

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:
 12/14/2010

 Fiscal Year End:
 5/31/2010

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$994.85	\$1,009.77	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS:
	Budget
$\frac{1}{\lambda}$	Unaudited Cost
	Field Audited Cost
,	Revised Field Audit
·	Cost Report Late Test
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	W. Rydell Samuel

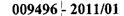
DISTRIBUTION:

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 Cost Reimbursement Analysis







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Medicaid Reimbursement Rate Change Form

UCHLTACH at Connerton 9441 Health Center Drive Land O' Lakes FL 34637

Provider Number:	0009496-00
Date:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Interim Budget [4]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$799.70	\$811.69	1/1/2011
Outpatient	<u>\$16.79</u>	\$17.05	1/1/2011

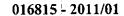
Rate Type:

x Interim	<u>Prospective</u>	ŀ
Total Interim X Settlement Based on Cost	Total Prospective	1
•	BASIS: X Budget Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test	
	W. Rydell Samuel	·
	Medicaid Cost Reimbursement Analysis	

DISTRIBUTION:

Hospitals:
Managed Care
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Medicaid Reimbursement Rate Change Form

Kindred Hospital Melbourne 765 W Nasa Blvd Melbourne FL 32901
 Provider Number:
 0016815-00

 Date:
 12/14/2010

 Fiscal Year End:
 7/31/2010

 Audit Status:
 Interim Budget [4]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,352.98	\$1,403.37	1/1/2011
Outpatient	\$16.16	\$17.05	1/1/2011

Rate Type:

X Interim	<u>Prospective</u>
Total Interim 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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DISTRIBUTION:

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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:
 12/14/2010

 Fiscal Year End:
 6/30/2011

 Audit Status:
 Interim Budget [4]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,063.96	\$941.77	1/1/2011
Outpatient	\$218.51	\$176.77	1/1/2011

Rate Type:

X Interim	<u>Prospective</u>	
Total Interim 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	

DISTRIBUTION:

Hospitals:
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Medicaid Reimbursement Rate Change Form

Shands Teaching Hospital Box J-100336 Gainesville Fl 32610
 Provider Number:
 0100030-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,335.59	\$2,386.97	1/1/2011
Outpatient	\$240.60	\$246.24	1/1/2011
Inpatient County Billing Rate	\$1,325.67	\$1,345.55	1/1/2011

Rate Type:

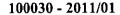
<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS:
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
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DISTRIBUTION:

Hospitals:
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Medicaid Reimbursement Rate Change Form

Shands Teaching Hospital Box J-100336 Gainesville Fl 32610

0100030-01 Provider Number: 12/14/2010 Date: Fiscal Year End: 6/30/2009 Unaudited Cost Report [1] Audit Status: Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$2,335.59	\$2,386.97	1/1/2011
Outpatient	\$240.60	\$246.24	1/1/2011
Inpatient County Billing Rate	\$1,325.67	\$1,345.55	1/1/2011

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 Cost Reimbursement Analysis

Managed Care Contract Management Area Adm. Children's Medical Services

DISTRIBUTION: Hospitals:

> Florida Hospital Association AHCA - County Billings

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Medicaid Reimbursement Rate Change Form

Shands Teaching Hospital Box J-100336 Gainesville Fl 32610 | Provider Number: 0100030-02 |
| Date: 12/14/2010 |
| Fiscal Year End: 6/30/2009 |
| Audit Status: Unaudited Cost Report [1] |
| Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,335.59	\$2,386.97	1/1/2011
Outpatient	\$240.60	\$246.24	1/1/2011
Inpatient County Billing Rate	\$1,325.67	\$1,345.55	1/1/2011

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

Ed Fraser Memorial Hospital 159 North Third Street MacClenney FL 32063
 Provider Number:
 0100048-00

 Date:
 12/14/2010

 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	\$4,792.25	\$14,567.96	1/1/2011
Outpatient	\$78.33	\$106.66	1/1/2011

Rate Type:

<u>Interim</u>		<u>X</u> <u>Prospective</u>
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
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Medicaid Reimbursement Rate Change Form

Bay Medical Center
P.O. Box 2515
Panama City FL 32402-2515

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,162.97	\$1,417.07	1/1/2011
Outpatient	\$110.19	\$131.16	1/1/2011
Inpatient County Billing Rate	\$804.00	\$816.06	1/1/2011

Rate Type:

<u>Interim</u>	X Frospective
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 Starke
Post Office Box 100336
Gainesville FL 32610-0336

 Provider Number:
 0100072-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,874.68	\$1,897.99	1/1/2011
Outpatient	\$109.68	\$112.25	1/1/2011

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

Holmes Regional Medical Center 3300 Fiske Boulevard Rockledge FL 32955
 Provider Number:
 0100081-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,762.72	\$1,825.56	1/1/2011
Outpatient	\$164.62	\$170.92	1/1/2011
Inpatient County Billing Rate	\$966.75	\$981.25	1/1/2011

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

Cape Canaveral Hospital 3300 Fiske Boulevard Rockledge FL 32955
 Provider Number:
 0100099-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$938.12	\$952.19	1/1/2011
Outpatient	\$110.57	\$114.28	1/1/2011

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 La	Cost Report Late Test
	
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Medicaid Cost Reimbursement Analysis



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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:
 12/20/2010

 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	\$1,455.32	\$1,771.80	1/1/2011
Outpatient	\$78.28	\$93.18	1/1/2011
Inpatient County Billing Rate	\$882.74	\$895.98	1/1/2011

Rate Type:

Total Interim	X Total Prospective
Settlement Based on Cost	· ·
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	BASIS:
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
•	Cost Report Late Test
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Hospitals:
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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:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$762.03	\$773.46	1/1/2011
Outpatient	\$81.97	\$84.72	1/1/2011

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 Cost Reimbursement Analysis

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DISTRIBUTION:

Hospitals:
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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 12/14/2010 Date: 9/30/2009 Fiscal Year End: Unaudited Cost Report [1] Audit Status:

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$762.03	\$773.46	1/1/2011
Outpatient	\$81.97	\$84.72	1/1/2011

Rate Type:

<u>X</u> <u>Prospective</u>
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

Hospitals: Managed Care Contract Management Area Adm.

DISTRIBUTION:

Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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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:
 0100111-02

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$762.03	\$773.46	1/1/2011
Outpatient	\$81.97	\$84.72	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
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Medicaid Reimbursement Rate Change Form

Broward General Hospital 1600 S. Andrews Avenue Ft. Lauderdale FL 33316
 Provider Number:
 0100129-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,504.13	\$1,557.52	1/1/2011
Outpatient	\$204.88	\$212.73	1/1/2011
Inpatient County Billing Rate	\$960.73	\$975.14	1/1/2011

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 Cost Reimbursement Analysis

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DISTRIBUTION:

Hospitals:
Managed Care
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Medicaid Reimbursement Rate Change Form

Broward General Hospital 1600 S. Andrews Avenue Ft. Lauderdale FL 33316
 Provider Number:
 0100129-01

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,504.13	\$1,557.52	1/1/2011
Outpatient	\$204.88	\$212.73	1/1/2011
Inpatient County Billing Rate	\$960.73	\$975.14	1/1/2011

Rate Type:

Intermi	A Hospective
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
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Medicaid Reimbursement Rate Change Form

Broward General Hospital 1600 S. Andrews Avenue Ft. Lauderdale FL 33316
 Provider Number:
 0100129-05

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,504.13	\$1,557.52	1/1/2011
Outpatient	\$204.88	\$212.73	1/1/2011
Inpatient County Billing Rate	\$960.73	\$975.14	1/1/2011

Rate Type:

<u>x</u> <u>Prospective</u>
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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DISTRIBUTION:

Hospitals:
Managed Care
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100188 - 2011/01



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Holy Cross Hospital, Inc. P.O. Box 23460 Ft. Lauderdale FL 33307

Provider Number:	0100188-00
Date:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$877.50	\$902.85	1/1/2011
Outpatient	\$90.56	\$93.60	1/1/2011

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
STRIBUTION:	W. Rydell Samuel Medicaid Cost Reimbursement Analysis

<u>DIŞTRIBUTION:</u>

Hospitals:
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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:	12/14/2010
Fiscal Year End:	8/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$772.64	\$784.23	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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

Memorial Hospital 3501 Johnson St. Hollywood FL 33021
 Provider Number:
 0100200-00

 Date:
 12/14/2010

 Fiscal Year End:
 4/30/2010

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,916.43	\$2,092.20	1/1/2011
Outpatient	\$172.01	\$258.34	1/1/2011
Inpatient County Billing Rate	\$932.33	\$983.89	1/1/2011

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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DISTRIBUTION:
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Managed Care

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Medicaid Reimbursement Rate Change Form

North Broward Medical Center 303 South East 17th St. Ft. Lauderdale FL 33316 Provider Number: 0100218-00

Date: 12/14/2010

Fiscal Year End: 6/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,395.49	\$1,445.63	1/1/2011
Outpatient	\$143.37	\$148.86	1/1/2011
Inpatient County Billing Rate	\$788.92	\$800.76	1/1/2011

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
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Medicaid Reimbursement Rate Change Form

North Broward Medical Center 303 South East 17th St. Ft. Lauderdale FL 33316 Provider Number: 0100218-02

Date: 12/14/2010

Fiscal Year End: 6/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,395.49	\$1,445.63	1/1/2011
Outpatient	\$143.37	\$148.86	1/1/2011
Inpatient County Billing Rate	\$788.92	\$800.76	1/1/2011

Rate Type:

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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

H

DISTRIBUTION:

Hospitals:
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Medicaid Reimbursement Rate Change Form

North Broward Medical Center 303 South East 17th St. Ft. Lauderdale FL 33316
 Provider Number:
 0100218-03

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,395.49	\$1,445.63	1/1/2011
Outpatient	\$143.37	\$148.86	1/1/2011
Inpatient County Billing Rate	\$788.92	\$800.76	1/1/2011

Rate Type:

<u>Interim</u>	<u> x</u>	_ <u>Pro</u>	<u>ospective</u>
Total Interim Settlement Based on Cost		<u>x</u>	Total Prospective
•	BASIS: Budget X Unaudited (Field Audit Revised Fiel Cost Report	ed Cost Id Aud	it

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Medicaid Cost Reimbursement Analysis

A)

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 10
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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:
 12/14/2010

 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	\$1,471.21	\$1,491.67	1/1/2011
Outpatient	\$45.53	\$46.60	1/1/2011

Rate Type:

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

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Medicaid Cost Reimbursement Analysis

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Contract Management
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Medicaid Reimbursement Rate Change Form

Charlotte Regional Medical Center 809 E. Marion Ave. Punta Gorda FL 33950-3898

Provider Number:	0100277-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$848.02	\$860.74	1/1/2011
Outpatient	\$67.06	\$69.31	1/1/2011

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 Cost Reimbursement Analysis

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DISTRIBUTION: Hospitals:

Managed Care
Contract Management
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Children's Medical Services
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Medicaid Reimbursement Rate Change Form

Charlotte Regional Medical Center 809 E. Marion Ave. Punta Gorda FL 33950-3898

Provider Number:	0100277-02
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$848.02	\$860.74	1/1/2011
Outpatient	\$67.06	\$69.31	1/1/2011

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

Peace River Regional Medical Center 2500 Harbor Blvd Port Charlotte FL 33952
 Provider Number:
 0100285-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$775.28	\$749.69	1/1/2011
Outpatient	\$67.83	\$70.10	1/1/2011

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

DISTRIBUTION: Hospitals:

Hospitals:
Managed Care
Contract Management
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Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Naples Community Hospital 350 7th Street North Naples FL 33941-3029
 Provider Number:
 0100315-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,469.81	\$1,524.50	1/1/2011
Outpatient	\$84.30	\$87.62	1/1/2011
Inpatient County Billing Rate	\$914.29	\$928.00	1/1/2011

Rate Type:

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
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Medicaid Cost Reimbursement Analysis



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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: 12/14/2010 |
| Fiscal Year End: 6/30/2009 |
| Audit Status: Unaudited Cost Report [1] |
| Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,364.95	\$1,393.81	1/1/2011_
Outpatient	\$98.68	\$101.00	1/1/2011

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

DISTRIBUTION:

Hospitals:
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Contract Management
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Children's Medical Services
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Medicaid Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

Baptist Of Miami 8900 North Kendall Dr. Miami FL 33176

Provider Number: 0100358-00 12/14/2010 Date: Fiscal Year End: 9/30/2009 Unaudited Cost Report [1] Audit Status:

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$2,223.02	\$2,304.73	1/1/2011
Outpatient	\$196.22	\$203.94	1/1/2011
Inpatient County Billing Rate	\$1,012.11	\$1,027.29	1/1/2011

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

Cedars Medical Center, Inc. 1400 NW 12th Avenue Miami FL 33136
 Provider Number:
 0100366-00

 Date:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,494.77	\$1,548.93	1/1/2011
Outpatient	\$162.10	\$168.48	1/1/2011
Inpatient County Billing Rate	\$790.84	\$802.70	1/1/2011

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

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Cedars Medical Center, Inc. 1400 NW 12th Avenue Miami FL 33136
 Provider Number:
 0100366-03

 Date:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,494.77	\$1,548.93	1/1/2011
Outpatient	\$162.10	\$168.48	1/1/2011
Inpatient County Billing Rate	\$790.84	\$802.70	1/1/2011

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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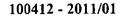
Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Hialeah Hospital 651 E. 25th Street Dept. 7202 Miami FL 33013-3878
 Provider Number:
 0100412-00

 Date:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,478.05	\$1,533.71	1/1/2011
Outpatient	\$99.64	\$103.56	1/1/2011
Inpatient County Billing Rate	\$696.01	\$706.45	1/1/2011

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 1611 N.W. 12th Avenue Miami FL 33136

Provider Number:	0100421-00
Date:	12/14/2010
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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

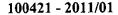
Rate Type:

<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 1611 N.W. 12th Avenue Miami FL 33136

0100421-01
12/14/2010
9/30/2009
Unaudited Cost Report [1]
Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

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
	W. Rydell Samuel Medicaid Cost Reimbursement Analysis

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital 1611 N.W. 12th Avenue Miami FL 33136

Provider Number:	0100421-02
Date:	12/14/2010
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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

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 1611 N.W. 12th Avenue Miami FL 33136
 Provider Number:
 0100421-07

 Date:
 12/14/2010

 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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

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

DISTRIBUTION:

Hospitals:
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Medicaid Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital 1611 N.W. 12th Avenue Miami FL 33136
 Provider Number:
 0100421-17

 Date:
 12/14/2010

 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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

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

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital 1611 N.W. 12th Avenue Miami FL 33136

Provider Number:	0100421-18
Date:	12/14/2010
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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

Rate Type:

<u>Interim</u>	<u>X</u> Prospective		
Total Interim Settlement Based on Cost		X	Total Prospective
	BASIS: Budget X Unaudited C Field Audite Revised Fiel	d Cost	•
ı	Cost Report	Late T	est

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Medicaid Cost Reimbursement Analysis

DISTRIBUTION: Hospitals:

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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital 1611 N.W. 12th Avenue Miami FL 33136

Provider Number:	0100421-19
Date:	12/14/2010
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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

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
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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital 1611 N.W. 12th Avenue Miami FL 33136

Provider Number:	0100421-27
Date:	12/14/2010
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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

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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DISTRIBUTION:

Hospitals:
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Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital 1611 N.W. 12th Avenue Miami FL 33136

Provider Number:	0100421-34
Date:	12/14/2010
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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

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

DISTRIBUTION:

Hospitals:
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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

Jackson Memorial Hospital 1611 N.W. 12th Avenue Miami FL 33136

Provider Number:	0100421-35
Date:	12/14/2010
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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

Rate Type:

<u>Interim</u>		<u>x</u> <u>Prospective</u>
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

DISTRIBUTION:

Hospitals:
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Contract Management
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Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

Jackson Memorial Hospital 1611 N.W. 12th Avenue Miami FL 33136
 Provider Number:
 0100421-36

 Date:
 12/14/2010

 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	\$2,557.68	\$2,614.19	1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011
Inpatient County Billing Rate	\$1,226.44	\$1,244.84	1/1/2011

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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Managed Care
Contract Management
Area Adm. 11
Children's Medical Services
Florida Hospital Association
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<u>DISTRIBUTION:</u> Hospitals:

For Information Only

(No Change In Rate)

100439 - 2011/01



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

Mercy Hospital, Inc. 3663 S Miami Ave. Miami FL 33133 Provider Number: 0100439-00

Date: 12/14/2010

Fiscal Year End: 12/31/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$901.62	\$923.39	1/1/2011
Outpatient	\$132.43	\$136.87	1/1/2011

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

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Mercy Hospital, Inc. 3663 S Miami Ave. Miami FL 33133
 Provider Number:
 0100439-03

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$901.62	\$923.39	1/1/2011
Outpatient	\$132.43	\$136.87	1/1/2011

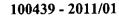
Rate Type:

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
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	W. Rydell Samuel
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Medicaid Reimbursement Rate Change Form

Mercy Hospital, Inc. 3663 S Miami Ave. Miami FL 33133

0100439-04 Provider Number: 12/14/2010 Date: 12/31/2009 Fiscal Year End: Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$901.62	\$923.39	1/1/2011
Outpatient	\$132.43	\$136.87	1/1/2011

Rate Type:

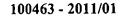
<u>Interim</u>	x <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
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Medicaid Cost Reimbursement Analysis







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

Medicaid Reimbursement Rate Change Form

Mt. Sinai Medical Center 4300 Alton Rd Miami Beach FL 33140
 Provider Number:
 0100463-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,719.32	\$1,803.75	1/1/2011
Outpatient	\$158.03	\$172.53	1/1/2011
Inpatient County Billing Rate	\$1,025.63	\$1,047.60	1/1/2011

Rate Type:

<u>x</u> <u>Prospective</u>
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

Mt. Sinai Medical Center 4300 Alton Rd Miami Beach FL 33140

Provider Number:	0100463-22
Date:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,719.32	\$1,803.75	1/1/2011
Outpatient	\$158.03	\$172.53	1/1/2011
Inpatient County Billing Rate	\$1,025.63	\$1,047.60	1/1/2011

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

University Of Miami Hospital and Clinics P.O. Box 016217 Miami FL 33101
 Provider Number:
 0100471-00

 Date:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,742.70	\$2,812.29	1/1/2011
Outpatient	\$400.44	\$416.20	1/1/2011
Inpatient County Billing Rate	\$2,178.45	\$2,211.12	1/1/2011

Rate Type:

<u>Interim</u>	<u>X</u> <u>Prospective</u>	
Total Interim Settlement Based on Cost	X_ Total Prospective	
	BASIS:	
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Medicaid Reimbursement Rate Change Form

Northshore Medical Center 1100 N.W. 95th Street Miami FL 33150-2098

Provider Number:	0100498-00
Date:	12/14/2010
Fiscal Year End:	5/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,284.91	\$1,333.19	1/1/2011
Outpatient	\$90.23	\$93.78	1/1/2011
Inpatient County Billing Rate	\$702.66	\$713.19	1/1/2011

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

Northshore Medical Center 1100 N.W. 95th Street Miami FL 33150-2098
 Provider Number:
 0100498-07

 Date:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,284.91	\$1,333.19	1/1/2011
Outpatient	\$90.23	\$93.78	1/1/2011
Inpatient County Billing Rate	\$702.66	\$713.19	1/1/2011

Rate Type:

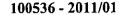
<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
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	Cost Report Late Test
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Medicaid Cost Reimbursement Analysis





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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:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$650.35	\$652.06	1/1/2011
Outpatient	\$38.45	\$39.74	1/1/2011

Rate Type:

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS:
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	Field Audited Cost
	Revised Field Audit
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Medicaid Reimbursement Rate Change Form

Metropolitan Hospital Miami 5959 NW 7th Street Miami FL 33126
 Provider Number:
 0100544-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$832.80	\$836.97	1/1/2011
Outpatient	\$98.08	\$101.37	1/1/2011

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 Miami Hospital 6200 S.W. 73rd Street Miami FL 33143

Provider Number:	0100587-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,042.96	\$1,058.60	1/1/2011
Outpatient	\$106.90	\$110.49	1/1/2011

Rate Type:

X Total Prospective

ASIS:
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Unaudited Cost
Field Audited Cost
Revised Field Audit
Cost Report Late Test

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Medicaid Reimbursement Rate Change Form

Miami Childrens Hospital 3100 S.W. 62nd Avenue Miami FL 33155-3009

Provider Number:	0100609-00
Date:	12/14/2010
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	\$2,633.82	\$2,713.08	1/1/2011
Outpatient	\$155.24	\$159.70	1/1/2011
Inpatient County Billing Rate	\$1,678.33	\$1,700.73	1/1/2011

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

Westchester General Hospital 2500 SW 75th Avenue Miami FL 33155

Provider Number:	0100625-00
Date:	12/14/2010
Fiscal Year End:	12/31/2008
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$852.66	\$884.28	1/1/2011
Outpatient	\$110.36	\$114.70	1/1/2011
Inpatient County Billing Rate	\$499.36	\$398.80	1/1/2011

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
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Medicaid Reimbursement Rate Change Form

Baptist Medical Center 800 Prudential Drive Jacksonville FL 32207

Provider Number:	0100641-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,308.63	\$1,356.32	1/1/2011
Outpatient	\$99.10	\$102.99	1/1/2011
Inpatient County Billing Rate	.\$819.99	\$832.29	1/1/2011

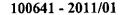
Rate Type:

<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 Medical Center 800 Prudential Drive Jacksonville FL 32207

Provider Number:	0100641-02
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,308.63	\$1,356.32	1/1/2011
Outpatient	\$99.10	\$102.99	1/1/2011
Inpatient County Billing Rate	\$819.99	\$832.29	1/1/2011

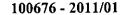
Rate Type:

<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

Shands Jacksonville 580 West 8th Street Jacksonville FL 32209
 Provider Number:
 0100676-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,704.21	\$1,740.84	1/1/2011
Outpatient	\$248.77	\$254.60	1/1/2011
Inpatient County Billing Rate	\$1,078.33	\$1,094.51	1/1/2011

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

Shands Jacksonville 580 West 8th Street Jacksonville FL 32209
 Provider Number:
 0100676-01

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,704.21	\$1,740.84	1/1/2011
Outpatient	\$248.77	\$254.60	1/1/2011
Inpatient County Billing Rate	\$1,078.33	\$1,094.51	1/1/2011

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

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Medicaid Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

Mayo Clinic 4500 San Pablo Road Jacksonville FL 32216
 Provider Number:
 0100722-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$2,706.43	\$2,852.33	1/1/2011
Outpatient	\$128.51	\$146.71	1/1/2011
Inpatient County Billing Rate	\$1,241.53	\$1,271.93	1/1/2011

Rate Type:

<u>Interim</u>	<u>x</u> <u>Prospective</u>	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS:	
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	W. Rydell Samuel	
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Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

St. Vincent's Hospital 1800 Barrs Street 3rd Floor, Seton Hall Jacksonville FL 32204
 Provider Number:
 0100731-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,229.05	\$1,273.76	1/1/2011
Outpatient	\$85.24	\$88.60	1/1/2011
Inpatient County Billing Rate	\$822.50	\$834.84	1/1/2011

Rate Type:

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		<u>x</u>	Total Prospective
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W. Rydell Samuel

Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Baptist Hospital (Pensacola)
P.O. Box 17500
Pensacola FL 32522-7500

 Provider Number:
 0100749-00

 Date:
 12/20/2010

 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	\$1,297.18	\$1,555.02-	1/1/2011
Outpatient	\$91.64	\$107.65	1/1/2011
Inpatient County Billing Rate	\$700.03	\$710.53	1/1/2011

Rate Type:

Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS:	
	Budget	
	X Unaudited Cost	
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	Revised Field Audit	
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Medicaid Reimbursement Rate Change Form

Baptist Hospital (Pensacola)
P.O. Box 17500
Pensacola FL 32522-7500

 Provider Number:
 0100749-01

 Date:
 12/20/2010

 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	\$1,297.18	\$1,555.02	1/1/2011
Outpatient	\$91.64	\$107.65	1/1/2011
Inpatient County Billing Rate	\$700.03	\$710.53	1/1/2011

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
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Medicaid Reimbursement Rate Change Form

Baptist Hospital (Pensacola) P.O. Box 17500 Pensacola FL 32522-7500 | Provider Number: 0100749-02 |
| Date: 12/20/2010 |
| 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	\$1,297.18	\$1,555.02	1/1/2011
Outpatient	\$91.64	\$107.65	1/1/2011
Inpatient County Billing Rate	\$700.03	\$710.53	1/1/2011

Rate Type:

Total Interim	X Total Prospective
Settlement Based on Cost	·
	BASIS:
	Budget
	X Unaudited Cost
	Field Audited Cost
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Baptist Hospital (Pensacola) P.O. Box 17500 Pensacola FL 32522-7500

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,297.18	\$1,555.02	1/1/2011
Outpatient	\$91.64	\$107.65	1/1/2011
Inpatient County Billing	Rate \$700.03	\$710.53	1/1/2011

Rate Type:

<u>Interim</u>	<u>x 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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DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Sacred Heart Hospital Post Office Box 2728 Pensacola FL 32513-2728
 Provider Number:
 0100765-00

 Date:
 12/20/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,347.51	\$1,616.514	1/1/2011
Outpatient	\$137.26	\$161.24	1/1/2011
Inpatient County Billing Rate	\$831.94	\$844.42	1/1/2011

Rate Type:

Interim	<u>X</u> <u>Frospective</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:

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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:
 12/14/2010

 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	\$2,839.88	\$2,882.88	1/1/2011
Outpatient	\$87.12	\$89.16	1/1/2011

Rate Type:

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

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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: 12/14/2010

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	\$1,829.60	\$1,866.62	1/1/2011
Outpatient	\$60.61	\$62.03	1/1/2011

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
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Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Brooksville Regional Hospital Post Office Box 37 Brooksville FL 34605-0037
 Provider Number:
 0100871-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,131.17	\$1,172.41	1/1/2011
Outpatient	\$73.02	\$75.89	1/1/2011
Inpatient County Billing Rate	\$779.36	\$791.05	1/1/2011

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

Brooksville Regional Hospital Post Office Box 37 Brooksville FL 34605-0037
 Provider Number:
 0100871-01

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,131.17	\$1,172.41	1/1/2011
Outpatient	\$73.02	\$75.89	1/1/2011
Inpatient County Billing Rate	\$779.36	\$791.05	1/1/2011

Rate Type:

<u>Interim</u>		<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost		X Total Prospective
	BA	ASIS:
		Budget
-	Х	Unaudited Cost
_		Field Audited Cost
_		Revised Field Audit
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DISTRIBUTION:

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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:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$670.63	\$680.69	1/1/2011
Outpatient	\$74.77	\$77.28	1/1/2011

Rate Type:

<u>Interim</u>	x Prospective	
Total Interim Settlement Based on Cost	X Total Prospective	ļ
	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

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

0100901-00 Provider Number: 12/14/2010 Date: 12/31/2009 Fiscal Year End: Unaudited Cost Report [1] Audit Status:

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$810.06	\$807.73	1/1/2011
Outpatient	\$99.54	\$97.87	1/1/2011

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 Cost Reimbursement Analysis

Managed Care Contract Management Area Adm. 6 Children's Medical Services Florida Hospital Association

DISTRIBUTION: Hospitals:

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Medicaid Reimbursement Rate Change Form

University Community Hospital Carrollwood
3100 East Fletcher Avenue
Tampa FL 33613

 Provider Number:
 0100943-00

 Date:
 12/21/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL		<u>C</u>	urrent Rate	New Rate	Effective Date
	Inpatient		\$910.67	\$1,087.51	1/1/2011
•	Outpatient		\$86.41	\$102.28	1/1/2011

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

St. Joseph's Hospital		
3001 W. ML King Blvd. Post Office	Box	4227
Tampa FL 33677-4227	•	

| Date: 0100978-00 | | Date: 12/20/2010 | | Fiscal Year End: 12/31/2009 | Unaudited Cost Report [1] | Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,475.01	\$1,767.31	1/1/2011
Outpatient	\$122.98	\$144.47	1/1/2011
Inpatient County Billing Rate	\$936.84	\$950.89	1/1/2011

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
	Cost Report Late Test
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Medicaid Reimbursement Rate Change Form

St. Joseph's Hospital	
3001 W. ML King Blvd. Post Office	Box 4227
Tampa FL 33677-4227	

| Provider Number: 0100978-02 |
| Date: 12/20/2010 |
| 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	\$1,475.01	\$1,767.31	1/1/2011
Outpatient	\$122.98	\$144.47	1/1/2011
Inpatient County Billing Rate	\$936.84	\$950.89	1/1/2011

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:

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Medicaid Reimbursement Rate Change Form

St. Joseph's Hospital
3001 W. ML King Blvd. Post Office Box 4227
Tampa FL 33677-4227

| Date: 0100978-03 | | Date: 12/20/2010 | | 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	\$1,475.01	\$1,767.31	1/1/2011
Outpatient	\$122.98	\$144.47	1/1/2011
Inpatient County Billing Rate	\$936.84	\$950.89	1/1/2011

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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DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

St. Joseph's Hospital 3001 W. ML King Blvd. Post Office Box 4227 Tampa FL 33677-4227

Provider Number:	0100978-06
Date:	12/20/2010
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	\$1,475.01	\$1,767.31	1/1/2011
Outpatient	\$122.98	\$144.47	1/1/2011
Inpatient County Billing Rate	\$936.84	\$950.89	1/1/2011

Rate Type:

	<u> </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

South Florida Baptist 301 N Alexander Street Plant City FL 33566
 Provider Number:
 0100986-00

 Date:
 12/21/2010

 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	\$1,634.88	\$1,994.32	1/1/2011
Outpatient	\$78.21	\$93.10	1/1/2011
Inpatient County Billing Rate	\$821.53	\$833.85	1/1/2011

Rate Type:

_ interim		<u>X</u> Frospective
Total Interim		X Total Prospective
Settlement Based on Cost		
	В	ASIS:
		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 P.O. Box 1289 Tampa FL 33601

Provider Number: 0100994-00 12/20/2010 Date: Fiscal Year End: 9/30/2009 Unaudited Cost Report [1] Audit Status:

Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,855.47	\$2,225.864	1/1/2011
Outpatient	\$189.71	\$222.854	1/1/2011
Inpatient County Billing Rate	\$1,030.54	\$1,046.00	1/1/2011

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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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

Tampa General Hospital
P.O. Box 1289
Tampa FL 33601

 Provider Number:
 0100994-01

 Date:
 12/20/2010

 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	\$1,855.47	\$2,225.86	1/1/2011
Outpatient	\$189.71	\$222.85	1/1/2011
Inpatient County Billing Rate	\$1,030.54	\$1,046.00	1/1/2011

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:

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Medicaid Reimbursement Rate Change Form

Tampa General Hospital P.O. Box 1289 Tampa FL 33601 | Provider Number: 0100994-12 |
| Date: 12/20/2010 |
| 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	\$1,855.47	\$2,225.86	1/1/2011
Outpatient	\$189.71	\$222.85	1/1/2011
Inpatient County Billing Rate	\$1,030.54	\$1,046.00	1/1/2011

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
	7-
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Medicaid Reimbursement Rate Change Form

Tampa General Hospital
P.O. Box 1289
Tampa FL 33601

| Provider Number: 0100994-13 |
| Date: 12/20/2010 |
| 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	\$1,855.47	\$2,225.86	1/1/2011
Outpatient	\$189.71	\$222.85	1/1/2011
Inpatient County Billing Rate	\$1,030.54	\$1,046.00	1/1/2011

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

Tampa General Hospital P.O. Box 1289 Tampa FL 33601 | Provider Number: 0100994-14 |
| Date: 12/20/2010 |
| 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	\$1,855.47	\$2,225.86	1/1/2011
Outpatient	\$189.71	\$222.85	1/1/2011
Inpatient County Billing Rate	\$1,030.54	\$1,046.00	1/1/2011

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

University Community Hospital-Tampa
3100 East Fletcher Avenue
Tampa FL 33613

| Provider Number: 0101028-00 |
| Date: 12/21/2010 |
| Fiscal Year End: 9/30/2009 |
| Audit Status: Unaudited Cost Report [1] |
| Rate Includes Buy Back

Provider Type:

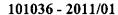
<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,133.32	\$1,030.56	1/1/2011
Outpatient	\$83.04	\$91.954	1/1/2011

Rate Type:

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

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Doctors Memorial Hospital P.O. Box 188 Bonifay FL 32425
 Provider Number:
 0101036-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

<u>HOSPI</u>	<u>TAL</u>	Current Rate	New Rate	Effective Date
-	Inpatient	\$1,367.72	\$1,380.26	1/1/2011
	Outpatient	\$207.14	\$211.99	1/1/2011

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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DISTRIBUTION:

Hospitals:
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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: 12/14/2010 |
| Fiscal Year End: 9/30/2009 |
| Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$868.37	\$881.39	1/1/2011
Outpatient	\$100.38	\$103.74	1/1/2011

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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DISTRIBUTION: Hospitals:

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Medicaid Reimbursement Rate Change Form

Jackson Hospital 4250 Hospital Drive Marianna FL 32446
 Provider Number:
 0101061-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2008

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,228.21	\$2,264.04	1/1/2011
Outpatient	\$121.27	\$124.11	1/1/2011

Rate Type:

<u>X</u> <u>Prospective</u>
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: Hospitals: Managed Care

For Information Only

(No Change In Rate)





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Medicaid Reimbursement Rate Change Form

Leesburg Regional Medical Center 600 E Dixie Ave Leesburg FL 32748
 Provider Number:
 0101079-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$840.56	\$853.16	1/1/2011
Outpatient	\$92.64	\$95.75	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 3
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Medicaid Reimbursement Rate Change Form

South Lake Memorial Hospital 847 8th Street Clermont FL 32711

Provider Number:	0101087-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$966.87	\$981.37	1/1/2011
Outpatient	\$104.25	\$107.74	1/1/2011

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 Cost Reimbursement Analysis

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 3
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

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Medicaid Reimbursement Rate Change Form

Florida Hospital Waterman P.O. Box 333 Eustis FL 32727-0333

Provider Number:	0101095-00
Date:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$860.43	\$803.29	1/1/2011
Outpatient	\$82.49	\$85.26	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 3
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

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Medicaid Cost Reimbursement Analysis



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

Medicaid Reimbursement Rate Change Form

Lee Memorial Hospital PO Box 151247 Cape Coral FL 33915
 Provider Number:
 0101109-00

 Date:
 12/20/2010

 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	\$1,350.96	\$1,620.174	1/1/2011
Outpatient	\$126.01	\$148.02	1/1/2011
Inpatient County Billing Rate	\$903.26	\$916.81	1/1/2011

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
	· PA
	W. Rydell Samuel
	Medicaid Cost Reimbursement Analysis

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

Lee Memorial Hospital
PO Box 151247
Cape Coral FL 33915

 Provider Number:
 0101109-11

 Date:
 12/20/2010

 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	\$1,350.96	\$1,620.17	1/1/2011
Outpatient	\$126.01	\$148.02	1/1/2011
Inpatient County Billing Rate	\$903.26	\$916.81	1/1/2011

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	Cost Report Late Test
	
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	Medicaid Cost Reimbursement Analysis

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

Lee Memorial Hospital PO Box 151247 Cape Coral FL 33915
 Provider Number:
 0101109-17

 Date:
 12/20/2010

 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	\$1,350.96	\$1,620.17	1/1/2011
Outpatient	\$126.01	\$148.02	1/1/2011
Inpatient County Billing Rate	\$903.26	\$916.81	1/1/2011

Rate Type:

<u>x</u> <u>Frospective</u>
X Total Prospective
BASIS: Budget X

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 8
Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

Lee Memorial Hospital PO Box 151247 Cape Coral FL 33915

Provider Type:

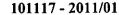
HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,350.96	\$1,620.17	1/1/2011
Outpatient	\$126.01	\$148.02	1/1/2011
Inpatient County Billing Rate	\$903.26	\$916.81	1/1/2011

Rate Type:

Total Interim Settlement Based on Cost	<u>X</u> To	otal 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
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Vocational Rehabilitation





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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:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$926.07	\$918.22	1/1/2011
Outpatient	\$53.88	\$55.69	1/1/2011

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

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

Tallahassee Memorial Regional M.C. 1300 Miccousukee Tallahassee FL 32308
 Provider Number:
 0101133-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,433.08	\$1,485.72	1/1/2011
Outpatient	\$117.00	\$121.47	1/1/2011
Inpatient County Billing Rate	\$774.83	\$786.45	1/1/2011

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

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

Tri-County Hospital Williston P.O. Drawer 460 Williston FL 32696 | Provider Number: 0101141-00 |
| Date: 12/14/2010 |
| 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	\$838.82	\$889.76	1/1/2011
Outpatient	\$41.47	\$52.87	1/1/2011

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 Cost Reimbursement Analysis

DISTRIBUTION: Hospitals:

Managed Care
Contract Management
Area Adm. 3
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation





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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:
 12/14/2010

 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	\$1,048.47	\$1,062.48	1/1/2011
Outpatient	\$43.70	\$44.73	1/1/2011

Rate Type:

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

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

Manatee Memorial Hospital 206 Second Street East Bradenton FL 34208
 Provider Number:
 0101168-00

 Date:
 12/20/2010

 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	\$1,266.20	\$1,660.204	1/1/2011
Outpatient	\$87.50	\$111.64	1/1/2011
Inpatient County Billing Rate	\$764.92	\$776.75	1/1/2011

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
	P
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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 6
Children's Medical Services
Florida Hospital Association
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Vocational Rehabilitation



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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: 12/20/2010 |
| 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	\$1,872.32	\$2,283.36	1/1/2011
Outpatient	\$92.11	\$109.65	1/1/2011
Inpatient County Billing Rate	\$906.69	\$920.29	1/1/2011

Rate Type:

_ 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. 3
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

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

Provider Number:	0101184-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$930.92	\$944.88	1/1/2011
Outpatient	\$105.46	\$108.99	1/1/2011

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 Cost Reimbursement Analysis

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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 9
Children's Medical Services
Florida Hospital Association
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101192 - 2011/01



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

Lower Florida Keys Hospital P.O. Box 9107 Key West FL 33401 Provider Number: 0101192-00

Date: 12/14/2010

Fiscal Year End: 9/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,357.65	\$1,407.23	1/1/2011
Outpatient	\$84.75	\$88.08	1/1/2011
Inpatient County Billing Rate	\$688.38	\$698.70	1/1/2011

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

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 Cost Reimbursement Analysis





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Medicaid Reimbursement Rate Change Form

Lower Florida Keys Hospital P.O. Box 9107 Key West FL 33401
 Provider Number:
 0101192-01

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,357.65	\$1,407.23	1/1/2011
Outpatient	\$84.75	\$88.08	1/1/2011
Inpatient County Billing Rate	\$688.38	\$698.70	1/1/2011

Rate Type:

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

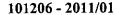
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Medicaid Cost Reimbursement Analysis

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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 11
Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

Fishermen's Hospital 3301 Overseas Highway Marathon FL 33050

Provider Number:	0101206-00
Date:	12/14/2010
Fiscal Year End:	2/18/2010
Audit Status:	Unaudited Cost Report [1]
_	Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$3,494.20	\$2,920.22	1/1/2011_
Outpatient	\$116.79	\$112.01	1/1/2011

Rate Type:

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

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Medicaid Cost Reimbursement Analysis

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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101214 - 2011/01



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Mariners Hospital 91500 Overseas Highway Tavernier FL 33070
 Provider Number:
 0101214-00

 Date:
 12/14/2010

 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	\$3,766.32	\$3,833.63	1/1/2011
Outpatient	\$311.21	\$318.50	1/1/2011

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 Cost Reimbursement Analysis

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DISTRIBUTION:

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





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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:
 12/14/2010

 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	\$2,742.03	\$2,798.32	1/1/2011
Outpatient	\$82.03	\$83.96	1/1/2011

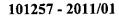
Rate Type:

<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

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

Twin Cities Hospital 2190 Hwy 85 North Niceville FL 32578

Provider Number:	0101257-00
Date:	12/14/2010
Fiscal Year End:	5/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$982.91	\$997.66	1/1/2011
Outpatient	\$72.35	\$74.77	1/1/2011

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		

DISTRIBUTION:

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

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Medicaid Cost Reimbursement Analysis





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Medicaid Reimbursement Rate Change Form

North Okaloosa Medical Center 151 Redstone Ave. Crestview FL 32536

Provider Number: 0101265-00 12/14/2010 Date: Fiscal Year End: 3/31/2010 Unaudited Cost Report [1] Audit Status:

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$842.08	\$884.65	1/1/2011
Outpatient	\$92.64	\$95.13	1/1/2011

Rate Type:

<u>X</u> <u>Prospective</u>
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

Hospitals: Managed Care Contract Management Area Adm.

DISTRIBUTION:

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

Florida Hospital 500 East Rollins Street Orlando FL 32803
 Provider Number:
 0101290-00

 Date:
 12/20/2010

 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	\$1,552.74	\$2,017.454	1/1/2011
Outpatient	\$115.21	\$140.80	1/1/2011
Inpatient County Billing Rate	\$903.66	\$899.08	1/1/2011

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	
	P	
	W. Rydell Samuel	
	Medicaid Cost Reimbursement Analysis	

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 7
Children's Medical Services
Florida Hospital Association
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Office of Medicaid Cost Reimbursement Planning and Analysis 2727 Mahan Drive Mail Stop 21 Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form

Florida Hospital 500 East Rollins Street Orlando FL 32803
 Provider Number:
 0101290-01

 Date:
 12/20/2010

 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	\$1,552.74	\$2,017.45	1/1/2011
Outpatient	\$115.21	\$140.80	1/1/2011
Inpatient County Billing Rate	\$903.66	\$899.08	1/1/2011

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
-	12-
	W. Rydell Samuel
	Medicaid Cost Reimbursement Analysis

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 7
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation



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

Medicaid Reimbursement Rate Change Form

Florida Hospital 500 East Rollins Street Orlando FL 32803

Provider Number: 0101290-02 12/20/2010 Date: Fiscal Year End: 12/31/2009 Unaudited Cost Report [1

Audit Status:

Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,552.74	\$2,017.45	1/1/2011
Outpatient	\$115.21	\$140.80	1/1/2011
Inpatient County Billing Rate	\$903.66	\$899.08	1/1/2011

Rate Type:

Interim	<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
	W. Rydell Samuel
•	Medicaid Cost Reimbursement Analysis

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

Florida Hospital 500 East Rollins Street Orlando FL 32803
 Provider Number:
 0101290-03

 Date:
 12/20/2010

 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	\$1,552.74	\$2,017.45	1/1/2011
Outpatient	\$115.21	\$140.80	1/1/2011
Inpatient County Billing Rate	\$903.66	\$899.08	1/1/2011

Rate Type:

<u>x</u> <u>Prospective</u>
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 500 East Rollins Street Orlando FL 32803
 Provider Number:
 0101290-04

 Date:
 12/20/2010

 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	\$1,552.74	\$2,017.45	1/1/2011
Outpatient	\$115.21	\$140.80	1/1/2011
Inpatient County Billing Rate	\$903.66	\$899.08	1/1/2011

Rate Type:

	X Total Prospective
Total Interim Settlement Based on Cost	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 500 East Rollins Street Orlando FL 32803

Provider Number: 0101290-06 12/20/2010 Date: 12/31/2009 Fiscal Year End: Unaudited Cost Report [1] Audit Status:

Rate Includes Buy Back

Provider Type:

<u>HOSPI</u>	TAL.	Current Rate	New Rate	Effective Date
	Inpatient	\$1,552.74	\$2,017.45	1/1/2011
	Outpatient	\$115.21	\$140.80	1/1/2011
Inpa	atient County Billing Rate	\$903.66	\$899.08	1/1/2011

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

Orlando Health
1414 S. Kuhl Avenue
Orlando FL 32806

| Provider Number: 0101338-00 |
| Date: 12/20/2010 |
| 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	\$1,745.09	\$2,019.494	1/1/2011
Outpatient	\$134.88	\$153.92	1/1/2011
Inpatient County Billing Rate	\$1,080.47	\$1,096.68	1/1/2011

Rate Type:

	<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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For Information Only
(No Change In Rate)

Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Health Central 10000 West Colonial Dr. Ocoee FL 34761 Provider Number: 0101354-00

Date: 12/14/2010

Fiscal Year End: 9/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,288.36	\$1,335.24	1/1/2011
Outpatient	\$103.62	\$107.69	1/1/2011
Inpatient County Billing Rate	\$889.38	\$902.72	1/1/2011

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

Osceola Regional Medical Center 700 West Oak St. Kissimmee FL 32742-2589

Provider Number:	0101389-00
Date:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,333.01	\$1,454.63	1/1/2011_
Outpatient	\$108.17	\$105.32	1/1/2011
Inpatient County Billing Rate	\$821.03	\$835.33	1/1/2011

Rate Type:

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
·	BAS	<u> IS :</u>
	E	Budget
	$\overline{\mathbf{x}}$	Jnaudited Cost
	F	ield Audited Cost
		Revised Field Audit
		Cost Report Late Test
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Medicaid Cost Reimbursement Analysis

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Rate Includes Buy Back



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Medicaid Reimbursement Rate Change Form

Bethesda Mem. Hosp.
2815 S Seacrest Blvd.
Boynton Beach FL 33435

Provider Number: 0101401-00

Date: 12/20/2010

Fiscal Year End: 9/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,265.45	\$1,543.594	1/1/2011
Outpatient	\$96.68	\$115.09	1/1/2011
Inpatient County Billing Rate	\$917.91	\$931.67	1/1/2011

Rate Type:

BASIS: Budget Unaudited Cost	Budget
X Unaudited Cost	Y Unaudited Cost Field Audited Cost
	Field Audited Cost
Field Audited Cost	Revised Field Audit
Revised Field Audit	
Cost Report Late Test	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:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$880.99	\$894.20	1/1/2011
Outpatient	\$87.52	\$90.46	1/1/2011

Rate Type:

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

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Medicaid Reimbursement Rate Change Form

Glades General Hospital P.O. BOX 8002 Belle Glade FL 33430
 Provider Number:
 0101443-00

 Date:
 12/20/2010

 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	\$1,927.00	\$1,974.05	1/1/2011
Outpatient	\$81.46	\$83.37	1/1/2011

Rate Type:

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 5301 S. Congress Ave. Lake Worth FL 33462-1149
 Provider Number:
 0101460-00

 Date:
 12/20/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,351.99	\$1,649.04	1/1/2011
Outpatient	\$127.90	\$152.25	1/1/2011
Inpatient County Billing Rate	\$742.93	\$754.08	1/1/2011

Rate Type:

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
Sectionient Bused on Cost	BASIS:
	X Budget 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 1300 N. Flagler Drive West Palm Beach FL 33401
 Provider Number:
 0101486-00

 Date:
 12/20/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,267.81	\$1,452.36	1/1/2011
Outpatient	\$104.51	\$119.26	1/1/2011
Inpatient County Billing Rate	\$919.17	\$932.96	1/1/2011

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	Cost Report Late Test
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Medicaid Reimbursement Rate Change Form

St. Mary's Hospital
1300 N. Flagler Drive
West Palm Beach FL 3340

 Provider Number:
 0101486-01

 Date:
 12/20/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,267.81	\$1,452.36	1/1/2011
Outpatient	\$104.51	\$119.26	1/1/2011
Inpatient County Billing Rate	\$919.17	\$932.96	1/1/2011

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

Florida Hospital Zephyrhills 7050 Gall Blvd Zephyrhills FL 33541
 Provider Number:
 0101494-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPIT</u>	CAL	Current Rate	New Rate	Effective Date
$\overline{}$	Inpatient	\$825.79	\$832.55	1/1/2011
	Outpatient	\$73.95	\$76.42	1/1/2011

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

North Bay Medical Center 6600 Madison St. New Port Richey FL 34562

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$828.38	\$991.75	1/1/2011
Outpatient	\$84.10	\$99.55	1/1/2011

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

All Children's Hospital 801 6th St. South St. Petersburg FL 33701
 Provider Number:
 0101516-00

 Date:
 12/14/2010

 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	\$2,385.82	\$2,483.32	1/1/2011
Outpatient	\$200.12	\$218.73	1/1/2011
Inpatient County Billing Rate	\$1,528.61	\$1,752.60	1/1/2011

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

Good Samaritan Hospital 1300 N. Flagler Drive West Palm Beach FL 33401 | Provider Number: 0101524-00 |
| Date: 12/20/2010 |
| Fiscal Year End: 5/31/2009 |
| Audit Status: Unaudited Cost Report [1] |
| Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$880.79	\$1,051.834	1/1/2011
Outpatient	\$96.46	\$114.19	1/1/2011

Rate Type:

_ Total Interim	X Total Prospective
Settlement Based on Cost	
•	BASIS:
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
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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:
 12/21/2010

 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	\$860.07	\$1,080.81	1/1/2011
Outpatient	\$91.99	\$107.00	1/1/2011

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 701 6th St. South St. Petersburg FL 33701

Provider Number: 0101567-00 12/20/2010 Date: Fiscal Year End: 12/31/2009 Unaudited Cost Report [1] Audit Status:

Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,365.74	\$1,688.284	1/1/2011
Outpatient	\$71.18	\$86.25 \$	1/1/2011
Inpatient County Billing Rate	\$868.10	\$891.22	1/1/2011

Rate Type:

<u>Interim</u>	<u>A Hospective</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 701 6th St. South St. Petersburg FL 33701
 Provider Number:
 0101567-07

 Date:
 12/20/2010

 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	\$1,365.74	\$1,688.28	1/1/2011
Outpatient	\$71.18	\$86.25	1/1/2011
Inpatient County Billing Rate	\$868.10	\$891.22	1/1/2011

Rate Type:

<u>Interim</u>		x <u>Prospective</u>
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

Morton F. Plant Hospital PO Box 210 Mailstation 102 Clearwater FL 33517
 Provider Number:
 0101583-00

 Date:
 12/21/2010

 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	\$1,821.89	\$2,220.06	1/1/2011
Outpatient	\$143.75	\$171.12	1/1/2011
Inpatient County Billing Rate	\$657.46	\$667.32	1/1/2011

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

Helen Ellis Memorial Hospital
1395 South Pinellas Ave.
Tarpon Springs FL 34689-1487

 Provider Number:
 0101613-00

 Date:
 12/20/2010

 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	\$884.44	\$1,056.18%	1/1/2011
Outpatient	\$100.27	\$118.70 \$	1/1/2011

Rate Type:

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

Lakeland Regional Medical Center P.O.Box 95448 Lakeland FL 33804 | Provider Number: 0101648-00 |
| Date: 12/14/2010 |
| 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	\$1,580.95	\$1,614.99	1/1/2011
Outpatient	\$125.24	\$128.18	1/1/2011
Inpatient County Billing Rate	\$791.14	\$803.01	1/1/2011

Rate Type:

<u> </u>	<u>A</u> Hospective
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

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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:	12/14/2010
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	\$1,394.07	\$1,492.83	1/1/2011
Outpatient	\$71.44	\$72.71	1/1/2011

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

Winter Haven Hospital 200 Avenue "F" Northeast Winter Haven FL 33880
 Provider Number:
 0101699-00

 Date:
 12/14/2010

 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	\$1,730.37	\$1,768.09	1/1/2011
Outpatient	\$116.39	\$119.12	1/1/2011
Inpatient County Billing Rate	\$637.18	\$646.74	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 6
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

R

Medicaid Cost Reimbursement Analysis



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

Medicaid Reimbursement Rate Change Form

West Gables Rehabilitation 2525 Southwest 75th Av. Miami FL 33155
 Provider Number:
 0101702-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$424.24	\$427.49	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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

DISTRIBUTION:

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

FU





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

Medicaid Reimbursement Rate Change Form

Flagler Hospital 400 Health Park Blvd. St. Augustine FL 32086

Provider Number:	0101711-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$856.10	\$868.94	1/1/2011
Outpatient	\$53.61	\$55.40	1/1/2011

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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DISTRIBUTION:

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





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

Medicaid Reimbursement Rate Change Form

Jay Hospital 221 South Alabama Street Jay FL 32565
 Provider Number:
 0101737-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Amended Cost Report [2]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$994.06	\$1,014.74	1/1/2011_
Outpatient	\$51.43	\$52.64	1/1/2011

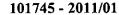
Rate Type:

<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. l
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

A





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

Medicaid Reimbursement Rate Change Form

Santa Rosa Hospital P.O. BOX 648 Milton FL 32570
 Provider Number:
 0101745-00

 Date:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$845.73	\$858.42	1/1/2011
Outpatient	\$74.46	\$76.96	1/1/2011

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

DISTRIBUTION:

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

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

Medicaid Reimbursement Rate Change Form

HealthSouth Rehabilitation Hospital-Largo 901 Clearwater Largo Rd. Largo FL 34640
 Provider Number:
 0101753-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$480.54	\$483.10	1/1/2011
Outpatient	\$46.71	\$48.28	1/1/2011

Rate Type:

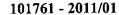
<u>Interim</u>	x Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS: Budget Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

W. Rydell Samuel

Medicaid Cost Reimbursement Analysis

DISTRIBUTION:

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





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

Medicaid Reimbursement Rate Change Form

Memorial Hospital 1901 Arlington St. Sarasota FL 33579
 Provider Number:
 0101761-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2008

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,446.55	\$1,499.98	1/1/2011
Outpatient	\$195.41	\$203.10	1/1/2011
Inpatient County Billing Rate	\$736.39	\$747.43	1/1/2011

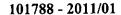
Rate Type:

<u>Interim</u>		<u>Prospective</u>
Total Interim Settlement Based on Cost	•	X Total Prospective
	BASIS :	
	Budget	
	X Unaudited	l Cost
	Field Aud	ited Cost
	Revised F	ield Audit
	Cost Repo	ort Late Test
		W. Rydell Samuel
		Medicaid Cost Reimbursement Analysis

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

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

Provider Number:	0101788-00
Date:	12/14/2010
Fiscal Year End:	5/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$868.58	\$881.61	1/1/2011
Outpatient	\$88.10	\$91.05	1/1/2011

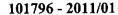
Rate Type:

<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. 7
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

A





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

Medicaid Reimbursement Rate Change Form

Shands at Live Oak Post Office Box 100336 Gainesville FL 32610-0336
 Provider Number:
 0101796-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,696.06	\$1,726.67	1/1/2011
Outpatient	\$90.56	\$92.69	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 3
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

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Medicaid Cost Reimbursement Analysis



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

Medicaid Reimbursement Rate Change Form

Doctor's Memorial Hospital 407 East Ash Street Perry FL 32347
 Provider Number:
 0101800-00

 Date:
 12/14/2010

 Fiscal Year End:
 5/31/2008

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,420.86	\$1,437.82	1/1/2011
Outpatient		\$83.73	1/1/2011

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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DISTRIBUTION:
Hospitals:
Managed Care

Contract Management
Area Adm. 2
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation



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

Medicaid Reimbursement Rate Change Form

Florida Hospital - Fish Memorial 1055 Sax Boulevard Orange City FL 32763
 Provider Number:
 0101826-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,043.49	\$1,014.03	1/1/2011
Outpatient	\$84.23	\$87.06	1/1/2011

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	

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:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Amended Cost Report [2]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$970.39	\$984.94	1/1/2011
Outpatient	\$80.18	\$82.87	1/1/2011

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

DISTRIBUTION:

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



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

Medicaid Reimbursement Rate Change Form

Halifax Medical Center P.O. Box 2830 Daytona Beach FL 32115-2830
 Provider Number:
 0101842-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,417.37	\$1,469.64	1/1/2011
Outpatient	\$193.38	\$200.79	
Inpatient County Billing Rate	\$761.83	\$773.25	1/1/2011

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

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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101842 - 2011/01



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

Halifax Medical Center P.O. Box 2830 Daytona Beach FL 32115-2830

Provider Number:	0101842-03
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,417.37	\$1,469.64	1/1/2011
Outpatient	\$193.38	\$200.79	1/1/2011
Inpatient County Billing Rate	\$761.83	\$773.25	1/1/2011

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. Rydeil 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





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

Medicaid Reimbursement Rate Change Form

Ormond Beach Memorial Hospital 875 Sterthaus Avenue Ormond Beach FL 32174
 Provider Number:
 0101869-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Amended Cost Report [2]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,016.81	\$1,032.06	1/1/2011
Outpatient	\$87.18	\$90.11	1/1/2011

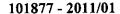
Rate Type:

<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. 4
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

A





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

Medicaid Reimbursement Rate Change Form

Memorial Hospital - West Volusia 701 West Plymouth Avenue Deland FL 32720
 Provider Number:
 0101877-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$907.01	\$934.03	1/1/2011
Outpatient	\$70.19	\$72.55	1/1/2011

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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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

101877 - 2011/01



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

Memorial Hospital - West Volusia 701 West Plymouth Avenue Deland FL 32720
 Provider Number:
 0101877-01

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$907.01	\$934.03	1/1/2011
Outpatient	\$70.19	\$72.55	1/1/2011

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. 4
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

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

Medicaid Reimbursement Rate Change Form

Healthmark Regional Medical Center PO Box 1326 Defuniak Springs FL 32433

0101885-00 Provider Number: 12/14/2010 Date: 9/30/2009 Fiscal Year End: Unaudited Cost Report [1] Audit Status: Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,219.99	\$1,233.26	1/1/2011
Outpatient	\$56.23	\$57.55	1/1/2011

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

W. Rydell Samuel Medicaid Cost Reimbursement Analysis

DISTRIBUTION:

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

For Information Only

Revised Field Audit Cost Report Late Test





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

Medicaid Reimbursement Rate Change Form

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

Provider Number:	0101893-00
Date:	12/14/2010
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	\$1,536.44	\$1,619.70	1/1/2011
Outpatient	\$69.08	\$75.02	1/1/2011

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

DISTRIBUTION:

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



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

Medicaid Reimbursement Rate Change Form

Northwest Community Hospital Post Office Box 889 Chipley FL 32428
 Provider Number:
 0101907-00

 Date:
 12/14/2010

 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	\$1,616.42	\$1,631.02	1/1/2011
Outpatient	\$130.34	\$133.40	1/1/2011

Rate Type:

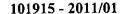
X Total Prospective
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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 2
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

A

Medicaid Cost Reimbursement Analysis





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

Medicaid Reimbursement Rate Change Form

Kindred Hospital-Hollywood 1859 Van Buren St. Hollywood FL 33022
 Provider Number:
 0101915-00

 Date:
 12/14/2010

 Fiscal Year End:
 8/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$656.22	\$666.06	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

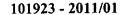
Rate Type:

<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. 10
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

M





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

Medicaid Reimbursement Rate Change Form

Desoto Memorial Hospital PO Box 2180 Arcadia FL 33821
 Provider Number:
 0101923-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2008

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,984.53	\$2,016.62	1/1/2011
Outpatient	\$129.98	\$133.02	1/1/2011

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

DISTRIBUTION:

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

For Information Only

(No Change In Rate)



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

Medicaid Reimbursement Rate Change Form

Memorial Hospital of Jacksonville PO Box16325 Jacksonville FL 32216

Provider Number:	0101931-00
Date:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$813.75	\$841.95	1/1/2011
Outpatient	\$73.22	\$75.67	1/1/2011

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. 4
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
Vocational Rehabilitation

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

Medicaid Reimbursement Rate Change Form

Memorial Hospital of Jacksonville PO Box16325 Jacksonville FL 32216
 Provider Number:
 0101931-01

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$813.75	\$841.95	1/1/2011
Outpatient	\$73.22	\$75.67	1/1/2011

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 Cost Reimbursement Analysis

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DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Campbellton-Graceville Hospital 5429 College Dr. Graceville FL 32240
 Provider Number:
 0101940-00

 Date:
 12/14/2010

 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	\$2,129.38	\$2,493.05	1/1/2011
Outpatient	\$130.57	\$103.53	1/1/2011

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

Wiregrass Hospital 1200 Maple Av. Geneva AL 36340 Provider Number: 0101991-00

Date: 12/14/2010

Fiscal Year End: 9/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$440.48	\$447.08	1/1/2011
Outpatient	\$88.25	\$91.22	1/1/2011

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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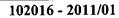
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Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Florala Memorial Hospital PO BOX 206 Florala AL 36442

Provider Number:	0102016-00
Date:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$333.23	\$338.23	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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

D.W.Mcmillan Memorial PO BOX 908 Brewton AL 36427

0102024-00
12/14/2010
9/30/2004
Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$557.86	\$566.23	1/1/2011
Outpatient	\$147.40	\$152.34	1/1/2011

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 Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Archbold Memorial Hospital Post Office Box 1018 Thomasville GA 31799-1018

0102041-00 Provider Number: 12/14/2010 Date: 9/30/2003 Fiscal Year End: Unaudited Cost Report [1] Audit Status:

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$802.20	\$814.24	1/1/2011
Outpatient	\$88.23	\$91.19	1/1/2011

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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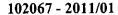
Medicaid Cost Reimbursement Analysis

Managed Care Contract Management Area Adm. Children's Medical Services

DISTRIBUTION: Hospitals:

> Florida Hospital Association AHCA - County Billings

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Medicaid Reimbursement Rate Change Form

Southeast Alabama General PO BOX 6987 Dothan AL 36301

Provider Number:	0102067-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$769.31	\$780.85	1/1/2011
Outpatient	\$118.59	\$122.56	1/1/2011

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 PO BOX 1727 Valdosta GA 31601

Provider Number:	0102075-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$663.80	\$699.42	1/1/2011
Outpatient	\$104.22	\$86.47	1/1/2011

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

Flowers Hospital PO BOX 6907 Dothan AL 36302
 Provider Number:
 0102091-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$578.09	\$586.76	1/1/2011
Outpatient	\$117.72	\$121.67	1/1/2011

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

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

 Provider Number:
 0102105-00

 Date:
 12/20/2010

 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	\$902.96	\$1,099.76\$	1/1/2011
Outpatient	\$81.49	\$96.46%	1/1/2011

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

Grady General Hospital 1155 5th St. Cairo GA 31728 Provider Number: 0102121-00

Date: 12/14/2010

Fiscal Year End: 9/30/1999

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$502.80	\$510.34	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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

Wellington Regional Medical Center 10101 Forest Hill Blvd.. West Palm Beach FL 33414

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,059.31	\$1,290.18	1/1/2011
Outpatient	\$102.73	\$124.28	1/1/2011
Inpatient County Billing Rate	\$896.29	\$900.56	1/1/2011

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

Mizell Memorial Hospital PO BOX 429 Opp AL 36467
 Provider Number:
 0102164-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/1992

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$537.35	\$545.41	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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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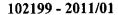
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DISTRIBUTION:

Hospitals:
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Medicaid Cost Reimbursement Analysis





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Medicaid Reimbursement Rate Change Form

Citrus Memorial Hospital 502 Highland Blvd. Iverness FL 32652
 Provider Number:
 0102199-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,069.45	\$922.41	1/1/2011
Outpatient	\$73.14	\$68.96	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 3
Children's Medical Services
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Medicaid Reimbursement Rate Change Form

Cleveland Clinic Hospital 2835 North Ocean Blvd. Ft. Lauderdale FL 33308

Provider Number: 0102202-00 12/14/2010 Date: Fiscal Year End: 12/31/2009 Unaudited Cost Report [1] Audit Status:

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$888.18	\$927.70	1/1/2011
Outpatient	\$70.71	\$61.19	1/1/2011

Rate Type:

DISTRIBUTION: Hospitals: Managed Care Contract Management

Area Adm.

10 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation

<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 Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

Pembroke Pines Hospital 2301 University Dr. Pembroke Pines FL 33024
 Provider Number:
 0102229-00

 Date:
 12/14/2010

 Fiscal Year End:
 4/30/2010

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,031.67	\$2,307.28	1/1/2011
Outpatient	\$95.76	\$126.92	1/1/2011
Inpatient County Billing Rate	\$956.31	\$988.45	1/1/2011

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

DISTRIBUTION:
Hospitals:

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Area Adm. 10
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Medicaid Reimbursement Rate Change Form

Homestead Hospital 160 N.W. 13th Street Homestead FL 33030
 Provider Number:
 0102261-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$2,518.46	\$2,608.86	1/1/2011
Outpatient	\$178.33	\$185.36	1/1/2011
Inpatient County Billing Rate	\$1,128.60	\$1,145.53	1/1/2011

Rate Type:

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
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Medicaid Reimbursement Rate Change Form

Heart Of Florida Hospital P.O. Box 67 Haines City FL 33845

Provider Number: 0102288-00 Date: 12/14/2010 6/30/2009 Fiscal Year End: Amended Cost Report [2] Audit Status: Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,883.11	\$1,923.98	1/1/2011
Outpatient	\$83.39	\$85.34	1/1/2011
Inpatient County Billing Rate	\$660.90	\$670.82	1/1/2011

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 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

Kindred Hospital Central Tampa 4801 N HOWARD AVE. Tampa FL 33604

Provider Number:	0102300-00
Date:	12/14/2010
Fiscal Year End:	8/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$816.43	\$828.68	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

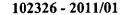
<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS:
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
•	
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Hospitals:
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Medicaid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





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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:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$847.82	\$860.53	1/1/2011
Outpatient	\$66.05	\$68.27	1/1/2011

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
OTDIDI MION.	W. Rydell Samuel Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Atmore Community Hospital
401 Medical Park Dr.
Atmore AL 36502

Provider Number:	0102334-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$608.59	\$617.72	1/1/2011
Outpatient	\$53.01	\$54.79	1/1/2011

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

Kindred Hospital (Tampa) 4555 SOUTH MANHATTAN AVE. Tampa FL 33611
 Provider Number:
 0102342-00

 Date:
 12/14/2010

 Fiscal Year End:
 8/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$677.84	\$688.01	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

<u>Interim</u>		<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost		X Total Prospective
	<u>B</u> .	ASIS:
		Budget
_	X	Unaudited Cost
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· ·		Revised Field Audit
-		Cost Report Late Test
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Hospitals:
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Medicaid Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

Smith Hospital P.O. Box 10010 Valdosta GA 31604
 Provider Number:
 0102369-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/1994

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$355.72	\$361.05	1/1/2011
Outpatient	\$102.20	\$105.63	1/1/2011

Rate Type:

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

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DISTRIBUTION:

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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:	12/14/2010	
Fiscal Year End:	9/30/2009	•
Audit Status:	Unaudited Cost Report [1]	

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$663.13	\$673.08	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

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

South Baldwin Hospital 1613 West McKenzie St. Foley AL 36536

Provider Number:	0102474-00
Date:	12/14/2010
Fiscal Year End:	9/30/1995
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$622.59	\$631.93	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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 Cost Reimbursement Analysis

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Memorial Hosp. - West 703 North Flamingo Road Pembroke Pines FL 33028 Provider Number: 0102521-00

Date: 12/14/2010

Fiscal Year End: 4/30/2010

Audit Status: Unaudited Cost Report [1]

Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,722.43	\$1,926.45	1/1/2011
Outpatient	\$112.51	\$153.14	1/1/2011
Inpatient County Billing Rate	\$960.09	\$1,010.42	1/1/2011

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
TO IDITION.	W. Rydell Samuel Medicaid Cost Reimbursement Analysis

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Englewood Community Hospital 700 Medical Blvd. Englewood FL 34223
 Provider Number:
 0102539-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$874.83	\$875.34	1/1/2011
Outpatient	\$48.42	\$50.05	1/1/2011

Rate Type:

<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Co	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 Georgia Medical Center 3100 Kemble Avenue Brunswick GA 31520 | Date: 0102555-00 | Date: 12/14/2010 | Fiscal Year End: 9/30/2008 | Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$742.71	\$753.85	1/1/2011
Outpatient	\$97.20	\$100.46	1/1/2011

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

Edward White Hospital	
2323 9th Avenue North P.O. Box 1	2018
St. Petersburg Fl 33733	

Provider Number: 0102598-00

Date: 12/20/2010

Fiscal Year End: 12/31/2009

Audit Status: Unaudited Cost Report [1]

Rate Includes Buy Back

Provider Type:

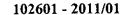
HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$897.08	\$1,063.864	1/1/2011
Outpatient	\$94.62	\$111.06 \$	1/1/2011

Rate Type:

Total Interim Settlement Based on Cost	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

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

Provider Number:	0102601-00
Date:	12/14/2010
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	\$4,220.41	\$6,114.15	1/1/2011
Outpatient	\$98.98	\$110.29	1/1/2011

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

A.G. Holley State Hospital 1199 Lantana Rd. P.O. Box 3084 Lantana FL 33465
 Provider Number:
 0102610-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$785.90	\$815.96	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011
Inpatient County Billing Rate	\$492.70	\$500.09	1/1/2011

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

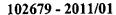
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Medicaid Reimbursement Rate Change Form

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

Provider Number:	0102679-00
Date:	12/14/2010
Fiscal Year End:	8/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$664.31	\$674.27	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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

HealthSouth Rehab - Dothan 1736 East Main Street Dothan AL 36301 Provider Number: 0102687-00

Date: 12/14/2010

Fiscal Year End: 12/31/1999

Audit Status: Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$539.92	\$548.01	1/1/2011
Outpatient	\$67.16	\$69.40	1/1/2011

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

HealthSouth Rehabililation Hospital - Miami 20601 Old Cutler Road Miami FL 33188
 Provider Number:
 0102709-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$434.25	\$432.97	1/1/2011
Outpatient	\$45.31	\$46.83	1/1/2011

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

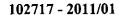
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Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Brooks Rehabilitation Hospital 3599 University Blvd., S Jacksonville FL 32216
 Provider Number:
 0102717-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$661.40	\$686.57	1/1/2011
Outpatient	\$57.60	\$59.54	1/1/2011

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

Healthsouth Emerald Coast Hospital 1847 Florida Avenue Panama City FL 32405
 Provider Number:
 0102750-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSP</u>	<u>ITAL</u>	Current Rate	New Rate	Effective Date
	Inpatient	\$455.27	\$458.82	1/1/2011
	Outpatient	\$45.05	\$46.56	1/1/2011

Rate Type:

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

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DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Kindred Hospital-St. Petersburg 3030 6th Street, South St. Petersburg FL 33705

Provider Number:	0102768-00
Date:	12/14/2010
Fiscal Year End:	8/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$669.81	\$679.86	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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

Douglas Gardens Hospital 5200 NE 2nd Avenue Miami FL 33137

Provider Number:	0102776-00
Date:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,156.32	\$1,173.66	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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

Physicians Regional Medical Center 6101 Pine Ridge Road Naples FL 34119
 Provider Number:
 0103144-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,061.48	\$1,083.42	1/1/2011_
Outpatient	\$109.77	\$102.12	1/1/2011

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

The Villages Regional Hospital 1451 El Camino Real The Villages FL 32159
 Provider Number:
 0103179-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,286.97	\$1,306.27	1/1/2011
Outpatient	\$93.70	\$96.84	1/1/2011

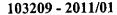
Rate Type:

<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

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

Provider Number:	0103209-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$995.73	\$1,010.66	1/1/2011
Outpatient	\$123.58	\$127.73	1/1/2011

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

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

Provider Number:	0103233-00
Date:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]
_	Rate Includes Buy Back

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$3,090.28	\$3,137.45	1/1/2011
Outpatient	\$129.81	\$132.85	1/1/2011

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

DISTRIBUTION:

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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:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$753.01	\$697.53	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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 Cost Reimbursement Analysis

DISTRIBUTION: Hospitals:

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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:	12/14/2010
Fiscal Year End:	8/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$902.29	\$915.82	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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

Select Specialty Hospital - Orlando 601 E Rollins Street Orlando FL 32803

Provider Number:	0103390-00	
Date:	12/14/2010	
Fiscal Year End:	5/10/2004	
Audit Status:	Interim Budget [4]	

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,189.21	\$1,207.05	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

<u>X</u> <u>Interim</u>	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 Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

Charlton Memorial Hospital Post Office Box 188 Folkston GA 31537

Provider Number:	0103411-00
Date:	12/14/2010
Fiscal Year End:	6/30/2003
Audit Status:	Interim Budget [4]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,013.22	\$1,028.42	1/1/2011
Outpatient	\$52.76	\$53.58	1/1/2011

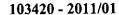
Rate Type:

X Interim	<u>Prospective</u>
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

Lakewood Ranch Medical Center 8330 Lakewood Ranch Boulevard Bradenton FL 34202
 Provider Number:
 0103420-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,116.09	\$1,054.94	1/1/2011
Outpatient	\$97.74	\$101.01	1/1/2011

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

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Medicaid Cost Reimbursement Analysis

DISTRIBUTION: Hospitals:

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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:	12/14/2010
Fiscal Year End:	12/31/2005
Audit Status:	Interim Budget [4]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$756.35	\$767.69	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

<u>x</u> <u>Interim</u>	<u>Prospective</u>	
Total Interim 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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Contract Management
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Medicaid Reimbursement Rate Change Form

Memorial Hospital Miramar 1901 SW 172nd Avenue Miramar FL 33029
 Provider Number:
 0103454-00

 Date:
 12/14/2010

 Fiscal Year End:
 4/30/2010

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,097.70	\$2,175.03	1/1/2011
Outpatient	\$103.01	\$129.16	1/1/2011
Inpatient County Billing Rate	\$1,205.73	\$1,174.11	1/1/2011

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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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 10
Children's Medical Services
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Medicaid Cost Reimbursement Analysis



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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:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$992.23	\$942.43	1/1/2011
Outpatient	\$63.51	\$65.35	1/1/2011

Rate Type:

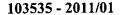
<u>Interim</u>	<u>X</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS: Budget X Unaudited Cost Field Audited Cost Revised Field Audit Cost Report Late Test

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Medicaid Cost Reimbursement Analysis

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 7
Children's Medical Services
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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:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$818.23	\$830.50	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

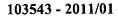
Rate Type:

<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 Cost Reimbursement Analysis

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 3
Children's Medical Services
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Medicaid Reimbursement Rate Change Form

Doctors Hospital 5000 University Drive Coral Gables FL 33146
 Provider Number:
 0103543-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,066.90	\$1,082.90	1/1/2011
Outpatient	\$170.23	\$175,94	1/1/2011

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	
	- 	

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 11
Children's Medical Services
Florida Hospital Association
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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:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$544.76	\$543.35	1/1/2011
Outpatient	\$138.03	\$142.66	1/1/2011

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

DISTRIBUTION:

Hospitals:
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Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Healthsouth Ridgelake Hospital 6150 Edgelake Drive Sarasota FL 34240

Provider Number:	0103560-00
Date:	12/14/2010
Fiscal Year End:	3/31/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$841.42	\$872.49	1/1/2011
Outpatient	\$141.67	\$17.05	1/1/2011

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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Hospitals:
Managed Care
Contract Management
Area Adm. 8
Children's Medical Services
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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:
 12/14/2010

 Fiscal Year End:
 12/31/2008

 Audit Status:
 Interim Budget [4]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,496.35	\$1,518.79	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

X 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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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. l
Children's Medical Services
Florida Hospital Association
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Medicaid Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

BayCare Alliant Hospital 601 Main Street, MS 469 Dunedin FL 34698
 Provider Number:
 0103721-00

 Date:
 12/21/2010

 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	\$933.98	\$1,115.35	1/1/2011
Outpatient	\$16.79	\$19.534	1/1/2011

Rate Type:

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 5
Children's Medical Services
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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:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
. Inpatient	\$958.90	\$973.28	1/1/2011
Outpatient	\$140.72	\$145.45	1/1/2011

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
	W. Rydell Samuel
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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 4
Children's Medical Services
Florida Hospital Association
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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:
 12/14/2010

 Fiscal Year End:
 2/28/2010

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,243.05	\$1,171.00	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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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Hospitals:
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Contract Management
Area Adm. 2
Children's Medical Services
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Medicaid Reimbursement Rate Change Form

Select Specialty Hospital Palm Beach

 Provider Number:
 0103764-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2008

 Audit Status:
 Interim Budget [4]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$824.24	\$836.60	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

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

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Hospitals:
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Contract Management
Area Adm. 9
Children's Medical Services
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Medicaid Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

Select Speciality Hospital Gainesville 2708 SW Archer Road Gainesville FL 32608

Provider Number:	0103772-00
Date:	12/14/2010
Fiscal Year End:	12/31/2008
Audit Status:	Interim Budget [4]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$732.83	\$743.83	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

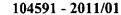
Rate Type:

<u>x</u> <u>Interim</u>	<u>Prospective</u>
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
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DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Northwest Medical Center 5801 North State Road 7 Margate FL 33063
 Provider Number:
 0104591-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$835.69	\$854.52	1/1/2011
Outpatient	\$60.13	\$62.15	1/1/2011

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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104591 - 2011/01



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Medicaid Reimbursement Rate Change Form

Northwest Medical Center 5801 North State Road 7 Margate FL 33063
 Provider Number:
 0104591-01

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$835.69	\$854.52	1/1/2011
Outpatient	\$60.13	\$62.15	1/1/2011

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

DISTRIBUTION:

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Area Adm. 10
Children's Medical Services
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Medicaid Reimbursement Rate Change Form

Palmetto General Hospital 2001 West 68th St. Hialeah FL 33016
 Provider Number:
 0104604-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,490.89	\$1,272.48	1/1/2011
Outpatient	\$102.47	\$96.66	1/1/2011
Inpatient County Billing Rate	\$720.52	\$734.41	1/1/2011

Rate Type:

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

Medicaid Cost Reimbursement Analysis

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DISTRIBUTION:
Hospitals:

Managed Care
Contract Management
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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:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,271.05	\$1,318.45	1/1/2011
Outpatient	\$39.52	\$40.84	1/1/2011

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

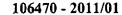
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Medicaid Cost Reimbursement Analysis

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DISTRIBUTION: Hospitals:

Managed Care
Contract Management
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Medicaid Reimbursement Rate Change Form

Specialty Hospital Jacksonville 4901 Richard Street Jacksonville FL 32207

Provider Number:	0106470-00
Date:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$703.17	\$715.31	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

Rate Type:

<u>X</u> <u>Prospective</u>
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. 4
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108219 - 2011/01



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Imperial Point Hospital 1608 S.E. 3rd Avenue Ft. Lauderdale FL 33316
 Provider Number:
 0108219-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,119.74	\$1,159.64	1/1/2011
Outpatient	\$121.75	\$126.54	1/1/2011
Inpatient County Billing Rate	\$716.52	\$727.27	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 10
Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

Imperial Point Hospital 1608 S.E. 3rd Avenue Ft. Lauderdale FL 33316

Provider Number:	0108219-01
Date:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,119.74	\$1,159.64	1/1/2011
Outpatient	\$121.75	\$126.54	1/1/2011
Inpatient County Billing Rate	\$716.52	\$727.27	1/1/2011

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
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DISTRIBUTION:

Hospitals:
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Contract Management
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Medicaid Reimbursement Rate Change Form

Imperial Point Hospital 1608 S.E. 3rd Avenue Ft. Lauderdale FL 33316 Provider Number: 0108219-02

Date: 12/14/2010

Fiscal Year End: 6/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,119.74	\$1,159.64	1/1/2011
Outpatient	\$121.75	\$126.54	1/1/2011
Inpatient County Billing Rate	\$716.52	\$727.27	1/1/2011

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
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DISTRIBUTION:

Hospitals:
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Contract Management
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Medicaid Reimbursement Rate Change Form

Imperial Point Hospital 1608 S.E. 3rd Avenue Ft. Lauderdale FL 33316

Provider Number:	0108219-05
Date:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,119.74	\$1,159.64	1/1/2011
Outpatient	\$121.75	\$126.54	1/1/2011
Inpatient County Billing Rate	\$716.52	\$727.27	1/1/2011

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

DISTRIBUTION:

Hospitals:
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Contract Management
Area Adm. 10
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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:
 12/14/2010

 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	\$2,937.12	\$3,133.85	1/1/2011
Outpatient	\$65.17	\$72.66	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 3
Children's Medical Services
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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: 12/14/2010

Fiscal Year End: 2/28/2010

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$753.45	\$758.89	1/1/2011
Outpatient	\$97.74	\$101.01	1/1/2011

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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Hospitals: Managed Care Contract Management

DISTRIBUTION:

Area Adm. 3 Children's Medical Services

Florida Hospital Association AHCA - County Billings

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Medicaid Reimbursement Rate Change Form

Pasco Community Hospital 13100 Fort King Road Dade City FL 33525

Provider Number:	0109592-00
Date:	12/14/2010
Fiscal Year End:	9/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$744.47	\$755.64	1/1/2011
Outpatient	\$74.85	\$77.36	1/1/2011

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
TRIBUTION	

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 5
Children's Medical Services
Florida Hospital Association
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Office of Medicaid Cost Reimbursement Planning and Analysis 2727 Mahan Drive Mail Stop 21 Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form

Coral Gables Hospital P.O. BOX 610 Coral Gables FL 33134
 Provider Number:
 0109606-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,285.71	\$1,464.09	1/1/2011
Outpatient	\$121.44	\$148.89	1/1/2011
Inpatient County Billing Rate	\$755.59	\$782.38	1/1/2011

Rate Type:

	X Prospective
	X Total Prospective
<u>B</u>	ASIS:
	Budget
<u> X</u>	Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
	W. Rydell Samuel

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
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Children's Medical Services
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Medicaid Cost Reimbursement Analysis

109886 - 2011/01



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Ocala Regional Medical Center 1431 SW 1st Avenue Post Office Box 2200 Ocala FL 32678
 Provider Number:
 0109886-00

 Date:
 12/14/2010

 Fiscal Year End:
 8/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$723.20	\$734.04	1/1/2011
Outpatient	\$83.18	\$85.97	1/1/2011

Rate Type:

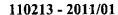
<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS:
	Budget
	X Unaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
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DISTRIBUTION:

Hospitals:
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Medicaid Cost Reimbursement Analysis





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Medicaid Reimbursement Rate Change Form

Blake Memorial Hospital 2020 59th St. West Bradenton FL 33505

Provider Number:	0110213-00
Date:	12/14/2010
Fiscal Year End:	4/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$743.91	\$765.43	1/1/2011
Outpatient	\$65.72	\$67.92	1/1/2011

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
STRIBUTION:	W. Rydell Samuel Medicaid Cost Reimbursement Analysis

Hospitals: Managed Care Contract Management Area Adm. 6 Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation







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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:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$675.83	\$685.96	1/1/2011
Outpatient	\$41.86	\$43.26	1/1/2011

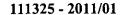
Rate Type:

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

Hospitals:
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Medicaid Reimbursement Rate Change Form

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

0111325-01 Provider Number: 12/14/2010 Date: 5/31/2009 Fiscal Year End: Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$675.83	\$685.96	1/1/2011
Outpatient	\$41.86	\$43.26	1/1/2011

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
	<u> </u>

W. Rydell Samuel

Medicaid Cost Reimbursement Analysis

Hospitals: Managed Care

DISTRIBUTION:

Contract Management Area Adm. Children's Medical Services

Florida Hospital Association AHCA - County Billings

Vocational Rehabilitation

Rate Includes Buy Back



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

Gulf Coast Medical Center
PO Box 151247
Cane Coral FL 33915

 Provider Number:
 0111341-00

 Date:
 12/20/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,694.20	\$2,065.014	1/1/2011
Outpatient	\$129.68	\$154.37	1/1/2011
Inpatient County Billing Rate	\$960.54	\$974.95	1/1/2011

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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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
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Medicaid Reimbursement Rate Change Form

Orange Park Medical Center 2001 Kingsley Avenue Orange Park FL 32073

Provider Number:	0111741-00
Date:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$783.28	\$795.03	1/1/2011
Outpatient	\$75.88	\$78.42	1/1/2011

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
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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:
 12/14/2010

 Fiscal Year End:
 1/31/2010

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$886.05	\$890.66	1/1/2011
Outpatient	\$50.78	\$52.48	1/1/2011

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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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 10
Children's Medical Services
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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: 12/14/2010

Fiscal Year End: 11/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$728.20	\$739.13	1/1/2011
Outpatient	\$122.39	\$126.50	1/1/2011

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
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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
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Children's Medical Services
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Medicaid Reimbursement Rate Change Form

University Hospital 7201 University Drive Tamarac FL 33321

Provider Number:	0112801-00
Date:	12/14/2010
Fiscal Year End:	4/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$504.64	\$503.65	1/1/2011
Outpatient	\$60.37	\$62.39	1/1/2011

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
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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
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Medicaid Reimbursement Rate Change Form

West Florida Hospital 8383 North Davis Hwy. Pensacola FL 32514
 Provider Number:
 0113212-00

 Date:
 12/14/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$701.99	\$712.11	1/1/2011
Outpatient	\$62.03	\$64.05	1/1/2011

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

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 1
Children's Medical Services
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Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

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

Provider Number:	0113514-00
Date:	12/14/2010
Fiscal Year End:	2/28/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$690.83	\$658.07	1/1/2011
Outpatient	\$60.90	\$62.94	1/1/2011

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:
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Medicaid Reimbursement Rate Change Form

Northside Hospital 6000 49th St. North St. Petersburg FL 33709 | Provider Number: 0115193-00 |
| Date: 12/20/2010 |
| 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	\$1,444.22	\$1,761.644	1/1/2011
Outpatient	\$84.38	\$100.45	1/1/2011
Inpatient County Billing Rate	\$622.94	\$632.29	1/1/2011

Prospective

Rate Type:

Interim

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

Hospitals:
Managed Care
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Medicaid Reimbursement Rate Change Form

Anne Bates Leach Eye Hospital 900 NW 17th St. Miami FL 33136 Provider Number: 0116483-00

Date: 12/14/2010

Fiscal Year End: 5/31/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$8,075.48	\$8,296.25	1/1/2011
Outpatient	\$396.53	\$412.13	1/1/2011
Inpatient County Billing Rate	\$5,112.71	\$5,189.39	1/1/2011

Rate Type:

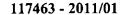
<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	<u>B</u> .	ASIS:
		_ Budget
	<u> </u>	Unaudited Cost
		Field Audited Cost
		Revised Field Audit
		Cost Report Late Test
•		W. Rydell Samuel

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 Cost Reimbursement Analysis





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Medicaid Reimbursement Rate Change Form

Fawcett Memorial Hospital PO BOX 494960 Port Charlotte FL 33952 Provider Number: 0117463-00

Date: 12/14/2010

Fiscal Year End: 12/31/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$683.41	\$678.90	1/1/2011
Outpatient	\$75.82	\$78.36	1/1/2011

Rate Type:

T ... 4 a

X Prospective
X Total Prospective
BASIS: Budget X Unaudited Cost Field Audited Cost Revised Field Audit
Cost Report Late Test W. Rydell Samuel

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 8
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
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Medicaid Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

Gulf Coast Medical Center 449 West 23rd Street Panama City FL 32405
 Provider Number:
 0117617-00

 Date:
 12/14/2010

 Fiscal Year End:
 1/31/2010

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,243.81	\$1,288.19	1/1/2011
Outpatient	\$91.99	\$99.91	1/1/2011
Inpatient County Billing Rate	\$651.93	\$663.01	1/1/2011

Rate Type:

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

W. Rydell Samuel

Medicaid Cost Reimbursement Analysis

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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 2
Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

Brandon Regional Hospital
119 Oakfield Drive
Brandon FL 33511

 Provider Number:
 0118079-00

 Date:
 12/21/2010

 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	\$1,288.04	\$1,612.85	1/1/2011
Outpatient	\$85.14	\$103.53	1/1/2011
Inpatient County Billing Rate	\$799.32	\$808.86	1/1/2011

Rate Type:

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
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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
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Medicaid Reimbursement Rate Change Form

Lawnwood Regional Medical Center P.O. Box 188 Ft Pierce FL 33450
 Provider Number:
 0119695-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,277.47	\$1,324.52	1/1/2011
Outpatient	\$87.26	\$90.70	1/1/2011
Inpatient County Billing Rate	\$800.40	\$812.40	1/1/2011

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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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 9
Children's Medical Services
Florida Hospital Association
AHCA - County Billings
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Medicaid Reimbursement Rate Change Form

Cape Coral Hospital PO Box 151247 Cape Coral FL 33915
 Provider Number:
 0119717-00

 Date:
 12/20/2010

 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	\$1,380.02	\$1,683.84	1/1/2011
Outpatient	\$81.16	\$96.62	1/1/2011
Inpatient County Billing Rate	\$887.79	\$901.11	1/1/2011

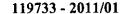
Rate Type:

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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
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Medicaid Reimbursement Rate Change Form

Venice Hospital 540 THE RIALTO Venice FL 34285 Provider Number: 0119733-00

Date: 12/14/2010

Fiscal Year End: 12/31/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$678.21	\$675.89	1/1/2011
Outpatient	\$66.26	\$68.49	1/1/2011

Rate Type:

DISTRIBUTION:
Hospitals:
Managed Care
Contract Management

Area Adm.

Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation

<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

Largo Medical Center 201 14th St., SW Largo FL 33540
 Provider Number:
 0119741-00

 Date:
 12/20/2010

 Fiscal Year End:
 2/28/2010

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,127.67	\$1,032.02	1/1/2011
Outpatient	\$95.66	\$98.15	1/1/2011

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. 5
Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

Raulerson Hospital P.O.Box 1307 Okeechobee FL 34974 | Provider Number: 0119750-00 |
| Date: 12/14/2010 |
| Fiscal Year End: 4/30/2010 |
| Audit Status: Unaudited Cost Report [1] |
| Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,510.60	\$1,601.85	1/1/2011
Outpatient	\$100.36	\$107.87	1/1/2011

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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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 9
Children's Medical Services
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Medicaid Reimbursement Rate Change Form

Lake City Medical Center 1050 N. Commerce Blvd Lake City FL 32055
 Provider Number:
 0119768-00

 Date:
 12/14/2010

 Fiscal Year End:
 10/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$618.46	\$627.73	1/1/2011
Outpatient	\$88.10	\$91.05	1/1/2011

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

DISTRIBUTION: Hospitals:

Managed Care
Contract Management
Area Adm. 3
Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

Florida State Hospital-Med
Medicaid Billing Office
Chattahoochee FL 32324

Provider Number:	0119784-00
Date:	12/14/2010
Fiscal Year End:	6/30/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

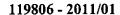
<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$702.93	\$713.47	1/1/2011
Outpatient			1/1/2011

Rate Type:

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

Hospitals:
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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:	12/14/2010
Fiscal Year End:	4/30/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$912.67	\$916.04	1/1/2011
Outpatient	\$88.19	\$91.15	1/1/2011

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:
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Area Adm. 2
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Medicaid Cost Reimbursement Analysis

Rate Includes Buy Back



Florida Agency For Health Care Administration

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Medicaid Reimbursement Rate Change Form

Town and Country Hospital 6001 Webb Road Tampa FL 33615
 Provider Number:
 0119849-00

 Date:
 12/21/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$981.82	\$825.794	1/1/2011
Outpatient	\$73.96	\$87.55	1/1/2011

Rate Type:

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

Hospitals:
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Contract Management
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Medicaid Reimbursement Rate Change Form

Regional Medical Center Bayonet Point 14000 FIVAY RD Hudson FL 34667

Provider Number: 0119881-00 12/14/2010 Date: Fiscal Year End: 2/28/2010 Unaudited Cost Report [1] Audit Status:

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$802.82	\$798.12	1/1/2011
Outpatient	\$83.37	\$86.17	1/1/2011

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 Cost Reimbursement Analysis

Area Adm. Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation

DISTRIBUTION: Hospitals: Managed Care Contract Management

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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:	12/14/2010
Fiscal Year End:	8/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$793.67	\$805.58	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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 Cost Reimbursement Analysis

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DISTRIBUTION:

Hospitals:
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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: 12/21/2010

Fiscal Year End: 8/31/2009

Audit Status: Unaudited Cost Report [1]

Rate Includes Buy Back

Provider Type:

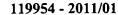
HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$806.17	\$962.72	1/1/2011
Outpatient	\$72.08	\$85.32	1/1/2011

Rate Type:

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

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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:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$885.87	\$916.23	1/1/2011
Outpatient	\$82.57	\$81.87	1/1/2011

Rate Type:

<u>x</u> <u>Prospective</u>
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. Lucie Medical Center 1800 SE TIFFANY AVE. Port St Lucie FL 34952 Provider Number: 0119971-00

Date: 12/14/2010

Fiscal Year End: 9/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$1,515.14	\$750.80	1/1/2011
Outpatient	\$82.91	\$85.69	1/1/2011

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

Seven Rivers Community Hospital 6201 N Suncoast Blvd. Crystal River FL 32629

Provider Number:	0119989-00
Date:	12/14/2010
Fiscal Year End:	5/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$719.53	\$730.32	1/1/2011
Outpatient	\$81.16	\$83.88	1/1/2011

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

Plantation General Hospital 401 NW 42ND AVENUE Plantation FL 33317
 Provider Number:
 0120006-00

 Date:
 12/14/2010

 Fiscal Year End:
 8/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,299.26	\$1,347.71	1/1/2011
Outpatient	\$99.95	\$103.89	1/1/2011
Inpatient County Billing Rate	\$871.54	\$884.61	1/1/2011

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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Hospitals:
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Medicaid Reimbursement Rate Change Form

Sebastian Hospital P.O. BOX 780838 Sebastian FL 32978
 Provider Number:
 0120014-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$759.72	\$771.11	1/1/2011
Outpatient	\$79.41	\$82.07	1/1/2011

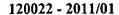
Rate Type:

<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

St. Catherine's Rehabilitation Hospital
1050 NE 125 ST
North Miami FL 33161

 Provider Number:
 0120022-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$554.44	\$562.75	1/1/2011
Outpatient	\$16.79	\$17.05	1/1/2011

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
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Medicaid Cost Reimbursement Analysis



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Medicaid Reimbursement Rate Change Form

Healthsouth Larkin Hospital-Miami 7031 SW 62 AVE. South Miami FL 33143 | Provider Number: 0120057-00 |
| Date: 12/14/2010 |
| Fiscal Year End: 12/31/2009 |
| Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,089.61	\$1,070.56	1/1/2011
Outpatient	\$118.29	\$151.65	1/1/2011
Inpatient County Billing Rate	\$606.99	\$613.61	1/1/2011

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 Cost Reimbursement Analysis

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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 11
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Medicaid Reimbursement Rate Change Form

Oak Hill Hospital P.O. BOX 5300 Spring Hill FL 33526

Provider Number:	0120073-00
Date:	12/14/2010
Fiscal Year End:	2/28/2010
Audit Status:	Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$617.01	\$630.84	1/1/2011
Outpatient	\$62.53	\$64.63	1/1/2011

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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DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Mease Hospital Countryside 16331 BayVista Drive Clearwater FL 33760

Provider Number: 0120081-00 12/21/2010 Date: 12/31/2009 Fiscal Year End: Unaudited Cost Report [1]

Audit Status:

Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$901.45	\$1,005.74	1/1/2011
Outpatient	\$73.57	\$87.09	1/1/2011

Prospective

Rate Type:

Interim

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. Children's Medical Services Florida Hospital Association AHCA - County Billings Vocational Rehabilitation



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Medicaid Reimbursement Rate Change Form

Delray Comm. Hosp. 5352 LINTON BLVD Delray Beach FL 33445
 Provider Number:
 0120090-00

 Date:
 12/20/2010

 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	\$714.84	\$868.34%	1/1/2011
Outpatient	\$90.42	\$105.63	1/1/2011

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
	2
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Medicaid Reimbursement Rate Change Form

St. Petersburg General Hospital 6500 38TH AVE., NORTH St Petersburg FL 33710
 Provider Number:
 0120103-00

 Date:
 12/20/2010

 Fiscal Year End:
 4/30/2010

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,342.25	\$1,615.84	1/1/2011
Outpatient	\$98.77	\$121.60 \$	1/1/2011
Inpatient County Billing Rate	\$800.70	\$808.24	1/1/2011

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Rate Type:

Intonim

<u> </u>	<u>A</u> <u>Hospective</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:
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Medicaid Reimbursement Rate Change Form

Palms Of Pasadena Hospital
1501 Pasadena Ave.
South Pasadena FL 33707

 Provider Number:
 0120111-00

 Date:
 12/20/2010

 Fiscal Year End:
 11/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

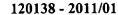
HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$810.34	\$967.69%	1/1/2011
Outpatient	\$104.00	\$123.10	1/1/2011

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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DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form

Kendall Medical Center 11750 SW 40TH ST Miami FL 33175 Provider Number: 0120138-00

Date: 12/14/2010

Fiscal Year End: 12/31/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,559.87	\$1,768.07	1/1/2011
Outpatient	\$92.83	\$107.35	1/1/2011
Inpatient County Billing Rate	\$981.43	\$1,022.24	1/1/2011

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
	

DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
Area Adm. 11
Children's Medical Services
Florida Hospital Association
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Medicaid Reimbursement Rate Change Form

St Anthonys Hospital	
3001 W. ML King Blvd. Post Office Box 422	27
Tampa FL 33677-4227	

 Provider Number:
 0120227-00

 Date:
 12/21/2010

 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	\$1,298.22	\$1,581.70	1/1/2011
Outpatient	\$148.67	\$176.98	1/1/2011
Inpatient County Billing Rate	\$763.06	\$774.50	1/1/2011

Rate Type:

<u>Interim</u>	x <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
	°
	W. Rydell Samuel
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DISTRIBUTION:

Hospitals:
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Contract Management
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Medicaid Reimbursement Rate Change Form

W. Boca Med. Ctr. 21644 STATE RD 7 Boca Raton FL 33428
 Provider Number:
 0120243-00

 Date:
 12/20/2010

 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	\$930.75	\$1,116.43%	1/1/2011
Outpatient	\$83.93	\$99.35	1/1/2011

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
	<u>—</u>
	W. Rydell Samuel
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DISTRIBUTION:

Hospitals:
Managed Care
Contract Management
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Medicaid Reimbursement Rate Change Form

Palms West Hospital			
P.O. BOX 1150			
Lovahatchee FL 33470			

 Provider Number:
 0120260-00

 Date:
 12/20/2010

 Fiscal Year End:
 5/31/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,374.28	\$1,676.194	1/1/2011
Outpatient	\$111.99	\$133.31	1/1/2011
Inpatient County Billing Rate	\$829.86	\$842.30	1/1/2011

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	
	<u>—</u>	
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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:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$485.55	\$482.45	1/1/2011
Outpatient	\$46.12	\$47.66	1/1/2011

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

DISTRIBUTION:

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Contract Management
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Medicaid Reimbursement Rate Change Form

Jupiter Hospital	
1210 S Old Dixie	Highway
Supiter FL 33458	

 Provider Number:
 0120294-00

 Date:
 12/20/2010

 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	\$946.43	\$1,130.21	1/1/2011
Outpatient	\$72.91	\$86.30	1/1/2011

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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DISTRIBUTION:

Hospitals:
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Medicaid Reimbursement Rate Change Form

Columbia Hospital 2201 45TH ST West Palm Beach FL 33407
 Provider Number:
 0120308-00

 Date:
 12/20/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

 Rate Includes Buy Back

Provider Type:

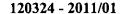
HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$905.87	\$1,104.79 6	1/1/2011
Outpatient	\$123.26	\$146.73	1/1/2011
Inpatient County Billing Rate	\$558.57	\$566.94	1/1/2011

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

H L Moffitt Cancer Center 12902 Magnolia Drive Tampa FL 33612-9497
 Provider Number:
 0120324-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,419.14	\$2,499.66	1/1/2011
Outpatient	\$314.35	\$326.72	1/1/2011
Inpatient County Billing Rate	\$2,084.73	\$2,116.00	1/1/2011

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

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Medicaid Reimbursement Rate Change Form

H L Moffitt Cancer Center 12902 Magnolia Drive Tampa FL 33612-9497
 Provider Number:
 0120324-01

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$2,419.14	\$2,499.66	1/1/2011
Outpatient	\$314.35	\$326.72	1/1/2011
Inpatient County Billing Rate	\$2,084.73	\$2,116.00	1/1/2011

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

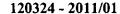
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Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form

H L Moffitt Cancer Center 12902 Magnolia Drive Tampa FL 33612-9497 Provider Number: 0120324-02

Date: 12/14/2010

Fiscal Year End: 6/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$2,419.14	\$2,499.66	1/1/2011
Outpatient	\$314.35	\$326.72	1/1/2011
Inpatient County Billing Rate	\$2,084.73	\$2,116.00	1/1/2011

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

HealthSouth Rehabiliation Hospital-Tallahassee 1675 RIGGINS RD Tallahassee FL 32308 Provider Number: 0120332-00

Date: 12/14/2010

Fiscal Year End: 12/31/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$488.74	\$476.23	1/1/2011
Outpatient	\$62.14	\$64.23	1/1/2011

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

HealthSouth Rehabilitation Hospital-Treasure Coast 1600 37TH ST Vero Beach FL 32960
 Provider Number:
 0120341-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$473.27	\$465.89	1/1/2011
Outpatient	\$51.44	\$53.16	1/1/2011

Rate Type:

<u>Interim</u>		X Prospective
Total Interim Settlement Based on Cost		X Total Prospective
	BASIS: Budget Unaudited Field Aud	
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Medicaid Reimbursement Rate Change Form

Aventura Hospital & Medical Center 20900 Biscayne Blvd Miami FL 33180
 Provider Number:
 0120375-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient	\$661.06	\$674.82	1/1/2011
Outpatient	\$37.87	\$39.14	1/1/2011

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

HealthSouth Rehabiliation Hospital Sarasota 3251 PROCTOR RD Sarasota FL 33581
 Provider Number:
 0120383-00

 Date:
 12/14/2010

 Fiscal Year End:
 12/31/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$423.24	\$413.62	1/1/2011
Outpatient	\$97.82	\$101.11	1/1/2011

Rate Type:

<u>Interim</u>	X Prospective
Total Interim Settlement Based on Cost	X Total Prospective
	BASIS:
	Budget 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 303 South East 17th St. Ft. Lauderdale FL 33316

0120405-00 Provider Number: 12/14/2010 Date: Fiscal Year End: 6/30/2009 Unaudited Cost Report [1] Audit Status:

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,468.29	\$1,522.93	1/1/2011
Outpatient	\$119.26	\$123.95	1/1/2011
Inpatient County Billing Rate	\$890.31	\$903.67	1/1/2011

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 Cost Reimbursement Analysis

Managed Care Contract Management Area Adm. 10 Children's Medical Services

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Medicaid Reimbursement Rate Change Form

Coral Springs Medical Center 303 South East 17th St. Ft. Lauderdale FL 33316 Provider Number: 0120405-02

Date: 12/14/2010

Fiscal Year End: 6/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,468.29	\$1,522.93	1/1/2011
Outpatient	\$119.26	\$123.95	1/1/2011
Inpatient County Billing Rate	\$890.31	\$903.67	1/1/2011

Rate Type:

Interim X Prospective	
Total Interim Settlement Based on Cost X Total Pros	pective
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:	12/14/2010
Fiscal Year End:	3/31/2009
Audit Status:	Unaudited Cost Report [1]
	Rate Includes Buy Back

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$1,013.56	\$1,013.56	1/1/2011
Outpatient	\$59.51	\$60.56	1/1/2011

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:

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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:	12/14/2010
Fiscal Year End:	12/31/2009
Audit Status:	Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient	\$456.77	\$458.46	1/1/2011
Outpatient	\$89.78	\$92.80	1/1/2011

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

North Dade Health Center 1611 N.W. 12th Avenue Miami FL 33136
 Provider Number:
 0140422-00

 Date:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient			1/1/2011
Outpatient	\$297.53	\$304.50	1/1/2011

Rate Type:

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

Medicaid Cost Reimbursement Analysis

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DISTRIBUTION: Hospitals: Managed Care

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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:
 12/14/2010

 Fiscal Year End:
 9/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient			1/1/2011
Outpatient	\$297.53	\$172.30	1/1/2011

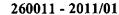
Rate Type:

<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

Medicaid Cost Reimbursement Analysis

DISTRIBUTION: Hospitals:

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Medicaid Reimbursement Rate Change Form

Florida State Hospital Building 260 Chattahoochee FL 32324 Provider Number: 0260011-00

Date: 12/14/2010

Fiscal Year End: 6/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>	Current Rate	New Rate	Effective Date
Inpatient		\$754.62	1/1/2011
Outpatient			1/1/2011

Rate Type:

<u>Interim</u>	<u>x</u> <u>Prospective</u>
Total Interim Settlement Based on Cost	X Total Prospective
•	BASIS:
	Budget Vinaudited Cost
	Field Audited Cost
	Revised Field Audit
	Cost Report Late Test
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Medicaid Reimbursement Rate Change Form

Northeast Florida State Hospital
HWY 121 SOUTH
Macclenny FL 32063

Provider Number: 0260029-00

Date: 12/14/2010

Fiscal Year End: 6/30/2009

Audit Status: Unaudited Cost Report [1]

Provider Type:

HOSPITAL	Current Rate_	New Rate	Effective Date
Inpatient		\$378.59	1/1/2011
Outpatient			1/1/2011

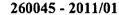
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<u>Interim</u>	<u>X</u> <u>Prospective</u>	
Total Interim Settlement Based on Cost	X Total Prospective	
	BASIS:	
	Budget	
	X Unaudited Cost	
	Field Audited Cost	
	Revised Field Audit	
	Cost Report Late Test	
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Medicaid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

So. Fla. State Hosp 800 East Cypress Dr Pembroke Pines FL 33025
 Provider Number:
 0260045-00

 Date:
 12/14/2010

 Fiscal Year End:
 6/30/2009

 Audit Status:
 Unaudited Cost Report [1]

Provider Type:

<u>HOSPITAL</u>		Current Rate	New Rate	Effective Date
Inpatient	•		\$459.19	1/1/2011
Outpatient				1/1/2011

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

W. Fla. Comm. Care 5500 Stewart St. Milton FL 32570

Provider Number:	0260053-00	
Date:	12/14/2010	
Fiscal Year End:	6/30/2005	
Audit Status:	Field Audit [3]	

Provider Type:

Current Rate	New Rate	Effective Date
	\$255.37	1/1/2011
•		1/1/2011
	Current Rate	

Rate Type:

<u>Interim</u>	<u>x</u> <u>Prospective</u>
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

University of South Alabama Medical Center 2451 Filligim Street Mobile AL 36617
 Provider Number:
 102814-00

 Date:
 12/14/2010

 Fiscal Year End:
 3/31/2000

 Audit Status:
 Interim Budget [4]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$836.34	1/1/2011
Outpatient	,	\$84.13	1/1/2011

Rate Type:

<u>X</u> <u>Interim</u>	<u>Prospective</u>
Total Interim 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

U.S.A Knollwood Park 2451 Filligim Street Mobile AL 36617
 Provider Number:
 102814-02

 Date:
 12/14/2010

 Fiscal Year End:
 3/31/2000

 Audit Status:
 Interim Budget [4]

Provider Type:

HOSPITAL	Current Rate	New Rate	Effective Date
Inpatient		\$791.58	1/1/2011
Outpatient		\$17.05	1/1/2011

Rate Type:

X <u>Interim</u>	<u>Prospective</u>
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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