

Office of Medicaid Cost Reimbursement Planning and Analysis 2727 Mahan Drive Mail Stop 21 Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form

Kindred Hospital The Palm Beaches 5555 W. Blue Heron Blvd Riviera Beach FL 33418-7813

Provider Number:	0004170-00
Date:	10/4/2011
Fiscal Year End:	5/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$902.50	\$902.50	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	x Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:



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Medicaid Reimbursement Rate Change Form

UCHLTACH at Connerton	Provider Number:	0009496-00
9441 Health Center Drive	Date:	10/4/2011
Land O' Lakes FL 34637	Fiscal Year End:	12/31/2009
	Audit Status:	Interim Budget [4]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$725.95	\$725.95	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>X</u> Interim	Prospective
Total Interim X Settlement Based on Cost	Total Prospective
	BASIS :
	X Budget
	Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Kindred Hospital Melbourne	Provider Number:	0016815-00
765 W Nasa Blvd	Date:	10/4/2011
Melbourne FL 32901	Fiscal Year End:	7/31/2010
	Audit Status:	Interim Budget [4]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,247.38	\$1,247.38	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>X</u> Interim	Prospective
Total Interim X Settlement Based on Cost	Total Prospective
	BASIS : X Budget Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Sacred Heart Hospital on the Gulf 3801 E Hwy 98 Port St. Joe FL 32456

Provider Number:	0020127-00
Date:	10/4/2011
Fiscal Year End:	6/30/2011
Audit Status:	Interim Budget [4]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,084.37	\$1,084.37	7/1/2011
Outpatient	\$225.38	\$225.38	7/1/2011

Rate Type :

<u>X</u> Interim	Prospective
Total Interim X Settlement Based on Cost	Total Prospective
	BASIS : X Budget Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Shriners Hospital for Children	Provider Number:	0025766-00
12502 USF Pine Dr	Date:	10/4/2011
Tampa FL 33612	Fiscal Year End:	12/31/2011
	Audit Status:	Interim Budget [4]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	\$2,508.89 \$203.81	\$2,508.89 \$203.81	7/1/2011 7/1/2011
Inpatient County Billing Rate	\$2,508.89	\$2,508.89	7/1/2011

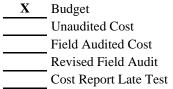
Rate Type :

Х	Interim	

Prospective

Total Interim Х Settlement Based on Cost **Total Prospective**

BA<u>SIS :</u>



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Medicaid Reimbursement Rate Change Form

Viera Hospital	Provider Number:	0031588-00
8745 Wickham Rd	Date:	10/4/2011
Melbourne FL 32940	Fiscal Year End:	9/30/2010
	Audit Status:	Interim Budget [4]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,243.60	\$1,243.60	7/1/2011
Outpatient	\$123.90	\$123.90	7/1/2011

Rate Type :

<u>X</u> Interim	Prospective
Total Interim X Settlement Based on Cost	Total Prospective
	BASIS :
	X Budget
	Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Shands Teaching Hospital	Provider Number:	0100030-00	
Box J-100336	Date:	10/4/2011	
Gainesville Fl 32610	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,898.85	\$2,588.46	7/1/2011
Outpatient	\$182.36	\$252.89	7/1/2011
Inpatient County Billing Rate	\$1,224.07	\$1,224.07	7/1/2011

Rate Type :

Interim		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	<u>B</u> A	ASIS :
		Budget
	Х	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
		=

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Medicaid Reimbursement Rate Change Form

Shands Teaching Hospital	Provider Number:	0100030-01	
Box J-100336	Date:	10/4/2011	
Gainesville Fl 32610	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,898.85	\$2,588.46	7/1/2011
Outpatient	\$182.36	\$252.89	7/1/2011
Inpatient County Billing Rate	\$1,224.07	\$1,224.07	7/1/2011

Rate Type :

Interim	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Shands Teaching Hospital	Provider Number:	0100030-02	
Box J-100336	Date:	10/4/2011	
Gainesville Fl 32610	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,898.85	\$2,588.46	7/1/2011
Outpatient	\$182.36	\$252.89	7/1/2011
Inpatient County Billing Rate	\$1,224.07	\$1,224.07	7/1/2011

Rate Type :

Interim	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Ed Fraser Memorial Hospital 159 North Third Street MacClenney FL 32063

Provider Number:	0100048-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status: Amended Cost Report [2]		
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$4,455.61	\$11,188.61	7/1/2011
Outpatient	\$19.53	\$88.62	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Bay Medical Center	Provider Number:	0100064-00	
P.O. Box 2515	Date:	10/4/2011	
Panama City FL 32402-2515	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	e Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$997.62	\$1,381.76	7/1/2011
Outpatient	\$101.24	\$132.67	7/1/2011
Inpatient County Billing Rate	\$726.03	\$726.03	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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0100072-00



Florida Agency For Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Analysis 2727 Mahan Drive Mail Stop 21 Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form

Shands at Starke Post Office Box 100336 Gainesville FL 32610-0336

Provider Type :

Date:	10/4/2011
Fiscal Year End:	6/30/2010
Audit Status:	Unaudited Cost Report [1]
Rate	Includes Buy Back

Provider Number:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,798.30	\$1,798.30	7/1/2011
Outpatient	\$105.35	\$105.35	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Holmes Regional Medical Center	Provider Number:	0100081-00	
3300 Fiske Boulevard	Date:	10/4/2011	
Rockledge FL 32955	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	e Includes Buy Back	
		·	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,357.64	\$1,357.64	7/1/2011
Outpatient	\$94.92	\$94.92	7/1/2011
Inpatient County Billing Rate	\$899.24	\$899.24	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Cape Canaveral Hospital	Provider Number:	0100099-00
3300 Fiske Boulevard	Date:	10/4/2011
Rockledge FL 32955	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$867.54	\$867.54	7/1/2011
Outpatient	\$104.73	\$104.73	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Parrish Medical Center 951 N. Washington Avenue 123 Titusville FL 32796

Provider Number:	0100102-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Amended Cost Report [2]	
Rate Includes Buy Back and 100% Self Exemption		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,490.03	\$2,139.31	7/1/2011
Outpatient	\$63.68	\$188.50	7/1/2011
Inpatient County Billing Rate	\$796.72	\$834.57	7/1/2011

Rate Type :

Interim

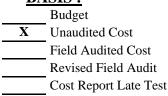
Total Interim

X Prospective

Settlement Based on Cost

X Total Prospective

BASIS:



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Medicaid Reimbursement Rate Change Form

	Wuesthoff Memorial Hospital
	110 Longwood Avenue P.O. Box 565002
]	Rockledge FL 32956-5002

Provider Number:	0100111-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$702.52	\$702.52	7/1/2011
Outpatient	\$77.64	\$77.64	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Wuesthoff Memorial Hospital	
110 Longwood Avenue P.O. Box 565002	
Rockledge FL 32956-5002	

Provider Number:	0100111-01
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$702.52	\$702.52	7/1/2011
Outpatient	\$77.64	\$77.64	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Broward General Hospital	Provider Number:	0100129-00	
1600 S. Andrews Avenue	Date:	10/4/2011	
Ft. Lauderdale FL 33316	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,325.64	\$1,860.76	7/1/2011
Outpatient	\$163.18	\$226.21	7/1/2011
Inpatient County Billing Rate	\$841.14	\$841.14	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Broward General Hospital	Provider Number:	0100129-01	
1600 S. Andrews Avenue	Date:	10/4/2011	
Ft. Lauderdale FL 33316	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,325.64	\$1,860.76	7/1/2011
Outpatient	\$163.18	\$226.21	7/1/2011
Inpatient County Billing Rate	\$841.14	\$841.14	7/1/2011

Rate Type :

Interim	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Broward General Hospital	Provider Number:	0100129-05	
1600 S. Andrews Avenue	Date:	10/4/2011	
Ft. Lauderdale FL 33316	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,325.64	\$1,860.76	7/1/2011
Outpatient	\$163.18	\$226.21	7/1/2011
Inpatient County Billing Rate	\$841.14	\$841.14	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Holy Cross Hospital, Inc.	Provider Number:	0100188-00
P.O. Box 23460	Date:	10/4/2011
Ft. Lauderdale FL 33307	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$806.81	\$806.81	7/1/2011
Outpatient	\$85.78	\$85.78	7/1/2011

Rate Type :

<u>X</u> Prospective
X Total Prospective
BASIS : Budget
X Unaudited Cost
Field Audited Cost
Revised Field Audit
Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Kindred Hospital-Ft. Lauderdale 1516 E Las Olas Blvd. Ft. Lauderdale FL 33301

Provider Number:	0100196-00
Date:	10/4/2011
Fiscal Year End:	8/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$726.40	\$726.40	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

Interim	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Memorial Hospital	Provider Number:	0100200-00	
3501 Johnson St.	Date:	10/4/2011	
Hollywood FL 33021	Fiscal Year End:	4/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,595.58	\$2,173.92	7/1/2011
Outpatient	\$190.64	\$269.78	7/1/2011
Inpatient County Billing Rate	\$878.62	\$878.62	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

North Broward Medical Center	Provider Number:	0100218-00	
303 South East 17th St.	Date:	10/4/2011	
Ft. Lauderdale FL 33316	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,178.18	\$1,755.34	7/1/2011
Outpatient	\$130.30	\$181.66	7/1/2011
Inpatient County Billing Rate	\$689.53	\$689.53	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

North Broward Medical Center	Provider Number:	0100218-03	
303 South East 17th St.	Date:	10/4/2011	
Ft. Lauderdale FL 33316	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,178.18	\$1,755.34	7/1/2011
Outpatient	\$130.30	\$181.66	7/1/2011
Inpatient County Billing Rate	\$689.53	\$689.53	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Calhoun Liberty Hospital Post Office Box 419 Blountstown FL 32424-0419

Provider Number:	0100269-00	
Date:	10/4/2011	
Fiscal Year End:	12/31/2008	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,495.49	\$1,495.49	7/1/2011
Outpatient	\$45.94	\$45.94	7/1/2011

Rate Type :

<u>Interim</u>		X	Pro	<u>spective</u>
Total Interim Settlement Based on Cost		-	X	Total Prospective
	BAS	<u>IS :</u>		
	В	udget		
	X U	naudited Co	ost	
	Fi	ield Audited	l Cost	
	R	evised Field	l Audit	t
	C	ost Report I	Late Te	est

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Medicaid Reimbursement Rate Change Form

Charlotte Regional Medical Center	Provider Number:	0100277-00
809 E. Marion Ave.	Date:	10/4/2011
Punta Gorda FL 33950-3898	Fiscal Year End:	9/30/2010
	Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$775.13	\$775.13	7/1/2011
Outpatient	\$52.55	\$57.69	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Charlotte Regional Medical Center	Provider Number:	0100277-02
809 E. Marion Ave.	Date:	10/4/2011
Punta Gorda FL 33950-3898	Fiscal Year End:	9/30/2010
	Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$775.13	\$775.13	7/1/2011
Outpatient	\$52.55	\$57.69	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Peace River Regional Medical Center 2500 Harbor Blvd Port Charlotte FL 33952

Provider Number:	0100285-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$669.87	\$669.87	7/1/2011
Outpatient	\$64.24	\$64.24	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Naples Community Hospital	Provider Number:	0100315-00
350 7th Street North	Date:	10/4/2011
Naples FL 33941-3029	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,134.87	\$1,134.87	7/1/2011
Outpatient	\$88.55	\$88.55	7/1/2011
Inpatient County Billing Rate	\$828.00	\$828.00	7/1/2011

Rate Type :

Interim	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost Field Audited Cost
	Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Shands At Lake Shore Post Office 100336 Gainesville FL 32610-0336

Provider Number:	0100331-00	
Date:	10/4/2011	
Fiscal Year End:	6/30/2010	
Audit Status:	Amended Cost Report [2]	
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,432.31	\$1,552.36	7/1/2011
Outpatient	\$96.36	\$103.25	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Baptist Of Miami	Provider Number:	0100358-00
8900 North Kendall Dr.	Date:	10/4/2011
Miami FL 33176	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,617.49	\$1,617.49	7/1/2011
Outpatient	\$154.35	\$154.35	7/1/2011
Inpatient County Billing Rate	\$905.16	\$905.16	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Cedars Medical Center, Inc.	Provider Number:	0100366-00	
1475 NW 12th Avenue, Hope Lodge Suite #205	Date:	10/4/2011	
Miami FL 33136	Fiscal Year End:	5/31/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,132.48	\$1,791.44	7/1/2011
Outpatient	\$139.95	\$200.00	7/1/2011
Inpatient County Billing Rate	\$716.52	\$716.52	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Cedars Medical Center, Inc.	Provider Number:	0100366-03	
1475 NW 12th Avenue, Hope Lodge Suite #205	Date:	10/4/2011	
Miami FL 33136	Fiscal Year End:	5/31/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,132.48	\$1,791.44	7/1/2011
Outpatient	\$139.95	\$200.00	7/1/2011
Inpatient County Billing Rate	\$716.52	\$716.52	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Hialeah Hospital	Provider Number:	0100412-00
651 E. 25th Street Dept. 7202	Date:	10/4/2011
Miami FL 33013-3878	Fiscal Year End:	5/31/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,162.71	\$1,162.71	7/1/2011
Outpatient	\$81.03	\$81.03	7/1/2011
Inpatient County Billing Rate	\$652.97	\$652.97	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-00	
1611 N.W. 12th Avenue	Date:	10/4/2011	
Miami FL 33136	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	e Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Rate Type :

	Interim
	Total Interim
-	Cattlement Dasad an Cast

X Prospective

X Total Prospective

Settlement Based on Cost

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Budget
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Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-01
1611 N.W. 12th Avenue	Date:	10/4/2011
Miami FL 33136	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

X Prospective

X Total Prospective

Rate Type :

<u>Interim</u>	
Total Interim Settlement Based on Cost	
Settlement Based on Cost	

BASIS : Budget Unaudited Cost

X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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 Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-02
1611 N.W. 12th Avenue	Date:	10/4/2011
Miami FL 33136	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Rate Type :

 merm
Total Interim
 Settlement Pased on Cost

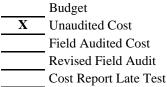
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X Total Prospective

Settlement Based on Cost

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-07
1611 N.W. 12th Avenue	Date:	10/4/2011
Miami FL 33136	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Χ

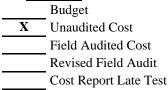
Rate Type :

 Interi	im	

Prospective

Total Interim Settlement Based on Cost X Total Prospective

BASIS:



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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-17
1611 N.W. 12th Avenue	Date:	10/4/2011
Miami FL 33136	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Rate Type :

<u>Interim</u>	

X

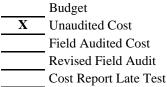
Total Interim

X Total Prospective

Prospective

Settlement Based on Cost

BASIS:



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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-18		
1611 N.W. 12th Avenue	Date:	10/4/2011		
Miami FL 33136	Fiscal Year End:	9/30/2010		
	Audit Status:	Unaudited Cost Report [1]		
	Rate	e Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Rate Type :

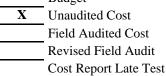
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Total Interim Settlement Based on Co	ost

X Prospective

X Total Prospective

BASIS : Budget



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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-19		
1611 N.W. 12th Avenue	Date:	10/4/2011		
Miami FL 33136	Fiscal Year End:	9/30/2010		
	Audit Status:	Unaudited Cost Report [1]		
	Rate	e Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Rate Type :

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Total I	nterim			
 G1		1	0	

Prospective X

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X Total Prospective

Settlement Based on Cost

BASIS:

Budget Х Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

> W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-27		
1611 N.W. 12th Avenue	Date:	10/4/2011		
Miami FL 33136	Fiscal Year End:	9/30/2010		
	Audit Status:	Unaudited Cost Report [1]		
	Rate	e Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Rate Type :

<u>Interim</u>		X	Pro	<u>ospective</u>
Total Interim Settlement Based on Cost			<u>X</u>	Total Pros
	BA	SIS : Budget		
	X	Unaudited (Cost	

Field Audited Cost **Revised Field Audit** Cost Report Late Test

> W. Rydell Samuel Medicaid Cost Reimbursement Analysis

Total Prospective

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-34		
1611 N.W. 12th Avenue	Date:	10/4/2011		
Miami FL 33136	Fiscal Year End:	9/30/2010		
	Audit Status:	Unaudited Cost Report [1]		
	Rate	e Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Rate Type :

<u>Interim</u>		X	<u>Pro</u>	<u>ospective</u>
Total Interim Settlement Based on Cost		-	X	Total Pros
	BASIS : Budge			
		lited Co	ost	

Field Audited Cost **Revised Field Audit** Cost Report Late Test

> W. Rydell Samuel Medicaid Cost Reimbursement Analysis

Total Prospective

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-35
1611 N.W. 12th Avenue	Date:	10/4/2011
Miami FL 33136	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

Rate Type :

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Total Interim

X Total Prospective

Settlement Based on Cost

BASIS:

Budget Х Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-36
1611 N.W. 12th Avenue	Date:	10/4/2011
Miami FL 33136	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

X

Prospective

X Total Prospective

Rate Type :

Intonim

<u> </u>	
	Total Interim
	Settlement Based on Cost

BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital	Provider Number:	0100421-42
1611 N.W. 12th Avenue	Date:	10/4/2011
Miami FL 33136	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,954.46	\$2,589.11	7/1/2011
Outpatient	\$249.55	\$338.02	7/1/2011
Inpatient County Billing Rate	\$1,123.31	\$1,123.31	7/1/2011

X Prospective

X Total Prospective

Rate Type :

Int	<u>erim</u>
	Total Interim
	Settlement Based on Cost

 BASIS :

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 X
 Unaudited Cost

 Field Audited Cost

 Revised Field Audit

 Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Mercy Hospital, Inc.	Provider Number:	0100439-00
3663 S Miami Ave.	Date:	10/4/2011
Miami FL 33133	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$825.30	\$825.30	7/1/2011
Outpatient	\$125.43	\$125.43	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Mercy Hospital, Inc.	Provider Number:	0100439-03
3663 S Miami Ave.	Date:	10/4/2011
Miami FL 33133	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$825.30	\$825.30	7/1/2011
Outpatient	\$125.43	\$125.43	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Mercy Hospital, Inc.	Provider Number:	0100439-04
3663 S Miami Ave.	Date:	10/4/2011
Miami FL 33133	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$825.30	\$825.30	7/1/2011
Outpatient	\$125.43	\$125.43	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Mt. Sinai Medical Center	Provider Number:	0100463-00	
4300 Alton Rd	Date:	10/4/2011	
Miami Beach FL 33140	Fiscal Year End:	12/31/2009	
	Audit Status: Unaudited Cost Report		
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,514.00	\$1,580.30	7/1/2011
Outpatient	\$152.52	\$152.52	7/1/2011
Inpatient County Billing Rate	\$937.42	\$937.42	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Mt. Sinai Medical Center	Provider Number:	0100463-22	
4300 Alton Rd	Date:	10/4/2011	
Miami Beach FL 33140	Fiscal Year End:	12/31/2009	
	Audit Status: Unaudited Cost Report		
	Rate	Rate Includes Buy Back	

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,514.00	\$1,580.30	7/1/2011
Outpatient	\$152.52	\$152.52	7/1/2011
Inpatient County Billing Rate	\$937.42	\$937.42	7/1/2011

Rate Type :

<u>Interim</u>		-	X	Prospective
Total Interim Settlement Based on Cost			-	X Total Prospective
	BA	ASIS :		
		Budget		
	X	Unaudit	ed Co	ost
		Field Au	udited	Cost
		Revised	Field	Audit
		Cost Re	port L	Late Test
		-	-	

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Medicaid Reimbursement Rate Change Form

University Of Miami Hospital and Clinics	Provider Number:	0100471-00	
P.O. Box 016217	Date:	10/4/2011	
Miami FL 33101	Fiscal Year End:	5/31/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,086.31	\$3,031.50	7/1/2011
Outpatient	\$221.70	\$353.96	7/1/2011
Inpatient County Billing Rate	\$1,727.40	\$1,727.40	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Northshore Medical Center	Provider Number:	0100498-00
1100 N.W. 95th Street	Date:	10/4/2011
Miami FL 33150-2098	Fiscal Year End:	5/31/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,019.26	\$1,019.26	7/1/2011
Outpatient	\$69.78	\$69.78	7/1/2011
Inpatient County Billing Rate	\$641.95	\$641.95	7/1/2011

Rate Type :

Interim	X <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Northshore Medical Center	Provider Number:	0100498-07
1100 N.W. 95th Street	Date:	10/4/2011
Miami FL 33150-2098	Fiscal Year End:	5/31/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,019.26	\$1,019.26	7/1/2011
Outpatient	\$69.78	\$69.78	7/1/2011
Inpatient County Billing Rate	\$641.95	\$641.95	7/1/2011

Rate Type :

Interim	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Palm Springs General Hospital 1475 West 49th Street Hialeah FL 33012

Provider Number:	0100536-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$584.04	\$584.04	7/1/2011
Outpatient	\$36.41	\$36.41	7/1/2011

Rate Type :

<u>Interim</u>	x Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
	*

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Medicaid Reimbursement Rate Change Form

Metropolitan Hospital MiamiProvider Number:0100544-005959 NW 7th StreetDate:10/4/2011Miami FL 33126Fiscal Year End:12/31/2009Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$748.79	\$748.79	7/1/2011
Outpatient	\$92.90	\$92.90	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

South Miami Hospital	Provider Number:	0100587-00
6200 S.W. 73rd Street	Date:	10/4/2011
Miami FL 33143	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$939.47	\$939.47	7/1/2011
Outpatient	\$101.25	\$101.25	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Miami Childrens Hospital	Provider Number:	0100609-00	
3100 S.W. 62nd Avenue	Date:	10/4/2011	
Miami FL 33155-3009	Fiscal Year End:	12/31/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	e Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,711.26	\$2,711.26	7/1/2011
Outpatient	\$171.51	\$171.51	7/1/2011
Inpatient County Billing Rate	\$1,774.97	\$1,774.97	7/1/2011

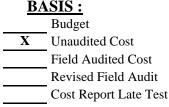
Rate Type :

Total Interim

X Total Prospective

X Prospective

Settlement Based on Cost



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Medicaid Reimbursement Rate Change Form

Westchester General Hospital	Provider Number:	0100625-00
2500 SW 75th Avenue	Date:	10/4/2011
Miami FL 33155	Fiscal Year End:	12/31/2008
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$659.45	\$659.45	7/1/2011
Outpatient	\$105.79	\$105.79	7/1/2011
Inpatient County Billing Rate	\$356.55	\$356.55	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Baptist Medical Center	Provider Number:	0100641-00
800 Prudential Drive	Date:	10/4/2011
Jacksonville FL 32207	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,083.69	\$1,083.69	7/1/2011
Outpatient	\$96.55	\$96.55	7/1/2011
Inpatient County Billing Rate	\$744.16	\$744.16	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Baptist Medical Center	Provider Number:	0100641-02
800 Prudential Drive	Date:	10/4/2011
Jacksonville FL 32207	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,083.69	\$1,083.69	7/1/2011
Outpatient	\$96.55	\$96.55	7/1/2011
Inpatient County Billing Rate	\$744.16	\$744.16	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Shands Jacksonville	Provider Number:	0100676-00	
580 West 8th Street	Date:	10/4/2011	
Jacksonville FL 32209	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	te Includes Buy Back	

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,419.98	\$1,900.29	7/1/2011
Outpatient	\$172.96	\$241.83	7/1/2011
Inpatient County Billing Rate	\$981.32	\$981.32	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Mayo Clinic	Provider Number:	0100722-00	
4500 San Pablo Road	Date:	10/4/2011	
Jacksonville FL 32216	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,237.07	\$2,237.07	7/1/2011
Outpatient	\$125.00	\$125.67	7/1/2011
Inpatient County Billing Rate	\$1,135.70	\$1,135.70	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

St. Vincent's Hospital	Provider Number:	0100731-00
1800 Barrs Street 3rd Floor, Seton Hall	Date:	10/4/2011
Jacksonville FL 32204	Fiscal Year End:	6/30/2010
	Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,132.71	\$1,083.72	7/1/2011
Outpatient	\$56.24	\$55.78	7/1/2011
Inpatient County Billing Rate	\$728.98	\$729.04	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Baptist Hospital (Pensacola)	Provider Number:	0100749-00	
P.O. Box 17500	Date:	10/4/2011	
Pensacola FL 32522-7500	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$996.68	\$996.68	7/1/2011
Outpatient	\$80.39	\$80.39	7/1/2011
Inpatient County Billing Rate	\$640.18	\$640.18	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit

Cost Report Late Test

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 Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Baptist Hospital (Pensacola)	Provider Number:	0100749-02	
P.O. Box 17500	Date:	10/4/2011	
Pensacola FL 32522-7500	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$996.68	\$996.68	7/1/2011
Outpatient	\$80.39	\$80.39	7/1/2011
Inpatient County Billing Rate	\$640.18	\$640.18	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Baptist Hospital (Pensacola)	Provider Number:	0100749-03	
P.O. Box 17500	Date:	10/4/2011	
Pensacola FL 32522-7500	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$996.68	\$996.68	7/1/2011
Outpatient	\$80.39	\$80.39	7/1/2011
Inpatient County Billing Rate	\$640.18	\$640.18	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost

Field Audited Cost
Revised Field Audit
Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Sacred Heart Hospital	Provider Number:	0100765-00	
Post Office Box 2728	Date:	10/4/2011	
Pensacola FL 32513-2728	Fiscal Year End:	6/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,222.89	\$1,285.66	7/1/2011
Outpatient	\$117.55	\$122.90	7/1/2011
Inpatient County Billing Rate	\$810.99	\$810.99	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

George E. Weems Memorial Hospital P.O. Drawer 610 Apalachicola FL 32320

Provider Number:	0100803-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$3,032.34	\$3,032.34	7/1/2011
Outpatient	\$79.53	\$79.53	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Hendry Regional Medical Center 524 W Sagamore Street Clewiston FL 33440

Provider Number:	0100862-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	<u>\$1,878.77</u>	\$1,878.77	7/1/2011
Outpatient	\$92.79	\$92.79	7/1/2011

Rate Type :

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	B	ASIS :
		Budget
	X	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
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Medicaid Reimbursement Rate Change Form

Brooksville Regional Hospital	Provider Number:	0100871-00
Post Office Box 37	Date:	10/4/2011
Brooksville FL 34605-0037	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,019.34	\$1,444.84	7/1/2011
Outpatient	\$67.32	\$89.13	7/1/2011
Inpatient County Billing Rate	\$706.82	\$698.84	7/1/2011

Rate Type :

Interim	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Brooksville Regional Hospital	Provider Number:	0100871-01
Post Office Box 37	Date:	10/4/2011
Brooksville FL 34605-0037	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,019.34	\$1,444.84	7/1/2011
Outpatient	\$67.32	\$89.13	7/1/2011
Inpatient County Billing Rate	\$706.82	\$698.84	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim	X Total Prospective
Settlement Based on Cost	
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Highlands Regional Medical Center P.O. Drawer 2066 Sebring FL 33870

Provider Number:	0100897-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Amended Cost Report [2]
Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$621.03	\$1,399.49	7/1/2011
Outpatient	\$56.78	\$80.28	7/1/2011
Inpatient County Billing Rate		\$621.03	7/1/2011

Rate Type :

Interim		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	BA	ASIS :
		Budget
	Х	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
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Medicaid Reimbursement Rate Change Form

Florida Hospital Heartland Medical Center Highway 27 North Avon Park FL 33825

Provider Number:	0100901-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$722.25	\$722.25	7/1/2011
Outpatient	\$89.69	\$89.69	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit Cost Report Late Test
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

University Community Hospital Carrollwood	Provider Number:	0100943-00
3100 East Fletcher Avenue	Date:	10/4/2011
Tampa FL 33613	Fiscal Year End:	8/31/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate Includ	es 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$808.03	\$1,241.87	7/1/2011
Outpatient	\$80.99	\$80.99	7/1/2011
Inpatient County Billing Rate		\$808.03	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

St. Joseph's Hospital	Provider Number:	0100978-00
3001 W. ML King Blvd. Post Office Box 4227	Date:	10/4/2011
Tampa FL 33677-4227	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]
	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,425.44	\$1,836.19	7/1/2011
Outpatient	\$125.78	\$150.86	7/1/2011
Inpatient County Billing Rate	\$968.17	\$849.58	7/1/2011

Rate Type :

Interim		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	BA	ASIS :
		Budget
	Х	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
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W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

St. Joseph's Hospital	Provider Number:	0100978-02	
3001 W. ML King Blvd. Post Office Box 4227	Date:	10/4/2011	
Tampa FL 33677-4227	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,425.44	\$1,836.19	7/1/2011
Outpatient	\$125.78	\$150.86	7/1/2011
Inpatient County Billing Rate	\$968.17	\$849.58	7/1/2011

Rate Type :

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	<u>B</u> 2	ASIS :
		Budget
	Х	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
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Medicaid Reimbursement Rate Change Form

St. Joseph's Hospital	Provider Number:	0100978-03	
3001 W. ML King Blvd. Post Office Box 4227	Date:	10/4/2011	
Tampa FL 33677-4227	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,425.44	\$1,836.19	7/1/2011
Outpatient	\$125.78	\$150.86	7/1/2011
Inpatient County Billing Rate	\$968.17	\$849.58	7/1/2011

Rate Type :

<u>Interim</u>		_	X	Prospective
Total Interim Settlement Based on Cost			_	X Total Prospective
	BA	ASIS :		
		Budget		
	Х	Unaudite	ed Co	st
		Field Au	dited	Cost
		Revised	Field	Audit
		Cost Rep	ort L	ate Test
		_		

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

St. Joseph's Hospital	Provider Number:	0100978-06
3001 W. ML King Blvd. Post Office Box 4227	Date:	10/4/2011
Tampa FL 33677-4227	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]
	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,425.44	\$1,836.19	7/1/2011
Outpatient	\$125.78	\$150.86	7/1/2011
Inpatient County Billing Rate	\$968.17	\$849.58	7/1/2011

Rate Type :

<u>Interim</u>	x Prospective	
Total Interim Settlement Based on Cost	X Total Prospec	ctive
	<u>BASIS :</u>	
	Budget	
	X Unaudited Cost	
	Field Audited Cost	
	Revised Field Audit	
	Cost Report Late Test	

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Medicaid Reimbursement Rate Change Form

South Florida Baptist	Provider Number:	0100986-00
301 N Alexander Street	Date:	10/4/2011
Plant City FL 33566	Fiscal Year End:	12/31/2009
	Audit Status:	Amended Cost Report [2]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,284.04	\$2,075.41	7/1/2011
Outpatient	\$71.17	\$97.22	7/1/2011
Inpatient County Billing Rate	\$745.37	\$745.37	7/1/2011

Rate Type :

X Prospective
X Total Prospective
BASIS :
Budget
X Unaudited Cost
Field Audited Cost
Revised Field Audit
Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Tampa General Hospital	Provider Number:	0100994-00	
P.O. Box 1289	Date:	10/4/2011	
Tampa FL 33601	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,939.88	\$2,511.55	7/1/2011
Outpatient	\$167.78	\$226.83	7/1/2011
Inpatient County Billing Rate	\$973.31	\$952.01	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
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W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Tampa General Hospital	Provider Number:	0100994-01	
P.O. Box 1289	Date:	10/4/2011	
Tampa FL 33601	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,939.88	\$2,511.55	7/1/2011
Outpatient	\$167.78	\$226.83	7/1/2011
Inpatient County Billing Rate	\$973.31	\$952.01	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
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W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Tampa General Hospital	Provider Number:	0100994-12	
P.O. Box 1289	Date:	10/4/2011	
Tampa FL 33601	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,939.88	\$2,511.55	7/1/2011
Outpatient	\$167.78	\$226.83	7/1/2011
Inpatient County Billing Rate	\$973.31	\$952.01	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
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W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Tampa General Hospital	Provider Number:	0100994-13	
P.O. Box 1289	Date:	10/4/2011	
Tampa FL 33601	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,939.88	\$2,511.55	7/1/2011
Outpatient	\$167.78	\$226.83	7/1/2011
Inpatient County Billing Rate	\$973.31	\$952.01	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Tampa General Hospital	Provider Number:	0100994-14	
P.O. Box 1289	Date:	10/4/2011	
Tampa FL 33601	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,939.88	\$2,511.55	7/1/2011
Outpatient	\$167.78	\$226.83	7/1/2011
Inpatient County Billing Rate	\$973.31	\$952.01	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

University Community Hospital-Tampa	Provider Number:	0101028-00
3100 East Fletcher Avenue	Date:	10/4/2011
Tampa FL 33613	Fiscal Year End:	8/31/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate Include	es Partial Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$790.01	\$1,021.85	7/1/2011
Outpatient	\$73.57	\$78.09	7/1/2011
Inpatient County Billing Rate		\$790.01	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Doctors Memorial Hospital P.O. Box 188 Bonifay FL 32425

Provider Number:	0101036-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,357.73	\$1,357.73	7/1/2011
Outpatient	\$152.51	\$152.51	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Indian River Memorial Hospital 1000 36th Street Vero Beach FL 32960

Provider Number:	0101044-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]
Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$802.87	\$1,804.64	7/1/2011
Outpatient	\$89.83	\$115.80	7/1/2011
Inpatient County Billing Rate		\$802.87	7/1/2011

Rate Type :

Interim

Total Interim

X Total Prospective

X Prospective

Settlement Based on Cost

BASIS: Budget X Unaudited Cost Field Audited Cost Revised Field Audit

Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Jackson HospitalProvider Number:0101061-004250 Hospital DriveDate:10/4/2011Marianna FL 32446Fiscal Year End:9/30/2010Audit Status:Unaudited Cost Report [1]Rate Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,266.10	\$2,182.17	7/1/2011
Outpatient	\$121.07	\$111.37	7/1/2011

Rate Type :

<u>Interim</u>			X	<u>Pro</u>	ospective
Total Interim Settlement Based on Cost			-	X	Total Prospective
	BA	SIS :			
		Budget			
	X	Unaudi	ted Co	ost	
		Field A	udited	Cost	
		Revised	d Field	Audi	it
		Cost Re	eport L	Late T	'est
		-			

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Medicaid Reimbursement Rate Change Form

Leesburg Regional Medical Center	Provider Number:	0101079-00
600 E Dixie Ave	Date:	10/4/2011
Leesburg FL 32748	Fiscal Year End:	6/30/2009
	Audit Status:	Unaudited Cost Report [1]
	Rate Include	es Partial Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	\$762.75 \$87.74	\$1,689.26 \$100.87	7/1/2011 7/1/2011
Inpatient County Billing Rate		\$762.75	7/1/2011

Rate Type :

<u>Interim</u>			X	Prospective
Total Interim Settlement Based on Cost				X Total Prospective
	BA	SIS :		
		Budget		
	Х	Unaudited	l Cos	t
		Field Audi	ited	Cost
		Revised Fi	ield .	Audit
		Cost Repo	ort La	ate Test
		-		

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Medicaid Reimbursement Rate Change Form

South Lake Memorial Hospital 847 8th Street Clermont FL 32711

Provider Number:	0101087-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Amended Cost Report [2]
Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$927.54	\$2,307.93	7/1/2011
Outpatient	\$72.57	\$93.22	7/1/2011
Inpatient County Billing Rate		\$865.81	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Florida Hospital WatermanProvider Number:0101095-00P.O. Box 333Date:10/4/2011Eustis FL 32727-0333Fiscal Year End:12/31/2009Audit Status:Unaudited Cost Report [1]Rate Includes Buy Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$717.70	\$2,149.16	7/1/2011
Outpatient	\$78.14	\$141.01	7/1/2011
Inpatient County Billing Rate		\$717.70	7/1/2011

Rate Type :

Interim	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Lee Memorial Hospital	Provider Number:	0101109-00	
PO Box 151247	Date:	10/4/2011	
Cape Coral FL 33915	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,153.53	\$1,679.30	7/1/2011
Outpatient	\$111.38	\$156.28	7/1/2011
Inpatient County Billing Rate	\$811.28	\$811.28	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Lee Memorial Hospital	Provider Number:	0101109-11	
PO Box 151247	Date:	10/4/2011	
Cape Coral FL 33915	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,153.53	\$1,679.30	7/1/2011
Outpatient	\$111.38	\$156.28	7/1/2011
Inpatient County Billing Rate	\$811.28	\$811.28	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Lee Memorial Hospital	Provider Number:	0101109-17	
PO Box 151247	Date:	10/4/2011	
Cape Coral FL 33915	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,153.53	\$1,679.30	7/1/2011
Outpatient	\$111.38	\$156.28	7/1/2011
Inpatient County Billing Rate	\$811.28	\$811.28	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Lee Memorial Hospital	Provider Number:	0101109-18	
PO Box 151247	Date:	10/4/2011	
Cape Coral FL 33915	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,153.53	\$1,679.30	7/1/2011
Outpatient	\$111.38	\$156.28	7/1/2011
Inpatient County Billing Rate	\$811.28	\$811.28	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Lehigh Regional Medical Center 1500 Lee Blvd. Lehigh Acres FL 33936

Provider Number:	0101117-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$820.33	\$820.33	7/1/2011
Outpatient	\$51.03	\$51.03	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Tallahassee Memorial Regional M.C.	Provider Number:	0101133-00	
1300 Miccousukee	Date:	10/4/2011	
Tallahassee FL 32308	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	\$1,179.13 \$102.05	\$1,179.13 \$102.05	<u>7/1/2011</u> 7/1/2011
Inpatient County Billing Rate	\$723.40	\$723.40	7/1/2011

Rate Type :

Interim		X	<u> </u>	Prospective
Total Interim Settlement Based on Cost				X Total Prospective
	B	ASIS :		
		Budget		
	Х	Unaudited	Cos	st
		Field Audit	ted	Cost
		Revised Fie	eld	Audit
		Cost Repor	rt La	ate Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Tri-County Hospital Williston P.O. Drawer 460 Williston FL 32696

Provider Number:	0101141-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,224.35	\$1,224.35	7/1/2011
Outpatient	\$36.33	\$36.33	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Madison County Memorial Hospital 201 East Marion Street Madison FL 32340

Provider Number:	0101150-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,275.74	\$1,275.74	7/1/2011
Outpatient	\$51.16	\$51.16	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Manatee Memorial Hospital	Provider Number:	0101168-00
206 Second Street East	Date:	10/4/2011
Bradenton FL 34208	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,093.18	\$1,727.40	7/1/2011
Outpatient	\$86.54	\$116.58	7/1/2011
Inpatient County Billing Rate	\$694.48	\$694.48	7/1/2011

Rate Type :

Interim	x Prospective
Total Interim	X Total Prospective
Settlement Based on Cost	
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Munroe Regional Medical Center Post Office Box 6000 Ocala FL 34478

Provider Number:	0101176-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]
Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,362.46	\$1,825.06	7/1/2011
Outpatient	\$80.18	\$103.35	7/1/2011
Inpatient County Billing Rate	\$766.53	\$766.53	7/1/2011

Rate Type :

Interim

Total Interim

X Prospective

X Total Prospective

Settlement Based on Cost

BASIS:

Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

> W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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0101184-00 10/4/2011



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Martin Memorial Hospital P.O. Box 9033 Stuart FL 34995-9033

Fisca	l Year End:	9/30/2010
А	udit Status: Ui	naudited Cost Report [1]
	Rate Inclu	des Buy Back
Current Rate	New Rate	Effective Date

Date:

Provider Number:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$814.63	\$1,091.23	7/1/2011
Outpatient	\$91.13	\$114.90	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Lower Florida Keys Hospital	Provider Number:	0101192-00	
P.O. Box 9107	Date:	10/4/2011	
Key West FL 33401	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	e Includes Buy Back	

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,050.33	\$1,681.96	7/1/2011
Outpatient	\$70.09	\$111.25	7/1/2011
Inpatient County Billing Rate	\$631.44	\$634.43	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Lower Florida Keys Hospital	Provider Number:	0101192-01	
P.O. Box 9107	Date:	10/4/2011	
Key West FL 33401	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	te Includes Buy Back	

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,050.33	\$1,681.96	7/1/2011
Outpatient	\$70.09	\$111.25	7/1/2011
Inpatient County Billing Rate	\$631.44	\$634.43	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Fishermen's Hospital 3301 Overseas Highway Marathon FL 33050

Provider Type :

Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]
Rate	Includes Buy Back

Provider Number:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$3,149.23	\$3,149.23	7/1/2011
Outpatient	\$119.47	\$119.47	7/1/2011

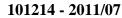
Rate Type :

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	BASIS	<u>:</u>
	Budg	get
	X Unau	udited Cost
	Field	d Audited Cost
	Revi	sed Field Audit
	Cost	Report Late Test

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Medicaid Reimbursement Rate Change Form

Mariners Hospital 91500 Overseas Highway Tavernier FL 33070

Provider Type :

Provider Number:	0101214-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$5,559.88	\$5,559.88	7/1/2011
Outpatient	\$331.73	\$331.73	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Baptist Medical Center - Nassau 1250 South 18th Street Fernandina Beach FL 32034

Provider Number:	0101231-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,937.40	\$2,937.40	7/1/2011
Outpatient	\$120.56	\$120.56	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Twin Cities Hospital	Provider Number:	0101257-00
2190 Hwy 85 North	Date:	10/4/2011
Niceville FL 32578	Fiscal Year End:	5/31/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$906.36	\$906.36	7/1/2011
Outpatient	\$68.52	\$68.52	7/1/2011

Rate Type :

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	<u>B</u>	ASIS :
		Budget
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		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
		_ `

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Medicaid Reimbursement Rate Change Form

North Okaloosa Medical Center 151 Redstone Ave. Crestview FL 32536

Provider Number:	0101265-00
Date:	10/4/2011
Fiscal Year End:	3/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$789.88	\$789.88	7/1/2011
Outpatient	\$87.17	\$87.17	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Florida Hospital	Provider Number:	0101290-00	
500 East Rollins Street	Date:	10/4/2011	
Orlando FL 32803	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,407.55	\$1,591.90	7/1/2011
Outpatient	\$110.20	\$110.20	7/1/2011
Inpatient County Billing Rate	\$804.05	\$804.05	7/1/2011

Rate Type :

Interim		X	Pro	<u>ospective</u>
Total Interim Settlement Based on Cost			X	Total Pros
	<u>B</u>	ASIS :		
		Budget		
	X	Unaudited C		

Field Audited Cost **Revised Field Audit** Cost Report Late Test

> W. Rydell Samuel Medicaid Cost Reimbursement Analysis

Total Prospective

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Medicaid Reimbursement Rate Change Form

Florida Hospital	Provider Number:	0101290-01
500 East Rollins Street	Date:	10/4/2011
Orlando FL 32803	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,407.55	\$1,591.90	7/1/2011
Outpatient	\$110.20	\$110.20	7/1/2011
Inpatient County Billing Rate	\$804.05	\$804.05	7/1/2011

Rate Type :

	X	<u>Pro</u>	<u>ospective</u>
	-	X	Total Prospective
BASIS :			
Budge	t		
X Unaud	ited Co	ost	
Field A	Audited	l Cost	
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Revised Field Audit

Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Florida Hospital	Provider Number:	0101290-04
500 East Rollins Street	Date:	10/4/2011
Orlando FL 32803	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,407.55	\$1,591.90	7/1/2011
Outpatient	\$110.20	\$110.20	7/1/2011
Inpatient County Billing Rate	\$804.05	\$804.05	7/1/2011

Rate Type :

Interim		X	Pro	<u>spective</u>
Total Interim Settlement Based on Cost			X	Total Pros
	BAS			
	X U	Budget Inaudited Co		

Field Audited Cost Revised Field Audit Cost Report Late Test

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Total Prospective

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Medicaid Reimbursement Rate Change Form

Orlando Health	Provider Number:	0101338-00
1414 S. Kuhl Avenue	Date:	10/4/2011
Orlando FL 32806	Fiscal Year End:	9/30/2010
	Audit Status:	Amended Cost Report [2]
	Rate	Includes Buy Back
Dravidar Trma		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,484.17	\$1,635.55	7/1/2011
Outpatient	\$134.72	\$134.84	7/1/2011
Inpatient County Billing Rate	\$1,006.97	\$1,003.00	7/1/2011

Rate Type :

<u>Interim</u>

Total Interim

X Total Prospective

X Prospective

Settlement Based on Cost

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	Budget
Х	Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Health Central	Provider Number:	0101354-00
10000 West Colonial Dr.	Date:	10/4/2011
Ocoee FL 34761	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,031.68	\$1,531.68	7/1/2011
Outpatient	\$90.40	\$125.45	7/1/2011
Inpatient County Billing Rate	\$804.78	\$804.78	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Osceola Regional Medical Center	Provider Number:	0101389-00
700 West Oak St.	Date:	10/4/2011
Kissimmee FL 32742-2589	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,138.17	\$1,138.17	7/1/2011
Outpatient	\$92.76	\$92.76	7/1/2011
Inpatient County Billing Rate	\$747.54	\$747.54	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Bethesda Mem. Hosp.	Provider Number:	0101401-00
2815 S Seacrest Blvd.	Date:	10/4/2011
Boynton Beach FL 33435	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,128.19	\$1,358.59	7/1/2011
Outpatient	\$87.13	\$87.13	7/1/2011
Inpatient County Billing Rate	\$846.02	\$836.69	7/1/2011

Rate Type :

<u>Interim</u>	x Prospective
Total Interim	X Total Prospective
Settlement Based on Cost	
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Boca Raton Community Hospital 800 Meadows Rd. Boca Raton FL 33486

Provider Number:	0101419-00
Date:	10/4/2011
Fiscal Year End:	6/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$769.00	\$769.00	7/1/2011
Outpatient	\$82.89	\$82.89	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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10/4/2011

Effective Date



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Medicaid Reimbursement Rate Change Form

Lakeside Medical Center 39200 Hooker Highway Belle Glade FL 33430

Provider Type :

Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]
Rate	Includes Buy Back

New Rate

Date:

Provider Number:

\$1,934.38	\$2,034.03	7/1/2011
\$87.32	\$93.00	7/1/2011
	. ,	

Current Rate

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

JFK Medical Center	Provider Number:	0101460-00
5301 S. Congress Ave.	Date:	10/4/2011
Lake Worth FL 33462-1149	Fiscal Year End:	6/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,107.55	\$1,641.96	7/1/2011
Outpatient	\$108.59	\$139.98	7/1/2011
Inpatient County Billing Rate	\$679.41	\$679.41	7/1/2011

Rate Type :

Interim		-	X	Prospective
Total Interim Settlement Based on Cost			_	X Total Prospective
	<u>B</u>	ASIS :		
	_	Budget		
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		Field Au	dited	Cost
		Revised	Field	Audit
		Cost Rep	oort L	ate Test

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Medicaid Reimbursement Rate Change Form

St. Mary's Hospital	Provider Number:	0101486-00	
1300 N. Flagler Drive	Date:	10/4/2011	
West Palm Beach FL 33401	Fiscal Year End:	5/31/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,085.19	\$1,454.22	7/1/2011
Outpatient	\$87.96	\$109.44	7/1/2011
Inpatient County Billing Rate	\$822.84	\$822.84	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

St. Mary's Hospital	Provider Number:	0101486-01	
1300 N. Flagler Drive	Date:	10/4/2011	
West Palm Beach FL 33401	Fiscal Year End:	5/31/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,085.19	\$1,454.22	7/1/2011
Outpatient	\$87.96	\$109.44	7/1/2011
Inpatient County Billing Rate	\$822.84	\$822.84	7/1/2011

Rate Type :

Interim		_	X	Prospective
Total Interim Settlement Based on Cost			_	X Total Prospective
	<u>B</u> 2	ASIS :		
		Budget		
	Х	Unaudited	d Co	st
		Field Aud	dited	Cost
		Revised F	Field	Audit
		Cost Rep	ort L	ate Test
		_		

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Medicaid Reimbursement Rate Change Form

Florida Hospital Zephyrhills	Provider Number:	0101494-00
7050 Gall Blvd	Date:	10/4/2011
Zephyrhills FL 33541	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$744.22	\$744.22	7/1/2011
Outpatient	\$70.04	\$70.04	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost
	Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Florida Hospital Zephyrhills	Provider Number:	0101494-01
7050 Gall Blvd	Date:	10/4/2011
Zephyrhills FL 33541	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$744.22	\$744.22	7/1/2011
Outpatient	\$70.04	\$70.04	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

North Bay Medical CenterProvider Number:0101508-0016255 Bay Vista DriveDate:10/4/2011Clearwater FL 33760Fiscal Year End:12/31/2009Audit Status:Unaudited Cost Report [1]Rate Includes Buy Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$752.89	\$1,882.69	7/1/2011
Outpatient	\$79.66	\$122.94	7/1/2011
Inpatient County Billing Rate		\$752.89	7/1/2011

Rate Type :

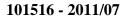
Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

All Children's Hospital	Provider Number:	0101516-00	
801 6th St. South	Date:	10/4/2011	
St. Petersburg FL 33701	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,512.04	\$2,765.67	7/1/2011
Outpatient	\$217.45	\$211.12	7/1/2011
Inpatient County Billing Rate	\$1,783.99	\$1,787.76	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim	X Total Prospective
Settlement Based on Cost	
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Good Samaritan Hospital 1300 N. Flagler Drive West Palm Beach FL 33401 Provider Number: 0101524-00 Date: 10/4/2011 5/31/2010 Fiscal Year End: Unaudited Cost Report [1] Audit Status: Rate Includes Buy Back and Partial Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	\$834.17 \$88.67	\$1,918.28 \$114.30	7/1/2011 7/1/2011
Inpatient County Billing Rate		\$834.17	7/1/2011

Rate Type :

Interim

Total Interim

X Total Prospective

X **Prospective**

Settlement Based on Cost

BASIS:

Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Mease Hospital Clinic Post Box 210 Mailstation 102 Clearwater FL 33517

Provider Number:	0101541-00	
Date:	10/4/2011	
Fiscal Year End:	12/31/2009	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back and 100% Self Exemption		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$821.22	\$1,613.09	7/1/2011
Outpatient	\$85.61	\$111.74	7/1/2011
Inpatient County Billing Rate		\$821.22	7/1/2011

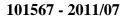
Rate Type :

<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Bayfront Medical Center	Provider Number:	0101567-00	
701 6th St. South	Date:	10/4/2011	
St. Petersburg FL 33701	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,180.03	\$1,756.52	7/1/2011
Outpatient	\$70.27	\$90.06	7/1/2011
Inpatient County Billing Rate	\$797.08	\$797.08	7/1/2011

Rate Type :

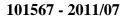
<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

T

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Medicaid Reimbursement Rate Change Form

Bayfront Medical Center	Provider Number:	0101567-07	
701 6th St. South	Date:	10/4/2011	
St. Petersburg FL 33701	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,180.03	\$1,756.52	7/1/2011
Outpatient	\$70.27	\$90.06	7/1/2011
Inpatient County Billing Rate	\$797.08	\$797.08	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS : Budget	
	X Unaudited Cost	
	Field Audited Cost	
	Revised Field Audit	
	Cost Report Late Test	

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Morton F. Plant Hospital	Provider Number:	0101583-00	
16255 Bay Vista Dr, MS 100	Date:	10/4/2011	
Clearwater FL 33760	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Includes Buy Back	

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,349.35	\$2,164.55	7/1/2011
Outpatient	\$121.22	\$178.69	7/1/2011
Inpatient County Billing Rate	\$594.09	\$594.09	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Helen Ellis Memorial HospitalProvider Number:0101613-001395 South Pinellas Ave.Date:10/4/2011Tarpon Springs FL 34689-1487Fiscal Year End:8/31/2010Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$786.19	\$786.19	7/1/2011
Outpatient	\$94.98	\$94.98	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Lakeland Regional Medical Center	Provider Number:	0101648-00	
230 South Florida Ave, Reimb Dept 4th Floor	Date:	10/4/2011	
Lakeland FL 33801	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,125.14	\$1,521.55	7/1/2011
Outpatient	\$110.04	\$141.76	7/1/2011
Inpatient County Billing Rate	\$716.70	\$716.70	7/1/2011

Rate Type :

<u>Interim</u>		_	X	Prospective
Total Interim Settlement Based on Cost			_	X Total Prospective
	B	ASIS :		
		Budget		
	X	Unaudite	ed Co	st
		Field Au	dited	Cost
		Revised 1	Field	Audit
		Cost Rep	ort L	ate Test
		_ 1		

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Lake Wales Hospital Association 410 South 11th St. Lake Wales FL 33853

Provider Number:	0101664-00	
Date:	10/4/2011	
Fiscal Year End:	12/31/2009	
Audit Status: Unaudited Cost Report [1]		
Rate Includes Buy Back		

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,156.90	\$1,549.71	7/1/2011
Outpatient	\$58.17	\$74.99	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Winter Haven Hospital	Provider Number:	0101699-00
200 Avenue "F" Northeast	Date:	10/4/2011
Winter Haven FL 33880	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,080.89	\$1,530.80	7/1/2011
Outpatient	\$81.66	\$107.99	7/1/2011
Inpatient County Billing Rate	\$585.13	\$585.13	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

West Gables RehabilitationProvider Number:0101702-002525 Southwest 75th Av.Date:10/4/2011Miami FL 33155Fiscal Year End:12/31/2009Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$382.46	\$382.46	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

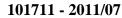
<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Flagler HospitalProvider Number:0101711-00400 Health Park Blvd.Date:10/4/2011St. Augustine FL 32086Fiscal Year End:9/30/2010Audit Status:Unaudited Cost Report [1]Rate Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$777.13	\$1,041.00	7/1/2011
Outpatient	\$50.77	\$57.71	7/1/2011

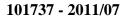
Rate Type :

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	B	ASIS :
		Budget
	Х	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
		-

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Jay Hospital 221 South Alabama Street Jay FL 32565

Provider Number:	0101737-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

HOSPITAL Current Rate New Rate Effective Date Inpatient \$1,109.78 \$1,109.78 7/1/2011 Outpatient \$62.64 \$62.64 7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

DISTRIBUTION: Hospitals:

Managed Care Contract Management Area Adm. 1 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation

> For Information Only (No Change In Rate)



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Medicaid Reimbursement Rate Change Form

Santa Rosa Hospital	Provider Number:	0101745-00	
P.O. BOX 648	Date:	10/4/2011	
Milton FL 32570	Fiscal Year End:	5/31/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate Includes Buy	Rate Includes Buy Back and 100% Self Exemption	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$899.96	\$1,819.23	7/1/2011
Outpatient	\$65.13	\$86.27	7/1/2011
Inpatient County Billing Rate		\$899.96	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

HealthSouth Rehabilitation Hospital-Largo 901 Clearwater Largo Rd. Largo FL 34640

Provider Number:	0101753-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$432.46	\$432.46	7/1/2011
Outpatient	\$44.24	\$44.24	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Memorial Hospital	Provider Number:	0101761-00	
1901 Arlington St.	Date:	10/4/2011	
Sarasota FL 33579	Fiscal Year End:	9/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate Includes Buy	Rate Includes Buy Back and 100% Self Exemption	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,351.58	\$1,810.49	7/1/2011
Outpatient	\$116.26	\$124.26	7/1/2011
Inpatient County Billing Rate	\$809.12	\$809.12	7/1/2011

Χ

Rate Type :

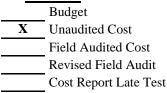
Interim

Total Interim

Prospective X Total Prospective

Settlement Based on Cost

BASIS:



W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Central Florida Regional Hospital 1401 West Seminole Blvd. Sanford FL 32771

Provider Number:	0101788-00
Date:	10/4/2011
Fiscal Year End:	5/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$789.48	\$789.48	7/1/2011
Outpatient	\$83.43	\$83.43	7/1/2011

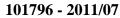
Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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DISTRIBUTION:



0101796-00



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Shands at Live Oak Post Office Box 100336 Gainesville FL 32610-0336

Provider Type :

Date:	10/4/2011	
Fiscal Year End:	6/30/2009	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Number:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,678.71	\$1,678.71	7/1/2011
Outpatient	\$90.42	\$90.42	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Doctor's Memorial Hospital 407 East Ash Street Perry FL 32347

Provider Number:	0101800-00	
Date:	10/4/2011	
Fiscal Year End:	5/31/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,501.89	\$1,501.89	7/1/2011
Outpatient	\$102.22	\$102.22	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Florida Hospital - Fish Memorial 1055 Sax Boulevard Orange City FL 32763

Provider Number:	0101826-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]
Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$904.05	\$1,921.43	7/1/2011
Outpatient	\$79.78	\$90.26	7/1/2011
Inpatient County Billing Rate		\$904.05	7/1/2011

Rate Type :

Interim

Total Interim

X Total Prospective

X Prospective

Settlement Based on Cost

BASIS: Budget X Unaudited Cost

Field Audited Cost Revised Field Audit

Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

DISTRIBUTION: Hospitals:

Managed Care **Contract Management** Area Adm. 4 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation

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Medicaid Reimbursement Rate Change Form

Bert Fish Memorial Hospital 401 Palmetto Street New Smyrna Beach FL 32170

Provider Number:	0101834-00
Date:	10/4/2011
Fiscal Year End:	6/30/2010
Audit Status:	Unaudited Cost Report [1]
Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	\$910.34 \$75.94	\$2,079.88 \$111.49	7/1/2011 7/1/2011
Inpatient County Billing Rate		\$910.34	7/1/2011

Rate Type :

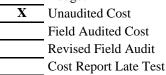
Intonim

111	
	Total Interim
	Settlement Based on Cost

X Prospective

X Total Prospective

BASIS : Budget



W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Halifax Medical Center	Provider Number:	0101842-00
P.O. Box 2830	Date:	10/4/2011
Daytona Beach FL 32115-2830	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,088.68	\$1,616.59	7/1/2011
Outpatient	\$114.39	\$156.46	7/1/2011
Inpatient County Billing Rate	\$732.40	\$732.40	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Ormond Beach Memorial Hospital 875 Sterthaus Avenue Ormond Beach FL 32174

Provider Number:	0101869-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$853.30	\$853.30	7/1/2011
Outpatient	\$82.57	\$82.57	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Memorial Hospital - West Volusia 701 West Plymouth Avenue Deland FL 32720

Provider Number:	0101877-00	
Date:	10/4/2011	
Fiscal Year End:	12/31/2009	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back and 100% Self Exemption		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$833.79	\$2,005.01	7/1/2011
Outpatient	\$66.48	\$80.46	7/1/2011
Inpatient County Billing Rate		\$833.79	7/1/2011

Rate Type :

<u>Interim</u>		<u></u>	<u>Pr</u>	<u>ospective</u>
Total Interim Settlement Based on Cost			<u> </u>	Total Pros
	<u>B</u>	ASIS : Budget		
	X	Budget Unaudited	Cost	

Field Audited Cost **Revised Field Audit** Cost Report Late Test

> W. Rydell Samuel Medicaid Cost Reimbursement Analysis

Total Prospective

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Medicaid Reimbursement Rate Change Form

Healthmark Regional Medical Center PO Box 1326 Defuniak Springs FL 32433

Provider Number:	0101885-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2009	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,227.44	\$1,227.44	7/1/2011
Outpatient	\$56.74	\$56.74	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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DISTRIBUTION:

0101893-00 10/4/2011



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Medicaid Reimbursement Rate Change Form

Florida Hospital - Flagler 60 Memorial Medical Pkwy Palm Coast FL 32164

Provider Type :

Fiscal	Year End:	12/31/2009
A	udit Status: Un	audited Cost Report [1]
	Rate Inclue	les Buy Back
Current Rate	New Rate	Effective Date

Date:

Provider Number:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,615.48	\$1,615.48	7/1/2011
Outpatient	\$73.96	\$73.96	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Northwest Community Hospital Post Office Box 889 Chipley FL 32428

Provider Number:	0101907-00	
Date:	10/4/2011	
Fiscal Year End:	9/30/2010	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,831.73	\$1,831.73	7/1/2011
Outpatient	\$117.29	\$117.29	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Kindred Hospital-Hollywood 1859 Van Buren St. Hollywood FL 33022

Provider Number:	0101915-00
Date:	10/4/2011
Fiscal Year End:	8/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$605.69	\$605.69	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Desoto Memorial Hospital PO Box 2180 Arcadia FL 33821

Provider Number:	0101923-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]
Rate	Includes Buy Back

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$2,135.03	\$2,135.03	7/1/2011
Outpatient	\$142.04	\$142.04	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Memorial Hospital of Jacksonville PO Box16325 Jacksonville FL 32216

Provider Number:	0101931-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$752.51	\$752.51	7/1/2011
Outpatient	\$69.35	\$69.35	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Campbellton-Graceville Hospital 5429 College Dr. Graceville FL 32240

Provider Number:	0101940-00
Date:	10/4/2011
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]
Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,490.26	\$2,490.26	7/1/2011
Outpatient	\$101.01	\$101.01	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Wiregrass Hospital	Provider Number:	0101991-00
1200 Maple Av.	Date:	10/4/2011
Geneva AL 36340	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$235.83	\$235.83	7/1/2011
Outpatient	\$83.59	\$83.59	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Florala Memorial Hospital	Provider Number:	0102016-00
PO BOX 206	Date:	10/4/2011
Florala AL 36442	Fiscal Year End:	6/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$304.12	\$304.12	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Florida Hospital Association AHCA - County Billings

Vocational Rehabilitation

Children's Medical Services

DISTRIBUTION: Hospitals: Managed Care Contract Management

Area Adm.

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Medicaid Reimbursement Rate Change Form

D.W.Mcmillan Memorial	Provider Number:	0102024-00
PO BOX 908	Date:	10/4/2011
Brewton AL 36427	Fiscal Year End:	9/30/2004
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$506.92	\$506.92	7/1/2011
Outpatient	\$139.61	\$139.61	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Archbold Memorial Hospital	Provider Number:	0102041-00
Post Office Box 1018	Date:	10/4/2011
Thomasville GA 31799-1018	Fiscal Year End:	9/30/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$524.85	\$524.85	7/1/2011
Outpatient	\$83.57	\$83.57	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Southeast Alabama GeneralProvider Number:0102067-00PO BOX 6987Date:10/4/2011Dothan AL 36301Fiscal Year End:9/30/2009Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$697.97	\$697.97	7/1/2011
Outpatient	\$112.32	\$112.32	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

South Georgia Medical Center	Provider Number:	0102075-00
PO BOX 1727	Date:	10/4/2011
Valdosta GA 31601	Fiscal Year End:	9/30/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$625.36	\$625.36	7/1/2011
Outpatient	\$79.24	\$79.24	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Flowers Hospital	Provider Number:	0102091-00
PO BOX 6907	Date:	10/4/2011
Dothan AL 36302	Fiscal Year End:	6/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$595.24	\$595.24	7/1/2011
Outpatient	\$111.50	\$111.50	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Palm Beach Gardens Medical Center 3360 Burns Rd. Palm Beach Gardens FL 33410

Provider Number:	0102105-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Amended Cost Report [2]
Rate Includes Buy Back and 100% Self Exemption	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$839.51	\$2,257.07	7/1/2011
Outpatient	\$77.18	\$109.70	7/1/2011
Inpatient County Billing Rate		\$839.51	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Grady General Hospital	Provider Number:	0102121-00
1155 5th St.	Date:	10/4/2011
Cairo GA 31728	Fiscal Year End:	9/30/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$497.78	\$497.78	7/1/2011
Outpatient	\$51.13	\$51.13	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Wellington Regional Medical Center	Provider Number:	0102130-00	
10101 Forest Hill Blvd.	Date:	10/4/2011	
West Palm Beach FL 33414	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$936.35	\$1,276.17	7/1/2011
Outpatient	\$94.78	\$123.88	7/1/2011
Inpatient County Billing Rate	\$805.41	\$805.41	7/1/2011

Rate Type :

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	<u>B</u>	ASIS :
		Budget
	X	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
		_ ^

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Mizell Memorial Hospital	Provider Number:	0102164-00
PO BOX 429	Date:	10/4/2011
Opp AL 36467	Fiscal Year End:	9/30/1992
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$487.66	\$487.66	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Citrus Memorial Hospital	Provider Number:	0102199-00
502 Highland Blvd.	Date:	10/4/2011
Iverness FL 32652	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$779.53	\$1,970.35	7/1/2011
Outpatient	\$63.19	\$89.23	7/1/2011
Inpatient County Billing Rate		\$779.53	7/1/2011

Rate Type :

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	B	ASIS :
		Budget
	X	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
		_

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Medicaid Reimbursement Rate Change Form

Cleveland Clinic Hospital-Weston 3100 Weston Rd Weston FL 33331

Provider Number:	0102202-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$831.18	\$831.18	7/1/2011
Outpatient	\$56.77	\$56.77	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Pembroke Pines Hospital	Provider Number:	0102229-00	
2301 University Dr.	Date:	10/4/2011	
Pembroke Pines FL 33024	Fiscal Year End:	4/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,594.27	\$2,398.78	7/1/2011
Outpatient	\$98.60	\$132.54	7/1/2011
Inpatient County Billing Rate	\$882.81	\$882.81	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Homestead Hospital	Provider Number:	0102261-00
160 N.W. 13th Street	Date:	10/4/2011
Homestead FL 33030	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,910.91	\$1,910.91	7/1/2011
Outpatient	\$158.11	\$158.11	7/1/2011
Inpatient County Billing Rate	\$987.57	\$987.57	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Heart Of Florida Hospital	Provider Number:	0102288-00	
P.O. Box 67	Date:	10/4/2011	
Haines City FL 33845	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,222.49	\$1,740.33	7/1/2011
Outpatient	\$60.21	\$77.61	7/1/2011
Inpatient County Billing Rate	\$608.03	\$608.03	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Kindred Hospital Central Tampa	Provider Number:	0102300-00
4801 N HOWARD AVE.	Date:	10/4/2011
Tampa FL 33604	Fiscal Year End:	8/31/2010
	Audit Status:	Field Audit [3]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$724.90	\$724.90	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	Unaudited Cost
	X Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Baptist Hospital Of Beaches 1350 13th AVE., SOUTH Jacksonville FL 32250

Provider Number:	0102326-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$773.86	\$773.86	7/1/2011
Outpatient	\$62.56	\$62.56	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Atmore Community Hospital 401 Medical Park Dr. Atmore AL 36502

Provider Number:	0102334-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$546.94	\$546.94	7/1/2011
Outpatient	\$50.21	\$50.21	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Kindred Hospital (Tampa)	Provider Number:	0102342-00
4555 SOUTH MANHATTAN AVE.	Date:	10/4/2011
Tampa FL 33611	Fiscal Year End:	8/31/2010
	Audit Status:	Field Audit [3]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$614.19	\$614.19	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

-

Interim	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	Unaudited Cost
	X Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Smith Hospital	Provider Number:	0102369-00
P.O. Box 10010	Date:	10/4/2011
Valdosta GA 31604	Fiscal Year End:	12/31/1994
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$323.31	\$323.31	7/1/2011
Outpatient	\$96.80	\$96.80	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

St. John'S Rehabilitation Hospital 3075 N.W. 35th Ave. Lauderdale Lake FL 33311

Provider Number:	0102407-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$592.38	\$592.38	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	x Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
	Budget X Unaudited Cost Field Audited Cost Revised Field Audit

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

South Baldwin Hospital	Provider Number:	0102474-00
1613 West McKenzie St.	Date:	10/4/2011
Foley AL 36536	Fiscal Year End:	9/30/1995
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$566.27	\$566.27	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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DISTRIBUTION:

0102521-00

10/4/2011

4/30/2010

Unaudited Cost Report [1]

Rate Includes Buy Back and 100% Self Exemption



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Memorial Hosp. - West 703 North Flamingo Road Pembroke Pines FL 33028

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,580.03	\$2,000.97	7/1/2011
Outpatient	\$130.21	\$159.92	7/1/2011
Inpatient County Billing Rate	\$902.48	\$902.48	7/1/2011

Rate Type :

Interim

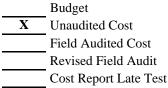
Total Interim

X Total Prospective

X **Prospective**

Settlement Based on Cost

BASIS:



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Provider Number:

Fiscal Year End:

Audit Status:

Date:

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Hospitals: Managed Care **Contract Management** Area Adm. 10 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Englewood Community Hospital 700 Medical Blvd. Englewood FL 34223

Provider Number:	0102539-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$781.29	\$781.29	7/1/2011
Outpatient	\$45.86	\$45.86	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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DISTRIBUTION:

Hospitals: Managed Care Contract Management Area Adm. 8 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Southeast Georgia Medical Center 3100 Kemble Avenue Brunswick GA 31520

Provider Number:	0102555-00
Date:	10/4/2011
Fiscal Year End:	4/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$673.66	\$669.60	7/1/2011
Outpatient	\$92.06	\$55.95	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS : Budget X Unaudited Cost	
	Field Audited Cost Revised Field Audit Cost Report Late Test	

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Hospitals: Managed Care Contract Management Area Adm. Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Edward White Hospital 2323 9th Avenue North P.O. Box 12018 St. Petersburg Fl 33733

Provider Number:	0102598-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$808.56	\$808.56	7/1/2011
Outpatient	\$88.86	\$88.86	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

Hospitals: Managed Care Contract Management Area Adm. 5 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Florida Hospital Wauchula 2501 U.S. Hwy 27 North P.O. Box 1200 Avon Park FL 33825

Provider Number:	0102601-00		
Date:	10/4/2011		
Fiscal Year End:	12/31/2009		
Audit Status:	tatus: Unaudited Cost Report [1]		
Rate Includes Buy Back			

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$6,087.70	\$6,087.70	7/1/2011
Outpatient	\$108.74	\$108.74	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
	·

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

A.G. Holley State Hospital	Provider Number:	0102610-00
1199 Lantana Rd. P.O. Box 3084	Date:	10/4/2011
Lantana FL 33465	Fiscal Year End:	6/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$609.83	\$609.83	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011
Inpatient County Billing Rate	\$447.21	\$447.21	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Kindred Hosp. - North Fla 801 Oak Street Green Cove Springs FL 32043

Provider Number:	0102679-00
Date:	10/4/2011
Fiscal Year End:	8/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$601.57	\$601.57	7/1/2011
Outpatient	\$130.11	\$130.11	7/1/2011

Rate Type :

Interim	x Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS :	
	Budget X Unaudited Cost Field Audited Cost	
	Revised Field Audit	
	Cost Report Late Test	

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

HealthSouth Rehab - Dothan 1736 East Main Street Dothan AL 36301

Provider Number:	0102687-00
Date:	10/4/2011
Fiscal Year End:	12/31/2002
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$490.19	\$423.25	7/1/2011
Outpatient	\$63.60	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

HealthSouth Rehabililation Hospital - Miami 20601 Old Cutler Road Miami FL 33188

Provider Number:	0102709-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$387.41	\$387.41	7/1/2011
Outpatient	\$42.91	\$42.91	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Brooks Rehabilitation Hospital 3599 University Blvd., S Jacksonville FL 32216

Provider Number:	0102717-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$613.79	\$613.79	7/1/2011
Outpatient	\$54.56	\$54.56	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Healthsouth Emerald Coast Hospital 1847 Florida Avenue Panama City FL 32405

Provider Number:	0102750-00		
Date:	10/4/2011		
Fiscal Year End:	12/31/2009		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$410.67	\$410.67	7/1/2011
Outpatient	\$42.67	\$42.67	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Kindred Hospital-St. Petersburg	Provider Number:	0102768-00
3030 6th Street, South	Date:	10/4/2011
St. Petersburg FL 33705	Fiscal Year End:	8/31/2010
	Audit Status:	Field Audit [3]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$622.85	\$622.85	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS :	
	Budget	
	Unaudited Cost	
	X Field Audited Cost	
	Revised Field Audit	
	Cost Report Late Test	

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Douglas Gardens Hospital 5200 NE 2nd Avenue Miami FL 33137

Provider Number:	0102776-00		
Date:	10/4/2011		
Fiscal Year End:	6/30/2010		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,305.75	\$1,305.75	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Physicians Regional Medical Center 6101 Pine Ridge Road Naples FL 34119

Provider Number:	0103144-00	
Date:	10/4/2011	
Fiscal Year End:	12/31/2009	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back and Partial Self Exemption		

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$967.05	\$1,643.92	7/1/2011
Outpatient	\$93.58	\$121.27	7/1/2011
Inpatient County Billing Rate		\$967.05	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Physicians Regional Medical Center 6101 Pine Ridge Road Naples FL 34119

Provider Number:	0103144-01		
Date:	10/4/2011		
Fiscal Year End:	12/31/2009		
Audit Status:	Unaudited Cost Report [1]		
Rate Includes Buy Back and Partial Self Exemption			

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$967.05	\$1,643.92	7/1/2011
Outpatient	\$93.58	\$121.27	7/1/2011
Inpatient County Billing Rate		\$967.05	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

The Villages Regional Hospital 600 East Dixie Ave Leesburg FL 34748

Provider Number:	0103179-00		
Date:	10/4/2011		
Fiscal Year End:	6/30/2009		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,163.79	\$1,163.79	7/1/2011
Outpatient	\$88.74	\$88.74	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Wuesthoff Medical Center Melbourne 250 N. Wickham Road Melbourne FL 32935

Provider Number:	0103209-00		
Date:	10/4/2011		
Fiscal Year End:	9/30/2010		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$898.79	\$898.79	7/1/2011
Outpatient	\$108.14	\$108.14	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Sacred Heart Hospital on the Emerald Coast 7800 US Highway 98 West Destin FL 32550-7228

Provider Number:	0103233-00		
Date:	10/4/2011		
Fiscal Year End:	6/30/2010		
Audit Status: Unaudited Cost Report [1]			
Rate Includes Buy Back			

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$3,039.52	\$3,039.52	7/1/2011
Outpatient	\$122.23	\$122.23	7/1/2011

Rate Type :

Interim	<u>X</u> Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit	
	Cost Report Late Test	

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Sister Emmanuel Hospital 3663 South Miami Ave, 4th Floor Miami FL 33133

Provider Number:	0103284-00		
Date:	10/4/2011		
Fiscal Year End:	12/31/2010		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$638.73	\$638.73	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Select Specialty Hospital Miami 955 NW 3rd Street, 8th Floor Miami FL 33128

Provider Number:	0103373-00		
Date:	10/4/2011		
Fiscal Year End:	8/31/2009		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$819.94	\$819.94	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Select Specialty Hospital - Orlando	Provider Number:	0103390-00
601 E Rollins Street	Date:	10/4/2011
Orlando FL 32803	Fiscal Year End:	12/31/2009
	Audit Status:	Field Audit [3]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$735.62	\$735.62	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	Unaudited Cost
	X Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

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0103411-00

10/4/2011

6/30/2010



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Charlton Memorial Hospital Provider Number: Post Office Box 188 Date: Folkston GA 31537 Fiscal Year End: Unaudited Cost Report [1] Audit Status:

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$797.62	\$797.62	7/1/2011
Outpatient	\$139.61	\$139.61	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit	
	Cost Report Late Test	

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

Hospitals: Managed Care **Contract Management** Area Adm. Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Lakewood Ranch Medical Center 8330 Lakewood Ranch Boulevard Bradenton FL 34202

Provider Number:	0103420-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$941.28	\$941.28	7/1/2011
Outpatient	\$92.56	\$92.56	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Select Specialty Hospital Panama City 615 N Bonita Avenue Panama City FL 32401

Provider Number:	0103438-00
Date:	10/4/2011
Fiscal Year End:	7/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$715.20	\$715.20	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Memorial Hospital Miramar Provider Number: 0103454-00 10/4/2011 1901 SW 172nd Avenue Date: Miramar FL 33029 4/30/2010 Fiscal Year End: Unaudited Cost Report [1] Audit Status: Rate Includes Buy Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,778.86	\$2,252.03	7/1/2011
Outpatient	\$109.84	\$134.88	7/1/2011
Inpatient County Billing Rate	\$1,046.24	\$1,046.24	7/1/2011

Rate Type :

Interim

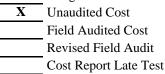
Total Interim

X <u>Prospective</u>

X Total Prospective

Settlement Based on Cost

BASIS: Budget



W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

St. Cloud Regional Medical Center 2906 17th Street Saint Cloud FL 34769

Provider Number:	0103462-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$841.61	\$841.61	7/1/2011
Outpatient	\$59.89	\$59.89	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Kindred Hospital Ocala 1500 SW 1st Avenue, 5th Floor Ocala FL 34474

Provider Number:	0103535-00		
Date:	10/4/2011		
Fiscal Year End:	5/31/2010		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$739.86	\$739.86	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Doctors Hospital	Provider Number:	0103543-00
5000 University Drive	Date:	10/4/2011
Coral Gables FL 33146	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$919.29	\$919.29	7/1/2011
Outpatient	\$161.23	\$161.23	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Healthsouth Hospital of Spring Hill 12440 Cortez Boulrvard Brooksville FL 34613

Provider Number:	0103551-00		
Date:	10/4/2011		
Fiscal Year End:	12/31/2009		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$486.74	\$486.74	7/1/2011
Outpatient	\$129.26	\$129.26	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Healthsouth Ridgelake Hospital 6150 Edgelake Drive Sarasota FL 34240

Provider Number:	0103560-00		
Date:	10/4/2011		
Fiscal Year End:	3/31/2010		
Audit Status:	Unaudited Cost Report [1]		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$780.91	\$780.91	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

Hospitals: Managed Care Contract Management Area Adm. 8 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Select Specialty Hospital Pensacola 7000 Cobble Creek Drive Pensacola Fl 32504

Provider Number:	0103683-00
Date:	10/4/2011
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,107.00	\$1,107.00	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

BayCare Alliant HospitalProvider Number:0103721-00601 Main Street, MS 469Date:10/4/2011Dunedin FL 34698Fiscal Year End:12/31/2009Audit Status:Unaudited Cost Report [1]Rate Includes Buy Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$847.00	\$1,256.12	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011
Inpatient County Billing Rate		\$847.00	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

St. Luke's-St. Vincent's Healthcare 4201 Belfort Road Jacksonville FL 32215

Provider Number:	0103730-00
Date:	10/4/2011
Fiscal Year End:	6/30/2010
Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$842.49	\$842.42	7/1/2011
Outpatient	\$60.93	\$78.55	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Select Specialty Hospital Tallahassee 1554 Surgeon's Drive Tallahassee FL 32308

Provider Number:	0103748-00
Date:	10/4/2011
Fiscal Year End:	2/28/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,043.12	\$1,043.12	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Select Specialty Hospital Palm Beach 3060 Melaleuca Lane Lake Worth FL 33461

Provider Number:	0103764-00
Date:	10/4/2011
Fiscal Year End:	11/30/2009
Audit Status:	Field Audit [3]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$955.38	\$955.38	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	Unaudited Cost
	X Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Select Speciality Hospital Gainesville	Provider Number:	0103772-00
2708 SW Archer Road	Date:	10/4/2011
Gainesville FL 32608	Fiscal Year End:	7/31/2009
	Audit Status:	Field Audit [3]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$977.39	\$977.39	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

-

Interim	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	Unaudited Cost
	X Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Northwest Medical CenterProvider Number:0104591-005801 North State Road 7Date:10/4/2011Margate FL 33063Fiscal Year End:12/31/2009Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$764.23	\$764.23	7/1/2011
Outpatient	\$56.95	\$56.95	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Palmetto General Hospital	Provider Number:	0104604-00
2001 West 68th St.	Date:	10/4/2011
Hialeah FL 33016	Fiscal Year End:	12/31/2009
	Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	<u>\$1,115.49</u> \$100.28	\$1,115.49 \$100.28	7/1/2011 7/1/2011
Inpatient County Billing Rate	<u>\$100.28</u> \$656.90	\$100.28 \$656.90	7/1/2011

Rate Type :

Interim	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Cost Report Late Test

DISTRIBUTION:

Hospitals: Managed Care Contract Management Area Adm. 11 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Community Hospital of New Port Richey 5637 Marine Parkway New Port Richey FL 34652

Provider Number:	0105520-00
Date:	10/4/2011
Fiscal Year End:	6/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,260.47	\$1,260.47	7/1/2011
Outpatient	\$37.43	\$37.43	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost
	Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Specialty Hospital Jacksonville 4901 Richard Street Jacksonville FL 32207

Provider Number:	0106470-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$640.05	\$640.05	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Imperial Point Hospital	Provider Number:	0108219-00	
1608 S.E. 3rd Avenue	Date:	10/4/2011	
Ft. Lauderdale FL 33316	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,071.74	\$1,617.93	7/1/2011
Outpatient	\$126.11	\$175.60	7/1/2011
Inpatient County Billing Rate	\$631.72	\$631.72	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Imperial Point Hospital	Provider Number:	0108219-05	
1608 S.E. 3rd Avenue	Date:	10/4/2011	
Ft. Lauderdale FL 33316	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,071.74	\$1,617.93	7/1/2011
Outpatient	\$126.11	\$175.60	7/1/2011
Inpatient County Billing Rate	\$631.72	\$631.72	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Lake Butler Hospital 850 EAST MAIN ST. P.O.B. 748 Lake Butler FL 32954

Provider Number:	0108227-00	
Date:	10/4/2011	
Fiscal Year End:	12/31/2009	
Audit Status:	Unaudited Cost Report [1]	
Rate Includes Buy Back		

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$3,119.67	\$3,119.67	7/1/2011
Outpatient	\$71.63	\$71.63	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS :	
	Budget	
	X Unaudited Cost	
	Field Audited Cost	
	Revised Field Audit	
	Cost Report Late Test	

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

North Florida Regional Medical Center P.O. Box NFR Gainesville FL 32602

Provider Number:	0108626-00	
Date:	10/4/2011	
Fiscal Year End:	2/28/2010	
Audit Status:	Amended Cost Report [2]	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$692.92	\$692.92	7/1/2011
Outpatient	\$92.56	\$92.56	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost
	Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Pasco Community HospitalProvider Number:0109592-0013100 Fort King RoadDate:10/4/2011Dade City FL 33525Fiscal Year End:9/30/2010Audit Status:Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$666.32	\$666.32	7/1/2011
Outpatient	\$56.75	\$70.89	7/1/2011

Rate Type :

<u>X</u> Prospective
X Total Prospective
BASIS : Budget
X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Coral Gables Hospital	Provider Number:	0109606-00
P.O. BOX 610	Date:	10/4/2011
Coral Gables FL 33134	Fiscal Year End:	12/31/2009
	Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,149.52	\$1,149.52	7/1/2011
Outpatient	\$118.20	\$118.20	7/1/2011
Inpatient County Billing Rate	\$704.09	\$704.09	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost
	Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Ocala Regional Medical Center	Provider Number:	0109886-00
1431 SW 1st Avenue Post Office Box 2200	Date:	10/4/2011
Ocala FL 32678	Fiscal Year End:	8/31/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$662.09	\$662.09	7/1/2011
Outpatient	\$78.78	\$78.78	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Blake Memorial HospitalProvider Number:0110213-002020 59th St. WestDate:10/4/2011Bradenton FL 33505Fiscal Year End:4/30/2010Audit Status:Unaudited Cost Report [1]Rate Includes Buy Back and Partial Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	\$683.78 \$62.24	\$1,421.15 \$95.44	7/1/2011 7/1/2011
Inpatient County Billing Rate		\$683.78	7/1/2011

Rate Type :

<u>Interim</u>		<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost		X Total Prospective
	B A	ASIS :
		Budget
	Х	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
		-

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Ft. Walton Beach Medical Center 1000 Mar-Walt Drive Ft. Walton FL 32547

Provider Number:	0111325-00
Date:	10/4/2011
Fiscal Year End:	5/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$604.19	\$604.19	7/1/2011
Outpatient	\$39.65	\$39.65	7/1/2011

Rate Type :

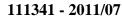
<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost
	X Onlaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

Gulf Coast Medical Center	Provider Number:	0111341-00
PO Box 151247	Date:	10/4/2011
Cape Coral FL 33915	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,397.36	\$1,871.82	7/1/2011
Outpatient	\$157.82	\$203.44	7/1/2011
Inpatient County Billing Rate	\$892.79	\$892.79	7/1/2011

Rate Type :

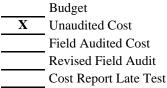
Total Interim
Settlement Based on Cost

Prospective Χ

X Total Prospective

Intonim

BASIS:

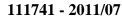


W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

Hospitals: Managed Care **Contract Management** Area Adm. 8 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation





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Medicaid Reimbursement Rate Change Form

Orange Park Medical CenterProvider Number:0111741-002001 Kingsley AvenueDate:10/4/2011Orange Park FL 32073Fiscal Year End:6/30/2010Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$712.39	\$712.39	7/1/2011
Outpatient	\$71.87	\$71.87	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Hospitals: Managed Care Contract Management Area Adm. 4 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Westside Regional Medical Center 8201 West Broward Blvd. Plantation FL 33324

Provider Number:	0112305-00
Date:	10/4/2011
Fiscal Year End:	1/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$796.37	\$796.37	7/1/2011
Outpatient	\$48.10	\$48.10	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Hospitals: Managed Care Contract Management Area Adm. 10 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Memorial Hospital Of Tampa 2901 Swann Avenue Tampa FL 33609-0409

Provider Number:	0112798-00
Date:	10/4/2011
Fiscal Year End:	11/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$659.85	\$659.85	7/1/2011
Outpatient	\$115.92	\$115.92	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form

University Hospital	Provider Number:	0112801-00
7201 University Drive	Date:	10/4/2011
Tamarac FL 33321	Fiscal Year End:	4/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$450.51	\$450.51	7/1/2011
Outpatient	\$57.17	\$57.17	7/1/2011

Rate Type :

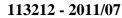
<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

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Hospitals: Managed Care Contract Management Area Adm. 10 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation





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Medicaid Reimbursement Rate Change Form

West Florida Hospital	Provider Number:	0113212-00
8383 North Davis Hwy.	Date:	10/4/2011
Pensacola FL 32514	Fiscal Year End:	5/31/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$623.18	\$623.18	7/1/2011
Outpatient	\$57.97	\$57.97	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Putnam Community Hospital P.O. Drawer 778 Palatka FL 32007

Provider Number:	0113514-00
Date:	10/4/2011
Fiscal Year End:	2/28/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,290.76	\$1,290.76	7/1/2011
Outpatient	\$73.43	\$73.43	7/1/2011

Rate Type :

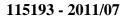
<u>Interim</u>	X Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS : Budget X Unaudited Cost Field Audited Cost	
	Revised Field Audit Cost Report Late Test	

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Medicaid Reimbursement Rate Change Form

Northside Hospital	Provider Number:	0115193-00
6000 49th St. North	Date:	10/4/2011
St. Petersburg FL 33709	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,092.16	\$1,092.16	7/1/2011
Outpatient	\$88.93	\$88.93	7/1/2011
Inpatient County Billing Rate	\$565.90	\$565.90	7/1/2011

Rate Type :

Interim	X <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Anne Bates Leach Eye Hospital	Provider Number:	0116483-00	
900 NW 17th St.	Date:	10/4/2011	
Miami FL 33136	Fiscal Year End:	5/31/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$4,717.81	\$7,250.50	7/1/2011
Outpatient	\$184.25	\$263.20	7/1/2011
Inpatient County Billing Rate	\$5,412.69	\$5,412.69	7/1/2011

Rate Type :

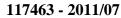
<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Fawcett Memorial HospitalProvider Number:0117463-00PO BOX 494960Date:10/4/2011Port Charlotte FL 33952Fiscal Year End:12/31/2009Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$607.16	\$607.16	7/1/2011
Outpatient	\$71.81	\$71.81	7/1/2011

Rate Type :

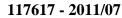
<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Gulf Coast Medical Center	Provider Number:	0117617-00
449 West 23rd Street	Date:	10/4/2011
Panama City FL 32405	Fiscal Year End:	1/31/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$984.81	\$984.81	7/1/2011
Outpatient	\$88.43	\$88.43	7/1/2011
Inpatient County Billing Rate	\$592.94	\$592.94	7/1/2011

Rate Type :

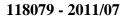
Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Brandon Regional Hospital	Provider Number:	0118079-00	
119 Oakfield Drive	Date:	10/4/2011	
Brandon FL 33511	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,078.90	\$1,378.12	7/1/2011
Outpatient	\$82.58	\$82.58	7/1/2011
Inpatient County Billing Rate	\$723.83	\$723.83	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Lawnwood Regional Medical Center	Provider Number:	0119695-00	
P.O. Box 188	Date:	10/4/2011	
Ft Pierce FL 33450	Fiscal Year End:	9/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,097.32	\$1,097.32	7/1/2011
Outpatient	\$79.63	\$79.63	7/1/2011
Inpatient County Billing Rate	\$733.23	\$733.23	7/1/2011

Rate Type :

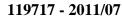
<u>Interim</u>		-	X	Prospective
Total Interim Settlement Based on Cost			-	X Total Prospective
	BA	ASIS :		
		Budget		
	X	Unaudit	ed Co	ost
		Field Au	udited	Cost
		Revised	Field	Audit
		Cost Re	port L	Late Test
		-	-	

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Medicaid Reimbursement Rate Change Form

Cape Coral Hospital	Provider Number:	0119717-00
PO Box 151247	Date:	10/4/2011
Cape Coral FL 33915	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,089.55	\$1,459.49	7/1/2011
Outpatient	\$77.20	\$99.52	7/1/2011
Inpatient County Billing Rate	\$794.35	\$794.35	7/1/2011

Rate Type :

Interi	im	

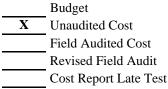
X Total Prospective

Prospective

Total Interim
Settlement Based on Cost

Χ

BASIS :	



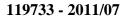
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Medicaid Reimbursement Rate Change Form

Venice Hospital	Provider Number:	0119733-00
540 THE RIALTO	Date:	10/4/2011
Venice FL 34285	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$603.34	\$603.34	7/1/2011
Outpatient	\$62.76	\$62.76	7/1/2011

Rate Type :

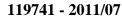
<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Largo Medical Center	Provider Number:	0119741-00	
201 14th St., SW	Date:	10/4/2011	
Largo FL 33540	Fiscal Year End:	2/28/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,062.47	\$1,062.47	7/1/2011
Outpatient	\$86.61	\$86.61	7/1/2011
Inpatient County Billing Rate	\$784.79	\$784.79	7/1/2011

Rate Type :

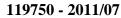
<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Raulerson HospitalProvider Number:0119750-00P.O.Box 1307Date:10/4/2011Okeechobee FL 34974Fiscal Year End:4/30/2010Audit Status:Unaudited Cost Report [1]Rate Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,600.24	\$1,600.24	7/1/2011
Outpatient	\$106.35	\$106.35	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test	

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Medicaid Reimbursement Rate Change Form

Lake City Medical CenterProvider Number:0119768-001050 N. Commerce BlvdDate:10/4/2011Lake City FL 32055Fiscal Year End:10/31/2010Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$541.20	\$541.20	7/1/2011
Outpatient	\$83.43	\$83.43	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Florida State Hospital-Med Medicaid Billing Office Chattahoochee FL 32324

Provider Number:	0119784-00
Date:	10/4/2011
Fiscal Year End:	6/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$582.90	\$582.90	7/1/2011
Outpatient			7/1/2011

Rate Type :

X Total Prospective
BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Capital Regional Medical Center 2626 CAPITAL MEDICAL BLVD Tallahassee FL 32308

Provider Number:	0119806-00	
Date:	10/4/2011	
Fiscal Year End:	4/30/2010	
Audit Status:	Amended Cost Report [2]	
Rate Includes Buy Back		

Provider Type :

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$818.79	\$945.06	7/1/2011
Outpatient	\$83.53	\$83.53	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Town and Country Hospital 6001 Webb Road Tampa FL 33615

Provider Number:	0119849-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]
Rate Includes Buy	Back and Partial Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	<u>\$626.38</u> \$70.05	\$849.03 \$90.65	7/1/2011 7/1/2011
Inpatient County Billing Rate		\$626.38	7/1/2011

Rate Type :

Interim

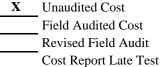
Total Interim

X Total Prospective

X Prospective

Settlement Based on Cost

BASIS: Budget



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Medicaid Reimbursement Rate Change Form

Regional Medical Center Bayonet Point 14000 FIVAY RD Hudson FL 34667

Provider Number:	0119881-00
Date:	10/4/2011
Fiscal Year End:	2/28/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$713.67	\$713.67	7/1/2011
Outpatient	\$78.97	\$78.97	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Kindred Hospital - Coral Gables 5190 SW 8TH ST Coral Gables FL 33134

Provider Number:	0119938-00
Date:	10/4/2011
Fiscal Year End:	8/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$731.25	\$731.25	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test	

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Medicaid Reimbursement Rate Change Form

South Bay Hospital 4016 STATE RD 674 EAST Sun City Center FL 33570

Provider Number:	0119946-00
Date:	10/4/2011
Fiscal Year End:	8/31/2010
Audit Status:	Unaudited Cost Report [1]
Rate Includes Buy	Back and Partial Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient Outpatient	\$722.94 \$68.27	\$1,368.28 \$104.47	7/1/2011 7/1/2011
Inpatient County Billing Rate		\$722.94	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Doctors Hospital Of Sarasota 5731 Bee Ridge Road Sarasota FL 34233

Provider Number:	0119954-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$819.33	\$819.33	7/1/2011
Outpatient	\$75.02	\$75.02	7/1/2011

Rate Type :

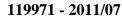
<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

St. Lucie Medical Center	Provider Number:	0119971-00
1800 SE TIFFANY AVE.	Date:	10/4/2011
Port St Lucie FL 34952	Fiscal Year End:	9/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,208.10	\$1,208.10	7/1/2011
Outpatient	\$76.72	\$76.72	7/1/2011
Inpatient County Billing Rate	\$694.12	\$694.12	7/1/2011

Rate Type :

<u>Interim</u>	x <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Seven Rivers Community Hospital 6201 N Suncoast Blvd. Crystal River FL 32629

Provider Number:	0119989-00
Date:	10/4/2011
Fiscal Year End:	5/31/2010
Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$632.59	\$633.39	7/1/2011
Outpatient	\$59.49	\$70.55	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Plantation General Hospital	Provider Number:	0120006-00
401 NW 42ND AVENUE	Date:	10/4/2011
Plantation FL 33317	Fiscal Year End:	8/31/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,047.15	\$1,047.15	7/1/2011
Outpatient	\$80.66	\$80.66	7/1/2011
Inpatient County Billing Rate	\$793.41	\$793.41	7/1/2011

X Prospective

X Total Prospective

Rate Type :

<u>nterim</u>	
Total Interim	
Settlement Based on Cost	

 BASIS :

 Budget

 X
 Unaudited Cost

 Field Audited Cost

 Revised Field Audit

 Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Sebastian Hospital	Provider Number:	0120014-00
P.O. BOX 780838	Date:	10/4/2011
Sebastian FL 32978	Fiscal Year End:	9/30/2010
	Audit Status:	Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$668.08	\$668.08	7/1/2011
Outpatient	\$63.50	\$71.15	7/1/2011

Rate Type :

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	BA	<u>SIS :</u>
		Budget
	X	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
		-

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Hospitals: Managed Care Contract Management Area Adm. 9 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

St. Catherine's Rehabilitation Hospital 1050 NE 125 ST North Miami FL 33161

Provider Number:	0120022-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$507.20	\$507.20	7/1/2011
Outpatient	\$15.15	\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Healthsouth Larkin Hospital-Miami	Provider Number:	0120057-00
7031 SW 62 AVE.	Date:	10/4/2011
South Miami FL 33143	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$836.96	\$836.96	7/1/2011
Outpatient	\$127.48	\$127.48	7/1/2011
Inpatient County Billing Rate	\$548.91	\$548.91	7/1/2011

Rate Type :

-

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Oak Hill Hospital	Provider Number:	0120073-00
P.O. BOX 5300	Date:	10/4/2011
Spring Hill FL 33526	Fiscal Year End:	2/28/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$563.91	\$563.91	7/1/2011
Outpatient	\$59.22	\$59.22	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Hospitals: Managed Care

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Medicaid Reimbursement Rate Change Form

Mease Hospital CountrysideProvider Number:0120081-0016331 BayVista DriveDate:10/4/2011Clearwater FL 33760Fiscal Year End:12/31/2009Audit Status:Unaudited Cost Report [1]Rate Includes Buy Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$763.42	\$1,888.65	7/1/2011
Outpatient	\$69.68	\$141.01	7/1/2011
Inpatient County Billing Rate		\$763.42	7/1/2011

Rate Type :

Interim		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	B	ASIS :
		Budget
	Х	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
		_

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0120090-00 10/4/2011

12/31/2009

Amended Cost Report [2]



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Medicaid Reimbursement Rate Change Form

Delray Comm. Hosp. 5352 LINTON BLVD Delray Beach FL 33445

Provider Type :

HOSPITAL

		Rate Includes Buy Back			
<u>-</u>	Current Rate	New Rate	Effective Date		
Inpatient	\$694.85	\$897.60	7/1/2011		
Outpatient	\$86.60	\$108.95	7/1/2011		

Provider Number:

Fiscal Year End:

Audit Status:

Date:

Rate Type :

Interim		X	Prospective
Total Interim Settlement Based on Cost			X Total Prospective
	BASIS : Budge X Unauc		ost
	Revise		d Cost d Audit Late Test

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Medicaid Reimbursement Rate Change Form

St. Petersburg General Hospital	Provider Number:	0120103-00
6500 38TH AVE., NORTH	Date:	10/4/2011
St Petersburg FL 33710	Fiscal Year End:	4/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,080.35	\$1,080.35	7/1/2011
Outpatient	\$92.93	\$92.93	7/1/2011
Inpatient County Billing Rate	\$723.31	\$723.31	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Palms Of Pasadena HospitalProvider Number:0120111-001501 Pasadena Ave.Date:10/4/2011South Pasadena FL 33707Fiscal Year End:11/30/2009Audit Status:Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$736.14	\$736.14	7/1/2011
Outpatient	\$98.49	\$98.49	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Kendall Medical Center	Provider Number:	0120138-00
11750 SW 40TH ST	Date:	10/4/2011
Miami FL 33175	Fiscal Year End:	12/31/2009
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,382.45	\$1,382.45	7/1/2011
Outpatient	\$95.50	\$95.50	7/1/2011
Inpatient County Billing Rate	\$913.07	\$913.07	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

St Anthonys Hospital	Provider Number:	0120227-00	
3001 W. ML King Blvd. Post Office Box 4227	Date:	10/4/2011	
Tampa FL 33677-4227	Fiscal Year End:	12/31/2009	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,049.59	\$1,546.78	7/1/2011
Outpatient	\$127.33	\$184.81	7/1/2011
Inpatient County Billing Rate	\$691.35	\$691.35	7/1/2011

Rate Type :

<u>Interim</u>	X Prospec	<u>tive</u>
Total Interim Settlement Based on Cost	X Tota	l Prospective
	BASIS :	
	Budget	
	X Unaudited Cost	
	Field Audited Cost	
	Revised Field Audit	
	Cost Report Late Test	

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Medicaid Reimbursement Rate Change Form

W. Boca Med. Ctr.	Provider Number:	0120243-00
21644 STATE RD 7	Date:	10/4/2011
Boca Raton FL 33428	Fiscal Year End:	12/31/2009
	Audit Status:	Amended Cost Report [2]
	Rate Includes Buy	Back and 100% Self Exemption

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$848.82	\$1,932.95	7/1/2011
Outpatient	\$79.49	\$114.60	7/1/2011
Inpatient County Billing Rate		\$848.82	7/1/2011

X Prospective

X Total Prospective

Rate Type :

Interim	
Total Interim Settlement Based on Cost	
	BASIS :

BA	<u> SIS :</u>
	Budget
Х	Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

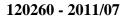
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Medicaid Reimbursement Rate Change Form

Palms West Hospital	Provider Number:	0120260-00	
P.O. BOX 1150	Date:	10/4/2011	
Loxahatchee FL 33470	Fiscal Year End:	5/31/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,067.74	\$1,483.37	7/1/2011
Outpatient	\$89.76	\$119.05	7/1/2011
Inpatient County Billing Rate	\$750.25	\$750.25	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
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Medicaid Reimbursement Rate Change Form

HealthSouth Rehabiliation Hospital-Sunrise 4399 NOB HILL RD Ft Lauderdale FL 33351

Provider Number:	0120278-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$431.53	\$431.53	7/1/2011
Outpatient	\$43.68	\$43.68	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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0120294-00



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Medicaid Reimbursement Rate Change Form

Jupiter Hospital 1210 S Old Dixie Highway Jupiter FL 33458

Date:	10/4/2011		
Fiscal Year End:	9/30/2010		
Audit Status:	Unaudited Cost Report [1]		
Rate Includes Buy Back			

Provider Number:

HOSPITAL Current Rate New Rate Effective Date Inpatient \$825.70 \$1,106.05 7/1/2011 Outpatient \$69.05 \$89.01 7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Columbia Hospital	Provider Number:	0120308-00	
2201 45TH ST	Date:	10/4/2011	
West Palm Beach FL 33407	Fiscal Year End:	6/30/2010	
	Audit Status:	Unaudited Cost Report [1]	
	Rate	e Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$768.24	\$1,072.43	7/1/2011
Outpatient	\$96.31	\$130.67	7/1/2011
Inpatient County Billing Rate	\$509.04	\$509.04	7/1/2011

Rate Type :

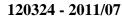
Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

H L Moffitt Cancer Center	Provider Number:	0120324-00	
12902 Magnolia Drive	Date:	10/4/2011	
Tampa FL 33612-9497	Fiscal Year End:	6/30/2010	
	Audit Status:	Amended Cost Report [2]	
	Rate	Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,071.99	\$3,001.38	7/1/2011
Outpatient	\$230.92	\$360.77	7/1/2011
Inpatient County Billing Rate	\$1,833.43	\$1,850.29	7/1/2011

Χ

Rate Type :

Total Interim

Prospective X Total Prospective

Settlement Based on Cost

BASIS:

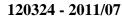
Budget Х Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

H L Moffitt Cancer Center	Provider Number:	0120324-02
12902 Magnolia Drive	Date:	10/4/2011
Tampa FL 33612-9497	Fiscal Year End:	6/30/2010
	Audit Status:	Amended Cost Report [2]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,071.99	\$3,001.38	7/1/2011
Outpatient	\$230.92	\$360.77	7/1/2011
Inpatient County Billing Rate	\$1,833.43	\$1,850.29	7/1/2011

Χ

Rate Type :

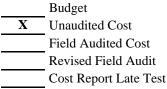
Interim	

Total Interim

Prospective X Total Prospective

Settlement Based on Cost

BASIS:



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Medicaid Reimbursement Rate Change Form

HealthSouth Rehabiliation Hospital-Tallahassee 1675 RIGGINS RD Tallahassee FL 32308

Provider Number:	0120332-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$425.70	\$425.70	7/1/2011
Outpatient	\$58.86	\$58.86	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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DISTRIBUTION: Hospitals:

Managed Care Contract Management Area Adm. 2 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation

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Medicaid Reimbursement Rate Change Form

HealthSouth Rehabilitation Hospital-Treasure Coast 1600 37TH ST Vero Beach FL 32960

Provider Number:	0120341-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$416.58	\$416.58	7/1/2011
Outpatient	\$48.72	\$48.72	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Aventura Hospital & Medical Center 20900 Biscayne Blvd Miami FL 33180

Provider Number:	0120375-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$602.58	\$602.58	7/1/2011
Outpatient	\$35.87	\$35.87	7/1/2011

Rate Type :

<u>Interim</u>		x Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	BA	SIS : Budget
	X	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

HealthSouth Rehabiliation Hospital Sarasota 3251 PROCTOR RD Sarasota FL 33581

Provider Number:	0120383-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$370.05	\$370.05	7/1/2011
Outpatient	\$92.66	\$92.66	7/1/2011

Rate Type :

<u>Interim</u>	<u>x</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Coral Springs Medical Center	Provider Number:	0120405-00
303 South East 17th St.	Date:	10/4/2011
Ft. Lauderdale FL 33316	Fiscal Year End:	6/30/2010
	Audit Status:	Unaudited Cost Report [1]
	Rate	Includes Buy Back

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,177.52	\$1,688.87	7/1/2011
Outpatient	\$104.56	\$143.49	7/1/2011
Inpatient County Billing Rate	\$810.83	\$810.83	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Bartow Memorial Hospital 2200 Osprey Blvd Post Office Box 1050 Bartow FL 33830

Provider Number:	0120413-00
Date:	10/4/2011
Fiscal Year End:	3/31/2010
Audit Status:	Unaudited Cost Report [1]
Rate Includes Buy Back	

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$769.80	\$1,014.83	7/1/2011
Outpatient	\$48.45	\$62.46	7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost
	Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

HealthSouth Rehabiliation Hospital-Sea Pines 101 E Florida Ave. Melbourne FL 32901

Provider Number:	0120421-00
Date:	10/4/2011
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$410.16	\$410.16	7/1/2011
Outpatient	\$85.04	\$85.04	7/1/2011

Rate Type :

<u>Interim</u>	<u>X</u> Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS : Budget X Unaudited Cost Field Audited Cost
	Revised Field Audit Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

North Dade Health Center 1611 N.W. 12th Avenue Miami FL 33136-

Provider Number:	0140422-00
Date:	10/4/2011
Fiscal Year End:	9/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient			7/1/2011
Outpatient	\$249.55	\$235.51	7/1/2011

Rate Type :

<u>Interim</u>	x Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS :	
	Budget	
	X Unaudited Cost	
	Field Audited Cost	
	Revised Field Audit	
	Cost Report Late Test	

Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

Hospitals: Managed Care Contract Management Area Adm. 11 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Florida State Hospital	Provider Number:	0260011-00
Building 260	Date:	10/4/2011
Chattahoochee FL 32324	Fiscal Year End:	6/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$678.32	7/1/2011
Outpatient			7/1/2011

Rate Type :

Interim	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Northeast Florida State Hospital HWY 121 SOUTH Macclenny FL 32063

Provider Number:	0260029-00
Date:	10/4/2011
Fiscal Year End:	6/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$364.59	7/1/2011
Outpatient			7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

So. Fla. State HospProvider Number:0260045-00800 East Cypress DrDate:10/4/2011Pembroke Pines FL 33025Fiscal Year End:6/30/2010Audit Status:Amended Cost Report [2]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$551.61	7/1/2011
Outpatient			7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

W. Fla. Comm. Care	Provider Number:	0260053-00
5500 Stewart St.	Date:	10/4/2011
Milton FL 32570	Fiscal Year End:	6/30/2010
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$211.53	7/1/2011
Outpatient			7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

University of South Alabama Medical Center	Provider Number:	102814-00
1504 Springhill Ave Suite #3170	Date:	10/4/2011
Mobile AL 36604	Fiscal Year End:	3/31/2000
	Audit Status:	Unaudited Cost Report [1]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$739.79	7/1/2011
Outpatient		\$15.15	7/1/2011

Rate Type :

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS :
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Infirmary West	Provider Number:	102814-02
5600 Girby Road	Date:	10/4/2011
Mobile AL 36693	Fiscal Year End:	3/31/2000
	Audit Status:	Interim Budget [4]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$709.81	7/1/2011
Outpatient		\$15.15	7/1/2011

Rate Type :

<u>X</u> Interim	Prospective
Total Interim X Settlement Based on Cost	Total Prospective
	BASIS : X Budget Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

U.S.A Children's & Women's Hospital 1504 Springhill Ave #3170 Mobile AL 36604

Provider Number:	102814-01
Date:	10/4/2011
Fiscal Year End:	3/31/2000
Audit Status:	Interim Budget [4]

Provider Type :

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$702.94	7/1/2011
Outpatient		\$50.87	7/1/2011

Rate Type :

<u>X</u> Interim	Prospective
Total Interim X Settlement Based on Cost	Total Prospective
	BASIS : XBudgetUnaudited CostField Audited CostRevised Field AuditCost Report Late Test

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

For Information Only (No Change In Rate)

DISTRIBUTION:

Hospitals: Managed Care Contract Management Area Adm. Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation