

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
AHCA
AGENCY CLERK

2014 FEB 25 A 7:59

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

BOCA DELRAY RENAL ASSOCIATES, INC.,

Respondent.

CASE NO.: 12-002585MPI

PROVIDER NO.: 212210300

C.I. NO.: 12-2163-000

NPI NO.: 1528047909

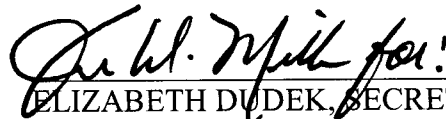
LICENSE NO.: ME39337

RENDITION NO.: AHCA- 14 - 0158 -S-MDO

FINAL ORDER

THE PARTIES resolved all disputed issues and executed a Settlement Agreement. The parties are directed to comply with the terms of the attached settlement agreement. Based on the foregoing, this file is **CLOSED**.

DONE and ORDERED on this the 24th day of February, 2014, in Tallahassee, Florida.



ELIZABETH DUDEK, SECRETARY
Agency for Health Care Administration

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

Katharine B. Heyward
Assistant General Counsel
Agency for Health Care Administration
Office of the General Counsel
(Interoffice Mail)

Vanessa A. Reynolds, Esquire
Broad and Cassel
One Financial Plaza, Suite 2700
Post Office Box 14010
Fort Lauderdale, FL 33394
(U.S. Mail)

Richard Zenuch, Bureau Chief, Medicaid Program Integrity

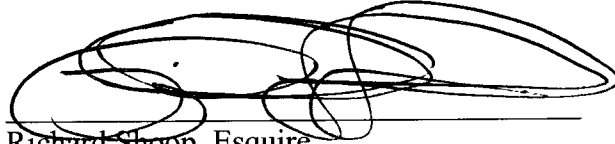
Finance and Accounting

Health Quality Assurance

Florida Department of Health

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the above named addressees by U.S. Mail or other designated method on this the 25 day of February, 2014.



Richard Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308-5403
(850) 412-3630/FAX (850) 921-0158

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION**

**STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,**

Petitioner,

vs.

**CASE NO.: 12-002585MPI
PROVIDER NO.: 212210300
C.I. NO.: 12-2163-000
NPI NO.: 1528047909
LICENSE NO.: ME39337**

BOCA DELRAY RENAL ASSOCIATES, INC.,

Respondent.

SETTLEMENT AGREEMENT

Petitioner, the **STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION**, (“AHCA” or “Agency”), and Respondent, **BOCA DELRAY RENAL ASSOCIATES, INC.**, (“PROVIDER”), by and through the undersigned, hereby stipulate and agree as follows:

1. The parties enter into this agreement for the purpose of memorializing the resolution of this matter.
2. PROVIDER is a Medicaid provider in the State of Florida, provider number 212210300, and was a provider during the audit period.
3. In its Final Audit Report, dated June 18, 2012, the Agency notified PROVIDER that a review of Medicaid claims performed by the Agency’s Office of the Inspector General, Bureau of Medicaid Program Integrity (“MPI”), indicated that certain claims, in whole or in part, were inappropriately paid by Medicaid. The Agency sought repayment of this overpayment, in the amount of forty-six thousand, two hundred dollars and eighty-eight cents (\$46,200.88). Additionally, the Agency applied sanctions in accordance with Sections 409.913(15), (16), and

(17), Florida Statutes, and Rule 59G-9.070(7), Florida Administrative Code. Specifically, the Agency assessed the following sanctions against PROVIDER: a fine in the amount of nine thousand, two hundred forty dollars and eighteen cents (\$9,240.18) for violation(s) of Rule 59G-9.070(7)(e), Florida Administrative Code; and costs in the amount of forty-seven dollars and sixteen cents (\$47.16). The total amount due was fifty-five thousand, four hundred eighty-eight dollars and twenty-two cents (\$55,488.22).

4. In response to the Final Audit Report dated June 18, 2012, PROVIDER filed a *Petition for Formal Administrative Hearing*. Subsequently, the PROVIDER submitted information which was reviewed but did not reduce the overpayment.

5. In order to resolve this matter without further administrative proceedings, PROVIDER and AHCA agree as follows:

- (1.) AHCA agrees to accept the payment set forth herein in settlement of the overpayment, fine, and costs arising from the above-referenced audit.
- (2.) PROVIDER agrees to pay AHCA the sum of fifty-five thousand, four hundred eighty-eight dollars and twenty-two cents (\$55,488.22).
- (3.) As of October 23, 2013, AHCA has recouped a total of forty-six thousand, two hundred dollars and eighty-eight cents (\$46,200.88). The remaining balance is nine thousand, two hundred eighty-seven dollars and thirty-four cents (\$9,287.34). The outstanding balance accrues at 10% interest per year. Within thirty (30) days of entry of the Final Order, PROVIDER will make a lump sum payment of the remaining balance in the amount of nine thousand, two hundred eighty-seven dollars and thirty-four cents (\$9,287.34). Should the provider's

enrollment with Medicaid be terminated, the full amount owed will be due within 30 days of termination.

(4.) PROVIDER and AHCA agree that full payment, as set forth above, resolves and settles this case completely and releases both parties from any administrative or civil liabilities arising from the findings relating to the claims determined to have been overpaid as referenced in audit C.I. 12-2163-000.

(5.) PROVIDER agrees that it shall not re-bill the Medicaid Program in any manner for claims that were not covered by Medicaid, which are the subject of the review in this case.

6. Payment shall be made to:

**AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid Accounts Receivable
2727 Mahan Drive, Mail Station #14
Tallahassee, Florida 32308**

7. PROVIDER agrees that failure to pay any monies due and owing under the terms of this Agreement shall constitute PROVIDER'S authorization for the Agency, without further notice, to withhold the total remaining amount due under the terms of this agreement from any monies due and owing to PROVIDER for any Medicaid claims.

8. AHCA reserves the right to enforce this Agreement under the laws of the State of Florida, the Rules of the Medicaid Program, and all other applicable rules and regulations.

9. This settlement does not constitute an admission of wrongdoing or error by either party with respect to this case or any other matter.

10. The signatories to this Agreement, acting in a representative capacity, represent that they are duly authorized to enter into this Agreement on behalf of the respective parties.

11. This Agreement shall be construed in accordance with the provisions of the laws of Florida. Venue for any action arising from this Agreement shall be in Leon County, Florida.

12. This Agreement constitutes the entire agreement between PROVIDER and AHCA, including anyone acting for, associated with or employed by them, concerning all matters and supersedes any prior discussions, agreements or understandings; there are no promises, representations or agreements between PROVIDER and AHCA other than as set forth herein. No modification or waiver of any provision shall be valid unless a written amendment to the Agreement is completed and properly executed by the parties.

13. This is an Agreement of Settlement and Compromise, made in recognition that the parties may have different or incorrect understandings, information and contentions as to facts and law, and with each party compromising and settling any potential correctness or incorrectness of its understandings, information and contentions as to facts and law, so that no misunderstanding or misinformation shall be a ground for rescission hereof.

14. PROVIDER expressly waives in this matter its right to any hearing pursuant to sections 120.569 or 120.57, Florida Statutes, the making of findings of fact and conclusions of law by the Agency, and all further and other proceedings to which it may be entitled by law or rules of the Agency regarding this proceeding and any and all issues raised herein. PROVIDER further agrees that it shall not challenge or contest any Final Order entered in this matter which is consistent with the terms of this settlement agreement in any forum now or in the future available to it, including the right to any administrative proceeding, circuit or federal court action or any appeal.

15. PROVIDER does hereby discharge the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys of and from all claims, demands,

actions, causes of action, suits, damages, losses and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter, AHCA's actions herein, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement.

16. The parties agree to bear their own attorney's fees and costs, if any. This does not include the above listed costs of the investigation and audit which PROVIDER agrees to pay.

17. This Agreement is and shall be deemed jointly drafted and written by all parties to it and shall not be construed or interpreted against the party originating or preparing it.

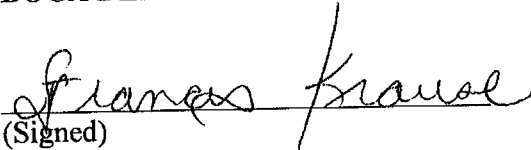
18. To the extent that any provision of this Agreement is prohibited by law for any reason, such provision shall be effective to the extent not so prohibited, and such prohibition shall not affect any other provision of this Agreement.

19. This Agreement shall inure to the benefit of and be binding on each party's successors, assigns, heirs, administrators, representatives and trustees.

20. All times stated herein are of the essence of this Agreement.

21. This Agreement shall be in full force and effect upon execution by the respective parties in counterpart.

BOCA DELRAY RENAL ASSOCIATES, INC.,

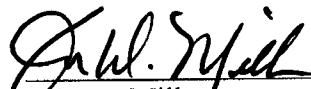

(Signed)

Dated: 12/4, 2013

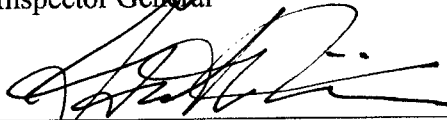
BY: FRANCES KRAUSE V.P.
(Print Name and Title)

**AGENCY FOR HEALTH CARE
ADMINISTRATION**


2727 Mahan Drive, Bldg. 3, Mail Stop #3
Tallahassee, FL 32308-5403


Eric W. Miller
Inspector General

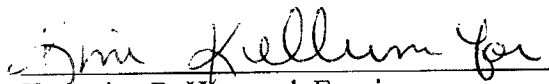
Dated: 2/24 ²⁰¹⁴ ~~2013~~


Stuart F. Williams, Esquire
General Counsel

Dated: 2/11, 2013 ⁴


Kim Kellum, Esquire
Chief Medicaid Counsel

Dated: 1/22, 2013 ⁴


Katharine B. Heyward, Esquire
Assistant General Counsel

Dated: 2/7, 2013 ⁴

Jul 19 12:30a

KRAUSE

5819940672

p.2

RICK SCOTT
GOVERNORELIZABETH OUDEK
SECRETARY**FEDERAL EXPRESS MAIL No. 8692 4606 3441**

June 18, 2012

Provider No: 212210300
NPI No: 1528047909
License No.: ME39337BOCA DELRAY RENAL ASSOC
1905 CLINT MOORE RD, SUITE 306
BOCA RATON, FL 33496In Reply Refer to
FINAL AUDIT REPORT
C.I. No. 12-2163-000

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period April 1, 2009 through March 31, 2010. A preliminary audit report dated May 24, 2012 was sent to you indicating that we had determined you were overpaid \$46,200.88. Since no documentation was produced to refute these billings, all the claims are considered overpayments. We have determined that you were overpaid \$46,200.88 for services that in whole or in part are not covered by Medicaid. A fine of \$9,240.18 has been applied. The cost assessed for this audit is \$47.16. The total amount due is \$55,488.22.

Be advised of the following:

- (1) In accordance with Sections 409.913(15), (16), and (17), Florida Statutes (F.S.), and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. This letter shall serve as notice of the following sanction(s):
 - A fine of \$9,240.18 for violation(s) of Rule Section 59G-9.070(7) (e), F.A.C.
- (2) Pursuant to Section 409.913(23) (a), F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.

This review and the determination of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining the appropriateness of Medicaid payment pursuant to Medicaid policy, the Medicaid program utilizes procedure codes, descriptions, policies, limitations and

2727 Mahan Drive, MS# 6
Tallahassee, Florida 32308Visit AHCA online at
<http://ahca.myflorida.com>

Jul 19 12 12:30a

KRAUSE

5619940672

p.3

Page 2

requirements found in the Medicaid provider handbooks and Section 409.913, F.S. In applying for Medicaid reimbursement, providers are required to follow the guidelines set forth in the applicable rules and Medicaid fee schedules, as promulgated in the Medicaid policy handbooks, billing bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

Below is a discussion of the particular guidelines related to the review of your claims, and an explanation of why these claims do not meet Medicaid requirements. The audit claims detail is included, listing the claims that are affected by this determination.

REVIEW DETERMINATION(S)

- 1. Florida Medicaid Provider General Handbook, dated October 2003, page 1-22 and January 2007, page 1-26, both state:

HMO Coverage

When a provider verifies a recipient's eligibility for Medicaid, he must also verify whether the recipient is enrolled in an HMO. If a recipient is an HMO member, the provider must seek authorization from the HMO in which the recipient is currently enrolled prior to providing services, unless it is an emergency.

If the recipient is in an HMO, Medicaid will not pay a provider for any HMO-covered services. Providers must seek authorization and reimbursement from the HMO for services the HMO covers for its members.

Note: See Chapter 3 in this handbook for information on verifying recipient eligibility and HMO enrollment.

- 2. Florida Medicaid Provider General Handbook, dated July 2008, page 1-28 states:

HMO Coverage

When a provider verifies a recipient's eligibility for Medicaid, he must also verify whether the recipient is enrolled in an HMO. If a recipient is an HMO member, the provider must seek authorization from the HMO in which the recipient is currently enrolled prior to providing services covered by the HMO, unless it is an emergency.

If the recipient is in an HMO, Medicaid will not pay a provider for any HMO-covered services. Providers must seek authorization and reimbursement from the HMO for services the HMO covers for its members.

Note: See Chapter 3 in this handbook for information on verifying recipient eligibility and HMO enrollment.

3. Florida Medicaid Provider General Handbook, dated July 2004, page 1-23 states:

HMO Covered Services

The services provided under contract with each HMO are negotiated with each HMO contractor. However, every HMO plan must include the following basic services up to the limits required by fee-for-service Medicaid:

- Child Health Check-Up
- Community mental health services (only in Areas 1 and 6)
- Dialysis treatment in freestanding centers
- Durable medical equipment and medical supplies
- Family planning services
- Hearing services
- Home health services
- Hospital services (inpatient, outpatient and emergency services)
- Laboratory services, including independent laboratory services
- Prescribed drug services
- Physician services (as described below)
- Mental health targeted case management (only in Areas 1 and 6)
- Therapy services
- Vision services
- X-ray services

4. Florida Medicaid Provider General Handbook, dated January 2007, page 1-27 and July 2008, page 1-29 both state:

HMO Covered Services

The services provided under contract with each HMO are negotiated with each HMO contractor. However, every HMO plan must include the following basic services up to the limits required by fee-for-service Medicaid:

- Child Health Check-Up
- Community mental health services
- Dialysis treatment in freestanding centers
- Durable medical equipment and medical supplies
- Family planning services
- Hearing services
- Home health services
- Hospital services (inpatient, outpatient and emergency services)
- Laboratory services, including independent laboratory services
- Prescribed drug services
- Physician services (as described below)
- Mental health targeted case management
- Therapy services
- Vision services
- X-ray services

Jul 19 12 12:31a

KRAUSE

5819940672

p.5

Page 4

5. Florida Medicaid Provider Reimbursement Handbook, CMS-1500, dated October 2003, page 1-8, February 2006, page 1-8, and July 2008, page 1-10 all state:

Before Completing the Form

Before filling out the claim form, answer the following questions:

- Was the recipient eligible for Medicaid on the date of service?
- Has the recipient's eligibility been verified?
- Was MediPass or HMO authorization obtained, if applicable?
- Was the service or item covered by Medicaid?
- Was service authorization obtained, if applicable?
- Was prior authorization obtained, if applicable?
- Has a claim been filed and a response received for all the recipient's other insurance?
- Was the procedure within the service limitations?
- Does this claim require any medical documentation or attachment?

If all of the above information is not available, review the instructions in this handbook. If the response to all of the above, applicable questions is "yes," fill out the claim form following the step-by-step instructions for each item on the form.

Medicaid fee-for-service payments have been identified for recipients that were currently enrolled in Medicaid managed care at the time of the service. These services were covered by the managed care plan. Medicaid providers must verify recipient eligibility, including enrollment in managed care, prior to providing services to a recipient unless it is an emergency. This Medicaid provider requirement can be referenced in the Florida Medicaid Provider General Handbook. The resulting Medicaid fee-for-service reimbursements are considered overpayments.

If you are currently involved in a bankruptcy, you should notify your attorney immediately and provide a copy of this letter for them. Please advise your attorney that we need the following information immediately: (1) the date of filing of the bankruptcy petition; (2) the case number; (3) the court name and the division in which the petition was filed (e.g., Northern District of Florida, Tallahassee Division); and, (4) the name, address, and telephone number of your attorney.

If you are not in bankruptcy and you concur with our findings, remit by certified check the total amount reflected on page one, paragraph one, of this letter which includes the overpayment amount as well as any fines imposed and assessed costs. The check must be payable to the Florida Agency for Health Care Administration. Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901. To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report. Please mail payment to:

Medicaid Accounts Receivable - MS # 14
 Agency for Health Care Administration
 2727 Mahan Drive Bldg. 2, Ste. 200
 Tallahassee, FL 32308

Pursuant to section 409.913(25)(d), F.S., the Agency may collect money owed by all means allowable by law, including, but not limited to, exercising the option to collect money from Medicare that is

Jul 19 12 12:31a

KRAUSE

5818940672

p.6

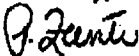
Page 5

payable to the provider. Pursuant to section 409.913(27), F.S., if within 30 days following this notice you have not either repaid the alleged overpayment amount or entered into a satisfactory repayment agreement with the Agency, your Medicaid reimbursements will be withheld; they will continue to be withheld, even during the pendency of an administrative hearing, until such time as the overpayment amount is satisfied. Pursuant to section 409.913(30), F.S., the Agency shall terminate your participation in the Medicaid program if you fail to repay an overpayment or enter into a satisfactory repayment agreement with the Agency, within 35 days after the date of a final order which is no longer subject to further appeal. Pursuant to sections 409.913(15)(q) and 409.913(25)(c), F.S., a provider that does not adhere to the terms of a repayment agreement is subject to termination from the Medicaid program. Finally, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C. and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be received by the Agency within twenty-one (21) days of receipt of this letter. For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.

Any questions you may have about this matter should be directed to: Sheri Creel, Auditor, Agency for Health Care Administration, Office of Inspector General, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 412-4600, facsimile (850) 410-1972, or by email at Sheri.Creel@ahca.myflorida.com.

Sincerely,



Pamela Fante
Program Administrator
Office of Inspector General
Medicaid Program Integrity

PF/SC/lj

Enclosure(s)

Copies furnished to:

Finance & Accounting
(Interoffice mail)

Department of Health (DOH)
(E-mail)

FROM Please print and press hard.

Date 6-27-12 Sender's FedEx Account Number 4509-1250-6

Sender's Name Sheri Creel Phone 850-442-4600

Company Agency for Health Care Admin

Address 2727 Mahan Dr Bldg 2; MS#6 Dept./Floor/Suite/Room

City Tallahassee State FL ZIP 32308-5407

Four Internal Billing Reference (up to 24 characters will appear on invoice) 68103010000

To Recipient's Name _____ Phone () _____

Company BOCA DELRAY RENAL ASSOC

Recipient Address 1905 CLINT MOORE RD., SUITE 306

BOCA RATON, FL 33496

C.I.# 12-2163-000/FAR/SC/LSJ

Address _____

City _____ State _____ ZIP _____

4a Express Package Service

FedEx Priority Overnight Next business morning.* Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.

FedEx Standard Overnight Next business afternoon.* Saturday Delivery NOT available.

FedEx First Overnight Earliest next business morning delivery in select locations.* Saturday Delivery NOT available.

FedEx 2Day Second business day.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected. FedEx Envelope rate not available. Minimum charge: One pound rate.

FedEx Express Saver Third business day.* Saturday Delivery NOT available.

Packages up to 150 lbs.

4b Express Freight Service

FedEx 1Day Freight* Next business day.* Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.

FedEx 2Day Freight Second business day.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.

FedEx 3Day Freight Third business day.* Saturday Delivery NOT available.

Packages over 150 lbs.

5 Packaging

FedEx Envelope* FedEx Pak* Includes FedEx Small Pak, FedEx Large Pak, and FedEx Sturdy Pak. FedEx Box FedEx Tube Other

* Declared value limit \$500.

6 Special Handling

SATURDAY Delivery NOT Available for FedEx Standard Overnight, FedEx First Overnight, FedEx Express Saver, or FedEx 2Day Freight.

HOLD Weekday at FedEx Location HLD Available for FedEx First Overnight.

HOLD Saturday at FedEx Location Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

Does this shipment contain dangerous goods? (See box must be checked)

No Yes (as per attached Shipper's Declaration) Yes Shipper's Declaration not required. Dry Ice Dry Ice, 3.0N 1845

Dangerous goods (including dry ice) cannot be shipped in FedEx packaging. Cargo Aircraft Only

7 Payment Bill to: Enter FedEx Acct. No. or Credit Card No. below.

Sender Acct. No. in Section 1 will be billed. Recipient Third Party Credit Card Cash/Check

FedEx Acct. No. / Credit Card No.	Total Packages	Total Weight	Total Declared Value	Exp. Date
			\$.00	

8 Residential Delivery Signature Options If you require a signature, check Direct or Indirect.

No Signature Required Package may be left without obtaining a signature for delivery.

Direct Signature Someone at recipient's address may sign for delivery. Fee applies.

Indirect Signature If no one is available at recipient's address, someone at a neighboring address may sign for delivery. Fee applies.

520





Detailed Results

Tracking no.: 869246063441

Select time format: 12H

Delivered

Delivered
Signed for by: L.LAURA

Shipment Dates

Ship date Jun 27, 2012
Delivery date Jun 28, 2012 11:53 AM

Destination

Signature Proof of Delivery

Shipment Options

Hold at FedEx Location

Hold at FedEx Location service is not available for this shipment.

Shipment Facts

Service type	FedEx 2Day Envelope	Delivered to Reference	Receptionist/Front Desk 68103010000
--------------	---------------------	------------------------	--

Shipment Travel History

Select time zone: Local Scan Time

All shipment travel activity is displayed in local time for the location

Date/Time	Activity	Location	Details
Jun 28, 2012 11:53 AM	Delivered		
Jun 28, 2012 8:23 AM	On FedEx vehicle for delivery	BOCA RATON, FL	
Jun 28, 2012 7:40 AM	At local FedEx facility	BOCA RATON, FL	
Jun 28, 2012 5:51 AM	At destination sort facility	FORT LAUDERDALE, FL	
Jun 28, 2012 3:00 AM	Departed FedEx location	MEMPHIS, TN	
Jun 28, 2012 2:27 PM	In transit	MEMPHIS, TN	
Jun 28, 2012 6:59 AM	Arrived at FedEx location	MEMPHIS, TN	
Jun 27, 2012 9:15 PM	Left FedEx origin facility	TALLAHASSEE, FL	
Jun 27, 2012 4:43 PM	Picked up	TALLAHASSEE, FL	