, AL 3630 | 1- | | | F | Fiscal Year End: | 9/30/2015 | |
| , | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type | <u>):</u> | | | | | | |
| | HOSPITAL | | Current Rate | | New Rate | Effective Date | |
| | Inpatient | | DRG | _ | DRG | 7/1/2016 | |
| | Outpatient | | 112.49 | | 120.93 | 7/1/2016 | |
| Inpatient | County Billing | Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| | <u>terim</u> | | Х <u></u> | Prospective | | | |
| | Total Inte | rim | | X | Total Prospec | tive | |
| | Settleme | nt Based on Cos | st – | | _ | | |
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| | _ | | BASIS: | | | | |
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| | _ | | audited Costs | | | | |
| | _ | | eld Audited Cost | | | | |
| | _ | | vised Field Audi | | | | |
| | _ | Cc | st Report Late T | est | | | |
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| | | | W. Ryde | ell Samuel o | r Chanda Farcas | | |
| | | | Medicai | d Cost Reim | bursement Anal | ysis | |
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102075 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| South Georgia Medical Cer | nter | | _ | Provider Number: | 0102075-00 |
|---------------------------|---------------------|-----------------|---------------|------------------------|-------------------------|
| PO BOX 1727 | itoi | | | Date: | 7/29/2016 |
| Valdosta, GA 31601- | | | | Fiscal Year End: | 9/30/2014 |
| valuosia, OA 51001 | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPI | TAL | Current Rat | <u>te</u> | New Rate | Effective Date |
| | patient | DRG | | DRG | 7/1/2016 |
| | utpatient | 67.35 | | 72.40 | 7/1/2016 |
| Inpatient County | - | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | Х | Prospectiv | e | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based on | Cost | | | |
| | | | | | |
| | | BASIS | <u>S:</u> | | |
| | | Budget | | _ | |
| | X | Unaudited Cost | S | | |
| | | Field Audited C | | | |
| | | Revised Field A | | | |
| | | Cost Report La | te Test | | |
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| | | W. R | ydell Samuel | or Chanda Farcas | s // |
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102091 - 2016/07

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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|----------------|----------------|---------------------|--------------------------|---------------|-----------------------|-------------------------|
| Flowers Hospit | tal | | | | Provider Number: | 0102091-00 |
| PO BOX 6907 | | | | | Date: | 7/29/2016 |
| Dothan, AL 36 | 6302- | | | | Fiscal Year End: | 6/30/2013 |
| | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | /pe: | | | | | |
| - | <u>HOSPITA</u> | <u>L</u> | Curren | t Rate | New Rate | Effective Date |
| | Inpa | tient | DR | G | DRG | 7/1/2016 |
| | Outp | atient | 60. | 75 | 65.31 | 7/1/2016 |
| Inpatie | ent County B | illing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| rato Typo. | <u>Interim</u> | | | X Prosp | <u>oective</u> | |
| | - To | tal Interim | | | X Total Prospec | tive |
| | Se | ttlement Based o | n Cost | | | |
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| | | | <u>B</u> | ASIS: | | |
| | | | Budget | | _ | |
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| | | | Field Audite | ed Costs | | |
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| | | | Ī | Medicaid Cos | st Reimbursement Anal | ysis |
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102105 - 2016/07

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

| Palm Beach G | ardone Mod | lical Contor | | | | | Pro | ovider Number: | 01021 | 05-00 |
|----------------|----------------|----------------|-------------|-----------|----------|------------|-------------|----------------------|----------|------------------|
| 3360 Burns Ro | | ilcai Cerilei | | | | | | Date: | 7/29/20 | 016 |
| | | 22/10 | | | | | Fi | scal Year End: | 12/31/2 | 2014 |
| Palm Beach G | arueris, FL | 33410- | | | | | | Audit Status: | Unaud | ited Cost Report |
| Provider Ty | ne: | | | | | | | | | |
| <u> </u> | HOSP | ITAL | | Curre | nt Rate | <u>9</u> | j | New Rate | | Effective Date |
| | | npatient | | D | RG | | | DRG | | 7/1/2016 |
| | | utpatient | | | 3.76 | | | 73.92 | | 7/1/2016 |
| Inpatie | ent Count | • | Rate | | | | | | 7/1/2016 | |
| - | ' | | | | | | | | | |
| Rate Type: | <u>Interim</u> | | | | Х | Prospec | ctive | | | |
| | - | Total Inte | rim | | | - X | | Total Prospec | tive | |
| | | – Settlemer | nt Based on | Cost | | - | | _ | | |
| | | = | | | | | | | | |
| | | | | <u>B</u> | BASIS | <u>:</u> | | | | |
| | | | | Budget | | | | | | |
| | | _ | Х | Unaudited | d Costs | 3 | | | | |
| | | _ | | Field Aud | ited Co | sts | | | | |
| | | _ | | Revised F | | | | | | |
| | | _ | | Cost Rep | ort Late | e Test | | | | |
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| | | | | | W. Ry | /dell Samı | uel or | Chanda Farcas | P | |
| | | | | | Medic | aid Cost I | Reimb | oursement Analy | /sis | |
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102121 - 2016/07

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

| Grady Genera | l Hospital | | | | | | Provider Number: | 0102121-00 | |
|----------------|----------------|-------------|-------------|--------------------------------------|----------|-------------|--------------------------|-------------------------|--|
| 1155 5th St. | | | | | | | Date: | 7/29/2016 | |
| Cairo, GA 317 | 728- | | | | | | Fiscal Year End: | 9/30/2014 | |
| Odiro, O/1 017 | . 20 | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | /pe: | | | | | | | | |
| - | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | | New Rate | Effective Date | |
| | li | npatient | | D | RG | | DRG | 7/1/2016 | |
| | 0 | utpatient | | 45 | .98 | | 49.43 | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Χ | Prospectiv | <u>ve</u> | | |
| | _ | Total Inte | erim | | | Х | Total Prospec | ctive | |
| | | Settleme | nt Based on | Cost | • | | | | |
| | | | | | | | | | |
| | | _ | | | ASIS: | | | | |
| | | _ | | Budget | | | | | |
| | | _ | Х | Unaudited | | | | | |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

102130 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Wellington Regional Medical Center | | | | Provider Number: | 0102130-00 | | |
|------------------------------------|-----------------------------------|------------------|-----------|--------------------|-------------------------|--|--|
| | | | | | 7/29/2016 | | |
| 10101 Forest Hill Blvd. | | | | Fiscal Year End: | | | |
| West Palm Beach, FL 33414- | | | | | Unaudited Cost Report | | |
| | | | | riddit Otaldo. | - Chadatoa Coot Roport | | |
| Provider Type: | | | | | | | |
| <u>HOSPITAL</u> | | Current Rate | | New Rate | Effective Date | | |
| Inpatient | | DRG | | DRG | 7/1/2016 | | |
| Outpatient | t | 67.97 | | 73.08 | 7/1/2016 | | |
| Inpatient County Billing | Rate | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | |
| Interim | | Х <u>і</u> | Prospect | <u>ive</u> | | | |
| Total Inte | erim | | X | Total Prospec | etive | | |
| Settleme | nt Based on Cos | - st | | | | | |
| | | | | | | | |
| | | BASIS : | | | | | |
| · | Bu | ıdget | | | | | |
| - | X Unaudited Costs | | | | | | |
| • | Fie | eld Audited Cost | ts | | | | |
| - | Re | evised Field Aud | it | | | | |
| | Co | ost Report Late | Гest | | | | |
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| | W. Rydell Samuel or Chanda Farcas | | | | | | |
| | | Medicai | id Cost R | eimbursement Anal | lysis | | |
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102164 - 2016/07

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

| Mizell Memoria | al Hospital | | | | | | Provider Number: | 0102164-00 |
|----------------|----------------|-------------|-------------|------------|----------|-------------|--------------------------|-------------------------|
| | | | | | | | Date: | 7/29/2016 |
| , | | | | | | | Fiscal Year End: | 9/30/1992 |
| , | | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | /pe: | | | | | | | |
| | <u>HOSPI</u> | <u>ITAL</u> | | Curre | nt Rate | | New Rate | Effective Date |
| | lı | npatient | | DI | ₹G | | DRG | 7/1/2016 |
| | 0 | utpatient | | 11 | .65 | | 12.52 | 7/1/2016 |
| Inpatie | ent County | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| | <u>Interim</u> | | | | Χ | Prospecti | <u>ve</u> | |
| | | Total Inte | rim | | | . X | Total Prospec | etive |
| | | Settleme | nt Based on | Cost | | | | |
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| | | _ | | | ASIS: | | | |
| | | - | | Budget | | | | |
| | | _ | X | Unaudited | | | | |
| | | _ | | Field Audi | | | | |
| | | - | | Revised F | | | | |
| | | _ | | Cost Repo | JII Lale | 1681 | | |
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| | | | | | Medica | aid Cost Re | eimbursement Anal | lysis |
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102199 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| <u></u> | odiodia itoliii | sareement rate enanger | <u> </u> | | | | | |
|--------------------------|-----------------|-----------------------------------|-----------------------|-------------------------|--|--|--|--|
| Citrus Memorial Hospital | | | Provider Number: | | | | | |
| 502 Highland Blvd. | | | Date: | 7/29/2016 | | | | |
| Iverness, FL 32652- | | | Fiscal Year End: | 10/31/2015 | | | | |
| | | | Audit Status: | Unaudited Cost Report | | | | |
| Provider Type: | | | | | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date | | | | |
| Inpatie | nt | DRG | DRG | 7/1/2016 | | | | |
| Outpation | | 56.45 | 60.69 | 7/1/2016 | | | | |
| Inpatient County Billi | | | | 7/1/2016 | | | | |
| | | | | _ | | | | |
| Rate Type: Interim | | X <u>Prosp</u> | <u>pective</u> | | | | | |
| | nterim | | X Total Prospec | tive. | | | | |
| | ment Based o | | | | | | | |
| | | | | | | | | |
| | | BASIS: | | | | | | |
| | | Budget | | | | | | |
| | X | | | | | | | |
| | | Field Audited Costs | | | | | | |
| | | — Revised Field Audit | | | | | | |
| | | Cost Report Late Test | | | | | | |
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| | | W. Rydell Samuel or Chanda Farcas | | | | | | |
| | | Medicaid Cos | st Reimbursement Anal | ysis | | | | |
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102202 - 2016/07

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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|---------------------------|-----------------------------------|------------------------|-----------------------|-------------------------|--|--|--|--|
| Cleveland Clinic Hospital | | | Provider Number: | | | | | |
| 3100 Weston Rd | | | Date: | 7/29/2016 | | | | |
| Weston, FL 33331- | | | Fiscal Year End: | 12/31/2014 | | | | |
| | | | Audit Status: | Unaudited Cost Report | | | | |
| Provider Type: | | | | | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date | | | | |
| Inpatient | İ | DRG | DRG | 7/1/2016 | | | | |
| Outpatier | | 52.33 | 56.25 | 7/1/2016 | | | | |
| Inpatient County Billing | | | | 7/1/2016 | | | | |
| | | | | | | | | |
| Rate Type: | | V | 4. | | | | | |
| Interim Total In | to rim | X Prosp | <u>Dective</u> | ati vo | | | | |
| Total In | terim ent Based or | | X Total Prospec | aive | | | | |
| Settlem | ent based of | 1 Cost | | | | | | |
| | | DACIC. | | | | | | |
| | | BASIS: | | | | | | |
| | | Budget | | | | | | |
| | X | Unaudited Costs | | | | | | |
| | | Field Audited Costs | | | | | | |
| | | Revised Field Audit | | | | | | |
| | | Cost Report Late Test | | | | | | |
| | W. Rydell Samuel or Chanda Farcas | | | | | | | |
| | | Medicaid Cos | st Reimbursement Anal | ysis | | | | |
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102229 - 2016/07

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

| Memorial Hosp | oital Pembro | ke | | | | | Provider Number: | : 0102229-00 | |
|-----------------|----------------|------------|-------------|-----------|-----------|------------|--------------------------------|-------------------------|--|
| 2301 University | y Dr. | | | | | | Date: 7/29/2016 | | |
| Pembroke Pine | | 4- | | | | | Fiscal Year End: | l: 4/30/2015 | |
| | , | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | | | |
| | <u>HOSPI</u> | <u>TAL</u> | | Curre | ent Rate | <u>•</u> | New Rate | Effective Date | |
| | Ir | npatient | | | RG | | DRG | 7/1/2016 | |
| | O | utpatient | | 8 | 9.38 | | 95.77 | 7/1/2016 | |
| Inpatie | nt County | / Billing | Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | _ | |
| | <u>Interim</u> | | | | Χ | Prospect | <u>tive</u> | | |
| | • | Total Inte | erim | _ | | - X | Total Prospec | ctive | |
| • | | Settleme | nt Based on | Cost | | | | | |
| • | | - | | | | | | | |
| | | _ | | <u> </u> | BASIS: | <u>.</u> | | | |
| | | _ | | Budget | | | | | |
| | | _ | Х | _Unaudite | ed Costs | | | | |
| | | _ | | Field Au | dited Co | sts | | | |
| | | _ | | Revised | Field Au | ıdit | | | |
| | | _ | | Cost Rep | oort Late | e Test | | | |
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| | | | | | W. Ry | dell Samu | el or Chanda Farca | s A T | |
| | | | | | Medic | aid Cost R | eimbursement Ana | lysis | |
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102261 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Homestead Hospital | | - | Pi | rovider Number: | 0102261-00 | | | |
|--------------------------|----------------|----------------------|---|-------------------|-------------------------|--|--|--|
| | | | | | 7/29/2016 | | | |
| 160 N.W. 13th Street | | | F | Fiscal Year End: | | | | |
| Homestead, FL 33030- | | | - | | Unaudited Cost Report | | | |
| | | | | | | | | |
| Provider Type: | | O D. 1 | | Name Bata | Effective Date | | | |
| <u>HOSPITAL</u> | | Current Rate | | New Rate | Effective Date | | | |
| Inpatient | | DRG | | DRG | 7/1/2016 | | | |
| Outpatient | | 144.60 | - | 155.45 | 7/1/2016 | | | |
| Inpatient County Billing | Rate | | | | 7/1/2016 | | | |
| Rate Type: | | | | | | | | |
| <u>Interim</u> | | X <u>Pro</u> | spective | | | | | |
| Total Inte | erim | | X | Total Prospec | tive | | | |
| Settleme | ent Based on (| Cost | | _ | | | | |
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| | | BASIS : | | | | | | |
| | Budget | | | | | | | |
| | Х | Unaudited Costs | | | | | | |
| | | Field Audited Costs | | | | | | |
| | | Revised Field Audit | | | | | | |
| | | Cost Report Late Tes | t | | | | | |
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| | | W. Rydell S | Samuel o | r Chanda Farcas | # (# | | | |
| | | Medicaid C | Cost Reim | bursement Anal | vsis | | | |
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102288 - 2016/07

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

| Heart Of Floric | da Hospital | | | | Provider Number: 0102288-00 | | | | |
|-----------------|----------------|------------------|--------------|---------------|-----------------------------|-------------------------|--|--|--|
| P.O. Box 67 | · | | | | Date: 7/29/2016 | | | | |
| Haines City, Fl | L 33845- | | | | Fiscal Year End: | 6/6/2015 | | | |
| | | | | | Audit Status: | Amended Cost Report | | | |
| Provider Ty | pe: | | | | | | | | |
| - | HOSF | PITAL | <u>Curre</u> | nt Rate | New Rate | Effective Date | | | |
| | | Inpatient | D | RG | DRG | 7/1/2016 | | | |
| | C | Dutpatient | 53 | 3.15 | 57.14 | 7/1/2016 | | | |
| Inpatie | | ty Billing Rate | | | | 7/1/2016 | | | |
| Rate Type: | | | | _ | | | | | |
| itale Type. | <u>Interim</u> | | | X Pros | <u>pective</u> | | | | |
| | | Total Interim | _ | | X Total Prospec | tive | | | |
| | | Settlement Based | on Cost | | <u> </u> | | | | |
| | | _ | | | | | | | |
| | | | <u>B</u> | BASIS: | | | | | |
| | | | Budget | | _ | | | | |
| | | | Unaudited | d Costs | | | | | |
| | | | Field Aud | ited Costs | | | | | |
| | | | Revised F | Field Audit | | | | | |
| | | | Cost Rep | ort Late Test | | | | | |
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| | | | | W. Rydell Sa | amuel or Chanda Farcas | s A T | | | |
| | | | | Medicaid Co | st Reimbursement Anal | ysis | | | |
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102300 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Kindred Hespital Central Tompo | • | Provider Number: | 0102300-00 | | | | |
|--------------------------------|---|------------------------|-------------------------|--|--|--|--|
| Kindred Hospital Central Tampa | | | 7/29/2016 | | | | |
| 4801 N HOWARD AVE. | | Fiscal Year End: | | | | | |
| Tampa, FL 33604- | | | Unaudited Cost Report | | | | |
| | | riddit Otatao. | | | | | |
| Provider Type: | | | | | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date | | | | |
| Inpatient | DRG | DRG | 7/1/2016 | | | | |
| Outpatient | 11.65 | 12.52 | 7/1/2016 | | | | |
| Inpatient County Billing Rate | | | 7/1/2016 | | | | |
| Rate Type: | | | | | | | |
| <u>Interim</u> | X <u>Pro</u> | <u>spective</u> | | | | | |
| Total Interim | | X Total Prospec | tive | | | | |
| Settlement Based or | n Cost | | | | | | |
| | | | | | | | |
| | BASIS : | | | | | | |
| | Budget | | | | | | |
| X | X Unaudited Costs | | | | | | |
| | Field Audited Costs | | | | | | |
| | Revised Field Audit | | | | | | |
| | Cost Report Late Test | t | | | | | |
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| | W. Rydell Samuel or Chanda Farcas | | | | | | |
| | Medicaid C | ost Reimbursement Anal | ysis | | | | |
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102326 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Dontiet Madical Contar Books | | Provider Number: | 0102326-00 | |
|----------------------------------|-----------------------|-----------------------|-------------------------|--|
| Baptist Medical Center - Beaches | | | 7/29/2016 | |
| 1350 13th AVE., SOUTH | | Fiscal Year End: | | |
| Jacksonville, FL 32250- | | | Unaudited Cost Report | |
| | | Addit Glatus. | — Chaddica Cost Report | |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date | |
| Inpatient | DRG | DRG | 7/1/2016 | |
| Outpatient | 58.87 | 63.29 | 7/1/2016 | |
| Inpatient County Billing Rate | | | 7/1/2016 | |
| Rate Type: | | | | |
| <u>Interim</u> | X <u>Pros</u> į | <u>pective</u> | | |
| Total Interim | | X Total Prospec | tive | |
| Settlement Based on C | Cost | | | |
| | | | | |
| | BASIS: | | | |
| | Budget | | | |
| X | Unaudited Costs | | | |
| | Field Audited Costs | | | |
| | Revised Field Audit | | | |
| | Cost Report Late Test | | | |
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| | W. Rydell Sa | muel or Chanda Farcas | F G | |
| | Medicaid Co | st Reimbursement Anal | ysis | |
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102334 - 2016/07

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

| Atmore Comm | unity Hospit | al | | | | | Provider Number: | : 0102334-00 | |
|----------------|----------------|-------------|-------------|----------------|----------|------------|--------------------------------|-------------------------|--|
| 401 Medical Pa | ark Dr. | | | | | | Date: | 7/29/2016 | |
| Atmore, AL 36 | | | | | | | Fiscal Year End: | 9/30/2013 | |
| , | | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | /pe: | | | | | | | | |
| | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | <u>!</u> | New Rate | Effective Date | |
| | lı | npatient | | D | RG | | DRG | 7/1/2016 | |
| | 0 | utpatient | | 34.23 | | | 36.80 | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Χ | Prospect | ive | | |
| | - | Total Inte | rim | | | X | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | | |
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| | | _ | | <u>B</u> | ASIS: | <u>:</u> | | | |
| | | _ | | Budget – | | | | | |
| | | _ | X | Unaudited | | | | | |
| | | _ | | Field Aud - | | | | | |
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| | | _ | | Cost Rep | ort Late | Test | | | |
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| | | | | | W. Ry | dell Samue | el or Chanda Farca | s 👭 | |
| | | | | | Medica | aid Cost R | eimbursement Anal | lysis | |
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102342 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Kindred Hospi | tal-Bay Area | n-Tampa | | | | _ | - Provider Number | : 0102342-00 |
|---------------|----------------|----------------|--------------|-----------|----------|----------------|----------------------|-------------------------|
| 4555 SOUTH | | | | | | | Date | 7/29/2016 |
| | | MIN AVE. | | | | | Fiscal Year End | : 8/31/2015 |
| Tampa, FL 33 | 0011- | | | | | | Audit Status | : Unaudited Cost Report |
| Duesdalen Ts | | | | | | | | · · · |
| Provider Ty | | I T | | Curro | ent Rat | • | Now Poto | Effective Date |
| | HOSP. | | | | | <u>e</u> | New Rate | Effective Date |
| | | npatient | | | RG | | DRG | 7/1/2016 |
| | | utpatien | | 11 | 1.65 | | 12.52 | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| | <u>Interim</u> | | | | Χ | <u>Prospec</u> | <u>tive</u> | |
| | - | Total Inte | erim | _ | | _ x | Total Prospec | otive |
| | | - Settleme | ent Based on | Cost | | | | |
| | | | | | | | | |
| | | | | <u> </u> | BASIS | <u>6:</u> | | |
| | | • | | Budget | | | | |
| | | • | Х | Unaudite | d Cost | S | | |
| | | , | | Field Auc | dited Co | osts | | |
| | | • | | Revised I | Field A | udit | | |
| | | | | Cost Rep | ort Lat | e Test | | |
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| | | | | | W. R | ydell Samu | el or Chanda Farca | s RG |
| | | | | | Medi | caid Cost R | Reimbursement Ana | lysis |
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102369 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Smith Hospital | | | | | | | Provider Number: | 0102369-00 | |
|-------------------|-------------|---------------|------------|------------|----------|------------|--------------------|-------------------------|--|
| P.O. Box 10010 | | | | | | | Date: | 7/29/2016 | |
| Valdosta, GA 3160 | 04- | | | | | | Fiscal Year End: | 12/31/2010 | |
| | | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | <u>.</u> | | | | | | | | |
| | HOSPI | <u>TAL</u> | | Currer | nt Rate | | New Rate | Effective Date | |
| | Ir | patient | | DF | RG | | DRG | 7/1/2016 | |
| | Οι | utpatient | | 74. | .19 | | 79.75 | 7/1/2016 | |
| Inpatient (| County | Billing R | ate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | |
| | <u>erim</u> | | | | Χ | Prospecti | <u>ve</u> | | |
| | | Total Interim | | | | X | Total Prospec | tive | |
| | | Settlement E | Based on (| Cost | _ | | | | |
| | | • | | | | | | | |
| | | | | <u>B</u> | ASIS: | | | | |
| | | | | Budget | | | | | |
| | | | Х | Unaudited | Costs | | | | |
| | | | | Field Audi | ted Cost | ts | | | |
| | | | | Revised F | ield Aud | it | | | |
| | | | | Cost Repo | ort Late | Γest | | | |
| | | | | | W. Ryd | ell Samuel | or Chanda Farcas | F | |
| | | | | | Medica | id Cost Re | imbursement Anal | ysis | |
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102407 - 2016/07

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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|--------------------|---|------------|---------------|------------|----------|------------|--------------|---------------------|------------|-----------------|
| St. Anthony's R | | n Hospitai | | | | | | | 7/29/20 | |
| 3075 N.W. 35th | | | | | | | Fi | scal Year End: | | |
| Lauderdale Lak | ke, FL 3331 | 1- | | | | | | | | ted Cost Report |
| | | | | | | | | Addit Otatus. | - Inaudit | Lea Cost Report |
| <u>Provider Ty</u> | - | | | _ | | | | | | |
| | <u>HOSPI</u> | | | Curre | | <u> </u> | | New Rate | | Effective Date |
| | | npatient | | DRG | | | DRG | | | 7/1/2016 |
| | | utpatient | | 11 | 11.65 | | | 12.52 | | 7/1/2016 |
| Inpatie | nt County | / Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | Χ | Prospec | <u>ctive</u> | | | |
| | • | Total Inte | erim | | | - x | | Total Prospec | tive | |
| | | Settleme | nt Based on (| Cost | | | | - | | |
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| | | _ | | <u>B</u> | ASIS | <u>:</u> | | | | |
| | | _ | | Budget | | | | | | |
| | | _ | Χ | Unaudited | d Costs | 3 | | | | |
| | | _ | | Field Audi | ited Co | sts | | | | |
| | | _ | | Revised F | ield Au | udit | | | | |
| | | | | Cost Repo | ort Late | e Test | | | | |
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| | | | | | W. Ry | /dell Samı | uel or | Chanda Farcas | s p(| |
| | | | | | Medic | aid Cost F | Reimb | ursement Anal | ysis | |
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102474 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| South Baldwin Hospital | | | _ | Provider Number: | 0102474-00 |
|-------------------------|-----------------|-------------|--------------|------------------------|-------------------------|
| • | | | | Date: | 7/29/2016 |
| 1613 West McKenzie St. | | | | Fiscal Year End: | |
| Foley, AL 36536 | | | | | Unaudited Cost Report |
| | | | | , taali Otatao. | |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | | Curren | | New Rate | Effective Date |
| Inpatier | nt | DR | G | DRG | 7/1/2016 |
| Outpatie | ent | 11. | 65 | 12.52 | 7/1/2016 |
| Inpatient County Billin | ng Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | | X Pros | spective | |
| Total li | nterim | | | X Total Prospec | tive |
| | nent Based on C | Cost | | <u> </u> | |
| | | | | | |
| | | В | ASIS: | | |
| | | Budget | | | |
| | | Unaudited | Costs | | |
| | | Field Audit | ed Costs | | |
| | | Revised Fi | | | |
| | | | rt Late Test | | |
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| | | | W. Rydell S | amuel or Chanda Farcas | F F |
| | | - | Medicaid Co | ost Reimbursement Anal | ysis |
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| | | | | For information or | nly - No Change in rate |

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102521 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Memorial Hospital West | | | - | | Provider Number: | 0102521-00 |
|---------------------------|-----------------|-------------|--------------|--------|--------------------|-------------------------|
| • | | | | | | 7/29/2016 |
| 703 North Flamingo Road | | | | | Fiscal Year End: | |
| Pembroke Pines, FL 33028- | | | | | | Unaudited Cost Report |
| | | | | | radit Status. | |
| Provider Type: | | | | | | |
| <u>HOSPITAL</u> | | Curren | | | New Rate | Effective Date |
| Inpatien | t | DR | G | _ | DRG | 7/1/2016 |
| Outpatie | nt | 128 | .52 | | 7/1/2016 | |
| Inpatient County Billin | g Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| Interim | | | X Pro: | specti | ve | |
| Total Ir | nterim | _ | | Х | Total Prospec | tive |
| Settlen | nent Based on (| Cost | | | <u> </u> | |
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| | | В | ASIS: | | | |
| | | Budget | | | | |
| | | Unaudited | Costs | | | |
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| | | Cost Repo | | t | | |
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| | | , | W. Rydell S | Samue | l or Chanda Farcas | FG |
| | | _ | Medicaid C | ost Re | eimbursement Anal | ysis |
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102539 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | المناهديمومو | : | | | | | Provider Number: | 0102539-00 |) | |
|----------------|----------------|-------------|--------------|------------|------------|------------|-----------------------|---------------|-------------|--|
| Englewood Co | - | ospitai | | | | | | 7/29/2016 | | |
| 700 Medical B | | | | | | | Fiscal Year End: | | | |
| Englewood, Fl | _ 34223- | | | | | | Audit Status: | | Cost Report | |
| D | | | | | | | | | | |
| Provider Ty | | | | 0 | -4 D-4- | | Now Date | F. | antina Data | |
| | HOSP | | | | nt Rate | | New Rate | | ective Date | |
| | | npatient | | | RG | | DRG | | 7/1/2016 | |
| | | Outpatient | _ , | 43.16 | | | 46.40 | | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | X <u>F</u> | Prospectiv | <u>e</u> | | | |
| | | Total Inter | rim | | _ | Х | Total Prospec | tive | | |
| | | Settlemen | t Based on (| Cost | | | | | | |
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| | | _ | | Cost Repo | ort Late T | est | | | | |
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| | | | | | W. Ryde | ell Samuel | or Chanda Farca | s 👭 | | |
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102555 - 2016/07

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

| Southeast Geo | orgia Medica | al Center | | | | i | Provider Number: | 0102555-00 |
|----------------|----------------|--------------|-------------|----------------|------------|------------|------------------------|-------------------------|
| 3100 Kemble / | _ | | | | | | Date: | 7/29/2016 |
| Brunswick, GA | | | | | | | Fiscal Year End: | 4/30/2010 |
| | . 0.020 | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | |
| - | HOSP | <u>ITAL</u> | | Curre | nt Rate | | New Rate | Effective Date |
| | I | npatient | | DI | RG | | DRG | 7/1/2016 |
| | 0 | utpatient | | 48.67 | | | 52.32 | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| rtato Typo. | <u>Interim</u> | | | | Х <u>і</u> | Prospectiv | <u>e</u> | |
| | - | Total Inte | erim | | | X | Total Prospec | tive |
| | | Settleme | nt Based on | Cost | - | | | |
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| | | _ | | <u>B</u> | ASIS: | | | |
| | | _ | | Budget — | | | | |
| | | _ | Х | Unaudited — | l Costs | | | |
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| | | _ | | Revised F | ield Aud | it | | |
| | | _ | | Cost Repo | ort Late | Test | | |
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| | | | | | Medicai | d Cost Rei | nbursement Anal | ysis |
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102598 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Edward White | Hospital | | | | | | Pro | ovider Number: | 01025 | 98-00 |
|----------------|----------------|-------------|-------------|-----------------------------|---------|-----------|--------------|---------------------|----------|-------------------|
| 2323 9th Aven | |) Box | | | | | | Date: | 7/29/2 | 016 |
| 12018 | | J. BOX | | | | | F | iscal Year End: | 11/23/ | 2014 |
| St. Petersburg | , FI 33733- | | | | | | | Audit Status: | Unaud | lited Cost Report |
| Provider Ty | /pe: | | | | | | | | | |
| | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | <u>e</u> | | New Rate | | Effective Date |
| | 1 | npatient | | D | RG | | | DRG | 7/1/2016 | |
| | 0 | utpatient | t | 73.12 | | | | 78.60 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| <u> </u> | <u>Interim</u> | | | | Х | Prospe | <u>ctive</u> | | | |
| | _ | Total Inte | erim | | | _ x | | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | _ | | |
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| | | - | | Budget | | _ | | | | |
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| | | - | | Cost Rep | | | | | | |
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| | | | | | W. Ry | ydell Sam | uel or | Chanda Farcas | P | T |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | ysis | |
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| Batch ID:J4VC6 | | | | | | | Printe | d on : 7/29/2016 4: | 56 PM | |



102601 - 2016/07

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

| Florida Hospita | al Wauchul | а | | | | | Provider Number: | 0102601-00 |
|-----------------|----------------|----------------|------------|--------------|----------|--------------|-----------------------|-------------------------|
| 2501 U.S. Hwy | / 27 NorthF | P.O. Box | | | | | Date: | 7/29/2016 |
| 1200 | | | | | | | Fiscal Year End: | 12/31/2014 |
| Avon Park, FL | 33825- | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>rpe:</u> | | | | | | | |
| - | HOSE | <u>PITAL</u> | | <u>Curre</u> | nt Rate | | New Rate | Effective Date |
| | | Inpatient | | DI | ₹G | | DRG | 7/1/2016 |
| | (| Outpatient | | 92 | .66 | | 100.93 | 7/1/2016 |
| Inpatie | ent Coun | ty Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | _ |
| rate Type. | <u>Interim</u> | | | | X | Prospectiv | re | |
| | - | Total Inter | rim | | | X | Total Prospec | tive |
| | | — Settlemen | t Based on | Cost | , | | | |
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| | | | | <u>B</u> | ASIS: | | | |
| | | | | Budget | | | | |
| | | | Х | Unaudited | Costs | | | |
| | | _ | | Field Audi | ted Cos | sts | | |
| | | | | Revised F | ield Au | dit | | |
| | | | | Cost Repo | ort Late | Test | | |
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102679 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Kindred Hosp. | - North Fla | | | | | | Pro | ovider Number: | 010267 | 79-00 |
|----------------|----------------|--------------|-------------|--------------|---------|-----------|---------|---------------------|----------|------------------|
| 801 Oak Stree | | | | | | | | Date: | 7/29/20 | 016 |
| Green Cove S | | 32043- | | | | | F | iscal Year End: | 8/31/20 | 015 |
| 0.00000 | pgo, < | 320 10 | | | | | | Audit Status: | Unaud | ited Cost Report |
| Provider Ty | /pe: | | | | | | | | | |
| | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rat | <u>e</u> | | New Rate | | Effective Date |
| | I | npatient | | D | RG | | | DRG | 7/1/2016 | |
| | 0 | utpatient | t | 11.65 | | | | 12.52 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | - | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| rtato Typo. | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | - | Total Inte | erim | | | _ | < | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | _ | | |
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| | | _ | | | BASIS | <u>6:</u> | | | | |
| | | - | | Budget - | | | | | | |
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| | | - | | Cost Rep | ort Lat | e rest | | | | |
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| | | | | | W. R | ydell San | nuel or | Chanda Farcas | 1 | V |
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102687 - 2016/07

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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|----------------------------|-----------------|----------------------|------------|----------------|-------------------------|
| HealthSouth Rehab - Dothan | | | Pro | vider Number: | 0102687-00 |
| 1736 East Main Street | | | | Date: | 7/29/2016 |
| Dothan, AL 36301- | | | Fi | scal Year End: | 12/31/2012 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Rate | <u>!</u> | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatient | t | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient County Billing | | | | | 7/1/2016 |
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| Rate Type: Interim | | X Pro | spective | | |
| Total Inte | erim | | X | Total Prospec | tive |
| | nt Based on | Cost — | | • | |
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| - | | Budget | | | |
| - | Х | Unaudited Costs | | | |
| - | | Field Audited Costs | | | |
| - | | Revised Field Audit | | | |
| - | | Cost Report Late Tes | st | | |
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| | | Medicaid C | Cost Reimb | ursement Anal | ysis |
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102709 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| HealthSouth Rehabililation Hospita | al of | | | Provider Number: | 0102709-00 |
|------------------------------------|-----------------|-----------------|---------------|---------------------|-------------------------|
| Miami | | | | Date: | 7/29/2016 |
| 20601 Old Cutler Road | | | | Fiscal Year End: | 12/31/2014 |
| Miami, FL 33188- | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Ra | <u>te</u> | New Rate | Effective Date |
| Inpatier | nt | DRG | | DRG | 7/1/2016 |
| Outpatie | | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient County Billir | | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | Х | Prospect | ive | |
| Total Ir | nterim | | X | Total Prospec | tive |
| Settlen | nent Based on (| Cost | | | |
| | | | | | |
| | | BASI | <u>S:</u> | | |
| | | Budget | | | |
| | X | Unaudited Cos | ts | | |
| | | Field Audited C | Costs | | |
| | | Revised Field A | Audit | | |
| | | Cost Report La | ite Test | | |
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| | | W. F | Rydell Samu | el or Chanda Farcas | F G |
| | | Med | licaid Cost R | eimbursement Anal | ysis |
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102717 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Brooks Rehabilitation Hospital | | | | Provider Number: | 0102717-00 |
|--------------------------------|------------------|------------------|-------------|---------------------|-------------------------|
| • | | | | Date: | 7/29/2016 |
| 3599 University Blvd., S | | | | Fiscal Year End: | 12/31/2014 |
| Jacksonville, FL 32216- | | | | Audit Status: | Unaudited Cost Report |
| Dravidar Type: | | | | | <u>'</u> |
| Provider Type: | | Current Rate | . | New Rate | Effective Date |
| <u>HOSPITAL</u> | nt. | DRG | <u>-</u> – | DRG | 7/1/2016 |
| Inpatie | | | | | _ |
| Outpat | | 36.58 | | 39.33 | 7/1/2016 |
| Inpatient County Bill | ing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | Prospect | | |
| | Interim | | X | Total Prospec | tive |
| Settle | ement Based on (| Cost | | | |
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| | | BASIS | <u>:</u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Co | | | |
| | | Revised Field Au | | | |
| | | Cost Report Late | e Test | | |
| | | W. Ry | dell Samue | el or Chanda Farcas | F G |
| | | Medic | aid Cost Re | eimbursement Anal | ysis |
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102750 - 2016/07

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

| <u>Medicaid Rei</u> | <u>imbursement Rate Change Fo</u> | <u>orm</u> | | | |
|--|--|------------------------|-----------------------|--|--|
| HealthSouth Emerald Coast Rehabilitation Hospital | | Provider Number: 0 | | | |
| 1847 Florida Avenue | Date: 7/29/2016 Fiscal Year End: 12/31/2014 | | | | |
| Panama City, FL 32405- | | _ | | | |
| , , | | Audit Status: C | Jnaudited Cost Report | | |
| <u>Provider Type:</u> | | | | | |
| <u>HOSPITAL</u> | <u>Current Rate</u> | New Rate | Effective Date | | |
| Inpatient | DRG | DRG | 7/1/2016 | | |
| Outpatient | 11.65 | 12.52 | 7/1/2016 | | |
| Inpatient County Billing Rate | | | 7/1/2016 | | |
| Rate Type: | | | | | |
| Interim | X <u>Prosp</u> | <u>ective</u> | | | |
| Total Interim | | X Total Prospectiv | /e | | |
| Settlement Based | d on Cost | | | | |
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| | BASIS: | | | | |
| | Budget | | | | |
| X | Unaudited Costs | | | | |
| | Field Audited Costs | | | | |
| | Revised Field Audit | | | | |
| | Cost Report Late Test | | | | |
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| | Medicaid Cos | t Reimbursement Analys | sis | | |
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102768 - 2016/07

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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|-----------------------------|--|--------------------|-----------------------|-------------------------|-------------------------|
| Kindred Hospi Petersburg | tal-Bay Area-St | | | Provider Number: | |
| 3030 6th Stree | et. South | | | | 7/29/2016 |
| St. Petersburg | | | | Fiscal Year End: | |
| ot. Fotoroburg | ,, | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | |
| | HOSPITAL | | Current Rate | New Rate | Effective Date |
| | Inpatient | | DRG | DRG | 7/1/2016 |
| | Outpatien | t | 11.65 | 12.52 | 7/1/2016 |
| Inpatie | ent County Billing | Rate | | | 7/1/2016 |
| Poto Typo: | | | | | |
| Rate Type: | <u>Interim</u> | | X Pro | <u>spective</u> | |
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| | | | Field Audited Costs | | |
| | | | Revised Field Audit | | |
| | | | Cost Report Late Test | • | |
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| | | | Medicaid C | ost Reimbursement Anal | ysis |
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102776 - 2016/07

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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|-----------------|------------------|--------------|------------------|--------------|--------------------|-------------------------|
| Douglas Gardens | s Hospital | | | | Provider Number: | 0102776-00 |
| 5200 NE 2nd Ave | enue | | | | Date: | 7/29/2016 |
| Miami, FL 33137 | | | | | Fiscal Year End: | 6/30/2015 |
| , | | | | | Audit Status: | Unaudited Cost Report |
| Provider Type | e: | | | | | |
| | _HOSPITAL | | Current Rate | <u>e</u> | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatient | | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient | t County Billing | | | | | 7/1/2016 |
| | | | | | | |
| Rate Type: | <u>iterim</u> | | Χ | Prospect | ive | |
| | Total Inte | erim | | X | Total Prospec | tive |
| _ | | nt Based on | Cost | | | |
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| | | | BASIS | <u>:</u> | | |
| | - | | Budget | | | |
| | - | Х | Unaudited Costs | 3 | | |
| | - | | Field Audited Co | osts | | |
| | - | | Revised Field A | udit | | |
| | - | | Cost Report Late | e Test | | |
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| | | | W. Ry | /dell Samue | el or Chanda Farca | s A G |
| | | | Medic | caid Cost Re | eimbursement Ana | lysis |
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103144 - 2016/07

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

| Physicians Reg | gional Medio | cal Center - | | | | Pro | ovider Number: | 0103 | 144-00 |
|----------------|----------------|------------------|------------------------|--------|-----------|---------|---------------------|---------|-----------------------|
| Pine Ridge | | | | | | | Date: | 7/29/ | 2016 |
| 6101 Pine Rido | - | | | | | F | iscal Year End: | 9/30/ | 2015 |
| Naples, FL 34 | 119- | | | | | | Audit Status: | Ame | nded Cost Report |
| Provider Ty | pe: | | | | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | Curre | nt Rat | <u>e</u> | ļ | New Rate | | Effective Date |
| | l: | npatient | D | RG | | | DRG | _ | 7/1/2016 |
| | 0 | utpatient | 67 | 7.63 | | | 72.71 | | 7/1/2016 |
| Inpatie | ent Count | y Billing Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | |
| | <u>Interim</u> | | | Χ | Prospe | ective | | | |
| | | Total Interim | | | > | (| Total Prospec | tive | |
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| | | | | Medic | caid Cost | Reimb | oursement Anal | ysis | |
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103144 - 2016/07

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

| Physicians Regional Medical Center - | | Provider Number: | 0103144-01 |
|--------------------------------------|----------------------|---------------------------|-------------------------|
| Pine Ridge | | Date: | 7/29/2016 |
| 6101 Pine Ridge Road | | Fiscal Year End: | 9/30/2015 |
| Naples, FL 34119- | | Audit Status: | Amended Cost Report |
| Provider Type: | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 67.63 | 72.71 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
| Interim | X <u>Pro</u> | <u>espective</u> | |
| Total Interim | | X Total Prospec | tive |
| Settlement Based on | Cost | | |
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| | BASIS: | | |
| | Budget — | | |
| | Unaudited Costs — | | |
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| | W. Rydell S | Samuel or Chanda Farcas | |
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103179 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| The Villages Regional | Hospital | | | Provider Number: | 0103179-00 |
|-----------------------|-------------------|--------------|---------------|---------------------------|-------------------------|
| 600 East Dixie Ave | | | | Date: | 7/29/2016 |
| Leesburg, FL 34748- | | | | Fiscal Year End: | 6/30/2015 |
| O. | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HC</u> | <u>SPITAL</u> | Current | t Rate | New Rate | Effective Date |
| | Inpatient | DR | G | DRG | 7/1/2016 |
| | Outpatient | 47.7 | 74 | 51.33 | 7/1/2016 |
| Inpatient Co | unty Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interin | <u>n</u> | | X Prospe | ctive | |
| | Total Interim | | X | Total Prospec | etive |
| | Settlement Based | on Cost | | | |
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| | | Field Audite | ed Costs | | |
| | | Revised Fie | eld Audit | | |
| | | Cost Repor | t Late Test | | |
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| | | \ | N. Rydell Sam | uel or Chanda Farcas | s A |
| | | <u>-</u> 1 | Medicaid Cost | Reimbursement Anal | lysis |
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103209 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Wuesthoff Medical Center Melbo | urne | | Provider Number: | 0103209-00 |
|--------------------------------|---------------------|------------------|---------------------------|-------------------------|
| 250 N. Wickham Road | | | Date: | 7/29/2016 |
| Melbourne, FL 32935- | | | Fiscal Year End: | 6/6/2015 |
| | | | Audit Status: | Amended Cost Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | <u>(</u> | Current Rate | New Rate | Effective Date |
| Inpatie | ent | DRG | DRG | 7/1/2016 |
| Outpati | ent | 35.38 | 38.04 | 7/1/2016 |
| Inpatient County Bill | ing Rate | | | 7/1/2016 |
| Rate Type: | | <u> </u> | | |
| <u>Interim</u> | | X <u>Pros</u> | <u>pective</u> | |
| Total | Interim | | X Total Prospec | tive |
| Settle | ement Based on Cost | | | |
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| | | BASIS: | | |
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| | | udited Costs | | |
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| | | W. Rydell Sa | amuel or Chanda Farca | s // |
| | | Medicaid Co | st Reimbursement Anal | ysis |
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103233 - 2016/07

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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|-------------------------|------------------------|--------------|--|------------|---------------------------------|-------------------------|
| Sacred Heart I Coast | Hospital on the Emeral | d | | | Provider Number: | |
| 7800 US High | wav 98 West | | | | | 7/29/2016 |
| Destin, FL 32 | • | | | | Fiscal Year End: | |
| Destill, FL 323 | 330-7228 | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | |
| | <u>HOSPITAL</u> | | Current Rate | | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatient | | 84.81 | _ | 92.39 | 7/1/2016 |
| Inpatie | ent County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | _ |
| itale Type. | <u>Interim</u> | | X <u>I</u> | Prospecti | ve | |
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| | - | | _ Cost Report Late 1 | est | | |
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| | | | W. Ryde | ell Samue | l or Chanda Farca | s A G |
| | | | Medicai | d Cost Re | eimbursement Anal | ysis |
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103284 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | <u> </u> | — Provider Number: | 0102201 00 |
|---------------------------------|-----------------------|-----------------------|-------------------------|
| Sister Emmanuel Hospital | | | 7/29/2016 |
| 3663 South Miami Ave, 4th Floor | | | |
| Wildriff, FL 33133- | | | 8/31/2015 |
| | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date |
| Inpatient | DRG | DRG | 7/1/2016 |
| Outpatient | 11.65 | 12.52 | 7/1/2016 |
| Inpatient County Billing Rate | | | 7/1/2016 |
| Rate Type: | | | |
| Interim | X <u>Prosp</u> e | ective | |
| Total Interim | | X Total Prospec | tive |
| Settlement Based on C | Cost | · | |
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| | BASIS: | | |
| | Budget | | |
| X | Unaudited Costs | | |
| | Field Audited Costs | | |
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| | Cost Report Late Test | | |
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103373 - 2016/07

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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|----------------|--------------------|------------------|-----------------------|---------------------|---------|-----------------------|--|
| Select Special | ty Hospital-Miami | | | Provider Num | nber: C | 103373-00 | |
| 955 NW 3rd St | treet, 8th Floor | | | С | Date: 7 | //29/2016 | |
| Miami, FL 331 | | | | Fiscal Year | End: 8 | /31/2015 | |
| · | | | | Audit Sta | atus: Ū | Inaudited Cost Report | |
| Provider Ty | /pe: | | | | | | |
| | <u>HOSPITAL</u> | | Current Rate | New Rate | | Effective Date | |
| | Inpatient | | DRG | DRG | | 7/1/2016 | |
| | Outpatient | t | 11.65 | 12.52 | | 7/1/2016 | |
| Inpatie | ent County Billing | Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| itale Type. | <u>Interim</u> | | X Pro | spective | | | |
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| | - | | Revised Field Audit | | | | |
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103390 - 2016/07

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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|--|----------------------------|--------------|------------|-----------------------------|-------------------------|--|
| Select Specialty Hospital - Orlando (South Campus) | | | Р | rovider Number: | | |
| 601 E Rollins Street | | | | | 7/29/2016 | |
| Orlando, FL 32803- | | | ı | Fiscal Year End: 12/31/2014 | | |
| | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| <u>HOSPITAL</u> | Curr | ent Rate | | New Rate | Effective Date | |
| Inpatient | | DRG | | DRG | 7/1/2016 | |
| Outpatient | 1 | 11.65 | | 12.52 | 7/1/2016 | |
| Inpatient County Billing | Rate | | _ | | 7/1/2016 | |
| Rate Type: | | | | | | |
| Interim | | Х <u>Р</u> | rospective | | | |
| Total Inte | rim _ | | X | Total Prospec | tive | |
| | nt Based on Cost | _ | | | | |
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| - | Budget | | | | | |
| _ | X Unaudite | ed Costs | | | | |
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103411 - 2016/07

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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|----------------------------|---------------|------------------------|-----------------------------------|-------------------------|--|--|--|--|
| Charlton Memorial Hospital | | | Provider Number: | | | | | |
| Post Office Box 188 | | | Date: | 7/29/2016 | | | | |
| Folkston, GA 31537- | | | Fiscal Year End: | 6/30/2012 | | | | |
| | | | Audit Status: | Unaudited Cost Report | | | | |
| Provider Type: | | | | | | | | |
| HOSPITAL | | Current Rate | New Rate | Effective Date | | | | |
| Inpatient | | DRG | DRG | 7/1/2016 | | | | |
| Outpatier | | 129.76 | 129.76 139.50 | | | | | |
| Inpatient County Billing | | | | 7/1/2016 | | | | |
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| Rate Type: | | V Broom | a a a tiva | | | | | |
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| | ent Based or | | Total Flospec | uve | | | | |
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| | | BASIS: | | | | | | |
| | | Budget | | | | | | |
| | X | Unaudited Costs | | | | | | |
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| | | Cost Report Late Test | | | | | | |
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| | | Medicaid Cos | st Reimbursement Anal | ysis | | | | |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

103420 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Lakewood Ran | nch Medical | l Center | | | Provider Number: | 0103420-00 |
|---------------|----------------|--------------------|-----------------------------|--------------|----------------------|-------------------------|
| 8330 Lakewoo | d Ranch Bo | oulevard | | | Date: | 7/29/2016 |
| Bradenton, FL | 34202- | | | | Fiscal Year End: | 12/31/2014 |
| , | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | |
| | <u>HOSP</u> | <u>PITAL</u> | Current R | <u>tate</u> | New Rate | Effective Date |
| | 1 | Inpatient | DRG | | DRG | 7/1/2016 |
| | C | Outpatient | 71.23 | | 76.58 | 7/1/2016 |
| Inpatie | nt Count | ty Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| | <u>Interim</u> | | X | Prospe | <u>ctive</u> | |
| | | Total Interim | | X | Total Prospec | tive |
| | | Settlement Based o | on Cost | | | |
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103438 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Coloot Coopiel | tu Hoonital I | Danama | | | — Provider Number: | 0103438-00 | |
|-------------------------|---------------|-----------------------------------|--------------------|-------------|-------------------------------------|---------------------------------------|--|
| Select Specials City | іу поѕрііаі-і | Fallallia | | | | 7/29/2016 | |
| 615 N Bonita A | Avenue | | | | Fiscal Year End: | 7/31/2015 | |
| Panama City, I | FL 32401- | | | | Audit Status: Unaudited Cost Report | | |
| Provider Ty | mo: | | | | | · · · · · · · · · · · · · · · · · · · | |
| <u>Fiovider Ty</u> | <u>HOSP</u> | ΙΤΔΙ | Current R | ate | New Rate | Effective Date | |
| | | npatient | DRG | | DRG | 7/1/2016 | |
| | | Outpatient | 11.65 | | 12.52 | 7/1/2016 | |
| Innatie | | y Billing Rate | 11.00 | | 12.02 | 7/1/2016 | |
| | in Oodin | y Dinning Rate | | | | | |
| Rate Type: | | | V | _ | | | |
| | Interim - | Total Interim | X | | | eti vo | |
| | | Total Interim Settlement Based on | Cost | | Total Prospec | tive | |
| | | | | | | | |
| | | | BAS | IS: | | | |
| | | | Budget | <u></u> | | | |
| | | X | _ Unaudited Co | sts | | | |
| | | | - Field Audited | Costs | | | |
| | | | – Revised Field | Audit | | | |
| | | | – Cost Report L | ate Test | | | |
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| | | | Me | dicaid Cost | Reimbursement Anal | ysis | |
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103454 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Memorial Hospital Miramar | | | | Provider Number: | 0103454-00 | | |
|---------------------------|----------------|--------------------|-----------|--------------------|-------------------------|--|--|
| · | | | | | 7/29/2016 | | |
| 1901 SW 172nd Avenue | | | | Fiscal Year End: | | | |
| Miramar, FL 33029- | | | | | Unaudited Cost Report | | |
| | | | | , idan Giaida. | | | |
| Provider Type: | | | | | | | |
| <u>HOSPITAL</u> | _ | Current Rate | | New Rate | Effective Date | | |
| Inpatient | _ | DRG | | DRG 7/1/201 | | | |
| Outpatient | : _ | 83.00 | | 88.88 | 7/1/2016 | | |
| Inpatient County Billing | Rate | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | |
| Interim | | Х <u>Р</u> | rospectiv | <u>⁄e</u> | | | |
| Total Inte | erim | | X | Total Prospec | tive | | |
| Settleme | nt Based on Co | est — | | <u> </u> | | | |
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103462 - 2016/07

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

| St Cloud Regio | nal Medica | al Center | | | Provider Number: 0103462-00 | | | |
|-----------------|----------------|----------------------|--------------|---------------|-----------------------------|-------------------------|--|--|
| 2906 17th Stre | et | | | | Date: | 7/29/2016 | | |
| Saint Cloud, FL | _ 34769- | | | | Fiscal Year End: | 12/31/2014 | | |
| , | | | | | Audit Status: | Amended Cost Report | | |
| Provider Ty | pe: | | | | | | | |
| · | <u>HOSF</u> | PITAL | <u>Curre</u> | nt Rate | New Rate | Effective Date | | |
| | | Inpatient | D | RG | DRG | 7/1/2016 | | |
| | C | Outpatient | 52 | 2.01 | 55.91 | 7/1/2016 | | |
| Inpatie | nt Coun | ty Billing Rate | | _ | | 7/1/2016 | | |
| Rate Type: | | | | | | | | |
| rate Type. | <u>Interim</u> | | | X Pros | spective | | | |
| | | Total Interim | | | X Total Prospec | tive | | |
| , | | Settlement Based | on Cost | | | | | |
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| | | | <u>B</u> | BASIS: | | | | |
| | | | Budget | | | | | |
| | | | Unaudited | d Costs | | | | |
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| | | | | Field Audit | | | | |
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| | | | | W. Rydell S | amuel or Chanda Farcas | s #1 | | |
| | | | | Medicaid Co | ost Reimbursement Anal | ysis | | |
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103535 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Kindred Hospital Ocala | | | F | Provider Number: | 0103535-00 | |
|-------------------------|---------------------|---------------------|---------------|-------------------|-------------------------|--|
| 1500 SW 1st Avenue, 5th | Floor | | | Date: | 7/29/2016 | |
| Ocala, FL 34474- | | | | Fiscal Year End: | 8/31/2015 | |
| , | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| <u>HOSP</u> | <u> ITAL</u> | Current Rate | | New Rate | Effective Date | |
| I | Inpatient | DRG | | DRG | 7/1/2016 | |
| C | Outpatient | 11.65 | | 12.52 | 7/1/2016 | |
| Inpatient Count | y Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | |
| Interim | | X | Prospective | <u>e</u> | | |
| | Total Interim | | X | Total Prospec | tive | |
| | Settlement Based or | n Cost | | | | |
| | | | | | | |
| | | BASIS: | | | | |
| | | Budget | | | | |
| | X | Unaudited Costs | | | | |
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| | | Medica | aid Cost Reir | mbursement Anal | ysis | |
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103543 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Doctors Hospital | | | - | Provider Number: | 0103543-00 |
|-------------------------|-----------------------|---------------|---------------|---------------------|-------------------------|
| 5000 University Drive | | | | Date: | 7/29/2016 |
| • | | | | Fiscal Year End: | 9/30/2015 |
| Coral Gables, FL 33146- | | | | | Unaudited Cost Report |
| . . | | | | | |
| Provider Type: | | | | | - |
| <u>HOSPI</u> | | Current R | <u>ate</u> | New Rate | Effective Date |
| | npatient | DRG | | DRG | 7/1/2016 |
| Oı | utpatient | 142.0 | <u> </u> | 152.70 | 7/1/2016 |
| Inpatient County | / Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Х | Prospect | tive | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based on C | Cost | | <u> </u> | |
| | - | | | | |
| | | BAS | SIS: | | |
| | | Budget | | | |
| | X | Unaudited Co | sts | | |
| | | Field Audited | Costs | | |
| | | Revised Field | Audit | | |
| | | Cost Report L | | | |
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| | | W. | Rydell Samu | el or Chanda Farcas | F G |
| | | Me | dicaid Cost R | eimbursement Anal | ysis |
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103551 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| HealthSouth R | ehabilitatio | n Hospital of | | | | | F | Provider Number: | 0103 | 551-00 | |
|-----------------|----------------|---------------|----------|-----------|----------|---------------|--------------|-------------------|----------|-----------------------|--|
| Spring Hill | | | | | | | | Date: | 7/29/ | 2016 | |
| 12440 Cortez E | Boulrvard | | | | | | | Fiscal Year End: | 12/3 | 1/2014 | |
| Brooksville, FL | . 34613- | | | | | | Audit Status | | | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | | | | | |
| | <u>HOSF</u> | PITAL | | Curre | ent Rat | : <u>e</u> | | New Rate | | Effective Date | |
| | | Inpatient | | | RG | | | DRG | 7/1/2016 | | |
| | (| Dutpatient | | 1 | 11.65 | | 12.52 | | _ | 7/1/2016 | |
| Inpatie | ent Coun | ty Billing F | Rate | | | | | | _ | 7/1/2016 | |
| Rate Type: | | | | | | | | | | | |
| | <u>Interim</u> | | | _ | Χ | <u>Prospe</u> | ctive | <u> </u> | | | |
| | | Total Interi | m | | | x | | Total Prospec | tive | | |
| | | Settlement | Based or | n Cost | | | | | | | |
| | | | | | | | | | | | |
| | | _ | | | BASIS | <u>S:</u> | | | | | |
| | | _ | | Budget | | | | | | | |
| | | _ | Х | Unaudite | | | | | | | |
| | | _ | | Field Aud | | | | | | | |
| | | _ | | Revised | | | | | | | |
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| | | | | | W. R | ydell Sam | uel c | or Chanda Farcas | 5 | F G | |
| | | | | | Medi | caid Cost | Rein | nbursement Anal | ysis | | |
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103560 - 2016/07

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

| Healthsouth Ri | idgelake Ho | ospital | | | Provider Number: 0103560-00 | | | |
|----------------|----------------|----------------|-------------|-----------------|-----------------------------|--------------|------------------------|-------------------------|
| 6150 Edgelake | e Drive | | | | | | Date: | 7/29/2016 |
| Sarasota, FL | | | | | | | Fiscal Year End: | 5/31/2015 |
| , | | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | | | |
| - | HOSE | <u>PITAL</u> | | <u>Curre</u> | nt Rate | | New Rate | Effective Date |
| | | Inpatient | | DI | RG | | DRG | 7/1/2016 |
| | | Dutpatient | | 11 | .65 | | 12.52 | 7/1/2016 |
| Inpatie | ent Coun | ty Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| rate Type. | <u>Interim</u> | | | | Х <u></u> | rospective | <u>9</u> | |
| | - | Total Inte | rim | | | X | Total Prospec | tive |
| | | — Settlemei | nt Based on | Cost | _ | | <u> </u> | |
| | | | | | | | | |
| | | _ | | <u>B</u> | ASIS: | | | |
| | | _ | | Budget – | | | | |
| | | _ | X | Unaudited — | | | | |
| | | _ | | Field Audi – | | | | |
| | | _ | | Revised F | | | | |
| | | _ | | Cost Repo | ort Late T | est | | |
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103683 - 2016/07

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

| Select Special | ty Hospital F | Pensacola | | | | _ | Pr | ovider Number: | 0103683 | 3-00 | |
|----------------|----------------|-------------|-------------|-----------------------------|---------|-----------|---------------|----------------------|------------|---------------------|--|
| Inc | , , | | | | | | | Date: | 7/29/201 | 6 | |
| 7000 Cobble C | Creek Drive | | | | | | F | iscal Year End: | 9/30/201 | 5 | |
| Pensacola, Fl | 32504- | | | | | | | Audit Status: | Unaudite | ed Cost Report | |
| Provider Ty | /pe: | | | | | | | | | | |
| • | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rat | <u>e</u> | | New Rate | | Effective Date | |
| | li | npatient | | D | RG | | | DRG | | 7/1/2016 | |
| | 0 | utpatient | t | 11.65 | | | 12.52 | | | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | | |
| | <u>Interim</u> | | | | X | Prosp | <u>ective</u> | | | | |
| | | Total Inte | erim | | | | X | Total Prospec | tive | | |
| | | Settleme | nt Based on | Cost | | | | _ | | | |
| | | | | | | | | | | | |
| | | - | | | BASIS | <u>5:</u> | | | | | |
| | | - | | Budget - | | _ | | | | | |
| | | - | X | Unaudited - Field Aud | | | | | | | |
| | | - | | Revised F | | | | | | | |
| | | - | | Cost Rep | | | | | | | |
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103721 - 2016/07

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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|--------------------------|---------------|------------------|-----------------------------|--------------------|-------------------------|
| BayCare Alliant Hospital | | | | Provider Number: | 0103721-00 |
| 601 Main Street, MS 469 | | | | Date: | 7/29/2016 |
| Dunedin, FL 34698- | | | | Fiscal Year End: | 12/31/2014 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Rat | <u>e</u> | New Rate | Effective Date |
| Inpatient | | DRG | | DRG | 7/1/2016 |
| Outpatien | t | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient County Billing | | | 7/1/2016 | | |
| | | | | | _ |
| Rate Type: Interim | | Х | <u>Prospect</u> | ive | |
| Total Inte | erim | | – 1 100росі Х | Total Prospec | ctive |
| | nt Based on (| Cost | | | |
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| | | BASIS | <u>):</u> | | |
| | | Budget | | | |
| | Х | Unaudited Costs | 3 | | |
| | | Field Audited Co | osts | | |
| | | Revised Field A | udit | | |
| | | Cost Report Lat | e Test | | |
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| | | W. R | ydell Samue | el or Chanda Farca | s M |
| | | Medic | caid Cost R | eimbursement Ana | lysis |
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103730 - 2016/07

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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|------------------------------|------------------------------|------------------|---------------------|-------------------|---------------------------|-------------------------|
| St. Vincent's M Southside | Medical Center | | | | Provider Number: | |
| 4201 Belfort R | oad | | | | Date: Fiscal Year End: | 7/29/2016 |
| Jacksonville, F | FL 32215- | | | | | |
| , | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | |
| | <u>HOSPITAL</u> | | Current Rate | | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatient | t | 63.83 | | 68.62 | 7/1/2016 |
| Inpatie | ent County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| itale Type. | <u>Interim</u> | | X <u>Pr</u> | <u>ospecti</u> | ve | |
| | _ o Total Inte | erim | <u></u> | <u>оороо</u> Х | Total Prospec | tive. |
| | | nt Based on (| Cost | | | |
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| | | | BASIS: | | | |
| | • | | Budget | | | |
| | | X | Unaudited Costs | | | |
| | • | | Field Audited Costs | | | |
| | • | | Revised Field Audit | | | |
| | - | | Cost Report Late Te | st | | |
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| | | | Medicaid | Cost Re | eimbursement Anal | ysis |
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103748 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Select Specialty | Hospital - | | | | | | Provider Number: | 0103748- | 00 |
|------------------|--------------------|---------------|---------------|------------|------------|-----------------|--------------------|-------------|----------------|
| Tallahassee | rioopitai | | | | | | Date: | 7/29/2016 | 3 |
| 1554 Surgeon's | Drive | | | | | | Fiscal Year End: | 2/28/2015 | 5 |
| Tallahassee, FL | 32308- | | | | | | Audit Status: | Unaudited | d Cost Report |
| Provider Typ | e: | | | | | | | | · |
| i i o viuor i yp | <u>u.</u> HOSPI | TAL | | Currer | t Rate | | New Rate | <u> </u> | Effective Date |
| | | npatient | | DF | RG | | DRG | | 7/1/2016 |
| | | utpatient | | 11 | 65 | | 12.52 | _ | 7/1/2016 |
| Inpatien | | • | | | | | | _ | 7/1/2016 |
| Rate Type: | | | | | | | | | |
| | nterim_ | | | | X <u>Р</u> | <u>rospecti</u> | ve | | |
| _ | | Total Inte | erim | | | X | Total Prospec | tive | |
| _ | | - Settleme | nt Based on (| Cost | _ | | <u> </u> | | |
| _ | | - | | | | | | | |
| | | | | <u>B</u> | ASIS: | | | | |
| | | _ | | Budget | | | | | |
| | | | Х | Unaudited | Costs | | | | |
| | | _ | | Field Audi | ed Costs | i | | | |
| | | _ | | Revised F | eld Audit | | | | |
| | | _ | | Cost Repo | rt Late Te | est | | | |
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| | | | | | Medicaid | l Cost Re | imbursement Anal | ysis . | |
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103764 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Select Special | tv Hosnital-F | Palm Reac | h | | | - | Pro | ovider Number: | 0103764-00 | |
|----------------|----------------|---------------|-------------|-----------|---------|-----------|---------|---------------------|------------------------|------|
| 3060 Melaleud | | ann Beae | | | | | | Date: | 7/29/2016 | |
| Lake Worth, F | | | | | | | F | iscal Year End: | 11/30/2014 | |
| Lake Worth, I | L 35401 | | | | | | | Audit Status: | Unaudited Cost Repo | ort |
| Provider Ty | ne: | | | | | | | | | |
| <u> </u> | HOSP | ITAL | | Curre | nt Rat | <u>e</u> | | New Rate | Effective Da | ate_ |
| | | npatient | | D | RG | | | DRG | 7/1/2016 | |
| | | utpatient | t | 11 | 11.65 | | | 12.52 | 7/1/2016 | |
| Inpatie | ent Count | - | | | | | | | 7/1/2016 | 3 |
| | | | | | | | | | - | |
| Rate Type: | <u>Interim</u> | | | | Χ | Prospe | ective | | | |
| | - | Total Inte | erim | _ | | _ | Κ | Total Prospec | tive | |
| | | - Settleme | nt Based on | Cost | | | | <u> </u> | | |
| | | _ | | | | | | | | |
| | | | | <u> </u> | BASIS | <u>):</u> | | | | |
| | | - | | Budget | | | | | | |
| | | _ | Х | Unaudited | d Costs | 6 | | | | |
| | | | | Field Aud | ited Co | osts | | | | |
| | | _ | | Revised F | Field A | udit | | | | |
| | | _ | | Cost Rep | ort Lat | e Test | | | | |
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103772 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Salast Speciali | ity Hoopital | Cainagailla | | | | Provider Number: | 0103772- | 00 |
|-------------------------|---------------------------|---------------------|-----------------|--------------|---------------|------------------------|-------------|----------------------|
| Select Speciali Inc. | пу поѕрцаг | Gairiesville | | | | | 7/29/2016 | |
| 2708 SW Arch | er Road | | | | | Fiscal Year End: | | |
| Gainesville, FL | 32608- | | | | | Audit Status: | Unaudited | d Cost Report |
| Provider Ty | me: | | | | | | | <u> </u> |
| <u>i iovidei iy</u> | <u>pe.</u> <u>HOSP</u> | ΙΤΔΙ | Currei | nt Rate | | New Rate | E | Effective Date |
| | | npatient | | RG | | DRG | | 7/1/2016 |
| | | Outpatient | | .65 | | | | |
| Inpatie | | y Billing Rate | | | | 12.02 | | 7/1/2016 7/1/2016 |
| | one ooun | y Dinning Italia | | | · <u>-</u> | | | 77172010 |
| Rate Type: | lasta nima | | | V | | _ | | |
| | <u>Interim</u> - | Total Interim | _ | X <u>Pro</u> | ospectiv X | | tivo | |
| | | Settlement Based or | n Cost | | ^ | Total Prospec | uve | |
| | | _ | | | | | | |
| | | | В | ASIS: | | | | |
| | | | Budget | <u> </u> | | | | |
| | | X | — Unaudited | l Costs | | | | |
| | | | — Field Audi | | | | | |
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| | | | — Cost Repo | ort Late Tes | st | | | |
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104591 - 2016/07

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

| | <u>Medicaid Reimb</u> | <u>oursement Rate Chan</u> | ge Form | | |
|-------------------------|-----------------------|----------------------------|-----------|--------------------|-------------------------|
| Northwest Medical Cente | r | | | Provider Number: | 0104591-00 |
| 5801 North State Road 7 | | | | Date: | 7/29/2016 |
| Margate, FL 33063- | | | | Fiscal Year End: | 12/31/2014 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSE | <u>PITAL</u> | Current Rate | | New Rate | Effective Date |
| | Inpatient | DRG | | DRG | 7/1/2016 |
| (| Outpatient | 41.09 | | 44.18 | 7/1/2016 |
| Inpatient Coun | ty Billing Rate | • | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Х <u></u> | Prospecti | <u>ve</u> | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based or | n Cost | | | |
| | | | | | |
| | | BASIS: | | | |
| | | Budget | | | |
| | X | Unaudited Costs | _ | | |
| | | Field Audited Costs | | | |
| | | Revised Field Audi | | | |
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| | | Medicai | d Cost Re | imbursement Anal | ysis |
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104604 - 2016/07

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

| Palmetto Gene | eral Hospital | | | | | | Pr | ovider Number: | 0104604-00 | |
|----------------|----------------|----------------|-------------|-----------------|---------|-----------|---------------|---------------------|-------------------------|-----------|
| 2001 West 68t | - | | | | | | | Date: | 7/29/2016 | |
| Hialeah, FL 33 | | | | | | | F | iscal Year End: | 12/31/2014 | |
| , | | | | | | | | Audit Status: | Unaudited Cost Repo | rt |
| Provider Ty | pe: | | | | | | | | | |
| _ | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rat | <u>e</u> | | New Rate | Effective Da | <u>te</u> |
| | I | npatient | | DF | ₹G | | | DRG | 7/1/2016 | |
| | 0 | utpatient | | 67.79 | | | 72.88 | | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| rato Typo. | <u>Interim</u> | | | | Х | Prosp | <u>ective</u> | | | |
| | - | Total Inte | rim | | | _ | X | Total Prospec | tive | |
| | | - Settlemer | nt Based on | Cost | | | | _ | | |
| | | - - | | | | | | | | |
| | | _ | | | ASIS | <u>}:</u> | | | | |
| | | _ | | Budget - | | | | | | |
| | | _ | X | Unaudited - | | | | | | |
| | | _ | | Field Audi - | | | | | | |
| | | _ | | Revised F | | | | | | |
| | | _ | | Cost Repo | ort Lat | e Test | | | | |
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| | | | | | W. R | ydell Sar | nuel or | Chanda Farcas | s #1 | |
| | | | | | Medic | caid Cos | t Reiml | oursement Anal | ysis | |
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105520 - 2016/07

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

| Medical Center | r of Trinity | | | | | | Provider Number: | 0105520-00 |
|----------------|----------------|------------|-------------|----------------------|--------------|----------------|---------------------------|-------------------------|
| 5637 Marine P | - | | | | | | Date: | 7/29/2016 |
| New Port Riche | - | 52- | | | | | Fiscal Year End: | 6/30/2015 |
| | 0,, 0 .00 | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>pe:</u> | | | | | | | |
| | HOSPI | TAL | | Curre | nt Rate | <u> </u> | New Rate | Effective Date |
| | lr | npatient | | D | RG | | DRG | 7/1/2016 |
| | 0 | utpatient | | 35 | 5.23 | | 7/1/2016 | |
| Inpatie | ent County | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| | <u>Interim</u> | | | | Χ | <u>Prospec</u> | <u>tive</u> | |
| | _ | Total Inte | rim | | | X | Total Prospec | ctive |
| | | Settleme | nt Based or | Cost | | | | |
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| | | _ | | | <u>BASIS</u> | <u>.</u> | | |
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| | | _ | | Revised F | | | | |
| | | - | | Cost Rep | | | | |
| | | _ | | | ort Late | , 1000 | | |
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| | | | | | w. Ky | deli Samu | el or Chanda Farca | s /V |
| | | | | | Medic | aid Cost R | teimbursement Ana | lysis |
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106470 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Specialty Hosp | oital Jackso | nville | | | | | Provider Number: | 0106 | 470-00 |
|-----------------|----------------|-----------------|----------|-------------|--------------|----------|--------------------|----------|-----------------------|
| 4901 Richard | Street | | | | | | Date: | 7/29/ | 2016 |
| Jacksonville, F | L 32207- | | | | | | Fiscal Year End: | 12/31 | 1/2014 |
| | | | | | | | Audit Status: | Unau | idited Cost Report |
| Provider Ty | /pe: | | | | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | | Curren | t Rate | | New Rate | | Effective Date |
| | I | npatient | | DR | G | | DRG | | 7/1/2016 |
| | С | Outpatient | | 11. | 11.65 12.52 | | | | 7/1/2016 |
| Inpatie | ent Count | y Billing F | Rate | | | 7/1/2 | | | |
| Rate Type: | | | | | | | | | |
| <u></u> | <u>Interim</u> | | | | X <u>Pro</u> | ospectiv | <u>⁄e</u> | | |
| | - | Total Interi | m | | | Χ | Total Prospec | tive | |
| | | _ Settlement | Based on | Cost | | | | | |
| | | . | | | | | | | |
| | | | | <u>B</u> | ASIS: | | | | |
| | | | | Budget | | | | | |
| | | | Х | Unaudited | | | | | |
| | | | | Field Audit | | | | | |
| | | | | Revised Fi | | | | | |
| | | | | Cost Repo | rt Late Tes | st | | | |
| | | | | - | | | or Chanda Farcas | (| F G |
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108219 - 2016/07

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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|----------------|----------------|---------------|-----------------|----------------|------------|----------------|--------------------|-----------------|-----------|
| Broward Healt | th Imperial P | oint | | | | | Provider Number: | : 0108219-00 | |
| 1608 S.E. 3rd | Avenue | | | | | | Date | 7/29/2016 | |
| Ft. Lauderdale | e, FL 33316 | - | | | | | Fiscal Year End: | 6/30/2015 | |
| | , | | | | | | Audit Status: | Unaudited Cos | st Report |
| Provider Ty | /pe: | | | | | | | | |
| • | HOSP | <u>ITAL</u> | | <u>Currer</u> | t Rate | | New Rate | <u>Effec</u> | tive Date |
| | I | npatient | | DF | RG | · — | DRG | 7/1 | /2016 |
| | 0 | utpatien | t | 80 | 84 | | 86.55 | 7/1 | /2016 |
| Inpatie | ent Count | y Billing | g Rate | | | · — | | 7/1 | /2016 |
| Rate Type: | | | | | | - | | | |
| rtate Type. | <u>Interim</u> | | | | X Pro | <u>ospecti</u> | ive | | |
| | _ | Total Int | erim | | | Х | Total Prospec | ctive | |
| | | – Settleme | ent Based on | Cost | | | <u> </u> | | |
| | - | _ | | | | | | | |
| | | | | <u>B</u> | ASIS: | | | | |
| | | | | Budget | | | | | |
| | | | X | _ Unaudited | Costs | | | | |
| | | | | Field Audi | ted Costs | | | | |
| | | | | Revised F | ield Audit | | | | |
| | | | | Cost Repo | rt Late Te | st | | | |
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| | | | | | Medicaid | Cost Re | eimbursement Ana | lysis | |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

108219 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| 5 | | | | | | | Provider Number: | . 0108219-05 |
|----------------|----------------|---------------|----------------|---------------|----------|------------------|--------------------|-------------------------|
| Broward Healt | • | oint | | | | | | 7/29/2016 |
| 1608 S.E. 3rd | | | | | | | Fiscal Year End: | |
| Ft. Lauderdale | e, FL 33316 | - | | | | | | : Unaudited Cost Report |
| | | | | | | | Audit Status. | Onaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | | Curre | nt Rate | | New Rate | Effective Date |
| | I | npatient | | D | RG | | DRG | 7/1/2016 |
| | 0 | utpatien | t | 80 | .84 | | 86.55 | 7/1/2016 |
| Inpatie | ent Count | y Billing | g Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| rato Typo. | <u>Interim</u> | | | | Χ | <u>Prospecti</u> | ive | |
| | | Total Int | erim | | | X | Total Prospec | ctive |
| | - | - Settleme | ent Based on (| Cost | | | <u> </u> | |
| | | | | | | | | |
| | | | | <u>B</u> | ASIS: | | | |
| | | | | Budget | | | | |
| | | | X | Unaudited | d Costs | | | |
| | | | | Field Aud | ited Cos | its | | |
| | | | | Revised F | ield Aud | dit | | |
| | | | | - Cost Rep | ort Late | Test | | |
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| | | | | | Medica | id Cost Re | eimbursement Ana | lysis |
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108227 - 2016/07

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

| Lake Butler Hospital | | | Р | rovider Number: | 0108227-00 |
|----------------------------|-------------------|---------------------|----------------|----------------------|-------------------------|
| 850 EAST MAIN ST.P.O.B. 74 | 18 | | | Date: | 7/29/2016 |
| Lake Butler, FL 32954- | | | | Fiscal Year End: | 12/31/2014 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITA | <u>.L</u> | Current Rate | <u>e</u> | New Rate | Effective Date |
| Inpa | atient | DRG | | DRG | 7/1/2016 |
| Outp | atient | 96.40 | | 7/1/2016 | |
| Inpatient County B | illing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospective | <u>!</u> | |
| | tal Interim | - | _ X | Total Prospec | tive |
| Se | ettlement Based o | n Cost | - | _ | |
| | | | | | |
| | | BASIS | <u>):</u> | | |
| | | Budget — | | | |
| | X | Unaudited Costs | 5 | | |
| | | Field Audited Co | | | |
| | | Revised Field A | | | |
| | | Cost Report Late | e Test | | |
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| | | W. R | ydell Samuel o | r Chanda Farcas | |
| | | Medic | caid Cost Reim | bursement Anal | ysis |
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| Batch ID:J4VC6 | | | | ed on : 7/29/2016 4: | |



108626 - 2016/07

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

| North Florida F | Regional Me | dical | | | | _ | Pro | ovider Number: | 0108 | 626-00 |
|-------------------------------|----------------|-------------|-------------|-----------------------------|---------|-----------|---------|---------------------|----------|--------------------|
| Center | 3 | | | | | | | Date: | 7/29/ | 2016 |
| P.O. Box NFR | | | | | | | Fi | iscal Year End: | 2/28/ | 2015 |
| Gainesville, FL | 32602- | | | | | | | Audit Status: | Unau | udited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | | | |
| - | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | <u>e</u> |] | New Rate | | Effective Date |
| | 1 | npatient | | D | RG | | | DRG | | 7/1/2016 |
| | 0 | utpatient | t | 80 | .08 | | | 86.10 | | 7/1/2016 |
| Inpatient County Billing Rate | | | | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | Χ | Prospe | ctive | | | |
| | | Total Inte | erim | | | × | (| Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | | | |
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| | | | | | SASIS | <u>:</u> | | | | |
| | | - | | Budget - | | | | | | |
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| | | - | | Revised F | | | | | | |
| | | | | Cost Rep | | | | | | |
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| | | | | | W. Ry | ydell Sam | nuel or | Chanda Farcas | 1 | M J |
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| | | | | | | | | | - | o onange in rate |
| Batch ID:J4VC6 | | | | | | | Printe | d on : 7/29/2016 4: | 56 PM | |



109592 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Bayfront Health Dade City | | | | Provider Number | : 0109592-00 | | | |
|---------------------------|---------------|------------------|-----------|--|-------------------------|--|--|--|
| 13100 Fort King Road | | | | Date | 7/29/2016 | | | |
| Dade City, FL 33525- | | | | Fiscal Year End: 9/30/2015 | | | | |
| Dade City, FL 33323- | | | | Audit Status | : Unaudited Cost Report | | | |
| Dravidar Tuna | | | | | <u>'</u> | | | |
| Provider Type: | | Current Rat | • | New Rate | Effective Date | | | |
| <u>HOSPITAL</u> | | | <u> </u> | | | | | |
| Inpatient | | DRG | | DRG | 7/1/2016 | | | |
| Outpatient | - | 55.12 | | 59.26 | 7/1/2016 | | | |
| Inpatient County Billing | Rate | | | | 7/1/2016 | | | |
| Rate Type: | | | | | | | | |
| <u>Interim</u> | | X | Prospect | ive | | | | |
| Total Inte | erim | | _ X | Total Prospec | ctive | | | |
| Settleme | nt Based on C | Cost | | | | | | |
| | | | | | | | | |
| | | BASIS | <u>):</u> | | | | | |
| - | | Budget | _ | | | | | |
| - | | Unaudited Costs | 6 | | | | | |
| - | | Field Audited Co | osts | | | | | |
| - | | Revised Field A | | | | | | |
| - | | Cost Report Lat | | | | | | |
| - | | Cost Report Lat | 0 1000 | | | | | |
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109606 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Coral Gables Hospital | | | Pro | vider Number: | 0109606-00 |
|-------------------------|-----------------------|-------------------|----------------|----------------|-------------------------|
| P.O. BOX 610 | | | | Date: | 7/29/2016 |
| Coral Gables, FL 33134- | | | Fi | scal Year End: | 12/31/2014 |
| Coral Cables, I L 33134 | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITA | ۸L | Current Rate | ļ | New Rate | Effective Date |
| | atient | DRG | | DRG | 7/1/2016 |
| · | patient | 69.98 | | 75.23 | 7/1/2016 |
| Inpatient County B | | | _ | | 7/1/2016 |
| | | | | | |
| Rate Type: Interim | | Χ | Prospective | | |
| | otal Interim | | X | Total Prospect | tive |
| | ettlement Based on | Cost | | • | |
| | | | | | |
| | | BASIS : | | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Cos | sts | | |
| | - | Revised Field Aud | dit | | |
| | | Cost Report Late | Test | | |
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| | | W. Ryd | dell Samuel or | Chanda Farcas | # G |
| | | Medica | aid Cost Reimb | ursement Analy | ysis |
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109886 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Ocala Regional Medical Center | | | | Provider Number: | 0109886-00 | | |
|------------------------------------|------------------|------------------|-------------|----------------------------|-------------------------|--|--|
| _ | Davi | | | | 7/29/2016 | | |
| 1431 SW 1st AvenuePost Office 2200 | BOX | | | Fiscal Year End: 8/31/2015 | | | |
| Ocala, FL 32678- | | | | | Unaudited Cost Report | | |
| Duaridan Trusa. | | | | | | | |
| Provider Type: | | Current Rate | | New Rate | Effective Date | | |
| <u>HOSPITAL</u> | | | <u> </u> | | | | |
| Inpati | DRG | | DRG | 7/1/2016 | | | |
| Outpat | | 38.93 | | 41.85 | 7/1/2016 | | |
| Inpatient County Bil | ling Rate | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | |
| <u>Interim</u> | | X | Prospect | <u>ive</u> | | | |
| | I Interim | | X | Total Prospec | tive | | |
| Settl | ement Based on (| Cost | | | | | |
| | | | | | | | |
| | | BASIS | <u>:</u> | | | | |
| | | Budget | | | | | |
| | | Unaudited Costs | | | | | |
| | | Field Audited Co | | | | | |
| | | Revised Field Au | ıdit | | | | |
| | | Cost Report Late | e Test | | | | |
| | | | | | | | |
| | | W. Ry | rdell Samue | el or Chanda Farcas | * FG | | |
| | | Medic | aid Cost Re | eimbursement Anal | ysis | | |
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110213 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Diales Managial Hamital | | • | Provider Number: | 0110213-00 |
|--------------------------|------------------|-----------------|------------------------|-------------------------|
| Blake Memorial Hospital | | | | 7/29/2016 |
| 2020 59th St. West | | | Fiscal Year End: | |
| Bradenton, FL 33505- | | | | Unaudited Cost Report |
| | | | Audit Status. | |
| <u>Provider Type:</u> | | | | |
| <u>HOSPITAL</u> | <u>Cur</u> | rent Rate | New Rate | Effective Date |
| Inpatient | | DRG | DRG | 7/1/2016 |
| Outpatient | : | 58.57 | 62.97 | 7/1/2016 |
| Inpatient County Billing | Rate | | | 7/1/2016 |
| Rate Type: | | | | _ |
| Interim | | X <u>Pros</u> | <u>pective</u> | |
| Total Inte | erim | | X Total Prospec | tive |
| | nt Based on Cost | - | | |
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| | | BASIS: | | |
| - | Budget | <u> </u> | | |
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| - | | udited Costs | | |
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| | | Medicaid Co | st Reimbursement Anal | ysis |
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111325 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Et Welter Des | l- N | 0 | | | • | - Provider Number: | 0111325-00 |
|--------------------|----------------|-----------------|------------|-----------------|---------------|-----------------------|-------------------------|
| Ft. Walton Bea | | Center | | | | | 7/29/2016 |
| 1000 Mar-Wal | | | | | | Fiscal Year End: | |
| Ft. Walton, FL | 32547- | | | | | | Unaudited Cost Report |
| | | | | | | Addit Otatus. | - Chadalica Cost Report |
| <u>Provider Ty</u> | | | | | | | |
| | <u>HOSP</u> | | | Current Ra | <u>ate</u> – | New Rate | Effective Date |
| | | npatient | | DRG | | DRG | 7/1/2016 |
| | | Outpatient | | 37.31 | | 40.11 | 7/1/2016 |
| Inpatie | ent Count | y Billing R | ate | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| | <u>Interim</u> | | | Х | Prospec | <u>ctive</u> | |
| | _ | Total Interir | n | | X | Total Prospec | tive |
| | | _ Settlement | Based on 0 | Cost | | | |
| | | _ | | | | | |
| | | | | <u>BASI</u> | <u>S:</u> | | |
| | | | | Budget | | | |
| | | | Х | Unaudited Cos | sts | | |
| | | | | Field Audited (| Costs | | |
| | | | | Revised Field | Audit | | |
| | | | | Cost Report La | ate Test | | |
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| | | | | W. | Rydell Samu | uel or Chanda Farcas | |
| | | | | Med | dicaid Cost F | Reimbursement Anal | ysis |
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111341 - 2016/07

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

| | <u> </u> | sement Rate Cha | ange Form | | | |
|--------------------------|---|------------------|-------------|----------------------------|-------------------------|--|
| Gulf Coast Medical Cente | r Lee | | | Provider Number: | | |
| Memorial Health System | | | | | 7/29/2016 | |
| PO Box 151247 | | | | Fiscal Year End: 9/30/2015 | | |
| Cape Coral, FL 33915- | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| <u>HOSF</u> | <u>PITAL</u> | Current Rate | <u> </u> | New Rate | Effective Date | |
| | Inpatient | DRG | | DRG | 7/1/2016 | |
| C | Outpatient | 72.26 | | 77.69 | 7/1/2016 | |
| Inpatient Count | ty Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | |
| Interim | | Х | Prospect | ive | | |
| | Total Interim | | X | Total Prospec | ctive | |
| | Settlement Based on 0 | Cost | | <u> </u> | | |
| | - | | | | | |
| | | BASIS | <u>.</u> | | | |
| | | Budget | | | | |
| | X | Unaudited Costs | | | | |
| | | Field Audited Co | sts | | | |
| | | Revised Field Au | ıdit | | | |
| | | Cost Report Late | Test | | | |
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| | | W. Ry | dell Samue | el or Chanda Farcas | s F G | |
| | | Medic | aid Cost Re | eimbursement Anal | lysis | |
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111741 - 2016/07

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

| Orange Park N | Medical Cent | ter | | | | I | Provider Number: | 0111741-00 |
|-------------------------------|----------------|----------------|-------------|-----------------|-------------|------------|------------------------|-------------------------|
| 2001 Kingsley | Avenue | | | | | | Date: | 7/29/2016 |
| Orange Park, I | | | | | | | Fiscal Year End: | 6/30/2015 |
| , | | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | | Currer | nt Rate | | New Rate | Effective Date |
| | li | npatient | | DF | ₹G | _ | DRG | 7/1/2016 |
| Outpatient | | | | 67 | .64 | | 72.71 | 7/1/2016 |
| Inpatient County Billing Rate | | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | |
| rate Type. | <u>Interim</u> | | | | X <u>Р</u> | rospectiv | <u>e</u> | |
| | - | Total Inte | erim | | | X | Total Prospec | etive |
| | | - Settleme | nt Based on | Cost | _ | | | |
| | | - - | | | | | | |
| | | _ | | <u>B</u> | ASIS: | | | |
| | | _ | | Budget - | | | | |
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| | | _ | | Revised F | | | | |
| | | _ | | Cost Repo | ort Late To | est | | |
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| | | | | | W. Ryde | II Samuel | or Chanda Farcas | s M |
| | | | | | Medicaio | d Cost Rei | mbursement Anal | lysis |
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| | | | | | | ſ | or Information or | nly - No Change in rate |
| Batch ID:J4VC6 | | | | | _ | Prir | nted on : 7/29/2016 4: | 56 PM |



112305 - 2016/07

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

| Westside Regi | onal Medica | l Center | | | | | Provider Number: 0112305-00 | | | | |
|-------------------------------|----------------|-------------|-------------|--------------|----------|-------------|-----------------------------|-------------------------|--|--|--|
| 8201 West Bro | | | | | | | Date: | 7/29/2016 | | | |
| Plantation, FL | | | | | | | Fiscal Year End: 1/31/2015 | | | | |
| | | | | | | | Audit Status: | Unaudited Cost Report | | | |
| Provider Ty | pe: | | | | | | | | | | |
| - | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | | New Rate | Effective Date | | | |
| | li | npatient | | DRG | | | DRG | 7/1/2016 | | | |
| | 0 | utpatient | | 40 | .84 | | 43.90 | 7/1/2016 | | | |
| Inpatient County Billing Rate | | | | | | | 7/1/2016 | | | | |
| Rate Type: | | | | | | | | | | | |
| | <u>Interim</u> | | | | Χ | Prospecti | <u>ve</u> | | | | |
| | - | Total Inte | rim | | | X | Total Prospec | tive | | | |
| | | Settlemer | nt Based on | Cost | | | | | | | |
| | | | | | | | | | | | |
| | | _ | | | ASIS: | | | | | | |
| | | _ | | Budget | | | | | | | |
| | | _ | Х | Unaudited | | | | | | | |
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| | | _ | | Revised F | | | | | | | |
| | | _ | | Cost Rep | ort Late | rest | | | | | |
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| | | | | | W. Ryo | dell Samue | l or Chanda Farcas | 5 M | | | |
| | | | | | Medica | aid Cost Re | imbursement Anal | ysis | | | |
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112798 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Memorial Hosp | nital Of Tam | ına | | | | - | Pro | ovider Number: | 01127 | 98-00 |
|-------------------------------|----------------|---------------|-------------|-----------|----------|-----------|----------|---------------------|----------|------------------|
| 2901 Swann A | | ipu | | | | | | Date: | 7/29/2 | 016 |
| Tampa, FL 33 | | | | | | | F | iscal Year End: | 10/31/2 | 2015 |
| rampa, r L oc | 0000 0400 | | | | | | | Audit Status: | Unaud | ited Cost Report |
| Provider Ty | /pe: | | | | | | | | | |
| | HOSP | ITAL | | Curre | nt Rate | <u>e</u> | | New Rate | | Effective Date |
| | | npatient | | DRG | | | | DRG | | 7/1/2016 |
| | | Outpatient | t | 100 | 6.15 | | | 114.12 | | 7/1/2016 |
| Inpatient County Billing Rate | | | | | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | | | | |
| itale Type. | <u>Interim</u> | | | | Χ | Prospe | ective | | | |
| | - | Total Inte | erim | _ | | _ | (| Total Prospec | tive | |
| | | – Settleme | nt Based on | Cost | | | | <u> </u> | | |
| | - | | | | | | | | | |
| | | | | <u>B</u> | ASIS | <u>:</u> | | | | |
| | | | | Budget | | | | | | |
| | | | Х | Unaudited | d Costs | 6 | | | | |
| | | _ | | Field Aud | ited Co | osts | | | | |
| | | | | Revised F | Field A | udit | | | | |
| | | - | | Cost Repo | ort Late | e Test | | | | |
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| | | | | | W. Ry | ydell Sam | nuel or | Chanda Farcas | P | |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | ysis | |
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| Batch ID:J4VC6 | | | | | | | | d on : 7/29/2016 4: | | |



112801 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| University Hosp | pital and M | edical | | | | Provider Number: | | |
|-----------------|----------------|------------------|------------|-------------|-----------------|--------------------|------------|----------------|
| Center | . Drive | | | | | Date: | 7/29/20 | 16 |
| 7201 University | , | | | | | Fiscal Year End: | 4/30/20 | 15 |
| Tamarac, FL 3 | 33321- | | | | | Audit Status: | Unaudit | ed Cost Report |
| Provider Ty | pe: | | | | | | | |
| | <u>HOSF</u> | <u>ITAL</u> | Curre | nt Rate | | New Rate | | Effective Date |
| | | Inpatient | DI | ₹G | | DRG | | 7/1/2016 |
| | C | Outpatient | 50 | .95 | | 54.77 | | 7/1/2016 |
| Inpatie | nt Count | ty Billing Rate | | | | | _ | 7/1/2016 |
| Rate Type: | | | | | | | | |
| | <u>Interim</u> | | | X Pr | <u>ospectiv</u> | <u>/e</u> | | |
| | • | Total Interim | | | Χ | Total Prospec | tive | |
| | | Settlement Based | on Cost | | | | | |
| | | | | | | | | |
| | | | · | ASIS: | | | | |
| | | | Budget | | | | | |
| | | X | Unaudited | | | | | |
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| | | | Cost Repo | ort Late Te | st | | | |
| | | | | | | or Chanda Farcas | _ (` | R G |
| | | | | | | For Information or | nly - No C | Change in rate |

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113212 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| West Florida Hospital | | | Provider Number: | 0113212-00 |
|------------------------|---------------------|--------------------|----------------------------|-------------------------|
| 8383 North Davis Hwy. | | | Date: | 7/29/2016 |
| Pensacola, FL 32514- | | | Fiscal Year End: | 5/31/2015 |
| 1 C113dCO1d, 1 E 32014 | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| HOSPIT | AL | Current Rate | New Rate | Effective Date |
| | oatient | DRG | DRG | |
| • | tpatient | 54.56 | | 7/1/2016 |
| Inpatient County | | | _ | 7/1/2016 |
| | | | | _ |
| Rate Type: Interim | | X <u>I</u> | Prospective | |
| | Total Interim | <u></u> | X Total Prospec | tive |
| | Settlement Based on | Cost | | |
| | | | | |
| | | BASIS : | | |
| | | Budget | | |
| | X | Unaudited Costs | | |
| | | Field Audited Cost | S | |
| | | Revised Field Aud | it | |
| | | Cost Report Late | Гest | |
| | | | | |
| | | W. Ryd | ell Samuel or Chanda Farca | s A I |
| | | Medicai | d Cost Reimbursement Anal | ysis |
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| | | _ | For Information or | nly - No Change in rate |



113514 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Putnam Comm | nunity Hosni | ital | | | | - | Pro | ovider Number: | 01135 | 14-00 |
|------------------|---------------------|--------------|--------------|----------------|---------|------------|---------|---------------------|----------|---|
| P.O. Drawer 7 | | itai | | | | | | Date: | 7/29/20 | 016 |
| Palatka, FL 32 | | | | | | | F | iscal Year End: | 8/31/20 | 015 |
| i alatka, i L 32 | 2007- | | | | | | | Audit Status: | Unaud | ited Cost Report |
| Provider Ty | me. | | | | | | | | | |
| 1 TOVIGET 19 | <u>HOSP</u> | ITAI | | Curre | nt Rat | e | | New Rate | | Effective Date |
| | | npatient | | | RG | | | DRG | | 7/1/2016 |
| | | outpatient | + | - | 6.84 | | | 94.88 | | 7/1/2016 |
| Inpatie | ent Count | - | | | | | | | | 7/1/2016 |
| | | , = <u>9</u> | | | | | | | | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| Rate Type: | l 4 | | | | V | D | 4 ! | | | |
| | <u>Interim</u> - | Total Inte | orim | _ | X | Prospe | ctive | Total Prospec | tivo | |
| | | _ | nt Based on | Cost | | | ` | - 10tai F105pec | uve | |
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| | | | | F | BASIS | } - | | | | |
| | | - | | Budget | 7.010 | <u> </u> | | | | |
| | | - | X | _ Unaudited | d Costs | 3 | | | | |
| | | - | | - Field Aud | | | | | | |
| | | - | | – Revised F | | | | | | |
| | | - | | - Cost Rep | | | | | | |
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| | | | | | W. K | ydell San | nuel or | Chanda Farcas | - 1 | V |
| | | | | | Medio | caid Cost | Reimb | oursement Anal | ysis | |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

115193 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| North cide Heavitel | - | Provider Number: | 0115193-00 | | | |
|-------------------------------|-----------------------|----------------------------|-----------------------|--|--|--|
| Northside Hospital | | | 7/29/2016 | | | |
| 6000 49th St. North | | Fiscal Year End: 9/30/2015 | | | | |
| St. Petersburg, FL 33709- | | | Unaudited Cost Report | | | |
| Day 1 Las Torre | | | | | | |
| Provider Type: | Occurrent Bate | Name Barra | Effective Date | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date | | | |
| Inpatient | DRG | DRG | 7/1/2016 | | | |
| Outpatient | 59.82 | 64.31 | 7/1/2016 | | | |
| Inpatient County Billing Rate | | | 7/1/2016 | | | |
| Rate Type: | | | | | | |
| <u>Interim</u> | X <u>Pros</u> | <u>pective</u> | | | | |
| Total Interim | | X Total Prospec | tive | | | |
| Settlement Based on 0 | Cost | | | | | |
| | | | | | | |
| | BASIS : | | | | | |
| | Budget | | | | | |
| X | Unaudited Costs | | | | | |
| | Field Audited Costs | | | | | |
| | Revised Field Audit | | | | | |
| | Cost Report Late Test | | | | | |
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| | W. Rydell Sa | amuel or Chanda Farcas | F G | | | |
| | Medicaid Co | st Reimbursement Anal | ysis | | | |
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116483 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Anne Bates Le | each Eye Ho | spital | | | | Р | rovider Number: | : 0116483-00 | |
|----------------|----------------|------------|-------------|------------------------------|--------------|-----------|----------------------------|-------------------------|--|
| 900 NW 17th | St. | | | | | | Date: | 7/29/2016 | |
| Miami, FL 33 | | | | | | i | Fiscal Year End: 5/31/2015 | | |
| , | | | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | <u>/pe:</u> | | | | | | | | |
| _ | HOSP | ITAL | | Curre | nt Rate | | New Rate | Effective Date | |
| | I | npatient | | DI | RG | | DRG | 7/1/2016 | |
| | 0 | outpatient | | 252 | 2.03 | | 270.95 | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | |
| | <u>Interim</u> | | | | X <u>Pro</u> | spective | | | |
| | _ | Total Inte | rim | _ | | X | Total Prospec | ctive | |
| | | Settlemer | nt Based on | Cost | | | _ | | |
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| | | _ | | | ASIS: | | | | |
| | | _ | V | Budget - | 1.0 | | | | |
| | | _ | X | Unaudited | | | | | |
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117463 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Fawcett Memo | orial Hospital | | | | | 1 | Provider Number: | 0117463-00 |
|-----------------|----------------|------------|-------------|-------------|------------|------------|------------------------|-------------------------|
| PO BOX 4949 | | | | | | | Date: | 7/29/2016 |
| Port Charlotte, | | | | | | | Fiscal Year End: | 12/31/2014 |
| , or originally | 0000_ | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | |
| - | HOSP | ITAL | | Curren | t Rate | | New Rate | Effective Date |
| | lı | npatient | | DF | G | | DRG | 7/1/2016 |
| | 0 | utpatient | | 67. | 58 | | 72.66 | 7/1/2016 |
| Inpatie | ent County | y Billing | Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | |
| rate Type. | <u>Interim</u> | | | | Х <u>Р</u> | rospectiv | <u>e</u> | |
| | - | Total Inte | erim | | | X | Total Prospec | etive |
| | | Settleme | nt Based on | Cost | _ | | | |
| | | = | | | | | | |
| | | _ | | <u>B</u> , | ASIS: | | | |
| | | _ | | Budget — | | | | |
| | | _ | Х | Unaudited | Costs | | | |
| | | _ | | Field Audit | ed Costs | 5 | | |
| | | _ | | Revised Fi | eld Audit | t | | |
| | | _ | | Cost Repo | rt Late T | est | | |
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| | | | | | W. Ryde | ell Samuel | or Chanda Farcas | s A |
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117617 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Gulf Coast Re | nional Medic | cal Center | | | | - | Pro | ovider Number: | 011761 | 7-00 |
|----------------|---------------------|-------------|---------------|----------------|----------|------------|---------------|---------------------|------------|---|
| 449 West 23rd | _ | bai Ceriter | | | | | | Date: | 7/29/20 | 16 |
| Panama City, | | | | | | | F | iscal Year End: | 1/31/20 | 15 |
| r anama City, | 1 L 32403- | | | | | | | Audit Status: | Unaudit | ted Cost Report |
| Provider Ty | ma. | | | | | | | | | |
| 1 TOVIGET TY | <u>HOSP</u> | ITAI | | Curre | nt Rate | e | | New Rate | | Effective Date |
| | | npatient | | | RG | | | DRG | _ | 7/1/2016 |
| | | utpatient | | | .42 | | | 59.58 | _ | 7/1/2016 |
| Inpatie | ent Count | • | | | | | | | | 7/1/2016 |
| | | <i>,</i> =9 | | | | | | | | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| Rate Type: | lusto uiuo | | | | V | Duane | | | | |
| | <u>Interim</u> - | Total Inte | vrim | _ | Х | Prospe | <u>ective</u> | Total Prospec | tivo | |
| | | _ | nt Based on | Cost | | | ` | - | live | |
| | | _ | THE BUSCU OFF | | | | | | | |
| | | | | Е | BASIS |) <u>:</u> | | | | |
| | | - | | Budget | | <u>-</u> | | | | |
| | | - | Х | _ Unaudited | d Costs | 3 | | | | |
| | | - | | – Field Aud | ited Co | osts | | | | |
| | | - | | – Revised F | Field A | udit | | | | |
| | | - | | Cost Rep | ort Late | e Test | | | | |
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118079 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Brandon Regio | onal Hospita | al | | | | | Pro | ovider Number: | 0118079-00 | |
|----------------|----------------|----------------|-------------|------------|----------|------------|----------|---------------------|-----------------------|-------------|
| 119 Oakfield D | - | | | | | | | Date: | 7/29/2016 | |
| Brandon, FL 3 | | | | | | | Fi | scal Year End: | 12/31/2014 | |
| Dranaon, r E | | | | | | | | Audit Status: | Unaudited Cost Re | port |
| Provider Ty | pe: | | | | | | | | | |
| | HOSP | ITAL | | Currer | nt Rate | <u>e</u> | <u> </u> | New Rate | Effective | <u>Date</u> |
| | I | npatient | | DF | ₹G | | | DRG | 7/1/20 | 16 |
| | 0 | utpatient | | 60.56 | | | 65.11 | | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | - | | | | | 7/1/20 | 16 |
| Rate Type: | | | | | | | | | | |
| itale Type. | <u>Interim</u> | | | | Χ | Prospe | ctive | | | |
| | - | Total Inte | rim | | | - <u> </u> | | Total Prospec | tive | |
| | | – Settlemer | nt Based on | Cost | | | | - | | |
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| | | _ | | <u>B</u> | ASIS | <u>):</u> | | | | |
| | | _ | | Budget | | | | | | |
| | | _ | Х | Unaudited | l Costs | 3 | | | | |
| | | _ | | Field Audi | ted Co | osts | | | | |
| | | _ | | Revised F | | | | | | |
| | | _ | | Cost Repo | ort Late | e Test | | | | |
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| | | | | | W. Ry | ydell Sam | uel or | Chanda Farcas | i N | |
| | | | | | Medic | caid Cost | Reimb | ursement Anal | ysis | |
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| Batch ID:J4VC6 | | | | | | | Printe | d on : 7/29/2016 4: | 56 PM | |



119695 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| INIE | alcaid Itellibu | isement itale change | ; i Oiiii | | |
|---|-----------------|---------------------------|-----------|-------------------|-------------------------|
| Lawnwood Regional Medical Cente & Heart Institute | r | | P | rovider Number: | |
| P.O. Box 188 | | | | | 7/29/2016 |
| Ft Pierce, FL 33450- | | | | Fiscal Year End: | |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | | Current Rate | | New Rate | Effective Date |
| Inpatient | : | DRG | | DRG | 7/1/2016 |
| Outpatier | nt | 67.39 | · | 72.19 | 7/1/2016 |
| Inpatient County Billing | g Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X Pro | spective | <u>.</u> | |
| Total In | terim | | X | Total Prospec | tive |
| | ent Based on | Cost — | | _ | |
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| | | BASIS: | | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | - | Field Audited Costs | | | |
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| | | - Cost Report Late Tes | st | | |
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119717 - 2016/07

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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|----------------|-------------------|------------------|---------------------|-----------------------|-------------------------|
| Cape Coral Hos | pital | | | Provider Number | : 0119717-00 |
| PO Box 151247 | | | | Date | 7/29/2016 |
| Cape Coral, FL | 33915- | | | Fiscal Year End | 9/30/2015 |
| • | | | | Audit Status | : Unaudited Cost Report |
| Provider Typ | oe: | | | | |
| | HOSPITAL | | Current Rate | New Rate | Effective Date |
| | Inpatient | | DRG | DRG | 7/1/2016 |
| | Outpatient | | 52.12 | 56.04 | 7/1/2016 |
| Inpatier | nt County Billing | | _ | | 7/1/2016 |
| Rate Type: | | | | | |
| | <u>nterim</u> | | X <u>Pros</u> i | <u>pective</u> | |
| <u> </u> | Total Inte | erim | | X Total Prospe | ctive |
| _ | Settleme | nt Based on Cost | | <u> </u> | |
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| | - | Bud | dget | | |
| | - | X Una | audited Costs | | |
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119733 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Venice Region | al Bavfront | Health | | | | | Pr | ovider Number: | 01197 | 33-00 |
|----------------|----------------|---------------|-------------|--------------|-------------|-----------|---------------|----------------------|----------|-------------------|
| 540 THE RIAL | • | | | | | | | Date: | 7/29/2 | 016 |
| Venice, FL 34 | | | | | | | F | iscal Year End: | 12/31/ | /2014 |
| | | | | | | | | Audit Status: | Unaud | dited Cost Report |
| Provider Ty | pe: | | | | | | | | | |
| • | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rat | <u>e</u> | | New Rate | | Effective Date |
| | I | npatient | | D | RG | | | DRG | | 7/1/2016 |
| | O | utpatient | | 47 | '.06 | | | 50.59 | | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| rtato Typo. | <u>Interim</u> | | | | Х | Prospe | <u>ective</u> | | | |
| | - | Total Inte | erim | _ | | _ | X | Total Prospec | tive | |
| | | Settleme | nt Based on | Cost | | | | _ | | |
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| | | - | | | BASIS | <u>}:</u> | | | | |
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119741 - 2016/07

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

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|----------------------|-------------------------|---------------------|------------------|--------------------|-------------------------|
| Largo Medical Center | | | | Provider Number: | 0119741-00 |
| 201 14th St., SW | | | | Date: | 7/29/2016 |
| Largo, FL 33540- | | | | Fiscal Year End: | 2/28/2015 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPITAL | | Current Rate | | New Rate | Effective Date |
| Inpati | ent | DRG | | DRG | 7/1/2016 |
| Outpat | tient | 72.35 | | 77.58 | 7/1/2016 |
| Inpatient County Bil | ling Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | <u>Prospecti</u> | <u>ve</u> | |
| Tota | I Interim | | X | Total Prospec | etive |
| Settl | ement Based o | n Cost | | | |
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| | | Budget — | | | |
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| | | Medica | aid Cost Re | eimbursement Anal | lysis |
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119750 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Raulerson Hospital | | | Provider Number | : 0119750-00 |
|-----------------------|---------------------|---------------------|--|--------------------------|
| P.O.Box 1307 | | | Date | 7/29/2016 |
| Okeechobee, FL 34974- | | | Fiscal Year End | : 4/30/2015 |
| , | | | Audit Status | : Unaudited Cost Report |
| Provider Type: | | | | |
| HOSP | <u>ITAL</u> | Current Rate | New Rate | Effective Date |
| li | npatient | DRG | DRG | 7/1/2016 |
| 0 | utpatient | 88.18 | 95.92 | 7/1/2016 |
| Inpatient Count | y Billing Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| Interim | | X | Prospective Prospe | |
| | Total Interim | | X Total Prospe | ctive |
| | Settlement Based or | n Cost | | |
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| | | BASIS: | | |
| | | Budget — | | |
| | X | Unaudited Costs | | |
| | | Field Audited Cost | | |
| | | Revised Field Aud | | |
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| | | Medica | id Cost Reimbursement Ana | lysis |
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119768 - 2016/07

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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|--------------------------|------------------|-----------------|---------------|---------------------|-------------------------|--|
| Lake City Medical Center | | | | Provider Number: | 0119768-00 | |
| 1050 N. Commerce Blvd | | | | Date: | 7/29/2016 | |
| Lake City, FL 32055- | | | | Fiscal Year End: | 10/31/2015 | |
| • | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| HOSPITAL | | Current Rate | <u> </u> | New Rate | Effective Date | |
| Inpatient | | DRG | _ | DRG | 7/1/2016 | |
| Outpatient | | 70.25 | | 75.53 | 7/1/2016 | |
| Inpatient County Billing | Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | _ | |
| Interim | | Х | Prospecti | ive | | |
| Total Inter | im | | - X | Total Prospec | tive | |
| Settlemer | t Based on Cos | st | | <u> </u> | | |
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| | | BASIS | <u>:</u> | | | |
| _ | Bu | dget | | | | |
| _ | X Un | audited Costs | ; | | | |
| _ | Fie | eld Audited Co | sts | | | |
| _ | Re | evised Field Au | udit | | | |
| | Со | st Report Late | e Test | | | |
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| | | Medic | aid Cost Re | eimbursement Anal | ysis | |
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119784 - 2016/07

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-Med | | - | Provider Number: | 0119784-00 |
|----------------------------|-----------------|------------------|------------------------|-------------------------|
| Medicaid Billing Office | | | Date: | 7/29/2016 |
| Chattahoochee, FL 32324- | | | Fiscal Year End: | 6/30/2015 |
| Chattanoochee, FL 32324- | | | Audit Status: | Unaudited Cost Report |
| Descrides Tomas | | | | |
| Provider Type: | 6 | urrent Dete | New Pote | Effective Date |
| <u>HOSPITAL</u> | | urrent Rate | New Rate | Effective Date |
| Inpatient | | DRG | DRG | 7/1/2016 |
| Outpatient | | 11.65 | 12.52 | 7/1/2016 |
| Inpatient County Billing | Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | | X <u>Pros</u> | pective | |
| Total Inter | im | | X Total Prospec | tive |
| Settlemen | t Based on Cost | | | |
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| _ | X Unau | udited Costs | | |
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| _ | Revis | sed Field Audit | | |
| _ | Cost | Report Late Test | | |
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| | | Medicaid Co | ost Reimbursement Anal | ysis |
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119806 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Capital Bagian | al Madiaal (| Contor | | | | Provider Number: | 0119806-00 |
|--------------------|----------------|------------------|-----------|-------------|---------|---------------------|-------------------------|
| Capital Region | | | | | | | 7/29/2016 |
| 2626 CAPITAL | | RLVD | | | | Fiscal Year End: | |
| Tallahassee, F | L 32308- | | | | | | Unaudited Cost Report |
| Duardan Tr | | | | | | | |
| <u>Provider Ty</u> | | IT A I | Curro | ent Rate | | New Rate | Effective Date |
| | HOSP | | | | | | _ |
| | | npatient | | RG | | DRG | 7/1/2016 |
| luu atia | | utpatient | | 6.30 | | 71.27 | 7/1/2016 |
| inpatie | ent County | y Billing Rate | | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| | <u>Interim</u> | | _ | X <u>Pr</u> | ospect | <u>ive</u> | |
| | | Total Interim | | | Х | Total Prospec | tive |
| | | Settlement Based | d on Cost | | | | |
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| | | | | BASIS: | | | |
| | | | Budget | | | | |
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| | | | Cost Rep | ort Late Te | est | | |
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| | | | | Medicaid | Cost R | eimbursement Anal | ysis |
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119849 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Tampa Community Hospita | al | | | Provider Number: | 0119849-00 |
|-------------------------|---------------------|-----------------------|-----------------------------|---------------------|-------------------------|
| 6001 Webb Road | u. | | | Date: | 7/29/2016 |
| Tampa, FL 33615- | | | | Fiscal Year End: | 10/31/2015 |
| Tampa, TE 33013- | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSP | ΙΤΔΙ | Current Rat | e | New Rate | Effective Date |
| | npatient | DRG | | DRG | 7/1/2016 |
| | utpatient | 64.24 | | 69.07 | 7/1/2016 |
| Inpatient Count | - | | | | 7/1/2016 |
| | ,g | | | | |
| Rate Type: Interim | | Х | <u>Prospecti</u> | VO. | |
| <u>interim</u> | Total Interim | | _ Frospecti X | ve Total Prospec | tive |
| | Settlement Based on | Cost | | | uvo |
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| | - | Budget | | | |
| | X | - Unaudited Cost | S | | |
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| | | - Revised Field A | udit | | |
| | | Cost Report Lat | e Test | | |
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| | | W. R | ydell Samue | l or Chanda Farcas | |
| | | Medi | caid Cost Re | eimbursement Anal | ysis |
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119881 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Regional Medical Center Bayonet | | | Provider Number: | |
|---------------------------------|-------------------|-----------------|---------------------------|-------------------------|
| Point | | | Date: | 7/29/2016 |
| 14000 FIVAY RD | | | Fiscal Year End: | 2/28/2015 |
| Hudson, FL 34667- | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | <u>Current</u> | Rate | New Rate | Effective Date |
| Inpatient | DR | G - | DRG | 7/1/2016 |
| Outpatien | t 62. 6 | <u> </u> | 67.39 | 7/1/2016 |
| Inpatient County Billing | Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | | X <u>Prospe</u> | ctive | |
| Total Inte | erim | X | Total Prospec | tive |
| Settleme | ent Based on Cost | | | |
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| | Budget | | | |
| | X Unaudited (| Costs | | |
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| | V | V. Rydell Sam | uel or Chanda Farcas | s // |
| | N | Medicaid Cost | Reimbursement Anal | ysis |
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119938 - 2016/07

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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|-------------------------------------|--------------------|-----------------------|------------------------|-------------------------|
| Kindred Hospital-South Florida-Cora | I | | Provider Number: | |
| Gables 5190 SW 8TH ST | | | | 7/29/2016 |
| | | | Fiscal Year End: | 8/31/2015 |
| Coral Gables, FL 33134- | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | | Current Rate | New Rate | Effective Date |
| Inpatient | | DRG | DRG | 7/1/2016 |
| Outpatien | t | 11.65 | 12.52 | 7/1/2016 |
| Inpatient County Billing | Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | | X <u>Pros</u> | <u>pective</u> | |
| Total Inte | erim | | X Total Prospec | tive |
| Settleme | ent Based on C | Cost | | |
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| | | Budget | | |
| | Х | Unaudited Costs | | |
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119946 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| South Bay Hospital | | | Provider Nun | nber: 0119946-00 |
|----------------------------|---------------|------------------|-------------------------|-----------------------------|
| | | | | Date: 7/29/2016 |
| 4016 STATE RD 674 EAST | | | | End: 8/31/2015 |
| Sun City Center, FL 33570- | | | | atus: Unaudited Cost Report |
| Duaridas Trusa. | | | | |
| Provider Type: | | Current Rate | New Rate | Effective Date |
| <u>HOSPITAL</u> | m t | | | |
| Inpatie | | DRG | DRG | 7/1/2016 |
| Outpation | | 60.75 | 65.31 | 7/1/2016 |
| Inpatient County Billi | ng Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| <u>Interim</u> | | X | Prospective | |
| | Interim | | X Total Pro | spective |
| Settle | ment Based on | Cost | | |
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| | | BASIS | <u>:</u> | |
| | | Budget - | | |
| | X | Unaudited Costs | | |
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| | | Revised Field Au | | |
| | | Cost Report Late | Test | |
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| | | W. Ry | dell Samuel or Chanda F | arcas ## |
| | | Medic | aid Cost Reimbursement | Analysis |
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119954 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Doctors Hospital Of Saras | sota | | | Provider Number: | 0119954-00 |
|---------------------------|---------------------|---------------------|--------------|--------------------|-------------------------|
| 5731 Bee Ridge Road | | | | Date: | 7/29/2016 |
| Sarasota, FL 34233- | | | | Fiscal Year End: | 12/31/2014 |
| · | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSPI</u> | <u>ITAL</u> | Current Rate | | New Rate | Effective Date |
| Ir | npatient | DRG | | DRG | 7/1/2016 |
| O | utpatient | 63.11 | | 67.85 | 7/1/2016 |
| Inpatient County | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | X | Prospectiv | <u>'e</u> | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based or | n Cost | | | |
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| | | BASIS: | <u>-</u> | | |
| | | Budget | | | |
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| | | Field Audited Cos | | | |
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| | | Cost Report Late | rest | | |
| | | W. Ryo | dell Samuel | or Chanda Farcas | F G |
| | | Medica | aid Cost Rei | mbursement Anal | ysis |
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119971 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St. Lucie Medical Center | | | | Provider Number: | 0119971-00 |
|--------------------------|---------------------|---------------------|-------------|--------------------|-------------------------|
| 1800 SE TIFFANY AVE. | | | | Date: | 7/29/2016 |
| Port St Lucie, FL 34952- | | | | Fiscal Year End: | 9/30/2015 |
| · | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| <u>HOSPI</u> | <u>TAL</u> | Current Rate | ! | New Rate | Effective Date |
| Ir | npatient | DRG | | DRG | 7/1/2016 |
| O | utpatient | 69.85 | | 75.09 | 7/1/2016 |
| Inpatient County | y Billing Rate | | <u> </u> | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | Prospectiv | <u>/e</u> | |
| | Total Interim | | X | Total Prospec | tive |
| | Settlement Based on | Cost | | | |
| | | | | | |
| | | BASIS: | <u></u> | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Cos | | | |
| | | Revised Field Au | | | |
| | | Cost Report Late — | rest | | |
| | | W. Ry | dell Samuel | or Chanda Farcas | F G |
| | | Medica | aid Cost Re | imbursement Anal | ysis |
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119989 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Seven Rivers I | Pagional Ma | odical | | • | - Provider Number: | 0119989-00 |
|---------------------|----------------|-----------------------|-----------------|--------------|-----------------------|---------------------------------------|
| Center | Kegioriai ivie | tuicai | | | | 7/29/2016 |
| 6201 N Sunco | ast Blvd. | | | | Fiscal Year End: | 5/31/2015 |
| Crystal River, | FL 32629- | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | ne: | | | | | · · · · · · · · · · · · · · · · · · · |
| <u>i iovidei iy</u> | <u>HOSP</u> | ITAI | Current Ra | te | New Rate | Effective Date |
| | | npatient | DRG | | DRG | 7/1/2016 |
| | | utpatient | 50.90 | | 53.02 | 7/1/2016 |
| Inpatie | | y Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| itale Type. | <u>Interim</u> | | Х | Prospec | tive | |
| | - | Total Interim | | — X | Total Prospec | tive |
| | | – Settlement Based | on Cost | | · | |
| | - | | | | | |
| | | | <u>BASI</u> | <u>S:</u> | | |
| | | | Budget | | _ | |
| | | X | Unaudited Cos | ts | | |
| | | | Field Audited C | | | |
| | | | Revised Field A | | | |
| | | | Cost Report La | te Test | | |
| | | | W. F | Rydell Samu | el or Chanda Farcas | s A G |
| | | | Med | icaid Cost F | Reimbursement Anal | ysis |
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Batch ID:J4VC6

Printed on: 7/29/2016 4:56 PM



120006 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Plantation Gene | eral Hospita | al | | | | | Provider Number: | 0120006-00 | |
|-----------------|----------------|---------------|---------------|---------------|-------------|----------|--------------------|-------------------------|-----------|
| 401 NW 42ND | - | | | | | | Date: | 7/29/2016 | |
| Plantation, FL | | | | | | | Fiscal Year End: | 8/31/2015 | |
| riamation, re | 00017 | | | | | | Audit Status: | Unaudited Cost Repor | rt |
| Provider Ty | pe: | | | | | | | | |
| | HOSPI | <u>ITAL</u> | | <u>Currer</u> | t Rate | | New Rate | Effective Date | <u>te</u> |
| | lı | npatient | | DF | RG | | DRG | 7/1/2016 | |
| | 0 | utpatient | | 79. | 64 | _ | 85.62 | 7/1/2016 | |
| Inpatie | nt County | - | | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | _ | |
| 1 | <u>Interim</u> | | | | X <u>Р</u> | rospecti | <u>ve</u> | | |
| | | Total Inte | erim | | | Х | Total Prospec | tive | |
| - | | - Settleme | nt Based on (| Cost | | | | | |
| | | | | | | | | | |
| | | _ | | <u>B</u> | ASIS: | | | | |
| | | | | Budget | | | | | |
| | | _ | Χ | Unaudited | Costs | | | | |
| | | | | Field Audi | ted Costs | i | | | |
| | | _ | | Revised F | ield Audit | | | | |
| | | | | Cost Repo | ort Late Te | est | | | |
| | | - | | | | | | | |
| | | | | | W. Ryde | ll Samue | l or Chanda Farcas | * F F | |
| | | | | | Medicaid | Cost Re | eimbursement Anal | ysis | |
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120006 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Plantation General Hospital | | | - | Provider Number: | 0120006-01 |
|-----------------------------|---------------------|-----------------|---------------|-------------------------|-------------------------|
| 401 NW 42ND AVENUE | | | | Date: | 7/29/2016 |
| | | | | Fiscal Year End: | 8/31/2015 |
| Plantation, FL 33317- | | | | | Unaudited Cost Report |
| Date ! Lau Tour | | | | | |
| Provider Type: | | 0 | -4- | Name Data | Effective Date |
| <u>HOSPITA</u> | - | Current Ra | <u>nte</u> | New Rate | Effective Date |
| Inpa | - | DRG | | DRG | 7/1/2016 |
| Outpa | atient . | 79.64 | | 85.62 | 7/1/2016 |
| Inpatient County B | Illing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Χ | Prospect | ive | |
| | al Interim | | | Total Prospec | tive |
| | ttlement Based on C | Cost | - | <u> </u> | |
| | | | | | |
| | | BASI | S: | | |
| | - | Budget | | | |
| | | Unaudited Cos | sts | | |
| | | Field Audited (| Costs | | |
| | | Revised Field | | | |
| | | Cost Report La | | | |
| | | ood Roport Ed | | | |
| | | W. I | Rydell Samue | el or Chanda Farcas | F G |
| | | Med | dicaid Cost R | eimbursement Anal | ysis |
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120014 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Cobootion Hoo | nital | | | | — Provider Number: | 0120014-00 |
|--------------------|---------------------|--------------------|---------------------|------------|-----------------------|-------------------------|
| Sebastian Hos | | | | | | 7/29/2016 |
| P.O. BOX 7808 | | | | | Fiscal Year End: | |
| Sebastian, FL | 32978- | | | | | Amended Cost Report |
| Drovidor Tv | . | | | | | |
| <u>Provider Ty</u> | | IΤΛΙ | Current R | ato | New Rate | Effective Date |
| | <u>HOSP</u> | npatient | DRG | <u>ate</u> | DRG | 7/1/2016 |
| | | • | 59.23 | | 63.68 | 7/1/2016 |
| Innotic | | outpatient | 59.23 | | 03.00 | 7/1/2016 |
| праце | ent Count | y Billing Rate | | | | |
| Rate Type: | | | | | | |
| | <u>Interim</u> - | | X | Prospe | | |
| | | Total Interim | | | X Total Prospec | tive |
| | | Settlement Based o | on Cost | | | |
| | | | DAG | 10. | | |
| | | | BAS | <u>15:</u> | | |
| | | | Budget Unaudited Co | ete | | |
| | | | Field Audited | | | |
| | | | Revised Field | | | |
| | | | Cost Report L | | | |
| | | | | 410 1001 | | |
| | | | W. | Rydell Sar | nuel or Chanda Farcas | s A G |
| | | | Me | dicaid Cos | t Reimbursement Anal | ysis |
| | | | | | | |
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| | | | | | For Information or | nly - No Change in rate |
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Batch ID:J4VC6 Printed on: 7/29/2016 4:56 PM



120022 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St. Catherine's | Rehahilitat | ion Hosnits | al | | | | Pro | ovider Number: | 01200 | 22-00 |
|-----------------|----------------|-------------------|-------------|----------------|----------|-----------|------------|---------------------|---------|-------------------|
| 1050 NE 125 S | | ion i iospite | ai | | | | | Date: | 7/29/2 | 016 |
| North Miami, F | | | | | | | F | iscal Year End: | 9/30/2 | 015 |
| North Miami, i | L 33101- | | | | | | | Audit Status: | Unauc | lited Cost Report |
| Provider Ty | me. | | | | | | | | | |
| 1 TOVIGET TY | HOSP | ITAI | | Curre | nt Rat | e | | New Rate | | Effective Date |
| | | npatient | | | RG | | | DRG | | 7/1/2016 |
| | | utpatient | | | .65 | | | 12.52 | | 7/1/2016 |
| Inpatie | ent Count | - | | | | | | | | 7/1/2016 |
| | | <i>,</i> <u>-</u> | | | | | | | | |
| Rate Type: | <u>Interim</u> | | | | Χ | Prospe | netivo | | | |
| | <u> </u> | Total Inte | erim | _ | | _ | X | Total Prospec | tive | |
| | - | _ | nt Based on | Cost | | | | - - | | |
| | | - | | | | | | | | |
| | | | | <u> </u> | BASIS | <u>}:</u> | | | | |
| | | - | | Budget | | | | | | |
| | | - | Х | _ Unaudited | d Costs | 6 | | | | |
| | | - | | Field Aud | ited Co | osts | | | | |
| | | _ | | – Revised F | Field A | udit | | | | |
| | | - | | Cost Rep | ort Late | e Test | | | | |
| | | _ | | _ | | | | | | |
| | | | | | | | | | | R al |
| | | | | | W. R | ydell San | nuel or | Chanda Farcas | ¢ | |
| | | | | | Medic | raid Cost | t Raimh | oursement Anal | veie / | • |
| | | | | | Medic | Jaiu Cosi | i iveiiiik | oursement Anai | yolo | |
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| | | | | | | | E^ | r Information or | dy - Na | Change in rate |
| | | | | | | | | | | Change in rate |
| Batch ID:J4VC6 | | | | | | | Printe | d on : 7/29/2016 4: | 56 PM | |



120057 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Healthsouth Larkin Hospital- | -Miami | | | Р | rovider Number: | 0120057-00 | |
|------------------------------|--------------------|--------------|---------|---------------|----------------------|-------------------------|--|
| 7031 SW 62 AVE. | | | | | Date: | 7/29/2016 | |
| South Miami, FL 33143- | | | | | Fiscal Year End: | 12/31/2014 | |
| , , | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | | |
| HOSPIT | <u> AL</u> | <u>Curre</u> | nt Rate | | New Rate | Effective Date | |
| In | patient | D | RG | | DRG | 7/1/2016 | |
| Ou | tpatient | 120 | 6.03 | | 135.49 | 7/1/2016 | |
| Inpatient County | Billing Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| Interim | | | Χ | Prospective | t. | | |
| | Total Interim | _ | | X | Total Prospec | tive | |
| | Settlement Based o | n Cost | • | | _ | | |
| | | Б | A CIC. | | | | |
| | | Budget | BASIS: | | | | |
| | X | — Unaudited | d Costs | | | | |
| | | — Field Aud | | ıts. | | | |
| | | — Revised F | | | | | |
| | | Cost Rep | | | | | |
| | | _ · | | | | | |
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| | | | W. Ryo | dell Samuel o | r Chanda Farcas | i A G | |
| | | | Medica | id Cost Reim | bursement Anal | ysis | |
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| | | | | F | or Information or | nly - No Change in rate | |
| Batch ID:J4VC6 | | | | Print | ed on : 7/29/2016 4: | 56 PM | |



120073 - 2016/07

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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|-----------------|----------------|---------------|-------------------|-----------------|-------------|--------------------|-------------------------|
| Oak Hill Hosp | ital | | | | | Provider Number: | 0120073-00 |
| P.O. BOX 530 | 0 | | | | | Date | 7/29/2016 |
| Spring Hill, FL | 33526- | | | | | Fiscal Year End: | 2/28/2015 |
| | | | | | | Audit Status: | Unaudited Cost Report |
| Provider Ty | pe: | | | | | | |
| | | <u>PITAL</u> | | Current Rat | <u>te</u> | New Rate | Effective Date |
| | | Inpatient | | DRG | | DRG | 7/1/2016 |
| | (| Outpatient | | 52.64 | | 56.59 | 7/1/2016 |
| Inpatie | ent Coun | ty Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | | _ |
| rate Type. | <u>Interim</u> | | | Х | Prospect | ive | |
| | | Total Inte | erim | | X | — Total Prospec | ctive |
| | | — Settleme | nt Based on (| Cost | | | |
| | | | | | | | |
| | | | | BASIS | <u>S:</u> | | |
| | | - | | Budget | | | |
| | | - | Х | Unaudited Cost | s | | |
| | | - | | Field Audited C | osts | | |
| | | - | | Revised Field A | udit | | |
| | | - | | Cost Report Lat | te Test | | |
| | | - | | • | | | |
| | | | | W. R | ydell Samue | el or Chanda Farca | s FG |
| | | | | Medi | caid Cost R | eimbursement Ana | lysis |
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120081 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Mease Country | vside Hosni | tal | | | | | Pro | ovider Number: | 0120081- | -00 |
|--------------------|---------------------|--------------------------|-------------|--------------|---------|----------------------|--------|---------------------|-------------|----------------|
| • | | ıaı | | | | | | Date: | 7/29/2016 | 6 |
| 16331 BayVist | | | | | | | F | iscal Year End: | 12/31/20 | 14 |
| Clearwater, FL | . 33700- | | | | | | | Audit Status: | Unaudite | d Cost Report |
| Providor Tv | mo: | | | | | | | | | |
| <u>Provider Ty</u> | <u>pe.</u> HOSP | IΤΛΙ | | <u>Curre</u> | nt Rat | _ | | New Rate | | Effective Date |
| | · | npatient | | | RG | <u>-</u> - | • | DRG | _ <u> </u> | 7/1/2016 |
| | | inpallerit Outpatient | | | 3.91 | | | 68.71 | | 7/1/2016 |
| Innatio | | • | | | .91 | | | 00.7 1 | | 7/1/2016 |
| Праце | ent Count | уышпу | Kale | | | | | | | 77172010 |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> - | | | | Х | _ <u>Prospe</u> _ | | | | |
| | | Total Inte | | | | X | | Total Prospec | tive | |
| | | Settlemei – | nt Based on | Cost | | | | | | |
| | | | | | | | | | | |
| | | _ | | | BASIS | <u>S:</u> | | | | |
| | | _ | | Budget | | | | | | |
| | | _ | Х | Unaudited | | | | | | |
| | | _ | | Field Aud | | | | | | |
| | | _ | | Revised F | | | | | | |
| | | _ | | Cost Rep | ort Lat | e Test | | | | |
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| | | | | | W. R | ydell Sam | uel or | Chanda Farcas | s #() | |
| | | | | | Medi | caid Cost | Reimb | oursement Anal | vsis | |
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120090 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Delray Comm. Hosp. | | | Provider Nur | mber: | 0120090-00 |
|-------------------------|---------------------|-------------------|-------------------------|------------|------------------------|
| | | | | Date: | 7/29/2016 |
| 5352 Linton Blvd | | | | | 12/31/2014 |
| Delray Beach, FL 33445- | | | | | Unaudited Cost Report |
| . . | | | , taut C | | |
| Provider Type: | | O | Name Barra | _ | Effective Date |
| <u>HOSPITAI</u> | _ | Current Rate | | <u> </u> | Effective Date |
| Inpa | | DRG | DRG | | 7/1/2016 |
| Outpa | | 75.76 | 81.74 | | 7/1/2016 |
| Inpatient County Bi | illing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| <u>Interim</u> | | Х | <u>Prospective</u> | | |
| Tot | al Interim | | X Total Pro | ospect | ive |
| Set | ttlement Based on C | Cost | | | |
| | | | | | |
| | | BASIS : | | | |
| | | Budget | | | |
| | X | Unaudited Costs | | | |
| | | Field Audited Cos | sts | | |
| | | Revised Field Au | dit | | |
| | | Cost Report Late | Test | | |
| | | | | | |
| | | W. Ryd | dell Samuel or Chanda F | - arcas | # Cf |
| | | Medica | aid Cost Reimbursement | t Analy | rsis |
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120103 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St. Petersburg General Hospital | | Pr | ovider Number: | 0120103-00 | |
|---------------------------------|---------------------|-----------------|----------------------|-------------------------|--|
| 6500 38TH AVE., NORTH | | | Date: | 7/29/2016 | |
| St Petersburg, FL 33710- | | F | iscal Year End: | 4/30/2015 | |
| of referabulg, r E 337 10- | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | |
| HOSPITAL | Current Rate | | New Rate | Effective Date | |
| Inpatient | DRG | | DRG | 7/1/2016 | |
| Outpatien | 70.28 | | 75.56 | 7/1/2016 | |
| Inpatient County Billing | - | | | 7/1/2016 | |
| | | | | | |
| Rate Type: Interim | X <u>F</u> | rospective | | | |
| Total Inte | | X | Total Prospec | tive | |
| | ' Based on Cost | | | uvo | |
| | | | | | |
| | BASIS: | | | | |
| | Budget | | | | |
| | X Unaudited Costs | | | | |
| | Field Audited Costs | 3 | | | |
| | Revised Field Audi | t | | | |
| | Cost Report Late T | est | | | |
| | | | | | |
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| | W. Ryde | ll Samuel or | · Chanda Farcas | i de t | |
| | Medicaio | d Cost Reim | bursement Anal | vsis | |
| | modical | 2 0001 1 101111 | | y 0.10 | |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

120111 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Palms Of Pasa | adena Hosp | ital | | | Provider Number: | 0120111-00 | |
|---------------|----------------|------------------|-------------|-----------------|-----------------------|-------------------------|--|
| 1501 Pasaden | a Ave. | | | | Date: | 7/29/2016 | |
| South Pasade | na, FL 3370 | 07- | | | Fiscal Year End: | 9/30/2015 | |
| | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | <u>/pe:</u> | | | | | | |
| | HOSP | <u>ITAL</u> | Curren | t Rate | New Rate | Effective Date | |
| | I | npatient | DF | RG | DRG | 7/1/2016 | |
| | 0 | outpatient | 80. | 05 | 86.06 | 7/1/2016 | |
| Inpatie | ent Count | y Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| | <u>Interim</u> | | | X <u>Pros</u> p | <u>pective</u> | | |
| | - | Total Interim | | | X Total Prospec | tive | |
| | | Settlement Based | on Cost | | | | |
| | <u> </u> | | | | | | |
| | | | | ASIS: | | | |
| | | | Budget | | | | |
| | | X | Unaudited | | | | |
| | | | Field Audit | | | | |
| | | | Revised Fi | rt Late Test | | | |
| | | | | il Lale Test | | | |
| | | | | W. Rydell Sa | muel or Chanda Farca | F If | |
| | | | • | Medicaid Cos | st Reimbursement Anal | ysis | |
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120138 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Kendall Region | nal Madical | Contor | | | | Pro | ovider Number: | 0120 | 138-00 |
|-------------------|--------------|---------------------|------------------------|----------|-------------------------------|---------|---------------------|----------|-------------------|
| 11750 SW 407 | | Center | | | | | Date: | 7/29/2 | 2016 |
| Miami, FL 331 | | | | | | Fi | iscal Year End: | 12/31 | /2014 |
| IVIIdIIII, FL 331 | 175- | | | | | | Audit Status: | Unau | dited Cost Report |
| Provider Ty | ne. | | | | | | | | |
| 1 TO VIGOT TY | HOSF | PITAI | Curre | ent Rat | e | | New Rate | | Effective Date |
| | | Inpatient | | RG | <u> </u> | - | DRG | | 7/1/2016 |
| | | Dutpatient | | 1.22 | | | 65.81 | | 7/1/2016 |
| Inpatie | | ty Billing Rate | | | | | | | 7/1/2016 |
| | | | | | | | | | |
| Rate Type: | lusta uiua | | | V | Ducana | | | | |
| | Interim - | Total Interim | _ | Х | _ Prospe _ X | | Total Prospec | tivo | |
| | | Settlement Based of | n Cost | | | ` | - | uve | |
| | - | | | | | | | | |
| | | | <u>I</u> Budget | BASIS | <u>):</u> | | | | |
| | | X | Budget Unaudite | nd Costs | 2 | | | | |
| | | | — Field Aud | | | | | | |
| | | | — Revised | | | | | | |
| | | | Cost Rep | | | | | | |
| | | | | | | | | | |
| | | | | W. R | ydell Sam | nuel or | Chanda Farcas | - | R G |
| | | | | Medio | caid Cost | Reimb | oursement Analy | ysis | |
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| Batch ID:J4VC6 | | | | | | Printe | d on : 7/29/2016 4: | 56 PM | |



120227 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| St Anthonys Hospital | | Pr | ovider Number: | 0120227-00 | |
|----------------------------------|------------------------------------|----------------|----------------------|-------------------------|--|
| 3001 W. ML King Blvd.Post Office | | | Date: | 7/29/2016 | |
| Box 4227 | | F | iscal Year End: | 12/31/2014 | |
| Tampa, FL 33677-4227 | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | |
| <u>HOSPITAL</u> | Current Rate | <u>)</u> | New Rate | Effective Date | |
| Inpatient | DRG | | DRG | 7/1/2016 | |
| Outpatient | 92.73 | | 99.69 | 7/1/2016 | |
| Inpatient County Billing | Rate | | | 7/1/2016 | |
| Rate Type: | | | | | |
| Interim | X | Prospective | | | |
| Total Inte | im | - X | Total Prospec | tive | |
| Settleme | t Based on Cost | | _ | | |
| | | | | | |
| | BASIS | <u>.</u> | | | |
| | Budget | | | | |
| | X Unaudited Costs | | | | |
| | Field Audited Co Revised Field Au | | | | |
| - | Cost Report Late | | | | |
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| | W. Ry | dell Samuel or | Chanda Farcas | A J | |
| | Medic | aid Cost Reim | bursement Anal | ysis | |
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| | | Fc | or Information on | nly - No Change in rate | |
| Batch ID:J4VC6 | | | ed on : 7/29/2016 4: | | |



120243 - 2016/07

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

| | <u>iviedicald Reimbu</u> | rsement Rate Un | ange Form | | |
|-----------------------|--------------------------|------------------|------------------|--------------------|-------------------------|
| W. Boca Med. Ctr. | | | | Provider Number: | 0120243-00 |
| 21644 STATE RD 7 | | | | Date: | 7/29/2016 |
| Boca Raton, FL 33428- | | | | Fiscal Year End: | 12/31/2014 |
| | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | |
| HOSPI | Γ <u>AL</u> | Current Rate | <u>e</u> | New Rate | Effective Date |
| In | patient | DRG | | DRG | 7/1/2016 |
| Ou | tpatient | 69.02 | | 74.20 | 7/1/2016 |
| Inpatient County | Billing Rate | | | | 7/1/2016 |
| Rate Type: | | | | | |
| Interim | | X | <u>Prospecti</u> | ve | |
| | Total Interim | | - X | — Total Prospec | ctive |
| | Settlement Based on | Cost | | | |
| | | | | | |
| | | <u>BASIS</u> | <u>:</u> | | |
| | | Budget | | _ | |
| | X | Unaudited Costs | 3 | | |
| | | Field Audited Co | sts | | |
| | | Revised Field Au | udit | | |
| | | Cost Report Late | e Test | | |
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| | | W. Ry | /dell Samue | l or Chanda Farcas | s A (f |
| | | Medic | caid Cost Re | eimbursement Anal | lysis |
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120260 - 2016/07

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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|--------------|----------------|---------------|------------------|-------------------|------------|--------------------|-------------------------|
| Palms West H | lospital | | | | | Provider Number | : 0120260-00 |
| P.O. BOX 115 | 0 | | | | | Date | 7/29/2016 |
| Loxahatchee, | FL 33470- | | | | | Fiscal Year End | 5/31/2015 |
| | | | | | | Audit Status | : Unaudited Cost Report |
| Provider Ty | /pe: | | | | | | |
| | HOSP | <u> ITAL</u> | | Current Rate | | New Rate | Effective Date |
| | I | Inpatient | | DRG | | DRG | 7/1/2016 |
| | C | Outpatien | t | 67.58 | | 72.65 | 7/1/2016 |
| Inpatie | ent Count | ty Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | | |
| itale Type. | <u>Interim</u> | | | X | Prospect | tive | |
| | - | Total Inte | erim | | . X | Total Prospec | ctive |
| | | – Settleme | ent Based on | Cost | | <u> </u> | |
| | | _ | | | | | |
| | | | | BASIS: | <u>.</u> | | |
| | | | | Budget | | | |
| | | | Х | Unaudited Costs | | | |
| | | | | Field Audited Cos | sts | | |
| | | | | Revised Field Au | dit | | |
| | | | | Cost Report Late | Test | | |
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| | | | | W. Ry | dell Samue | el or Chanda Farca | s R G |
| | | | | Medica | aid Cost R | eimbursement Ana | lysis |
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120278 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| HealthSouth R | Rehabiliation | Hospital- | | | | | Pro | ovider Number: | 01202 | 78-00 |
|----------------|----------------|---------------|-------------|--------------|---------|-----------|------------|---------------------|----------|-----------------------|
| Sunrise | | | | | | | | Date: | 7/29/20 | 016 |
| 4399 NOB HIL | | | | | | | F | iscal Year End: | 12/31/2 | 2014 |
| Ft Lauderdale, | , FL 33351- | | | | | | | Audit Status: | Unaud | ited Cost Report |
| Provider Ty | <u>/pe:</u> | | | | | | | | | |
| | <u>HOSP</u> | <u>ITAL</u> | | <u>Curre</u> | nt Rat | <u>e</u> | ; | New Rate | | Effective Date |
| | I | npatient | | D | RG | | | DRG | | 7/1/2016 |
| | 0 | utpatient | t | 11.65 | | | 12.52 | | _ | 7/1/2016 |
| Inpatie | ent Count | y Billing | Rate | | | | | | | 7/1/2016 |
| Rate Type: | | | | | | | | | | |
| rtato Typo. | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | - | Total Inte | erim | _ | | _ ` | Κ | Total Prospec | tive | |
| | | – Settleme | nt Based on | Cost | | | | _ | | |
| | | - | | | | | | | | |
| | | _ | | <u>B</u> | ASIS | <u>):</u> | | | | |
| | | _ | | Budget | | | | | | |
| | | _ | Х | Unaudited | d Costs | 3 | | | | |
| | | _ | | Field Aud | ited Co | osts | | | | |
| | | <u>-</u> | | Revised F | ield A | udit | | | | |
| | | _ | | Cost Rep | ort Lat | e Test | | | | |
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| | | | | | | | | | | \mathbb{Z} $\cap l$ |
| | | | | | W. R | ydell San | nuel or | Chanda Farcas | P | |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | ysis | |
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120294 - 2016/07

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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|-----------------|--------------------|-------------------|---------------------|------------------|---------------------|-------------------------|--|
| Jupiter Hospita | al | | | | Provider Number: | 0120294-00 | |
| 1210 S Old Dix | xie Highway | | | | Date: | 7/29/2016 | |
| Jupiter, FL 33 | | | | | Fiscal Year End: | 9/30/2015 | |
| , , | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | /pe: | | | | | | |
| | HOSPITAL | | Current Rate | | New Rate | Effective Date | |
| | Inpatient | | DRG | | DRG | 7/1/2016 | |
| | Outpatient | | 63.30 | | 68.06 | 7/1/2016 | |
| Inpatie | ent County Billing | Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| rtato Typo. | <u>Interim</u> | | X <u>Pr</u> | ospecti | ive | | |
| | - Total Inte | erim | | X | Total Prospec | tive | |
| | Settleme | nt Based on | Cost | | | | |
| | | | | | | | |
| | | | BASIS: | | | | |
| | • | | Budget | | | | |
| | • | Х | Unaudited Costs | | | | |
| | • | | Field Audited Costs | | | | |
| | • | | Revised Field Audit | | | | |
| | • | | Cost Report Late Te | st | | | |
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| | | | W. Rydell | Samue | el or Chanda Farcas | F | |
| | | | Medicaid | Cost Re | eimbursement Anal | ysis | |
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120308 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| West Palm Hospital | | | F | Provider Number: | 0120308-00 | |
|-------------------------|---------------------|------------------------|---------------|-------------------|-------------------------|--|
| 2201 45TH ST | | | | Date: | 7/29/2016 | |
| West Palm Beach, FL 334 | 107- | | | Fiscal Year End: | 6/30/2015 | |
| , | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | |
| HOSPI | <u>ITAL</u> | Current Rate | | New Rate | Effective Date | |
| Ir | npatient | DRG | | DRG | 7/1/2016 | |
| O | utpatient | 73.94 | | 79.49 | 7/1/2016 | |
| Inpatient County | y Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | _ | |
| Interim | | X | Prospective | <u>e</u> | | |
| | Total Interim | | X | Total Prospec | tive | |
| | Settlement Based or | n Cost | | | | |
| | - | | | | | |
| | | BASIS: | | | | |
| | | Budget — | | | | |
| | X | Unaudited Costs | | | | |
| | | Field Audited Cos — | | | | |
| | | Revised Field Aud | | | | |
| | | Cost Report Late | Test | | | |
| | | W. Ryc | dell Samuel | or Chanda Farcas | F G | |
| | | Medica | aid Cost Reir | mbursement Anal | ysis | |
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120324 - 2016/07

For Information only - No Change in rate

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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|-------------------------------|-----------------------|-----------------------------|-----------------------|--|
| H Lee Moffitt Cancer Center & | | Provider Number: 0120324-00 | | |
| Research Institute Hospital | | Date | 7/29/2016 | |
| 12902 Magnolia Drive | | Fiscal Year End: | 6/30/2015 | |
| Tampa, FL 33612-9497 | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date | |
| Inpatient | DRG | DRG | 7/1/2016 7/1/2016 | |
| Outpatient | 263.48 | 283.26 | | |
| Inpatient County Billing Rate | | | 7/1/2016 | |
| Rate Type: | | | | |
| <u>Interim</u> | X Pros | <u>spective</u> | | |
| Total Interim | | X Total Prospec | ctive | |
| Settlement Based of | on Cost | | | |
| | | | | |
| | BASIS: | | | |
| | Budget | | | |
| X | Unaudited Costs | | | |
| | Field Audited Costs | | | |
| | Revised Field Audit | | | |
| | Cost Report Late Test | | | |
| | | | | |
| | W. Rydell S | Samuel or Chanda Farca | s F G | |
| | Medicaid C | ost Reimbursement Ana | lysis | |
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120324 - 2016/07

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

| | <u>iviedicaid</u> | <u>Reimbursemen</u> | t Rate Cha | ange Form | | | | | |
|-----------------------------------|------------------------|---------------------|------------|---------------|------------------|-----------------------|--|--|--|
| H Lee Moffitt C Research Insti | Cancer Center & | | | ı | Provider Number: | - | | | |
| 12902 Magnol | • | | | | Date: 7/29/2016 | | | | |
| - | | | | | Fiscal Year End: | 6/30/2015 | | | |
| Tampa, FL 33 | 0012-9497 | | | | Audit Status: | Unaudited Cost Report | | | |
| Provider Ty | <u>rpe:</u> | | | | | | | | |
| | HOSPITAL | <u>Cu</u> | rrent Rate | <u>}</u> | New Rate | Effective Date | | | |
| | Inpatient | | DRG | | DRG | 7/1/2016 | | | |
| | Outpatient | | 263.48 | | 283.26 | 7/1/2016 | | | |
| Inpatie | ent County Billing Rat | е | | | | 7/1/2016 | | | |
| Rate Type: | | | | | | | | | |
| | <u>Interim</u> | | X | Prospectiv | <u>e</u> | | | | |
| | - Total Interim | | | X | Total Prospec | ctive | | | |
| | Settlement Ba | sed on Cost | | | | | | | |
| | | | | | | | | | |
| | | | BASIS | <u>:</u> | | | | | |
| | | Budge | t | | | | | | |
| | | X Unaud | ited Costs | | | | | | |
| | | Field A | udited Co | sts | | | | | |
| | | Revise | d Field Au | ıdit | | | | | |
| | | Cost R | eport Late | Test | | | | | |
| | | | | | | | | | |
| | | | W. Ry | dell Samuel | or Chanda Farca | s F I | | | |
| | | | Medic | aid Cost Reir | mbursement Ana | lysis | | | |
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For Information only - No Change in rate

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Batch ID:J4VC6

Florida Agency For Health Care Administration

120332 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| HealthSouth R Tallahassee | ehabiliatior | n Hospital of | | | Provider Number: | | | |
|------------------------------|----------------|------------------|-----------------|--------------|---------------------------------------|-------------------------|--|--|
| 1675 RIGGINS | S PN | | | | | 7/29/2016 | | |
| | | | | | Fiscal Year End: | | | |
| Tallahassee, F | L 32308- | | | | Audit Status: | Unaudited Cost Report | | |
| Provider Ty | pe: | | | | | | | |
| | <u>HOSF</u> | <u>PITAL</u> | Current Ra | <u>te</u> | New Rate | Effective Date | | |
| | | Inpatient | DRG | | DRG | 7/1/2016 | | |
| | Outpatient | | 55.39 | | 59.55 | 7/1/2016 | | |
| Inpatie | nt Coun | ty Billing Rate | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | | |
| | <u>Interim</u> | | X | Prospec | <u>etive</u> | | | |
| | - | Total Interim | | x | Total Prospec | tive | | |
| | | Settlement Based | on Cost | | | | | |
| | | | | | | | | |
| | | | BASI | <u>S:</u> | | | | |
| | | | Budget | | | | | |
| | | X | Unaudited Cos | ts | | | | |
| | | | Field Audited C | Costs | | | | |
| | | | Revised Field A | Audit | | | | |
| | | | Cost Report La | te Test | | | | |
| | | | W. F | Rydell Samu | uel or Chanda Farcas | F G | | |
| | | | Med | icaid Cost F | Reimbursement Anal | ysis | | |
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120341 - 2016/07

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

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|----------------|----------------|------------------|----------------|-------------------|----------|-----------------|--------------------|-----------------------|-----------|--|
| HealthSouth T | | oast | | | | | Provider Number | : 0120341-00 | | |
| Rehabilitation | • | | | | | Date: 7/29/2016 | | | | |
| 1600 37TH ST | | | | | | | Fiscal Year End | 12/31/2014 | | |
| Vero Beach, F | L 32960- | | | | | | Audit Status | Unaudited Cost Report | t | |
| Provider Ty | <u>pe:</u> | | | | | | | | | |
| | HOS | <u>PITAL</u> | | Curr | ent Rat | <u>e</u> | New Rate | Effective Date | <u>:е</u> | |
| | | Inpatient | | | RG | | DRG | 7/1/2016 | | |
| | | Outpatient | | 1 | 1.65 | | 12.52 | 7/1/2016 | | |
| Inpatie | ent Cour | nty Billing R | ate | | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | | | | |
| | <u>Interim</u> | | | | Χ | Prospect | <u>ive</u> | | | |
| | - | Total Interim | ı | _ | | _ x | Total Prospec | ctive | | |
| | | Settlement E | 3ased on | Cost | | | | | | |
| | | | | | | | | | | |
| | | | | • | BASIS | <u>8:</u> | | | | |
| | | | | Budget — | | | | | | |
| | | | Х | _ Unaudite _ | ed Cost | S | | | | |
| | | | | Field Au | dited Co | osts | | | | |
| | | | | Revised | Field A | udit | | | | |
| | | | | Cost Re | oort Lat | e Test | | | | |
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| | | | | | W. R | ydell Samue | el or Chanda Farca | s A G | | |
| | | | | | Medi | caid Cost Re | eimbursement Ana | lysis | | |
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Batch ID:J4VC6

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120375 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Aventura Hosp | oital and Me | dical Cente | er | | | - | Pro | ovider Number: | 01203 | 375-00 |
|-------------------------------|----------------|---------------|-------------|--------------|----------|-----------|---------|---------------------|----------|-------------------|
| 20900 Biscayr | | | | | | | | Date: | 7/29/2 | 2016 |
| Miami, FL 331 | | | | | | | F | iscal Year End: | 12/31 | /2014 |
| | | | | | | | | Audit Status: | Unau | dited Cost Report |
| Provider Ty | /pe: | | | | | | | | | |
| | HOSP | <u>ITAL</u> | | <u>Curre</u> | nt Rate | <u>e</u> | | New Rate | | Effective Date |
| | ı | npatient | | D | RG | | | DRG | 7/1/2016 | |
| | C | utpatient | t | 33 | 3.75 | | | 36.29 | | 7/1/2016 |
| Inpatient County Billing Rate | | Rate | | | | | | 7/1/2016 | | |
| Rate Type: | | | | | | | | | | |
| rtato Typo. | <u>Interim</u> | | | | Х | Prospe | ective | | | |
| | - | Total Inte | erim | _ | | _ | < | Total Prospec | tive | |
| | | _ Settleme | nt Based on | Cost | | | | _ | | |
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| | | - | | Budget - | | | | | | |
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| | | - | | Cost Rep | ort Late | e rest | | | | |
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| | | | | | W. Ry | ydell San | nuel or | Chanda Farcas | 1 | W J |
| | | | | | Medic | caid Cost | Reimb | oursement Analy | ysis | |
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120383 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| HealthSouth Rehabiliation Sarasota | on Hospital | | Provider Number | |
|------------------------------------|--------------------|------------------------|--|--------------------------|
| 6400 Edgelake Drive | | | | 2: 7/29/2016 |
| Sarasota, FL 34240 | | | Fiscal Year End | |
| Jarasota, 1 L 34240 | | | Audit Status | : Unaudited Cost Report |
| Provider Type: | | | | |
| <u>HOS</u> | <u>PITAL</u> | Current Rate | New Rate | Effective Date |
| | Inpatient | DRG | DRG | 7/1/2016 |
| | Outpatient | 11.65 | 12.52 | 7/1/2016 |
| Inpatient County Billing Rate | | | _ | 7/1/2016 |
| Poto Typo: | | | | <u> </u> |
| Rate Type: | | X | <u>Prospective</u> | |
| <u>Internit</u> | Total Interim | | . X Total Prospe | ctive |
| | Settlement Based o | n Cost | | ouvo |
| | | | | |
| | | BASIS: | | |
| | | Budget | <u>. </u> | |
| | X | Unaudited Costs | | |
| | | — Field Audited Cos | sts | |
| | | — Revised Field Au | dit | |
| | | Cost Report Late | Test | |
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| | | W. Ryo | dell Samuel or Chanda Farca | as A J |
| | | Medica | aid Cost Reimbursement Ana | alysis |
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120405 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Broward Health | h Coral Spi | rings | | | Provider Number: 0120405-00 | | |
|----------------|----------------|------------------|---------------|---------------|-----------------------------|-------------------------|--|
| 303 South Eas | t 17th St. | | | | Date: | 7/29/2016 | |
| Ft. Lauderdale | , FL 33316 | 6- | | | Fiscal Year End: 6/30/2015 | | |
| | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | |
| | HOSE | <u>PITAL</u> | Current F | <u>Rate</u> | New Rate | Effective Date | |
| | | Inpatient | DRG | | DRG | 7/1/2016 | |
| | | Outpatient | 77.13 | - | 82.64 | 7/1/2016 | |
| Inpatie | ent Coun | ty Billing Rate | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| itato iypo. | <u>Interim</u> | | Х | Prospe | ctive | | |
| | - | Total Interim | | X | Total Prospec | tive | |
| | | Settlement Based | on Cost | | | | |
| | | _ | | | | | |
| | | | BAS | SIS: | | | |
| | | | Budget — | | | | |
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| | | | Field Audited | | | | |
| | | | Revised Field | | | | |
| | | | Cost Report I | _ate Test | | | |
| | | | W | . Rydell Sam | uel or Chanda Farcas | F F | |
| | | | Me | edicaid Cost | Reimbursement Anal | ysis | |
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120413 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Bartow Region | al Madiaal | Contor | | <u>-</u> | — Provider Number: | 0120413-00 | |
|-------------------------------|---------------------|--------------------------------------|-------------------|---------------|----------------------------|-------------------------|--|
| _ | | | | | | 7/29/2016 | |
| 2200 Osprey E 1050 | SivaPost Oi | lice Box | | | Fiscal Year End: 9/30/2015 | | |
| Bartow, FL 33 | 3830- | | | | | Amended Cost Report | |
| Providor Tv | /no: | | | | | · | |
| <u>Provider Ty</u> | <u>HOSF</u> | ΝΤΔΙ | Current | Rate | New Rate | Effective Date | |
| | | Inpatient | DRO | | DRG | 7/1/2016 | |
| | | Dutpatient | 45.6 | | 49.02 | 7/1/2016 | |
| Inpatient County Billing Rate | | | <u> </u> | | 7/1/2016 | | |
| | Jill Oodiii | ty Dinning Rate | | | | | |
| Rate Type: | | | , | _ | | | |
| | <u>Interim</u> - | Total Interim | | Prospe | | 4in ca | |
| | | Total Interim Settlement Based (| on Coat | X | Total Prospec | tive | |
| | | | UII COSt | | | | |
| | | | RΔ | SIS: | | | |
| | | | Budget | <u> </u> | | | |
| | | | — Unaudited C | osts | | | |
| | | | Field Audited | | | | |
| | | | — Revised Fiel | | | | |
| | | | Cost Report | | | | |
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| | | | W | /. Rydell Sam | nuel or Chanda Farcas | | |
| | | | M | edicaid Cost | Reimbursement Anal | ysis | |
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120421 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| HealthSouth Rehabiliati | ion Hospital- | | | | Provider Number: | 0120421-00 |
|-------------------------|---------------|---------------|---------------|---------------|-------------------------|-------------------------|
| Sea Pines | | | | | Date: | 7/29/2016 |
| 101 E Florida Ave. | | | | | Fiscal Year End: | 12/31/2014 |
| Melbourne, FL 32901- | | | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | | | |
| <u>H08</u> | <u>SPITAL</u> | | Current Rat | <u>e</u> | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatient | | 11.65 | | 12.52 | 7/1/2016 |
| Inpatient Cou | nty Billing R | ate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| Interim | | | Х | Prospectiv | <u>/e</u> | |
| | Total Interim | 1 | | _ x | Total Prospec | tive |
| | Settlement E | Based on Cost | t | | | |
| | | | | | | |
| | | | BASIS | <u>6:</u> | | |
| | | | dget | | | |
| | | | audited Cost | | | |
| | | | ld Audited Co | | | |
| | | | vised Field A | | | |
| | | Cos | st Report Lat | e Test | | |
| | | | | | | |
| | | | W. R | ydell Samuel | or Chanda Farcas | s A CF |
| | | | Medi | caid Cost Rei | mbursement Anal | ysis |
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141144 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Kingsbay Com | ingsbay Community Hospital | | | | | | Provider Number: 0141144-00 | | | |
|-------------------------------|----------------------------|----------------|-------------|--------------|---------------|-----------------------|-----------------------------|--|--|--|
| 2000 Dan Pro | • | | | | | Date: | 7/29/2016 | | | |
| Saint Marys, | | | | | | Fiscal Year End: | Year End: 4/30/2014 | | | |
| Came Maryo, | 6 71 01000 | | | | | Audit Status: | Interim Budget | | | |
| Provider Ty | /pe: | | | | | | | | | |
| _ | HOSF | <u>PITAL</u> | | <u>Curre</u> | nt Rate | New Rate | Effective Date | | | |
| | | Inpatient | | DF | RG | DRG | 7/1/2016 | | | |
| Outpatient | | 11.65 | | 12.52 | 7/1/2016 | | | | | |
| Inpatient County Billing Rate | | - | | | 7/1/2016 | | | | | |
| Rate Type: | | | | | | | | | | |
| X | <u>Interim</u> | | | | Pros | <u>pective</u> | | | | |
| | _ | Total Inte | rim | | | Total Prospec | etive | | | |
| | X | _ Settlemer | nt Based on | Cost | | | | | | |
| | | _ | | | | | | | | |
| | | _ | | <u>B</u> | ASIS: | | | | | |
| | | _ | Χ | Budget | | | | | | |
| | | _ | | Unaudited | Costs | | | | | |
| | | _ | | Field Audi | ted Costs | | | | | |
| | | _ | | Revised F | ield Audit | | | | | |
| | | _ | | Cost Repo | ort Late Test | | | | | |
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| | | | | | W. Rydell Sa | amuel or Chanda Farca | s A G | | | |
| | | | | | Medicaid Co | st Reimbursement Ana | lysis | | | |
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142355 - 2016/07

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

| | | <u>Medicaid</u> | Reimbur | <u>sement Rate</u> | Change Fo | <u>orm</u> | | |
|--------------------------------|----------------|--------------------|-----------|--------------------|--------------|----------------------|-------------------------|--|
| Healthsouth R | | n of | | | | Provider Number: | | |
| Altamonte Spi 831 S State R | _ | | | | | Date: 7/29/2016 | | |
| Altamonte Springs, FL 32714 | | | | | | Fiscal Year End: | 12/31/2015 | |
| Altamonte Spi | rings, FL 3 | 2/14 | | | | Audit Status: | Interim Budget | |
| Provider Ty | ype: | | | | | | | |
| | <u>HOSI</u> | PITAL | | Current | Rate | New Rate | Effective Date | |
| | | Inpatient | • | DRO | | DRG | 7/1/2016 | |
| | (| Outpatient | • | 11.6 | <u></u> 5 | 12.52 | 7/1/2016 | |
| Inpatio | ent Coun | ty Billing Ra | te | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | |
| X | <u>Interim</u> | | | | Prosp | <u>pective</u> | | |
| | _ | Total Interim | | | | Total Prospec | ctive | |
| | X | — Settlement Ba | ased on C | Cost | | | | |
| | | | | | | | | |
| | | | | BA | SIS: | | | |
| | | | Χ | Budget | | _ | | |
| | | | | Unaudited C | osts | | | |
| | | | | Field Audited | d Costs | | | |
| | | | | Revised Fiel | d Audit | | | |
| | | | | Cost Report | Late Test | | | |
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| | | | | W | /. Rydell Sa | muel or Chanda Farca | s A G | |
| | | | | M | edicaid Cos | st Reimbursement Ana | lysis | |
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260011 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Florida State F | lospital | | | | | | Provider Number | : 0260011-00 | |
|-----------------|----------------|----------------|-------------|----------------|----------|-------------|-------------------------------|-------------------------|--|
| Building 260 | | | | | | | Date | 8/9/2016 | |
| Chattahooche | e FL 32324 | 1- | | | | | Fiscal Year End | 6/30/2015 | |
| Onalian ocono | 0,12 0202 | | | | | | Audit Status | : Unaudited Cost Report | |
| Provider Ty | pe: | | | | | | | | |
| | HOSP | ITAL | | <u>Curre</u> | nt Rate | <u>!</u> | New Rate | Effective Date | |
| | I | npatient | | 45 | 53.42 | | 482.92 | 7/1/2016 | |
| | 0 | utpatient | | 14 | .53 | | 13.04 | 7/1/2016 | |
| Inpatie | ent Count | y Billing | Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | | | |
| rato Typo. | <u>Interim</u> | | | | Χ | Prospecti | <u>ve</u> | | |
| | - | Total Inte | rim | | | - X | Total Prospec | ctive | |
| | | _ Settlemer | nt Based on | Cost | | | | | |
| | | | | | | | | | |
| | | _ | | | BASIS: | <u>.</u> | | | |
| | | _ | | Budget – | | | | | |
| | | _ | X | Unaudited – | | | | | |
| | | _ | | Field Aud | | | | | |
| | | _ | | Revised F | | | | | |
| | | _ | | Cost Rep | ort Late | e Lest | | | |
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| | | | | | W. Ry | dell Samue | l or Chanda Farca | s / () | |
| | | | | | Medic | aid Cost Re | eimbursement Ana | lysis | |
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260029 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| Northeast Florida State Hospital | | | Provider Number: | 0260029-00 |
|----------------------------------|------------------|---------------------|-----------------------|-------------------------|
| HWY 121 SOUTH | | | Date: | 8/9/2016 |
| Macclenny, FL 32063- | | | Fiscal Year End: | 6/30/2015 |
| • | | | Audit Status: | Unaudited Cost Report |
| Provider Type: | | | | |
| <u>HOSPITAL</u> | | Current Rate | New Rate | Effective Date |
| Inpatient | | 373.72 | 328.38 | 7/1/2016 |
| Outpatien | | 14.53 | 13.04 | 7/1/2016 |
| Inpatient County Billing | Rate | | | 7/1/2016 |
| Rate Type: | | | | |
| Interim | | X <u>Prosp</u> | <u>oective</u> | |
| Total Inte | erim | | X Total Prospec | tive |
| Settleme | ent Based on Cos | st —— | | |
| | | | | |
| | | BASIS: | | |
| | Bu | dget | | |
| | X Un | audited Costs | | |
| | Fie | eld Audited Costs | | |
| | | vised Field Audit | | |
| | Co | st Report Late Test | | |
| | | W. Rydell Sa | muel or Chanda Farcas | F G |
| | | Medicaid Cos | st Reimbursement Anal | ysis |
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| | | | For Information or | nly - No Change in rate |

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260045 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | <u> </u> | Provider Number: | · 0260045-00 | |
|-------------------------------|-----------------------|------------------------|-------------------------|--|
| So. Fla. State Hosp | | | 8/9/2016 | |
| 800 East Cypress Dr | | Fiscal Year End: | | |
| Pembroke Pines, FL 33025- | | | | |
| | | Audit Status | Unaudited Cost Report | |
| <u>Provider Type:</u> | | | | |
| <u>HOSPITAL</u> | Current Rate | New Rate | Effective Date | |
| Inpatient | 201.33 | 231.27 | 7/1/2016 | |
| Outpatient | 14.53 | 13.04 | 7/1/2016 | |
| Inpatient County Billing Rate | 9 | | 7/1/2016 | |
| Rate Type: | | | | |
| Interim | X Pros | spective | | |
| Total Interim | | X Total Prospec | ctive | |
| Settlement Bas | sed on Cost | <u> </u> | | |
| | | | | |
| | BASIS: | | | |
| | Budget | | | |
| | X Unaudited Costs | | | |
| | Field Audited Costs | | | |
| | Revised Field Audit | | | |
| | Cost Report Late Test | | | |
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| | W. Rydell S | samuel or Chanda Farca | s Af | |
| | Medicaid C | ost Reimbursement Ana | lysis | |
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260053 - 2016/07

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

| Me | <u>edicaid Reimbur</u> | rsement Rate (| <u>Change Fo</u> | <u>rm</u> | | | |
|-------------------------|------------------------|----------------|------------------|-----------|------------------|-----------------------|--|
| W. Fla. Comm. Care | | | | Pi | rovider Number: | 0260053-00 | |
| 5500 Stewart St. | | | | | Date: | 8/9/2016 | |
| Milton, FL 32570- | | | | F | Fiscal Year End: | 6/30/2015 | |
| , | | | | | Audit Status: | Unaudited Cost Report | |
| Provider Type: | | | | | | | |
| <u>HOSPITAL</u> | | Current R | ate | | New Rate | Effective Date | |
| Inpatier | ıt | 183.0 | 1 | | 263.25 | 7/1/2016 | |
| Outpatie | nt | 14.53 | | 13.04 | | 7/1/2016 | |
| Inpatient County Billin | g Rate | | | | | 7/1/2016 | |
| Rate Type: | | | | | | | |
| <u>Interim</u> | | Х | Prosp | ective | | | |
| Total Ir | nterim | | | X | Total Prospec | tive | |
| Settlen | nent Based on (| Cost | | | - | | |
| | | | | | | | |
| | | BAS | IS: | | | | |
| | | Budget | | | | | |
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| | | Cost Report L | ate Test | | | | |
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| | | W. | Rydell Sar | nuel o | r Chanda Farcas | s THE | |
| | | Me | dicaid Cos | t Reim | bursement Anal | ysis | |
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102814 - 2016/07

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

Medicaid Reimbursement Rate Change Form

| | | | | | Provider Number: 0 | 102814-00 |
|--------------------|---------------------|-------------|------------------------------------|------------------|----------------------|-----------------------|
| Center | outh Alabama Medica | I | | | | /29/2016 |
| 1504 Springhill | Ave Suite #3170 | | | | Fiscal Year End: 9/ | |
| Mobile, AL 36 | 604- | | | | _ | Inaudited Cost Report |
| | | | | | - Tradit Otalus. O | Tiddated Goot Report |
| <u>Provider Ty</u> | | | | | | |
| | <u>HOSPITAL</u> | | Current Rate | | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatien | t | 11.65 | | 12.52 | 7/1/2016 |
| Inpatie | nt County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| | <u>Interim</u> | | Χ | <u>Prospecti</u> | <u>ve</u> | |
| | Total Inte | erim | | X | Total Prospectiv | re |
| | Settleme | nt Based on | Cost | | <u> </u> | |
| | | | | | | |
| | | | BASIS: | | | |
| | | | Budget | | | |
| | | X | - Unaudited Costs | | | |
| | | | - Field Audited Cost | ts | | |
| | | | - Revised Field Aud | lit | | |
| | | | - Cost Report Late ⁻ | | | |
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| | | | Medica | id Cost Re | imbursement Analys | is |
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102814 - 2016/07

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

| | | Medicaid Reir | <u>mbursement Rate Change F</u> | <u>orm</u> | | |
|---------------|----------------|------------------|---------------------------------|------------------------|-------------------------|--|
| Infirmary Wes | t | | | Provider Number: | 0102814-02 | |
| 5600 Girby Ro | oad | | | Date: 7/29/2016 | | |
| Mobile, AL 36 | 693- | | | Fiscal Year End: | 3/31/2000 | |
| | | | | Audit Status: | Interim Budget | |
| Provider Ty | /pe: | | | | | |
| _ | HOSE | <u>PITAL</u> | Current Rate | New Rate | Effective Date | |
| | | Inpatient | DRG | DRG | 7/1/2016 | |
| | | Dutpatient | 11.95 | 12.85 | 7/1/2016 | |
| Inpatie | ent Coun | ty Billing Rate | | | 7/1/2016 | |
| Rate Type: | | | | | | |
| X | <u>Interim</u> | | <u>Pros</u> | <u>pective</u> | | |
| | _ | Total Interim | | Total Prospec | tive | |
| | X | Settlement Based | on Cost | | | |
| | | _ | | | | |
| | | | BASIS: | | | |
| | | X | Budget | | | |
| | | | Unaudited Costs | | | |
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Batch ID:J4VC6

Florida Agency For Health Care Administration

102814 - 2016/07

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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|------------------|---------------------|----------------|---------------------|------------------|-------------------|-------------------------|
| U.S.A Children's | s & Women's Hospita | l | | F | Provider Number: | 0102814-01 |
| 1504 Springhill | Ave #3170 | | | Date: 7/29/2016 | | |
| | Mobile, AL 36604- | | | | | 9/30/2014 |
| · | | | | | Audit Status: | Unaudited Cost Report |
| Provider Typ | oe: | | | | | |
| • | HOSPITAL | | Current Rate | | New Rate | Effective Date |
| | Inpatient | | DRG | | DRG | 7/1/2016 |
| | Outpatient | : | 111.24 | | 119.59 | 7/1/2016 |
| Inpatier | nt County Billing | Rate | | | | 7/1/2016 |
| Rate Type: | | | | | | |
| | <u>Interim</u> | | Х <u>Р</u> ! | rospectiv | <u>e</u> | |
| | Total Inte | erim | | X | Total Prospec | tive |
| - | Settleme | nt Based on Co | ost | | | |
| - | | | | | | |
| | | | BASIS: | | | |
| | - | Е | Budget | | | |
| | _ | Χ | Inaudited Costs | | | |
| | | F | ield Audited Costs | | | |
| | _ | F | Revised Field Audit | | | |
| | _ | C | Cost Report Late Te | est | | |
| | | | | | | |
| | | | W. Rydel | l Samuel (| or Chanda Farcas | F F |
| | | | Medicaid | Cost Reir | nbursement Anal | ysis |
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