

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
AHCA
AGENCY CLERK

2019 SEP 12 P 12:50

ADVENTIST HEALTH SYSTEM/
SUNBELT, INC. d/b/a FLORIDA
HOSPITAL,

PROVIDER NO.: 101290

Petitioner,

AHCA NO.: 15-078

vs.

RENDITION NO.: AHCA-19-0722-S-MDA


AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.

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 12 day of Sept., 2019, in Tallahassee,
Leon County, Florida.



MARY C. MAYHEW, 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:

Florida Hospital-Orlando
Attn: Hospital Administrator
900 Winderley Place, Suite 200
Maitland, FL 32751
(U.S. MAIL)

Joseph M. Goldstein, Esquire
Shutts & Bowen LLP
200 East Broward Blvd., Suite 2100
Fort Lauderdale, FL 33301
jgoldstein@shutts.com
(E-Mail)

Shena L. Grantham, Esquire
MAL & MPI Chief Counsel
Shena.Grantham@ahca.myflorida.com
(E-Mail)

Stefan Grow, General Counsel
Agency for Health Care Administration
(E-Mail)

Lisa Smith, Bureau Chief MPF
Agency for Health Care Administration
(E-Mail)

Steven T. Mindlin
Kyle L. Kemper
Sundstrom & Mindlin, LLP
smindlin@asfflaw.com
kkemper@sfflaw.com
(E-Mail)

Bureau of Health Quality Assurance
Agency for Health Care Administration
(E-Mail)

Division of Health Quality Assurance
Bureau of Central Services
CSMU-86@ahca.myflorida.com
(E-Mail)

Division of Administrative Hearings
The Desoto Building
1230 Apalachee Parkway
Tallahassee, FL 32399-3060

Deborah Kenon, MPF
(E-Mail)

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 17th day of September, 2019.



Richard J. Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308-5403
(850) 412-3689/FAX (850) 921-0158

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

ADVENTIST HEALTH SYSTEM/
SUNBELT, INC. d/b/a FLORIDA
HOSPITAL,

Petitioner,
v.

AHCA CASE NO.: 15-078
DOAH CASE NO. 15-1611
Medicaid Provider #: 101290

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.

_____ /

SETTLEMENT AGREEMENT

Petitioner, ADVENTIST HEALTH SYSTEM/SUNBELT, INC. f/d/b/a FLORIDA HOSPITAL (“AdventHealth Orlando”), and Respondent, the STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION (“AHCA” or “Agency”), and collectively referred to as the “Parties,” 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. AdventHealth Orlando is a Medicaid provider in the State of Florida, provider number 101290, and was a provider during the relevant period.
3. In its Notice of Agency Action dated February 13, 2015, (the “Notice”), the Agency notified AdventHealth Orlando, in part that “... AHCA has determined that all cost reports, desk or onsite audits of cost reports, audited per diem reimbursement rates calculated by AHCA, or adjustments to audited per diem reimbursement rates calculated by AHCA relating to the Medicaid inpatient and outpatient reimbursement rates identified in the Attached Exhibit A are ‘final’ ...

and therefore not subject to further re-opening or adjustment.” A copy of the Notice is attached hereto as **Exhibit “A.”**

4. In response to the Notice, on March 12, 2015, AdventHealth Orlando filed a Petition for Formal Administrative Hearing (“Petition”). A copy of the Petition (less exhibits) is attached hereto as **Exhibit “B.”** The Petition sought a determination that the Agency incorrectly calculated AdventHealth Orlando’s rates for the rate semesters set forth in the Notice.

5. In order to resolve this matter without further administrative proceedings, and based upon additional information reviewed during the pendency of litigation, AdventHealth Orlando and AHCA agree with the revised rates and payments as included on the attached **Exhibit “C”**. AdventHealth Orlando agrees to promptly make payment consistent with the terms on **Exhibit “C”** in the total amount of **\$15,039,944.43**, but no later than 90 days after the entry of the Final Order, which shall be entered no later than 90 days after this Agreement is fully executed by the Parties.

6. As to the adjustment of any outpatient rates on **Exhibit “C”** that are within the past seven years (rate semesters beginning July 1, 2012), AHCA agrees to promptly re-process all applicable claims using the revised rates, and the Parties agree that they are bound by such revised rates and will make any payments or adjustments required consistent with applicable law as required by such re-processing.

7. AdventHealth Orlando and AHCA agree that the revised rates as shown on **Exhibit “C”** supersede the rates on **Exhibit “A”** and shall be final and not subject to further re-opening or adjustment. AdventHealth Orlando and AHCA further agree that all other rates appearing at **Exhibit “A”** shall also be final and not subject to further re-opening or adjustment. Such finality,

however, may not affect any reconciliation that AHCA may have to make as a matter of law as a result of Medicaid Disproportionate Share Hospital (DSH) Payments. Such finality, however, may also not affect any adjustment to the rates resulting from any recalculation of the Medicaid Trend Adjustment which may be required as a result of the consolidated appeals styled *Southern Baptist Hospital of Florida, et al. v. Agency for Health Care Administration* (lowest Case No. 1D17-2027, Florida First District Court of Appeal).

8. The Parties otherwise agree that the above adjustments resolve and settle this case completely and release each from any administrative or civil liabilities arising from the findings relating to the claims of adjustment of Medicaid Inpatient and Outpatient Hospital Rates pursuant to the Notice. Such resolution, however, shall not prevent AHCA from recovering any overpayment that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. Further, such release shall not prevent AHCA, the United States Medicaid Fraud Control Unit, or any other nonsignatory to this Agreement from pursuing any action relating to fraud against AdventHealth Orlando.

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. The exclusive venue for any action arising from this Agreement shall be in Leon County, Florida.

12. This Agreement constitutes the entire agreement between AdventHealth Orlando 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 AdventHealth Orlando 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. AdventHealth Orlando 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. AdventHealth Orlando further agrees that it shall not challenge or contest any Final Order entered in this matter which is consistent with the terms of this 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. The Parties agree to bear their own attorneys fees and costs.

16. 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.

17. 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; provided, however, if any provision of this Agreement regarding the payments required herein is prohibited by law, this Agreement is null and void and of no further effect, and AHCA agrees that it will send this appeal to DOAH for hearing at the request of AdventHealth Orlando.

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

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

20. The Parties acknowledge that AHCA's payments required pursuant to the terms of this Agreement are subject to and contingent upon the review and approval of the Chief Financial Officer pursuant to his authority as set forth in the Florida Constitution and section 17.03, Florida Statutes, which provides in pertinent part: "The Chief Financial Officer of this state, using generally accepted auditing procedures for testing or sampling, shall examine, audit, and settle all accounts, claims, and demands, whatsoever, against the state, arising under any law or resolution of the Legislature, and issue a warrant directing the payment out of the State Treasury of such amount as he or she allows thereon." Should the Chief Financial Officer not approve such payments, then this Agreement shall be null and void and of no further effect, and AHCA shall immediately refer the matter to DOAH for a formal administrative hearing.

21. This Agreement shall be in full force and effect upon execution by the respective Parties in counterpart; provided, however, if AHCA does not execute the agreement within 90 days of execution by AdventHealth Orlando, such hospital may, in its sole discretion, withdraw its

acceptance of the agreement at any point thereafter.

THE REMAINDER OF THIS PAGE INTENTIONALLY BLANK

ADVENTIST HEALTH SYSTEM/SUNBELT, INC.

[Signature]
Providers' Representative

Dated: 7/10/19

BY: Tom Goodman, MD
(Print Name and Title)

[Signature]
Legal Counsel for Provider (as to form and sufficiency)

Dated: 7/23/19

BY: Kyle Kemper
(Print Name)

AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive, Bldg. 3, Mail Stop #3
Tallahassee, FL 32308-5403

[Signature]
Stefan R. Grow
General Counsel

Dated: 9/9/2019

Beth Kidder
Deputy Secretary for Medicaid

Dated: _____

[Signature]
Tom Wallace
ADS, Medicaid Finance & Analytics

Dated: 8/28/19

[Signature]
Lisa Smith
Bureau Chief, Medicaid Program Finance

Dated: 8/28/19

Kim A. Kellum
Chief Medicaid Counsel

Dated: _____

Joseph M. Goldstein, Esq.
(as to form and sufficiency)

Dated: _____

ADVENTIST HEALTH SYSTEM/SUNBELT, INC.

Providers' Representative

Dated: _____

BY: _____
(Print name and Title)

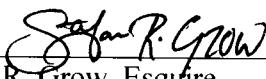
Legal Counsel for Provider (as to form and sufficiency)

Dated: _____

BY: _____
(Print Name)

AGENCY FOR HEALTH CARE ADMINISTRATION

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

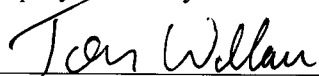


Stefan R. Grow, Esquire
General Counsel

Dated: 9/9, 2019

Beth Kidder
Deputy Secretary for Medicaid

Dated: _____, 2019

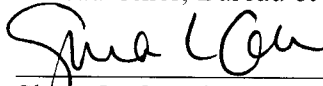


Tom Wallace
ADS, Medicaid Finance & Analytics

Dated: 8/28/, 2019

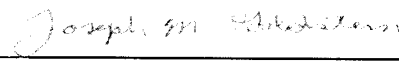
Lisa Smith
Bureau Chief, Bureau of Medicaid Program Finance

Dated: _____, 2019



Sheana L. Grantham
Chief Medicaid Administrative Litigation and
Medicaid Program Integrity Counsel

Dated: 9/4, 2019



Joseph M. Goldstein
Shutts & Bowen, AHCA Outside Counsel

Dated: August 6, 2019

(

Exhibit “A”



RECEIVED
FEB 21 2015
PATIENT FINANCIAL
SERVICES

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

February 13, 2015
Certified Mail Receipt No.:
91 7108 2133 3937 6299 5794

Florida Hospital - Orlando
Attn: Hospital Administrator
900 Winderley Place Suite 200
Maitland, Florida 32751

Reference(s): Notice of Agency Action
Historical Medicaid Inpatient and Outpatient Hospital Reimbursement Rates
Medicaid Provider Number 101290

Dear Administrator:

Section 409.905, Florida Statutes and Florida's Medicaid inpatient and outpatient hospital reimbursement plans provide, in relevant part, the following with regard to hospital cost reports and Medicaid reimbursement rates for inpatient or outpatient hospital services:

The agency [AHCA] may not make any adjustment to a hospital's reimbursement more than 5 years after a hospital is notified of an audited rate established by the agency. The prohibition against adjustments more than 5 years after notification is remedial and applies to actions by providers involving Medicaid claims for hospital services.³¹³

Effective October 1, 2013, for cost reports received prior to October 1, 2003, all desk or onsite audits of these cost reports shall be final and not subject to reopening.³¹⁴

For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the agency.³¹⁵

In accordance with these provisions, AHCA has determined that all cost reports, desk or onsite audits of cost reports, audited per diem reimbursement rates calculated by AHCA, or adjustments to audited per diem reimbursement rates calculated by AHCA relating to the

³¹³ §§ 409.905(5)(c)2 and (6)(b)2., Fla. Stat. (2013); Subsection I(M), Florida Title IX Inpatient Hospital Reimbursement Plan, Version XXXIX, incorporated by reference in 59G-6.020, Fla. Admin. Code ("Inpatient Plan"); Subsection I(O), Florida Title IX Outpatient Hospital Reimbursement Plan, version XXIII, incorporated by reference in 59-G 6.030, Fla. Admin. Code ("Outpatient Plan").

³¹⁴ Inpatient Plan § IV(H)(3); Outpatient Plan § IV(G)(5).

³¹⁵ Inpatient Plan §§ I(I), II(F), IV(H)(3); Outpatient Plan §§ II(F), IV(G)(5).



Medicaid inpatient and outpatient reimbursement rates identified in the attached Exhibit A are "final" as that term is used in the provisions quoted above, and therefore not subject to further re-opening or adjustment.

The authorities cited in this notice contain provisions which under certain circumstances authorize the Agency to re-open, correct or adjust historical cost reports and reimbursement rates.³¹⁶ AHCA's determination that the reimbursement rates identified in Exhibit A are final is without prejudice to, or limitation on, your hospital's entitlement to submit amended cost reports or request corrections or adjustments to reimbursement rates in accordance with, and subject to any limitations in, the provisions authorizing such adjustments in the authorities cited herein. If AHCA enters an order determining the reimbursement rates identified in Exhibit A are final, that determination of finality will apply only to a reimbursement rate as currently established and as reflected in Exhibit A, and will not preclude your hospital from requesting the re-opening of a cost report or the correction or adjustment of a reimbursement rate if your hospital was entitled to such adjustments both prior to and after the entry of AHCA's order determining the finality of the rate as currently calculated and as reflected in Exhibit A.

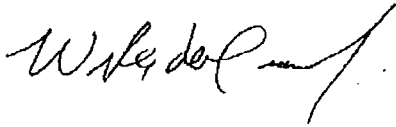
For audited reimbursement rates listed in Exhibit A which your hospital is not currently entitled to have re-opened under any other provisions set forth in the authorities cited above, any requests for cost report re-opening or adjustments to such rates before they become final as a matter of law must be in the form of a request for a hearing challenging the Agency action described in this notice, and must be made in strict compliance with the directions in this notice and the enclosed Notice of Administrative Hearing and Mediation Rights within twenty-one (21) days of your receipt of this letter, or else your hospital's opportunity to challenge this Agency action before it becomes final will be lost.

The Agency action/determination of finality described in this notice only applies to audited reimbursement rates listed in Exhibit A. It does not apply to any rates included in Exhibit A that are preliminary or unaudited as of the date of this notice. When final, audited reimbursement rates are established for any currently unaudited rate semesters included in Exhibit A, a separate Notice of Agency Action and Notice of Administrative Hearing and Mediation Rights will be sent with notice of those audited rates.

Pursuant to §120.57, Fla. Stat., you have the right to request a formal or informal hearing challenging the determinations set forth in this letter and Exhibit A to same. If a petition for a formal hearing is made, the petition must be made in compliance with Rule 28-106.201, Fla. Admin. Code. Please note that Rule 28-106.201(2) specifies that the petition must contain a concise discussion of specific items in dispute. Additionally, you are hereby informed that if a request for a hearing is made, the request or petition must be received within twenty-one (21) days of your receipt of this notice, and that failure to timely request a hearing shall be deemed a waiver of your right to a hearing. For more information regarding your hearing and mediation rights, please see the enclosed Notice of Administrative Hearing and Mediation Rights form. If you wish to request an administrative hearing, you must carefully follow all of the directions for doing so set out in that form.

³¹⁶ For example, Inpatient Plan § IV(H); Outpatient Plan § IV(G)

Sincerely,

A handwritten signature in black ink, appearing to read "W. Rydell Samuel". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

W. Rydell Samuel
Regulatory Analyst Supervisor
Medicaid Program Finance

Enclosures:

Exhibit A

Notice of Administrative Hearing and Mediation Rights

WRS/ba

Exhibit A

MCD PROV ID	NAME	CDE RATE TYPE	EFFECTIVE DATE	FMMIS RATE
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	19840701	348.80
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19840701	31.01
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	19850101	373.54
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	19850701	377.59
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19870101	54.37
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19870701	54.56
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	19880101	467.41
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	19880701	476.16
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19890101	84.60
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19890701	48.64
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19900701	59.21
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19910101	61.06
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19940701	61.77
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	19950101	787.11

Exhibit A

MCD PRQV ID	NAME	CDE RATE TYPE	EFFECTIVE DATE	FMMIS RATE
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19950101	65.02
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19980701	70.55
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19990101	71.65
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	19990701	901.20
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	19990701	73.09
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20000101	914.31
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20000101	74.36
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20000701	1,163.42
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20000701	107.78
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20010101	1,144.66
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20010101	108.50
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20010701	1,096.23
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20010701	104.24
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20040701	134.95

Exhibit A

MCD PROV ID	NAME	CDE RATE TYPE	EFFECTIVE DATE	FMMIS RATE
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010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20060701	142.94
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20070101	1,503.04
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20070101	144.95
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20070701	1,503.04
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20070701	144.28
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20080101	1,521.03
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20080101	129.26
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20080701	1,674.34
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20080701	131.66
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20090101	1,751.29
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20090101	121.45
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20090301	1,751.29
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20090301	121.45
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20090701	1,709.76
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20090701	117.91
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20100101	1,771.15
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20100101	130.17
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20100701	1,803.35
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20100701	132.83
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20110101	2,017.45
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20110101	140.80
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20110701	1,591.90
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20110701	110.20
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Inpatient	20120701	1,500.98
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20120701	127.85
010129000	ADVENTIST HEALTH SYSTEM/SUNBELT, I	Outpatient	20130701	135.83



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

**NOTICE OF ADMINISTRATIVE HEARING
AND MEDIATION RIGHTS**

You have the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If you disagree with the facts stated in the enclosed Notice of Agency Action, you may request a formal administrative hearing pursuant to Section 120.57(1), Florida Statutes. If you do not dispute the facts stated in the Notice of Agency Action, but believe there are additional reasons to grant the relief you seek, you may request an informal administrative hearing pursuant to Section 120.57(2), Florida Statutes. Additionally, pursuant to Section 120.573, Florida Statutes, mediation may be available if you have chosen a formal administrative hearing, as discussed more fully below.

Your written request for an administrative hearing must conform to the requirements of either Rule 28-106.201(2) or Rule 28-106.301(2), Florida Administrative Code, and must be received by the Agency Clerk for the Agency for Health Care Administration, by 5:00 P.M. no later than 21 days after the day you received the Notice of Agency Action. The address for filing the written request for an administrative hearing is:

**Richard J. Shoop, Esquire
Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 3
Tallahassee, Florida 32308
Fax: (850) 921-0158**

The request must be legible, on 8 ½ by 11-inch white paper, and contain:

1. Your name, address, telephone number, any Agency identifying number on the Notice of Agency Action, if known, and name, address, and telephone number of your representative, if any;
2. An explanation of how your substantial interests will be affected by the action described in the Notice of Agency Action;
3. A statement of when and how you received the Notice of Agency Action;
4. For a request for formal hearing, a statement of all disputed issues of material fact;
5. For a request for formal hearing, a concise statement of the ultimate facts alleged; as well as the rules and statutes which entitle you to relief;
6. For a request for formal hearing, whether you request mediation, if it is available;
7. For a request for informal hearing, what bases support an adjustment to the amount owed to the Agency; and
8. A demand for relief.

A formal hearing will be held if there are disputed issues of material fact. Additionally, mediation may be available in conjunction with a formal hearing. Mediation is a way to use a neutral third party to assist the parties in a legal or administrative proceeding to reach a settlement of their case. If you and the Agency agree to mediation, it does not mean that you give up the right to a hearing. Rather, you and the Agency will try to settle your case first with mediation.

2727 Mahan Drive • Mail Stop 23
Tallahassee, FL 32308
AHCA.MyFlorida.com



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Exhibit “B”

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RECEIVED
AGENCY CLERK

MAR 12 2015

Agency for Health
Care Administration

ADVENTIST HEALTH SYSTEM/
SUNBELT, INC. d/b/a FLORIDA
HOSPITAL,

Petitioner,

v.

AHCA Case No.:
Medicaid Provider #: 101290

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.

PETITION FOR FORMAL ADMINISTRATIVE HEARING

Petitioner, ADVENTIST HEALTH SYSTEM/SUNBELT, INC. d/b/a FLORIDA HOSPITAL ("Florida Hospital"), by and through its undersigned counsel, and pursuant to Sections 120.569 and 120.57(1), Florida Statutes, and Rule 28-106.201, Florida Administrative Code, hereby requests a formal administrative hearing regarding Respondent Agency for Health Care Administration's "Notice of Agency Action: Historical Medicaid Inpatient and Outpatient Hospital Reimbursement Rates" dated February 13, 2015. In support of this Petition, Petitioner states as follows:

1. For the purpose of this Petition, Petitioner's name, address and telephone number is Florida Hospital, Reimbursement Services, 900 Hope Way, Altamonte Springs, Florida 32714, 407-357-2315. The name, address, telephone number, facsimile number and e-mail address of the attorneys for Petitioner upon whom service of pleadings and other papers should be made is provided in the signature block below.

2. The name and address of Respondent is STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION (hereinafter "Agency" or "AHCA"), 2727 Mahan Drive, Mail Stop #3, Tallahassee, Florida 32308. The agency action at issue in this proceeding is a letter dated February 13, 2015, entitled "Notice of Agency Action: Historical Medicaid Inpatient and Outpatient Hospital Reimbursement Rates" (hereinafter "Notice"). A copy of the Notice is attached hereto as Exhibit "1." The Agency's file or identification number is not known.

3. The Petitioner's Medicaid Provider Number is 101290. Petitioner received the Notice via certified mail on February 19, 2015, and this Petition for Formal Administrative Hearing is timely filed within twenty-one (21) days from receipt of the Notice.

4. Florida Hospital is a hospital located in Orlando, Florida, which participates in the Florida Medicaid Program administered by the Respondent. The Agency's Notice states, in pertinent part, that "... AHCA has determined that all cost reports, desk or onsite audits of cost reports, audited per diem reimbursement rates calculated by AHCA, or adjustments to audited per diem reimbursement rates calculated by AHCA relating to the Medicaid inpatient and outpatient reimbursement rates identified in the Attached Exhibit A are 'final' ... and therefore not subject to further re-opening or adjustment." Exhibit 1, pgs. 1 and 2.

5. The Agency included as an attachment to the Notice a three page document identified as Exhibit A therein and referenced herein above, consisting of a list of the Medicaid inpatient and outpatient reimbursement rates which are the subject of the Notice (hereinafter, "Exhibit A"). For Petitioner, the list includes reimbursement rates going back as far as 1984, a total of over 110 different rates spanning a cumulative total of approximately thirty years.

6. The process for determining Medicaid reimbursement rates involves the filing by the hospital of a cost report, which is subject to audit. The Medicaid reimbursement rates are also the result of an audit process.

7. The procedures to be utilized to determine the Medicaid reimbursement rates for hospitals providing inpatient services or outpatient services to eligible Medicaid recipients are established by Section 409.905, Florida Statutes (2014), Rule 59G-6.020, Florida Administrative Code, Rule 59 G-6.030, Florida Administrative Code, the Florida Title IX Inpatient Hospital Reimbursement Plan, and the Florida Title IX Outpatient Hospital Reimbursement Plan (the latter two documents have been incorporated by reference into Florida rules). Generally speaking, the Agency over the years has established a Medicaid inpatient hospital reimbursement rate and a Medicaid outpatient hospital reimbursement rate for a given rate semester (which from 1984 through 2011 was for a six month period, and after 2011 is for a twelve month period), and uses the applicable hospital specific reimbursement rates to determine the payments due to the hospital for providing services to Medicaid eligible patients during the relevant rate semester.

8. The general purpose of the Agency Notice appears to be to “clean up” and render final the Medicaid hospital inpatient and outpatient reimbursement rates for Petitioner for the past thirty years. Although this is a laudable goal with which Petitioner agrees in principle, in practice AHCA has, with little warning, required that Petitioner must file a Petition for Administrative Hearing if it seeks to retain or exercise its rights to question the finality of any of the more than one hundred reimbursement rates potentially becoming “final” under the provisions of the Notice.

9. The listed Medicaid reimbursement rates included in Exhibit A of the Notice constitute all of the reimbursement rates established by AHCA for Petitioner going back to 1984, through and including 2013. AHCA has not, in Exhibit A, specified the status of any of these individual rates, and has apparently commingled reimbursement rates both audited and unaudited, as well as rates which may have been audited but which have not been utilized to process Medicaid claims, which would be the final step of the rate setting process necessary to bring to full closure the reimbursement due for the period of the reimbursement rate's applicability. The Agency's Notice is deficient in not clearly providing Petitioner with adequate notice as to which Medicaid rates are impacted in which ways by the Notice, and by including reimbursement rates which should not be subject to final Agency Action.

10. Petitioner's interests will be substantially and adversely affected if the action contained in the Notice were to become final, and if its rights to challenge the finality of each of the rates identified in the Agency's Exhibit A were thereby eliminated, lessened or compromised. The Medicaid reimbursement rates listed in Exhibit A are the rates at which AHCA will reimburse Petitioner for services provided to Medicaid eligible patients and the establishment of the final rates thus substantially affects Petitioner.

11. The disputed issues of material fact raised by this Petition include the following:

- A. What the status is of each individual Medicaid reimbursement rate contained in Exhibit A.
- B. Whether each of the rates contained in Exhibit A have been audited.
- C. Whether any requests for reopening or other challenges to each rate contained in Exhibit A have been filed and are pending.

D. Whether each individual rate contained in Exhibit A is unaudited.

E. Whether each individual rate contained in Exhibit A has been utilized by AHCA or its contractors to process all relevant claims for the applicable rate semester.

F. Whether each individual rate contained in Exhibit A is, has been, or should be considered final and not subject to further reopening or other proceedings.

G. Whether for each individual rate contained in Exhibit A, AHCA or its agents or contractors have completed all necessary steps to result in each rate being final, including the processing or reprocessing of all claims under each reimbursement rate.

12. The ultimate facts alleged by Petitioner are that many of the reimbursement rates contained in Exhibit A to the Agency Notice are not and should not be deemed "final," and that the Agency must determine which of the rates should be declared "final," and which should still be open for determining payments, reopening, or other adjustments.

13. The statutes and rules entitling Petitioner to relief include Sections 120.569, 120.57(1), and 409.905, Florida Statutes, Rules 59G-6.020, 59G-6.030, and Rule Chapters 28-106 and 59A-7, Florida Administrative Code, the Florida Title IX Inpatient Hospital Reimbursement Plan and the Florida Title IX Outpatient Hospital Reimbursement Plan. These statutes and rules require Respondent, now and in the future, to make adjustments to all of the Petitioner's unaudited reimbursement rates, as well as rates which may have been audited but which have not been utilized to process Medicaid claims, and preclude Respondent from making final all rates set forth in Exhibit A.

14. The ultimate relief sought by Petitioner is the withdrawal of the Agency's Notice and the issuance of an updated Notice which declares "Final" only those rates determined by this proceeding or agreement between the parties to be final under relevant law.

15. Petitioner is willing to participate in mediation of the issues herein presented.

WHEREFORE, Petitioner requests the following relief:

A. That the Agency accept Petitioner's Petition for Formal Administrative Hearing and transmit the Petition to the Division of Administrative Hearings for the conduct of a formal hearing;

B. That the Administrative Law Judge enter a Recommended Order recommending that the Agency's Notice be withdrawn;

C. That the Agency issue a Final Order withdrawing its Notice; and

D. That all other relief be granted as is appropriate under the circumstances.

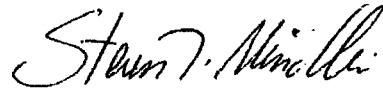
Respectfully submitted this 12th day of March, 2015.



STEVEN T. MINDLIN, P.A.
Fla. Bar #378534
smindlin@sflaw.com
KYLE L. KEMPER, ESQ.
Fla. Bar #628069
kkemper@sflaw.com
SUNDSTROM & MINDLIN, LLP
2548 Blairstone Pines Drive
Tallahassee, Florida 32301
Telephone: (850) 877-6555
Facsimile: (850) 656-4029
Attorneys for Florida Hospital

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that the original and one copy of the foregoing has been served by Hand Delivery to the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308 and a true and correct copy of the foregoing has been served by Hand Delivery to Don Freeman, Esquire, AHCA General Counsel's Office, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308 on this 12th day of March, 2015.



STEVEN T. MINDLIN, P.A.

Exhibit “C”



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1155.86	1158.96	1/1/2002
Outpatient	108.81	109.50	1/1/2002
Inpatient County Billing Rate			1/1/2002

Rate Type:

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

BASIS:

- _____ Budget
- _____ Unaudited Costs
- _____ Field Audited Costs
- X _____ Revised Field Audit
- _____ Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

_____ For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1155.86</u>	<u>1158.96</u>	<u>1/1/2002</u>
Outpatient	<u>108.81</u>	<u>109.50</u>	<u>1/1/2002</u>
Inpatient County Billing Rate			<u>1/1/2002</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1155.86	1158.96	1/1/2002
Outpatient	108.81	109.50	1/1/2002
Inpatient County Billing Rate			1/1/2002

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1229.64	1232.93	4/1/2002
Outpatient	115.76	116.49	4/1/2002
Inpatient County Billing Rate			4/1/2002

Rate Type:

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

BASIS:

- Budget
- Unaudited Costs
- Field Audited Costs
- X** Revised Field Audit
- Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1229.64	1232.93	4/1/2002
Outpatient	115.76	116.49	4/1/2002
Inpatient County Billing Rate			4/1/2002

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1229.64	1232.93	4/1/2002
Outpatient	115.76	116.49	4/1/2002
Inpatient County Billing Rate			4/1/2002

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1253.02</u>	<u>1256.27</u>	<u>7/1/2002</u>
Outpatient	<u>118.29</u>	<u>119.03</u>	<u>7/1/2002</u>
Inpatient County Billing Rate			<u>7/1/2002</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1253.02	1256.27	7/1/2002
Outpatient	118.29	119.03	7/1/2002
Inpatient County Billing Rate			7/1/2002

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2002/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2000
 Audit Status: Revised Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1253.02	1256.27	7/1/2002
Outpatient	118.29	119.03	7/1/2002
Inpatient County Billing Rate			7/1/2002

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

_____ For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2006/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: 3/17/2017
 Fiscal Year End: 12/31/2004
 Audit Status: Field Audit

Provider Type:

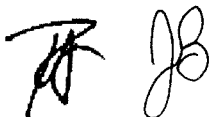
<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1444.12</u>	<u>1415.03</u>	<u>1/1/2006</u>
Outpatient	<u>141.35</u>	<u>135.24</u>	<u>1/1/2006</u>
Inpatient County Billing Rate			<u>1/1/2006</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher 
 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2006/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01

Date: 3/17/2017

Fiscal Year End: 12/31/2004

Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1444.12</u>	<u>1415.03</u>	<u>1/1/2006</u>
Outpatient	<u>141.35</u>	<u>135.24</u>	<u>1/1/2006</u>
Inpatient County Billing Rate			<u>1/1/2006</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2006/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04

Date: 3/17/2017

Fiscal Year End: 12/31/2004

Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1444.12</u>	<u>1415.03</u>	<u>1/1/2006</u>
Outpatient	<u>141.35</u>	<u>135.24</u>	<u>1/1/2006</u>
Inpatient County Billing Rate			<u>1/1/2006</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2006/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2004
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1452.90	1419.49	7/1/2006
Outpatient	142.94	133.34	7/1/2006
Inpatient County Billing Rate			7/1/2006

Rate Type:

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

BASIS:

- Budget
- Unaudited Costs
- X Field Audited Costs
- Revised Field Audit
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W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

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

101290 - 2006/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2004
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1452.90	1419.49	7/1/2006
Outpatient	142.94	133.34	7/1/2006
Inpatient County Billing Rate			7/1/2006

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

_____ For Information only - No Change in rate



Florida Agency For Health Care Administration

101290 - 2006/07

Office of Medicaid Cost Reimbursement Planning and Finance

2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

Medicaid Reimbursement Rate Change Form

Florida Hospital
500 East Rollins Street
Orlando, FL 32803-

Provider Number: 0101290-04

Date: _____

Fiscal Year End: 12/31/2004

Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1452.90	1419.49	7/1/2006
Outpatient	142.94	133.34	7/1/2006
Inpatient County Billing Rate			7/1/2006

Rate Type:

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

BASIS:

- _____ Budget
- _____ Unaudited Costs
- X _____ Field Audited Costs
- _____ Revised Field Audit
- _____ Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



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

101290 - 2007/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2004
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1503.04</u>	<u>1468.47</u>	<u>1/1/2007</u>
Outpatient	<u>144.95</u>	<u>138.68</u>	<u>1/1/2007</u>
Inpatient County Billing Rate			<u>1/1/2007</u>

Rate Type:

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

BASIS:

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- Unaudited Costs
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W. Rydell Samuel or Jesse Bottcher

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Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2004
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1503.04	1468.47	1/1/2007
Outpatient	144.95	138.68	1/1/2007
Inpatient County Billing Rate			1/1/2007

Rate Type:

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

BASIS:

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 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2004
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1503.04	1468.47	1/1/2007
Outpatient	144.95	138.68	1/1/2007
Inpatient County Billing Rate			1/1/2007

Rate Type:

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

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101290 - 2007/07

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Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2005
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1503.04	1493.81	7/1/2007
Outpatient	144.28	136.30	7/1/2007
Inpatient County Billing Rate			7/1/2007

Rate Type:

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

BASIS:

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 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2005
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1503.04	1493.81	7/1/2007
Outpatient	144.28	136.30	7/1/2007
Inpatient County Billing Rate			7/1/2007

Rate Type:

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

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 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2005
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1503.04	1493.81	7/1/2007
Outpatient	144.28	136.30	7/1/2007
Inpatient County Billing Rate			7/1/2007

Rate Type:

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

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101290 - 2008/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2006
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1521.03</u>	<u>1503.44</u>	<u>1/1/2008</u>
Outpatient	<u>129.26</u>	<u>128.61</u>	<u>1/1/2008</u>
Inpatient County Billing Rate			1/1/2008

Rate Type:

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

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Florida Hospital
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 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2006
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1521.03</u>	<u>1503.44</u>	<u>1/1/2008</u>
Outpatient	<u>129.26</u>	<u>128.61</u>	<u>1/1/2008</u>
Inpatient County Billing Rate			<u>1/1/2008</u>

Rate Type:

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

BASIS:

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 Medicaid Cost Reimbursement Analysis

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 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2006
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1521.03</u>	<u>1503.44</u>	<u>1/1/2008</u>
Outpatient	<u>129.26</u>	<u>128.61</u>	<u>1/1/2008</u>
Inpatient County Billing Rate			<u>1/1/2008</u>

Rate Type:

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

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 Medicaid Cost Reimbursement Analysis

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 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2008/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2006
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1674.34</u>	<u>1654.24</u>	<u>7/1/2008</u>
Outpatient	<u>131.66</u>	<u>130.99</u>	<u>7/1/2008</u>
Inpatient County Billing Rate			<u>7/1/2008</u>

Rate Type:

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

BASIS:

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Medicaid Cost Reimbursement Analysis

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 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2008/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2006
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1674.34</u>	<u>1654.24</u>	<u>7/1/2008</u>
Outpatient	<u>131.66</u>	<u>130.99</u>	<u>7/1/2008</u>
Inpatient County Billing Rate			<u>7/1/2008</u>

Rate Type:

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

BASIS:

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 Medicaid Cost Reimbursement Analysis

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Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2006
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1674.34</u>	<u>1654.24</u>	<u>7/1/2008</u>
Outpatient	<u>131.66</u>	<u>130.99</u>	<u>7/1/2008</u>
Inpatient County Billing Rate			<u>7/1/2008</u>

Rate Type:

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

BASIS:

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W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 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: _____
 Fiscal Year End: 12/31/2007
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1751.29</u>	<u>1737.45</u>	<u>1/1/2009</u>
Outpatient	<u>121.45</u>	<u>124.60</u>	<u>1/1/2009</u>
Inpatient County Billing Rate			<u>1/1/2009</u>

Rate Type:

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

BASIS:

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Florida Hospital
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Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2007
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1751.29</u>	<u>1737.45</u>	<u>1/1/2009</u>
Outpatient	<u>121.45</u>	<u>124.60</u>	<u>1/1/2009</u>
Inpatient County Billing Rate			<u>1/1/2009</u>

Rate Type:

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

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Provider Number: 0101290-04
 Date: _____
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 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1751.29</u>	<u>1737.45</u>	<u>1/1/2009</u>
Outpatient	<u>121.45</u>	<u>124.60</u>	<u>1/1/2009</u>
Inpatient County Billing Rate			1/1/2009

Rate Type:

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

BASIS:

- Budget
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- X Field Audited Costs
- Revised Field Audit
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Florida Hospital
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 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2007
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1751.29</u>	<u>1737.45</u>	<u>3/1/2009</u>
Outpatient	<u>121.45</u>	<u>124.60</u>	<u>3/1/2009</u>
Inpatient County Billing Rate			<u>3/1/2009</u>

Rate Type:

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

BASIS:

- Budget
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Provider Number: 0101290-01
 Date: _____
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 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1751.29</u>	<u>1737.45</u>	<u>3/1/2009</u>
Outpatient	<u>121.45</u>	<u>124.60</u>	<u>3/1/2009</u>
Inpatient County Billing Rate			<u>3/1/2009</u>

Rate Type:

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

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Provider Number: 0101290-04
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Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1751.29</u>	<u>1737.45</u>	<u>3/1/2009</u>
Outpatient	<u>121.45</u>	<u>124.60</u>	<u>3/1/2009</u>
Inpatient County Billing Rate			<u>3/1/2009</u>

Rate Type:

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

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 Fiscal Year End: 12/31/2007
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1709.76	1696.42	7/1/2009
Outpatient	117.91	120.96	7/1/2009
Inpatient County Billing Rate			7/1/2009

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2009/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2007
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1709.76</u>	<u>1696.42</u>	<u>7/1/2009</u>
Outpatient	<u>117.91</u>	<u>120.96</u>	<u>7/1/2009</u>
Inpatient County Billing Rate			<u>7/1/2009</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2009/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2007
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1709.76	1696.42	7/1/2009
Outpatient	117.91	120.96	7/1/2009
Inpatient County Billing Rate			7/1/2009

Rate Type:

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

BASIS:

- _____ Budget
- _____ Unaudited Costs
- X Field Audited Costs
- _____ Revised Field Audit
- _____ Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2010/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2008
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1771.15</u>	<u>1758.05</u>	<u>1/1/2010</u>
Outpatient	<u>130.17</u>	<u>137.64</u>	<u>1/1/2010</u>
Inpatient County Billing Rate			<u>1/1/2010</u>

Rate Type:

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

BASIS:

- Budget
- Unaudited Costs
- X Field Audited Costs
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- Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



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

101290 - 2010/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2008
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1771.15</u>	<u>1758.05</u>	<u>1/1/2010</u>
Outpatient	<u>130.17</u>	<u>137.64</u>	<u>1/1/2010</u>
Inpatient County Billing Rate			<u>1/1/2010</u>

Rate Type:

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

BASIS:

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- Unaudited Costs
- X Field Audited Costs
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W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



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 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2010/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2008
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1771.15</u>	<u>1758.05</u>	<u>1/1/2010</u>
Outpatient	<u>130.17</u>	<u>137.64</u>	<u>1/1/2010</u>
Inpatient County Billing Rate			<u>1/1/2010</u>

Rate Type:

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

BASIS:

- Budget
- Unaudited Costs
- X Field Audited Costs
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- Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



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

101290 - 2010/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2008
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1803.35	1789.59	7/1/2010
Outpatient	132.83	140.45	7/1/2010
Inpatient County Billing Rate			7/1/2010

Rate Type:

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

BASIS:

- Budget
- Unaudited Costs
- X Field Audited Costs
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W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



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 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2010/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2008
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1803.35</u>	<u>1789.59</u>	<u>7/1/2010</u>
Outpatient	<u>132.83</u>	<u>140.45</u>	<u>7/1/2010</u>
Inpatient County Billing Rate			<u>7/1/2010</u>

Rate Type:

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

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- Budget
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- Revised Field Audit
- Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2010/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2008
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1803.35	1789.59	7/1/2010
Outpatient	132.83	140.45	7/1/2010
Inpatient County Billing Rate			7/1/2010

Rate Type:

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

BASIS:

- _____ Budget
- _____ Unaudited Costs
- X _____ Field Audited Costs
- _____ Revised Field Audit
- _____ Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

_____ For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2011/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2009
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	2017.45	1973.38	1/1/2011
Outpatient	140.80	157.82	1/1/2011
Inpatient County Billing Rate			1/1/2011

Rate Type:

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

BASIS:

- _____ Budget
- _____ Unaudited Costs
- X _____ Field Audited Costs
- _____ Revised Field Audit
- _____ Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

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

101290 - 2011/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2009
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	2017.45	1973.38	1/1/2011
Outpatient	140.80	157.82	1/1/2011
Inpatient County Billing Rate			1/1/2011

Rate Type:

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

BASIS:

- Budget
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- Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



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

101290 - 2011/01

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2009
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	2017.45	1973.38	1/1/2011
Outpatient	140.80	157.82	1/1/2011
Inpatient County Billing Rate			1/1/2011

Rate Type:

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

BASIS:

- Budget
- Unaudited Costs
- X** Field Audited Costs
- Revised Field Audit
- Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2011/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2009
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1591.90</u>	<u>1562.98</u>	<u>7/1/2011</u>
Outpatient	<u>110.20</u>	<u>120.41</u>	<u>7/1/2011</u>
Inpatient County Billing Rate			<u>7/1/2011</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2011/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2009
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1591.90</u>	<u>1562.98</u>	<u>7/1/2011</u>
Outpatient	<u>110.20</u>	<u>120.41</u>	<u>7/1/2011</u>
Inpatient County Billing Rate			<u>7/1/2011</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

 For Information only - No Change in rate



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

101290 - 2011/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2009
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1591.90	1562.98	7/1/2011
Outpatient	110.20	120.41	7/1/2011
Inpatient County Billing Rate			7/1/2011

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2012/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: 9/5/2018
 Fiscal Year End: 12/31/2010
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>1500.98</u>	<u>1403.01</u>	<u>7/1/2012</u>
Outpatient	<u>127.85</u>	<u>107.16</u>	<u>7/1/2012</u>
Inpatient County Billing Rate			<u>7/1/2012</u>

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



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

101290 - 2012/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01

Date: 9/5/2018

Fiscal Year End: 12/31/2010

Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1500.98	1403.01	7/1/2012
Outpatient	127.85	107.16	7/1/2012
Inpatient County Billing Rate			7/1/2012

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



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101290 - 2012/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04

Date: 9/5/2018

Fiscal Year End: 12/31/2010

Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	1500.98	1403.01	7/1/2012
Outpatient	127.85	107.16	7/1/2012
Inpatient County Billing Rate			7/1/2012

Rate Type:

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

BASIS:

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

W. Rydell Samuel or Jesse Bottcher

Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



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101290 - 2013/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-00
 Date: _____
 Fiscal Year End: 12/31/2011
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>DRG</u>	<u>DRG</u>	<u>7/1/2013</u>
Outpatient	<u>135.83</u>	<u>119.50</u>	<u>7/1/2013</u>
Inpatient County Billing Rate			<u>7/1/2013</u>

Rate Type:

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

BASIS:

- _____ Budget
- _____ Unaudited Costs
- X _____ Field Audited Costs
- _____ Revised Field Audit
- _____ Cost Report Late Test

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

For Information only - No Change in rate



Florida Agency For Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 2727 Mahan Drive Mail Stop 23 Tallahassee, Florida 32308

101290 - 2013/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-01
 Date: _____
 Fiscal Year End: 12/31/2011
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	<u>DRG</u>	<u>DRG</u>	<u>7/1/2013</u>
Outpatient	<u>135.83</u>	<u>119.50</u>	<u>7/1/2013</u>
Inpatient County Billing Rate			<u>7/1/2013</u>

Rate Type:

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

BASIS:

- _____ Budget
- _____ Unaudited Costs
- X _____ Field Audited Costs
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W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

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101290 - 2013/07

Medicaid Reimbursement Rate Change Form

Florida Hospital
 500 East Rollins Street
 Orlando, FL 32803-

Provider Number: 0101290-04
 Date: _____
 Fiscal Year End: 12/31/2011
 Audit Status: Field Audit

Provider Type:

<u>HOSPITAL</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
Inpatient	DRG	DRG	7/1/2013
Outpatient	135.83	119.50	7/1/2013
Inpatient County Billing Rate			7/1/2013

Rate Type:

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

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

W. Rydell Samuel or Jesse Bottcher

 Medicaid Cost Reimbursement Analysis

_____ For Information only - No Change in rate



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester January 01, 2002 through March 31, 2002

101290 - 2002/01
1158.96 / 109.50

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2000 - 12/31/2000

Type of Action: Revised Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Florida Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	269,586,768.00	179,211,658.00	21,660,608.00	9,013,074.00	Total Bed Days	531,432
2. Routine	166,946,941.00		16,953,963.00		Total Inpatient Days	346,100
3. Special Care	61,244,596.00		4,720,387.00		Total Newborn Days	31,309
4. Newborn Routine	13,224,556.00		3,993,464.00		Medicaid Inpatient Days	35,391
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	4,240
6. Home Health					Medicare Inpatient Days	148,208
7. Malpractice	8,256,426.49	2,895,576.51	866,991.61	145,626.94	Prospective Inflation Factor	1.0658105939
8. Adjustments	(3,472,169.93)	(1,217,710.07)	(321,587.87)	(61,242.17)	Medicaid Paid Claims	83,237
9. Total Cost	515,787,117.56	180,889,524.44	47,873,825.74	9,097,458.77	Property Rate Allowance	0.80
10. Charges	1,389,723,287.00	622,329,691.00	117,828,359.00	27,785,793.00	First Rate Semester in Effect	2002/01
11. Fixed Costs	95,936,718.00		8,134,040.90		Last Rate Semester in Effect	2002/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
1. Normalized Rate	1,061.31	115.68	County Ceiling Base	760.89	138.73	Semester DRI Index	1.3280
2. Base Rate Semester	2001/01	2001/07	Variable Cost Base	789.60	78.16	Cost Report DRI Index	1.2460
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	991.37	140.95	FPLI Year Used	2000
4. Rate of Increase (Year/Sem.)	1.013373	1.020321	County Ceiling	998.31	141.94	FPLI	1.0070

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	47,873,825.74	9,097,458.77
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,134,040.90	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	39,739,784.85	9,097,458.77
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	42,355,083.69	9,696,167.93
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	39,631	83,237
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,068.74	116.49
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,068.74	116.49
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (1.0070) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,068.74	116.49
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	164.20	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,232.93	116.49
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	117,828,359.00	27,785,793.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	2,973.14	333.82
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	3,168.80	355.78
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,232.93	116.49
AU	Reduce Hospital Rates By 6%	(73.98)	(6.99)
AV			
AW			
AX			
AY	Final Prospective Rates	1,158.96	109.50



Florida Agency for Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester April 01, 2002 through June 30, 2002

101290 - 2002/01
1232.93 / 116.49

Florida Hospital

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2000 - 12/31/2000

Type of Action: Revised Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	269,586,768.00	179,211,658.00	21,660,608.00	9,013,074.00	Total Bed Days	531,432
2. Routine	166,946,941.00		16,953,963.00		Total Inpatient Days	346,100
3. Special Care	61,244,596.00		4,720,387.00		Total Newborn Days	31,309
4. Newborn Routine	13,224,556.00		3,993,464.00		Medicaid Inpatient Days	35,391
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	4,240
6. Home Health					Medicare Inpatient Days	148,208
7. Malpractice	8,256,426.49	2,895,576.51	866,991.61	145,626.94	Prospective Inflation Factor	1.0658105939
8. Adjustments	(3,472,169.93)	(1,217,710.07)	(321,587.87)	(61,242.17)	Medicaid Paid Claims	83,237
9. Total Cost	515,787,117.56	180,889,524.44	47,873,825.74	9,097,458.77	Property Rate Allowance	0.80
10. Charges	1,389,723,287.00	622,329,691.00	117,828,359.00	27,785,793.00	First Rate Semester in Effect	2002/01
11. Fixed Costs		95,936,718.00		8,134,040.90	Last Rate Semester in Effect	2002/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
1. Normalized Rate	1,061.31	115.68	County Ceiling Base	760.89	138.73	Semester DRI Index	1.3280
2. Base Rate Semester	2001/01	2001/07	Variable Cost Base	789.60	78.16	Cost Report DRI Index	1.2460
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	991.37	140.95	FPLI Year Used	2000
4. Rate of Increase (Year/Sem.)	1.013373	1.020321	County Ceiling	998.31	141.94	FPLI	1.0070

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	47,873,825.74	9,097,458.77
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,134,040.90	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	39,739,784.85	9,097,458.77
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	42,355,083.69	9,696,167.93
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	39,631	83,237
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,068.74	116.49
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,068.74	116.49
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (1.0070) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,068.74	116.49
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	164.20	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,232.93	116.49
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	117,828,359.00	27,785,793.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	2,973.14	333.82
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	3,168.80	355.78
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,232.93	116.49
AU			
AV			
AW			
AX			
AY	Final Prospective Rates	1,232.93	116.49



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2002 through December 31, 2002

101290 - 2002/07
1256.27 / 119.03

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2000 - 12/31/2000

Type of Action: Revised Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	269,586,768.00	179,211,658.00	21,660,608.00	9,013,074.00	Total Bed Days	531,432
2. Routine	166,946,941.00		16,953,963.00		Total Inpatient Days	346,100
3. Special Care	61,244,596.00		4,720,387.00		Total Newborn Days	31,309
4. Newborn Routine	13,224,556.00		3,993,464.00		Medicaid Inpatient Days	35,391
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	4,240
6. Home Health					Medicare Inpatient Days	148,208
7. Malpractice	8,256,426.49	2,895,576.51	866,991.61	145,626.94	Prospective Inflation Factor	1.0890850722
8. Adjustments	(3,472,169.93)	(1,217,710.07)	(321,587.87)	(61,242.17)	Medicaid Paid Claims	83,237
9. Total Cost	515,787,117.56	180,889,524.44	47,873,825.74	9,097,458.77	Property Rate Allowance	0.80
10. Charges	1,389,723,287.00	622,329,691.00	117,828,359.00	27,785,793.00	First Rate Semester in Effect	2002/01
11. Fixed Costs	95,936,718.00		8,134,040.90		Last Rate Semester in Effect	2002/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,131.57		123.34	County Ceiling Base	771.07	141.55
2. Base Rate Semester	2002/01	2002/01	Variable Cost Base	800.16	79.75	Cost Report DRI Index	1.2460
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,028.25	131.95	FPLI Year Used	2001
4. Rate of Increase (Year/Sem.)	1.021565	1.025206	County Ceiling	992.36	127.34	FPLI	0.9651

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	47,873,825.74	9,097,458.77
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,134,040.90	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	39,739,784.85	9,097,458.77
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	43,280,006.45	9,907,906.54
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	39,631	83,237
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,092.07	119.03
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,092.07	119.03
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9651) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,092.07	119.03
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	164.20	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,256.27	119.03
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	117,828,359.00	27,785,793.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	2,973.14	333.82
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	3,238.00	363.55
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,256.27	119.03
AU			
AV			
AW			
AX			
AY	Final Prospective Rates	1,256.27	119.03



Florida Agency for Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester January 01, 2006 through June 30, 2006

101290 - 2006/01

1415.03 / 135.24

Florida Hospital

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2004 - 12/31/2004

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	435,357,716.00	273,569,953.00	36,591,882.00	15,600,933.00	Total Bed Days	631,350
2. Routine	266,999,243.00		30,215,265.00		Total Inpatient Days	474,628
3. Special Care	83,075,434.00		8,580,532.00		Total Newborn Days	33,570
4. Newborn Routine	16,699,343.00		6,757,524.00		Medicaid Inpatient Days	54,607
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	4,964
6. Home Health					Medicare Inpatient Days	238,408
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0883152174
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	125,542
9. Total Cost	802,131,736.00	273,569,953.00	82,145,203.00	15,600,933.00	Property Rate Allowance	0.80
10. Charges	2,688,158,795.00	1,134,425,725.00	248,469,981.00	66,457,946.00	First Rate Semester in Effect	2006/01
11. Fixed Costs		94,070,770.00		8,695,082.48	Last Rate Semester in Effect	2007/01

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,375.72		138.65	County Ceiling Base	817.73	133.32
2. Base Rate Semester	2005/01	2005/07	Variable Cost Base	848.58	92.16	Cost Report DRI Index	1.4720
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,337.11	156.74	FPLI Year Used	2004
4. Rate of Increase (Year/Sem.)	1.018030	1.019494	County Ceiling	1,304.22	152.88	FPLI	0.9754

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	82,145,203.00	15,600,933.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,695,082.48	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	73,450,120.52	15,600,933.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	79,936,883.88	16,978,732.79
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	59,571	125,542
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,341.88	135.24
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,341.88	135.24
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9754) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,341.88	135.24
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	116.77	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,458.65	135.24
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	248,469,981.00	66,457,946.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	4,170.99	529.37
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	4,539.35	576.12
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,458.65	135.24
AU	Medicaid Trend Adjustment Lower of Test (IP%: 2.9901 %, OP%: 0.0000 %)	(43.62)	0.00
AV			
AW			
AX			
AY	Final Prospective Rates	1,415.03	135.24



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2006 through December 31, 2006

101290 - 2006/07
1419.49 / 133.34

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2004 - 12/31/2004

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	435,357,716.00	273,569,953.00	36,591,882.00	15,600,933.00	Total Bed Days	631,350
2. Routine	266,999,243.00		30,215,265.00		Total Inpatient Days	474,628
3. Special Care	83,075,434.00		8,580,532.00		Total Newborn Days	33,570
4. Newborn Routine	16,699,343.00		6,757,524.00		Medicaid Inpatient Days	54,607
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	4,964
6. Home Health					Medicare Inpatient Days	238,408
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.1188858696
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	125,542
9. Total Cost	802,131,736.00	273,569,953.00	82,145,203.00	15,600,933.00	Property Rate Allowance	0.80
10. Charges	2,688,158,795.00	1,134,425,725.00	248,469,981.00	66,457,946.00	First Rate Semester in Effect	2006/01
11. Fixed Costs	94,070,770.00		8,695,082.48		Last Rate Semester in Effect	2007/01

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
1. Normalized Rate	1,409.31	142.04	County Ceiling Base	832.47	135.93	Semester DRI Index	1.6470
2. Base Rate Semester	2006/01	2006/01	Variable Cost Base	863.88	93.95	Cost Report DRI Index	1.4720
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,338.56	151.05	FPLI Year Used	2005
4. Rate of Increase (Year/Sem.)	1.021685	1.029510	County Ceiling	1,310.32	147.86	FPLI	0.9789

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	82,145,203.00	15,600,933.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,695,082.48	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	73,450,120.52	15,600,933.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	82,182,301.97	17,455,663.49
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	59,571	125,542
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,379.57	139.04
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,379.57	139.04
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9789) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,379.57	139.04
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	116.77	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,496.34	139.04
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	248,469,981.00	66,457,946.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	4,170.99	529.37
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	4,666.86	592.30
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,496.34	139.04
AU	Medicaid Trend Adjustment (IP%: 5.1359 %, OP%: 4.0990 %)	(76.85)	(5.70)
AV			
AW			
AX			
AY	Final Prospective Rates	1,419.49	133.34



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester January 01, 2007 through June 30, 2007

101290 - 2007/01
1468.47 / 138.68

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2004 - 12/31/2004

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	435,357,716.00	273,569,953.00	36,591,882.00	15,600,933.00	Total Bed Days	631,350
2. Routine	266,999,243.00		30,215,265.00		Total Inpatient Days	474,628
3. Special Care	83,075,434.00		8,580,532.00		Total Newborn Days	33,570
4. Newborn Routine	16,699,343.00		6,757,524.00		Medicaid Inpatient Days	54,607
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	4,964
6. Home Health					Medicare Inpatient Days	238,408
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.1575016972
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	125,542
9. Total Cost	802,131,736.00	273,569,953.00	82,145,203.00	15,600,933.00	Property Rate Allowance	0.80
10. Charges	2,688,158,795.00	1,134,425,725.00	248,469,981.00	66,457,946.00	First Rate Semester in Effect	2006/01
11. Fixed Costs	94,070,770.00		8,695,082.48		Last Rate Semester in Effect	2007/01

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
1. Normalized Rate	1,457.94	146.94	County Ceiling Base	832.47	139.94	Semester DRI Index	1.7050
2. Base Rate Semester	2006/01	2006/07	Variable Cost Base	863.88	96.72	Cost Report DRI Index	1.4730
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,401.00	161.93	FPLI Year Used	2005
4. Rate of Increase (Year/Sem.)	1.021685	1.032773	County Ceiling	1,371.44	158.51	FPLI	0.9789

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	82,145,203.00	15,600,933.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,695,082.48	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	73,450,120.52	15,600,933.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	85,018,639.16	18,058,106.43
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	59,571	125,542
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,427.18	143.84
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,427.18	143.84
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9789) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,427.18	143.84
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	116.77	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,543.95	143.84
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	248,469,981.00	66,457,946.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	4,170.99	529.37
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	4,827.93	612.74
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,543.95	143.84
AU	Medicaid Trend Adjustment (IP%: 4.8887 %, OP%: 3.5855 %)	(75.48)	(5.16)
AV			
AW			
AX			
AY	Final Prospective Rates	1,468.47	138.68



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2007 through December 31, 2007

101290 - 2007/07
1493.81 / 136.30

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2005 - 12/31/2005

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	462,842,652.00	303,696,635.00	41,979,229.00	16,283,593.00	Total Bed Days	650,715
2. Routine	280,673,595.00		34,035,063.00		Total Inpatient Days	472,846
3. Special Care	83,513,737.00		8,505,103.00		Total Newborn Days	37,728
4. Newborn Routine	21,511,356.00		7,596,623.00		Medicaid Inpatient Days	58,045
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	5,156
6. Home Health					Medicare Inpatient Days	228,085
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0923076923
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	130,495
9. Total Cost	848,541,340.00	303,696,635.00	92,116,018.00	16,283,593.00	Property Rate Allowance	0.80
10. Charges	2,966,557,353.00	1,292,890,147.00	295,791,235.00	73,031,674.00	First Rate Semester in Effect	2007/07
11. Fixed Costs	89,919,775.00		8,965,773.50		Last Rate Semester in Effect	2007/07

Ceiling and Target Information

	IP (F)	OP (F)			Inflation / FPLI Data (H)		
			IP (G)	OP (G)			
1. Normalized Rate	1,468.07	139.24	County Ceiling Base	850.52	144.52	Semester DRI Index	1.7040
2. Base Rate Semester	2007/01	2007/01	Variable Cost Base	882.61	99.89	Cost Report DRI Index	1.5600
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,350.51	156.28	FPLI Year Used	2005
4. Rate of Increase (Year/Sem.)	1.024473	1.027648	County Ceiling	1,322.01	152.98	FPLI	0.9789

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) -Outpatient based on Medicaid Cost(D9)	92,116,018.00	16,283,593.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,965,773.50	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	83,150,244.50	16,283,593.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	90,825,651.69	17,786,693.89
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	63,201	130,495
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,437.09	136.30
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,437.09	136.30
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9789) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,437.09	136.30
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	113.49	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,550.58	136.30
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	295,791,235.00	73,031,674.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	4,680.17	559.65
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	5,112.18	611.31
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,550.58	136.30
AU	Medicaid Trend Adjustment (IP%: 3.6615 %, OP%: 0.0000 %)	(56.78)	0.00
AV			
AW			
AX			
AY	Final Prospective Rates	1,493.81	136.30



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester January 01, 2008 through June 30, 2008

101290 - 2008/01
1503.44 / 128.61

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2006 - 12/31/2006

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	472,183,149.00	308,730,254.00	42,729,434.00	16,567,440.00	Total Bed Days	643,224
2. Routine	303,048,006.00		34,190,883.00		Total Inpatient Days	474,060
3. Special Care	89,834,429.00		9,953,381.00		Total Newborn Days	36,883
4. Newborn Routine	23,289,204.00		9,161,292.00		Medicaid Inpatient Days	54,968
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	6,195
6. Home Health					Medicare Inpatient Days	215,566
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0653634698
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	132,257
9. Total Cost	888,354,788.00	308,730,254.00	96,034,990.00	16,567,440.00	Property Rate Allowance	0.80
10. Charges	3,279,006,799.00	1,408,394,748.00	324,998,570.00	76,988,683.00	First Rate Semester in Effect	2008/01
11. Fixed Costs	86,413,534.00		8,564,872.44		Last Rate Semester in Effect	2008/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,556.43		136.33	County Ceiling Base	850.52	148.52
2. Base Rate Semester	2007/01	2007/07	Variable Cost Base	882.61	102.65	Cost Report DRI Index	1.6370
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,447.50	159.94	FPLI Year Used	2005
4. Rate of Increase (Year/Sem.)	1.024473	1.025336	County Ceiling	1,416.96	156.57	FPLI	0.9789

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	96,034,990.00	16,567,440.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,564,872.44	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	87,470,117.56	16,567,440.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	93,187,467.94	17,650,345.36
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	61,163	132,257
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,523.59	133.45
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,523.59	133.45
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9789) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,523.59	133.45
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	112.03	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,635.62	133.45
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	324,998,570.00	76,988,683.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	5,313.65	582.11
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	5,660.96	620.16
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,635.62	133.45
AU	Medicaid Trend Adjustment (IP%: 8.0813 %, OP%: 3.6284 %)	(132.18)	(4.84)
AV			
AW			
AX			
AY	Final Prospective Rates	1,503.44	128.61



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2008 through December 31, 2008

101290 - 2008/07
1654.24 / 130.99

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2006 - 12/31/2006

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	472,183,149.00	308,730,254.00	42,729,434.00	16,567,440.00	Total Bed Days	643,224
2. Routine	303,048,006.00		34,190,883.00		Total Inpatient Days	474,060
3. Special Care	89,834,429.00		9,953,381.00		Total Newborn Days	36,883
4. Newborn Routine	23,289,204.00		9,161,292.00		Medicaid Inpatient Days	54,968
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	6,195
6. Home Health					Medicare Inpatient Days	215,566
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0900183711
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	132,257
9. Total Cost	888,354,788.00	308,730,254.00	96,034,990.00	16,567,440.00	Property Rate Allowance	0.80
10. Charges	3,279,006,799.00	1,408,394,748.00	324,998,570.00	76,988,683.00	First Rate Semester in Effect	2008/01
11. Fixed Costs		86,413,534.00		8,564,872.44	Last Rate Semester in Effect	2008/07

Ceiling and Target Information

1. Normalized Rate	IP (E)	OP (F)	County Ceiling Base	IP (G)	OP (G)	Inflation / FPLI Data (H)	
	2. Base Rate Semester	1,609.88		141.01	871.34	152.28	Semester DRI Index
3. Ultimate Base Rate Semester	2008/01	2008/01	Variable Cost Base	904.21	105.25	Cost Report DRI Index	1.6330
4. Rate of Increase (Year/Sem.)	1991/01	1993/01	State Ceiling	1,521.17	174.17	FPLI Year Used	2006
	1.019699	1.019943	County Ceiling	1,472.95	168.65	FPLI	0.9683

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	96,034,990.00	16,567,440.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	8,564,872.44	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	87,470,117.56	16,567,440.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	95,344,035.06	18,058,813.96
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	61,163	132,257
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,558.85	136.54
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,558.85	136.54
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9683) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,558.85	136.54
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	112.03	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,670.88	136.54
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	324,998,570.00	76,988,683.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	5,313.65	582.11
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	5,791.97	634.52
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,670.88	136.54
AU	Medicaid Trend Adjustment (IP%: 0.9958 %, OP%: 4.0659 %)	(16.64)	(5.55)
AV			
AW			
AX			
AY	Final Prospective Rates	1,654.24	130.99



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester January 01, 2009 through February 28, 2009

101290 - 2009/01
1737.45 / 124.60

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2007 - 12/31/2007

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	501,253,949.00	322,939,587.00	46,278,346.00	15,724,568.00	Total Bed Days	676,053
2. Routine	335,561,330.00		36,465,962.00		Total Inpatient Days	484,057
3. Special Care	94,266,321.00		8,564,608.00		Total Newborn Days	39,763
4. Newborn Routine	26,040,853.00		13,314,903.00		Medicaid Inpatient Days	52,945
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	10,780
6. Home Health					Medicare Inpatient Days	207,415
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0981087470
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	137,589
9. Total Cost	957,122,453.00	322,939,587.00	104,623,819.00	15,724,568.00	Property Rate Allowance	0.80
10. Charges	3,699,261,392.00	1,603,820,844.00	381,064,882.00	85,788,142.00	First Rate Semester in Effect	2009/01
11. Fixed Costs	98,641,611.00		10,161,178.10		Last Rate Semester in Effect	2009/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,681.42		129.63	County Ceiling Base	871.34	155.32
2. Base Rate Semester	2008/01	2008/07	Variable Cost Base	904.21	107.35	Cost Report DRI Index	1.6920
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,616.69	196.57	FPLI Year Used	2007
4. Rate of Increase (Year/Sem.)	1.019699	1.018321	County Ceiling	1,565.12	190.30	FPLI	0.9681

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	104,623,819.00	15,724,568.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	10,161,178.10	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	94,462,640.90	15,724,568.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	103,730,252.23	17,267,285.66
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	63,725	137,589
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,627.78	125.50
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,627.78	125.50
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9681) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,627.78	125.50
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	127.56	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,755.34	125.50
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	381,064,882.00	85,788,142.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	5,979.83	623.51
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	6,566.51	684.68
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,755.34	125.50
AU	Medicaid Trend Adjustment (IP%: 1.0190 %, OP%: 0.7194 %)	(17.89)	(0.90)
AV			
AW			
AX			
AY	Final Prospective Rates	1,737.45	124.60



Florida Agency for Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester March 01, 2009 through June 30, 2009

101290 - 2009/01

1737.45 / 124.60

Florida Hospital

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2007 - 12/31/2007

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	501,253,949.00	322,939,587.00	46,278,346.00	15,724,568.00	Total Bed Days	676,053
2. Routine	335,561,330.00		36,465,962.00		Total Inpatient Days	484,057
3. Special Care	94,266,321.00		8,564,608.00		Total Newborn Days	39,763
4. Newborn Routine	26,040,853.00		13,314,903.00		Medicaid Inpatient Days	52,945
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	10,780
6. Home Health					Medicare Inpatient Days	207,415
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0981087470
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	137,589
9. Total Cost	957,122,453.00	322,939,587.00	104,623,819.00	15,724,568.00	Property Rate Allowance	0.80
10. Charges	3,699,261,392.00	1,603,820,844.00	381,064,882.00	85,788,142.00	First Rate Semester in Effect	2009/01
11. Fixed Costs	98,641,611.00		10,161,178.10		Last Rate Semester in Effect	2009/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,681.42		129.63	County Ceiling Base	871.34	155.32
2. Base Rate Semester	2008/01	2008/07	Variable Cost Base	904.21	107.35	Cost Report DRI Index	1.6920
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,616.69	196.57	FPLI Year Used	2007
4. Rate of Increase (Year/Sem.)	1.019699	1.018321	County Ceiling	1,565.12	190.30	FPLI	0.9681

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	104,623,819.00	15,724,568.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	10,161,178.10	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	94,462,640.90	15,724,568.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	103,730,252.23	17,267,285.66
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	63,725	137,589
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,627.78	125.50
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,627.78	125.50
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9681) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,627.78	125.50
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	127.56	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,755.34	125.50
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	381,064,882.00	85,788,142.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	5,979.83	623.51
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	6,566.51	684.68
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,755.34	125.50
AU	Medicaid Trend Adjustment (IP%: 1.0190 %, OP%: 0.7195 %)	(17.89)	(0.90)
AV			
AW			
AX			
AY	Final Prospective Rates	1,737.45	124.60



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2009 through December 31, 2009

101290 - 2009/07
1696.42 / 120.96

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2007 - 12/31/2007

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	501,253,949.00	322,939,587.00	46,278,346.00	15,724,568.00	Total Bed Days	676,053
2. Routine	335,561,330.00		36,465,962.00		Total Inpatient Days	484,057
3. Special Care	94,266,321.00		8,564,608.00		Total Newborn Days	39,763
4. Newborn Routine	26,040,853.00		13,314,903.00		Medicaid Inpatient Days	52,945
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	10,780
6. Home Health					Medicare Inpatient Days	207,415
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0614657210
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	137,589
9. Total Cost	957,122,453.00	322,939,587.00	104,623,819.00	15,724,568.00	Property Rate Allowance	0.80
10. Charges	3,699,261,392.00	1,603,820,844.00	381,064,882.00	85,788,142.00	First Rate Semester in Effect	2009/01
11. Fixed Costs	98,641,611.00		10,161,178.10		Last Rate Semester in Effect	2009/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,625.31		125.31	County Ceiling Base	888.50	158.17
2. Base Rate Semester	2009/01	2009/01	Variable Cost Base	922.03	109.32	Cost Report DRI Index	1.6920
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,553.43	172.31	FPLI Year Used	2007
4. Rate of Increase (Year/Sem.)	1.008146	1.010999	County Ceiling	1,503.88	166.81	FPLI	0.9681

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	104,623,819.00	15,724,568.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	10,161,178.10	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	94,462,640.90	15,724,568.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	100,268,855.23	16,691,089.91
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	63,725	137,589
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,573.46	121.31
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,573.46	121.31
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9681) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,573.46	121.31
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	127.56	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,701.02	121.31
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	381,064,882.00	85,788,142.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	5,979.83	623.51
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	6,347.39	661.83
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,701.02	121.31
AU	Medicaid Trend Adjustment (IP%: 0.2709 %, OP%: 0.2872 %)	(4.61)	(0.35)
AV	(IP%: 0.0000 %, OP%: 0.0000 %)	0.00	0.00
AW			
AX			
AY	Final Prospective Rates	1,696.42	120.96



Florida Agency for Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester January 01, 2010 through June 30, 2010

101290 - 2010/01

1758.05 / 137.64

Florida Hospital

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2008 - 12/31/2008

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	549,691,485.00	358,073,088.00	53,714,758.00	17,946,383.00	Total Bed Days	721,752
2. Routine	383,945,626.00		42,376,196.00		Total Inpatient Days	500,032
3. Special Care	108,626,981.00		10,491,842.00		Total Newborn Days	37,572
4. Newborn Routine	29,229,822.00		13,494,025.00		Medicaid Inpatient Days	56,295
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	10,744
6. Home Health					Medicare Inpatient Days	204,208
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0137362637
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	131,707
9. Total Cost	1,071,493,914.00	358,073,088.00	120,076,821.00	17,946,383.00	Property Rate Allowance	0.80
10. Charges	4,184,060,525.00	1,858,039,484.00	441,392,541.00	106,641,907.00	First Rate Semester in Effect	2010/01
11. Fixed Costs	155,976,201.00		16,454,525.76		Last Rate Semester in Effect	2010/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,618.57		142.68	County Ceiling Base	888.50	159.91
2. Base Rate Semester	2009/01	2009/07	Variable Cost Base	922.03	110.52	Cost Report DRI Index	1.8200
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,591.01	173.14	FPLI Year Used	2007
4. Rate of Increase (Year/Sem.)	1.008146	1.014567	County Ceiling	1,540.26	167.62	FPLI	0.9681

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	120,076,821.00	17,946,383.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	16,454,525.76	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	103,622,295.24	17,946,383.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	105,045,678.41	18,192,899.25
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	67,039	131,707
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,566.93	138.13
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,566.93	138.13
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9681) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,566.93	138.13
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	196.36	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,763.29	138.13
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	441,392,541.00	106,641,907.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	6,584.12	809.69
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	6,674.56	820.81
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,763.29	138.13
AU	Medicaid Trend Adjustment (IP%: 0.2973 %, OP%: 0.3564 %)	(5.24)	(0.49)
AV	(IP%: 0.0000 %, OP%: 0.0000 %)	0.00	0.00
AW			
AX			
AY	Final Prospective Rates	1,758.05	137.64



Florida Agency for Health Care Administration
 Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2010 through December 31, 2010

101290 - 2010/07
1789.59 / 140.45

Type of Control: Nonprofit (Other)

Florida Hospital

County: Orange (48)

Fiscal Year: 1/1/2008 - 12/31/2008

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	549,691,485.00	358,073,088.00	53,714,758.00	17,946,383.00	Total Bed Days	721,752
2. Routine	383,945,626.00		42,376,196.00		Total Inpatient Days	500,032
3. Special Care	108,626,981.00		10,491,842.00		Total Newborn Days	37,572
4. Newborn Routine	29,229,822.00		13,494,025.00		Medicaid Inpatient Days	56,295
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	10,744
6. Home Health					Medicare Inpatient Days	204,208
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0307523339
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	131,707
9. Total Cost	1,071,493,914.00	358,073,088.00	120,076,821.00	17,946,383.00	Property Rate Allowance	0.80
10. Charges	4,184,060,525.00	1,858,039,484.00	441,392,541.00	106,641,907.00	First Rate Semester in Effect	2010/01
11. Fixed Costs	155,976,201.00		16,454,525.76		Last Rate Semester in Effect	2010/07

Ceiling and Target Information

	IP (F)		OP (F)		IP (G)		OP (G)		Inflation / FPLI Data (H)	
	1. Normalized Rate	1,626.58	143.39			County Ceiling Base	895.74	162.24	Semester DRI Index	1.8770
2. Base Rate Semester	2010/01	2010/01			Variable Cost Base	929.54	112.13	Cost Report DRI Index	1.8210	
3. Ultimate Base Rate Semester	1991/01	1993/01			State Ceiling	1,617.92	189.45	FPLI Year Used	2008	
4. Rate of Increase (Year/Sem.)	1.011969	1.008253			County Ceiling	1,584.75	185.57	FPLI	0.9795	

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	120,076,821.00	17,946,383.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	16,454,525.76	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	103,622,295.24	17,946,383.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	106,808,922.66	18,498,276.16
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	67,039	131,707
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,593.24	140.45
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,593.24	140.45
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9795) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,593.24	140.45
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	196.36	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,789.59	140.45
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	441,392,541.00	106,641,907.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	6,584.12	809.69
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	6,786.59	834.59
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,789.59	140.45
AU			
AV			
AW			
AX			
AY	Final Prospective Rates	1,789.59	140.45



Florida Agency for Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester January 01, 2011 through June 30, 2011

101290 - 2011/01

1973.38 / 157.82

Florida Hospital

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2009 - 12/31/2009

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	582,545,982.00	396,809,400.00	62,513,260.00	26,138,620.00	Total Bed Days	730,368
2. Routine	399,281,011.00		46,430,928.00		Total Inpatient Days	521,893
3. Special Care	125,298,287.00		13,175,236.00		Total Newborn Days	34,331
4. Newborn Routine	27,885,635.00		14,458,272.00		Medicaid Inpatient Days	62,818
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	8,918
6. Home Health					Medicare Inpatient Days	208,749
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0636766334
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	176,166
9. Total Cost	1,135,010,915.00	396,809,400.00	136,577,696.00	26,138,620.00	Property Rate Allowance	0.80
10. Charges	4,793,478,771.00	2,256,928,913.00	538,664,311.00	167,244,748.00	First Rate Semester in Effect	2011/01
11. Fixed Costs	125,271,549.00		14,077,315.42		Last Rate Semester in Effect	2011/07

Ceiling and Target Information

	IP (F)	OP (F)	County Ceiling Base	IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,854.41		161.13	895.74	163.57	Semester DRI Index
2. Base Rate Semester	2010/01	2010/07	Variable Cost Base	929.54	113.06	Cost Report DRI Index	1.8060
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,675.84	222.43	FPLI Year Used	2008
4. Rate of Increase (Year/Sem.)	1.011969	1.017712	County Ceiling	1,641.49	217.87	FPLI	0.9795

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	136,577,696.00	26,138,620.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	14,077,315.42	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	122,500,380.58	26,138,620.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	130,300,792.40	27,803,039.32
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	71,736	176,166
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,816.39	157.82
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,816.39	157.82
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9795) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,816.39	157.82
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	156.99	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	1,973.38	157.82
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	538,664,311.00	167,244,748.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	7,508.98	949.36
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	7,987.13	1,009.81
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	1,973.38	157.82
AU			
AV			
AW			
AX			
AY	Final Prospective Rates	1,973.38	157.82



Florida Agency for Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2011 through June 30, 2012

101290 - 2011/07

1562.98 / 120.41

Florida Hospital

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2009 - 12/31/2009

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	582,545,982.00	396,809,400.00	62,513,260.00	26,138,620.00	Total Bed Days	730,368
2. Routine	399,281,011.00		46,430,928.00		Total Inpatient Days	521,893
3. Special Care	125,298,287.00		13,175,236.00		Total Newborn Days	34,331
4. Newborn Routine	27,885,635.00		14,458,272.00		Medicaid Inpatient Days	62,818
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	8,918
6. Home Health					Medicare Inpatient Days	208,749
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.1107419712
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	176,166
9. Total Cost	1,135,010,915.00	396,809,400.00	136,577,696.00	26,138,620.00	Property Rate Allowance	0.80
10. Charges	4,793,478,771.00	2,256,928,913.00	538,664,311.00	167,244,748.00	First Rate Semester in Effect	2011/01
11. Fixed Costs	125,271,549.00		14,077,315.42		Last Rate Semester in Effect	2011/07

Ceiling and Target Information

	IP (F)	OP (F)	County Ceiling Base	IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,936.46		168.26	906.46	166.47	Semester DRI Index
2. Base Rate Semester	2011/01	2011/01	Variable Cost Base	940.66	115.06	Cost Report DRI Index	1.8060
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,739.90	183.72	FPLI Year Used	2008
4. Rate of Increase (Year/Sem.)	1.021231	1.031397	County Ceiling	1,704.23	179.95	FPLI	0.9795

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	136,577,696.00	26,138,620.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	14,077,315.42	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	122,500,380.58	26,138,620.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	136,066,314.20	29,033,262.30
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	71,736	176,166
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,896.76	164.81
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,896.76	164.81
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9795) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,896.76	164.81
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	156.99	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	2,053.75	164.81
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	538,664,311.00	167,244,748.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	7,508.98	949.36
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	8,340.54	1,054.49
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	2,053.75	164.81
AU	Medicaid Trend Adjustment (IP%: 25.1950 %, OP%: 22.4240 %)	(517.44)	(36.96)
AV	Exemption Tier Adjustment (IP%: 72.0000 %, OP%: 71.9910 %)	(203.39)	(10.02)
AW	Buy Back of Medicaid Trend Adjustment	230.06	2.58
AX			
AY	Final Prospective Rates	1,562.98	120.41



Florida Agency for Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2012 through June 30, 2013

101290 - 2012/07

1403.01 / 107.16

Florida Hospital

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2010 - 12/31/2010

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	626,660,841.00	428,142,818.00	70,107,932.00	26,086,846.00	Total Bed Days	754,455
2. Routine	413,305,952.00		46,169,439.00		Total Inpatient Days	556,388
3. Special Care	138,070,106.00		19,701,885.00		Total Newborn Days	27,926
4. Newborn Routine	18,013,905.00		11,000,237.00		Medicaid Inpatient Days	63,560
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	14,291
6. Home Health					Medicare Inpatient Days	209,074
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0988372093
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	189,472
9. Total Cost	1,196,050,804.00	428,142,818.00	146,979,493.00	26,086,846.00	Property Rate Allowance	0.80
10. Charges	5,397,378,296.00	2,526,254,208.00	633,095,557.00	176,879,679.00	First Rate Semester in Effect	2012/07
11. Fixed Costs		142,979,138.00		16,771,004.74	Last Rate Semester in Effect	2012/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	1,876.31		154.46	County Ceiling Base	925.71	171.70
2. Base Rate Semester	2011/07	2011/07	Variable Cost Base	960.63	118.67	Cost Report DRI Index	1.8920
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,754.32	204.30	FPLI Year Used	2008
4. Rate of Increase (Year/Sem.)	1.020787	1.045902	County Ceiling	1,718.36	200.11	FPLI	0.9795

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	146,979,493.00	26,086,846.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)	16,771,004.74	
AD	Total Medicaid Variable Operating Cost = (AA-AB)	130,208,488.26	26,086,846.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))	143,077,931.86	28,665,197.06
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)	77,851	189,472
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)	1,837.84	151.29
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)	Exempt	Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)	1,837.84	151.29
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9795) for Orange (48)	Exempt	Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)	Exempt	Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)	Exempt	Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)	1,837.84	151.29
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9	172.34	
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)	2,010.18	151.29
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)	633,095,557.00	176,879,679.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)	8,132.14	933.54
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)	8,935.90	1,025.81
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)	2,010.18	151.29
AU	Medicaid Trend Adjustment (IP%: 28.8649 %, OP%: 27.0837 %)	(580.24)	(40.97)
AV	Exemption Tier Adjustment (IP%: 71.0000 %, OP%: 71.0050 %)	(184.20)	(5.74)
AW	Buy Back of Medicaid Trend Adjustment	157.26	2.59
AX			
AY	Final Prospective Rates	1,403.01	107.16



Florida Agency for Health Care Administration

Office of Medicaid Cost Reimbursement Planning and Finance
 Computation of Hospital Prospective Payment Rates
 For Rate Semester July 01, 2013 through June 30, 2014

101290 - 2013/07

Outpatient Rate: 119.50

Florida Hospital

Type of Control: Nonprofit (Other)

County: Orange (48)

Fiscal Year: 1/1/2011 - 12/31/2011

Type of Action: Field Audit

District: 7

Hospital Classification: Statutory Teaching Hospital

Type of Cost / Charges	Total		Medicaid		Statistics (E)	
	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)		
1. Ancillary	651,253,992.00	461,906,973.00	81,479,791.00	29,623,697.00	Total Bed Days	781,465
2. Routine	447,971,834.00		55,744,127.00		Total Inpatient Days	557,940
3. Special Care	149,169,020.00		22,197,439.00		Total Newborn Days	38,906
4. Newborn Routine	21,993,436.00		11,177,308.00		Medicaid Inpatient Days	70,610
5. Intern-Resident	0.00		0.00		Medicaid Newborn IP Days	9,770
6. Home Health					Medicare Inpatient Days	214,468
7. Malpractice	0.00	0.00	0.00	0.00	Prospective Inflation Factor	1.0395395395
8. Adjustments	0.00	0.00	0.00	0.00	Medicaid Paid Claims	207,364
9. Total Cost	1,270,388,282.00	461,906,973.00	170,598,665.00	29,623,697.00	Property Rate Allowance	0.80
10. Charges	5,889,974,618.00	2,897,961,765.00	722,236,249.00	203,040,658.00	First Rate Semester in Effect	2013/07
11. Fixed Costs	151,831,275.00		18,617,745.86		Last Rate Semester in Effect	2013/07

Ceiling and Target Information

	IP (F)	OP (F)		IP (G)	OP (G)	Inflation / FPLI Data (H)	
	1. Normalized Rate	2,006.68		151.62	County Ceiling Base	944.95	179.58
2. Base Rate Semester	2012/07	2012/07	Variable Cost Base	980.60	124.12	Cost Report DRI Index	1.9980
3. Ultimate Base Rate Semester	1991/01	1993/01	State Ceiling	1,695.69	197.52	FPLI Year Used	2008
4. Rate of Increase (Year/Sem.)	1.011816	1.026091	County Ceiling	1,660.93	193.47	FPLI	0.9795

Rate Calculations

Rates are based on Medicaid Costs		Inpatient	Outpatient
AA	Inpatient based on Medicaid Cost (C9) :Outpatient based on Medicaid Cost(D9)	Reimbursed by Diagnosis Related Groups	29,623,697.00
AB	Apportioned Medicaid Fixed Costs = Total Fixed Costs x (Medicaid Charges/Total Charges)		
AD	Total Medicaid Variable Operating Cost = (AA-AB)		29,623,697.00
AE	Variable Operating Cost Inflated = (AD x Inflation Factor (E7))		30,795,004.34
AF	Total Medicaid Days (Inpatient E4+E5) or Medicaid Paid Claims (Outpatient)		207,364
AG	Variable Cost Rate: Cost Divided by Days (IP) or Medicaid Paid Claims (OP)		148.51
AH	Variable Cost Target = Base Rate Semester x Rate of Increase (G2 x F4)		Exempt
AI	Lesser of Inflated Variable Cost Rate (AG) or Target Rate (AH)		148.51
AJ	County Rate Ceiling = State Ceiling (70% IP & 80% OP) x FPLI (0.9795) for Orange (48)		Exempt
AK	County Ceiling Target Rate = County Ceiling Base x Rate of Increase (G1 x F4)		Exempt
AL	Lesser of County Rate Ceiling (AJ) or County Ceiling Target Rate (AK)		Exempt
AM	Lesser of Variable Cost (AI) or County Ceiling (AL)		148.51
AN	Plus Rate for Fixed costs and Property Allowance = (C11/AF) x E9		
AP	Total Rate Based on Medicaid Cost Data = (AM + AN)		148.51
AQ	Total Medicaid Charges, Inpatient (C10): Outpatient (D10)		203,040,658.00
AR	Charges divided by Medicaid Days (Inpatient) or Medicaid Paid Claims (Outpatient)		979.15
AS	Rate based on Medicaid Charges adjusted for Inflation (AR x E7)		1,017.87
AT	Prospective Rate = Lesser of rate based on Cost (AP) or Charges (AS)		148.51
AU	Medicaid Trend Adjustment (IP%: 30.4580 %, OP%: 24.9150 %)		(37.00)
AV	Exemption Tier Adjustment (IP%: 70.7683 %, OP%: 70.7670 %)		(4.64)
AW	Buy Back of Medicaid Trend Adjustment		12.64
AX			
AY	Final Prospective Rates		119.50

Provider Number	Provider Name	Cost Report Year Begin	Cost Report Year End	Rate Period Begin	Rate Period End	Cost Report Year Ending Only	IP - Current Rate	IP - New Rate	IP - Variance	Medicaid Days in Rate Period	IP - Impact of Rate Change	OP - Current Rate	OP - New Rate	OP - Variance	OOS in Rate Period	OP - Impact of Rate Change
101290	Florida Hospital	1/1/2000	12/31/2000	1/1/2002	3/31/2002	2000	\$ 1,158.86	\$ 1,158.96	\$ 3.10	11,147	\$ 34,555.70	\$ 108.81	\$ 109.50	\$ 0.69	21,743	\$ 15,002.67
101290	Florida Hospital	1/1/2000	12/31/2000	4/1/2002	6/30/2002	2000	\$ 1,229.64	\$ 1,232.93	\$ 3.29	11,147	\$ 96,673.63	\$ 115.76	\$ 116.49	\$ 0.73	22,778	\$ 16,627.94
101290	Florida Hospital	1/1/2000	12/31/2000	7/1/2002	12/31/2002	2000	\$ 1,253.02	\$ 1,256.27	\$ 3.25	22,293	\$ 72,492.25	\$ 118.29	\$ 119.03	\$ 0.74	46,988	\$ 34,771.12
101290	Florida Hospital	1/1/2004	12/31/2004	1/1/2006	6/30/2006	2004	\$ 1,444.12	\$ 1,415.03	\$ (29.09)	30,582	\$ (889,630.38)	\$ 141.35	\$ 135.24	\$ (6.11)	60,995	\$ (372,679.45)
101290	Florida Hospital	1/1/2004	12/31/2004	7/1/2006	12/31/2006	2004	\$ 1,452.90	\$ 1,419.49	\$ (33.41)	30,582	\$ (1,021,744.62)	\$ 142.94	\$ 133.34	\$ (9.60)	71,192	\$ (683,443.20)
101290	Florida Hospital	1/1/2005	12/31/2005	7/1/2007	12/31/2007	2005	\$ 1,503.04	\$ 1,468.47	\$ (34.57)	31,863	\$ (1,101,503.91)	\$ 144.95	\$ 138.68	\$ (6.27)	65,442	\$ (410,321.34)
101290	Florida Hospital	1/1/2006	12/31/2006	7/1/2007	6/30/2007	2006	\$ 1,521.03	\$ 1,503.44	\$ (17.59)	33,520	\$ (389,616.80)	\$ 129.26	\$ 128.61	\$ (0.65)	65,244	\$ (42,408.60)
101290	Florida Hospital	1/1/2006	12/31/2006	7/1/2008	12/31/2008	2006	\$ 1,674.34	\$ 1,654.24	\$ (20.10)	33,520	\$ (673,752.00)	\$ 131.66	\$ 130.99	\$ (0.67)	66,698	\$ (44,687.66)
101290	Florida Hospital	1/1/2007	12/31/2007	1/1/2009	2/28/2009	2007	\$ 1,751.29	\$ 1,737.45	\$ (13.84)	11,956	\$ (165,471.04)	\$ 121.45	\$ 124.60	\$ 3.15	25,750	\$ 81,112.50
101290	Florida Hospital	1/1/2007	12/31/2007	3/1/2009	6/30/2009	2007	\$ 1,751.29	\$ 1,737.45	\$ (13.84)	23,912	\$ (330,942.08)	\$ 121.45	\$ 124.60	\$ 3.15	59,059	\$ 186,035.85
101290	Florida Hospital	1/1/2007	12/31/2007	7/1/2009	12/31/2009	2007	\$ 1,709.76	\$ 1,696.42	\$ (13.34)	35,868	\$ (478,479.12)	\$ 117.91	\$ 120.96	\$ 3.05	94,249	\$ 287,439.45
101290	Florida Hospital	1/1/2008	12/31/2008	1/1/2010	6/30/2010	2008	\$ 1,771.15	\$ 1,758.05	\$ (13.10)	34,819	\$ (456,128.90)	\$ 130.17	\$ 137.64	\$ 7.47	98,586	\$ 736,437.42
101290	Florida Hospital	1/1/2008	12/31/2008	7/1/2010	12/31/2010	2008	\$ 1,803.35	\$ 1,789.59	\$ (13.76)	34,819	\$ (479,109.44)	\$ 132.83	\$ 140.45	\$ 7.62	94,642	\$ 721,172.04
101290	Florida Hospital	1/1/2009	12/31/2009	1/1/2011	6/30/2011	2009	\$ 2,017.45	\$ 1,973.38	\$ (44.07)	40,190	\$ (1,771,173.30)	\$ 140.80	\$ 157.82	\$ 17.02	97,386	\$ 1,657,509.72
101290	Florida Hospital	1/1/2009	12/31/2009	7/1/2011	12/31/2011	2009	\$ 1,591.90	\$ 1,562.98	\$ (28.92)	80,380	\$ (2,324,589.60)	\$ 110.20	\$ 120.41	\$ 10.21	225,361	\$ 2,299,870.21
101290	Florida Hospital	1/1/2010	12/31/2010	7/1/2012	6/30/2013	2010	\$ 1,500.98	\$ 1,403.01	\$ (97.97)	86,414	\$ (8,465,979.58)	\$ 127.85	\$ 107.16	\$ (20.69)	249,301	\$ (5,158,855.46)
101290	Florida Hospital	1/1/2011	12/31/2011	7/1/2013	6/30/2014	2011	\$ -	\$ -	\$ -	80,653	\$ -	\$ 135.83	\$ 119.50	\$ (16.33)	294,597	\$ (4,810,769.01)
Total IP							\$ (18,898,534.68)									

Lump sum fiscal amount (All of IP & OP over 7 years)
\$ (15,039,944.43)

Please note that the yellow highlighted cells are estimated values.