Reimbursement and Funding Methodology

Florida Medicaid Reform Section 1115 Waiver

Low Income Pool

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I. Overview

In accordance with the Special Terms and Conditions (STCs) for waiver number 11-W-00206/4, Medicaid reform Section 1115 Demonstration, the State of Florida, Agency for Health Care Administration (AHCA), Medicaid program (the State), submits to the Centers for Medicare and Medicaid Services (CMS) this Reimbursement and Funding Methodology document. This document fulfills STC Pre-Implementation Milestone requirement number 100(a), in addition to STCs 93, 97, 98, and 101.

In addition to the Reimbursement and Funding Methodology document, the State is providing the definition of expenditures eligible for Federal matching funds and the entities eligible to receive reimbursement. Permissible expenditures are discussed in STC 94:

> *"Funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These healthcare expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made) may include premium payments, payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS."*

Included in this document is the methodology used for the distribution of the $1 billion annual LIP funds as provided for in the STC. Providers in receipt of LIP funds are required to submit documentation of their permissible expenditures which will be used to calculate a Low Income Pool Cost Limit (LIP Cost Limit). Permissible expenditures are discussed in Section III of this document. Upon review of the permissible expenditures, the Agency will reconcile the LIP distributions against the LIP Cost Limit. Section V, Planning and Reconciliation, reviews this process.

A. The LIP is defined in STC 91 to "…ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations."

   Certain basic parameters of the LIP require consideration to gain an appropriate perspective for the State's proposal for LIP distributions:

   1. Although the State appreciates the $1 billion available through the LIP, it is important to recognize that the $1 billion is insufficient to fund a statewide benefit for the uninsured determined by a broad based methodology incorporating more than one healthcare service. Florida simply has too many uninsured individuals (estimated between 2.8 million

and 3.2 million)[1] and healthcare services are too expensive to provide broad benefits to all potential eligibles.

2. Local governments funding the LIP through intergovernmental transfers (IGTs) have a vested interest in ensuring that their localities benefit from the funding they provide for the program. The funding mechanism is an important component of the LIP, just as the State's funding of the Medicaid program is a primary determinant of how the State operates its Title XIX program (see Appendix A for a flow chart of local government funds provided for the LIP program). Florida has a vested interest in using its state share, coupled with federal matching dollars, to benefit the citizens of Florida. CMS does not require Florida to assist with the funding of any other state's Medicaid program, but allows Florida to use its state share specifically for the benefit of its citizens. The State has adopted a similar philosophy for how local funds are considered within the LIP. Although the State is not promoting a predetermined benefit for the local governments providing funding, the State does recognize that it is inappropriate to require a local government to assist with the funding of a benefit for providers outside that local government's area without consideration of the benefits received by providers within its political subdivision. The State believes it is sound public policy to provide each local government the assurance that its providers will not receive less from LIP than if the local government provided direct financial assistance to its providers.

3. An evaluation of services typically covered within a coverage model generally results in a broad array of services that vary in cost per unit and the financial risk for the insured related to the use of such services. An individual may be able to afford a dental visit or a single pharmaceutical, but would incur significant financial risk if a lengthy or acute hospital stay was required. Therefore, consistent with the prioritization of covered services in Medicare Part A and the general insurance market, the State recognizes a priority of services subject to coverage from the LIP. Just as Medicare and commercial coverage attempts to cover hospital services first, the LIP recognizes that the uninsured must have their hospital risk addressed first. Subsequent to addressing the hospital risk, the LIP can then address subsequent services such as physician services, clinic services, drugs or limited benefit packages as they present lower risks than critical hospital services.

4. Barring sufficient funding for a methodology that allows adequate coverage of needed services for Florida's uninsured, the State has adopted a basic distribution methodology similar to CMS' methodology of providing a predetermined pool to fund the uninsured, underinsured, and Medicaid shortfalls. In accordance with STC 101, "Providers with access

[1] Florida Health Insurance Study 2004

to the LIP and services funded from the LIP shall be known as the provider access system[s]" (PAS). A more detailed definition of a PAS is as follows:

> *Entities such as hospitals, clinics, or other provider types and entities designated by Florida Statute to improve health services access in rural communities, which incur uncompensated medical care costs in providing medical services to the uninsured and underinsured, and which receive a Low Income Pool (LIP) payment shall be known as Provider Access Systems. Provider Access Systems funded from the LIP shall provide services to Medicaid recipients, the uninsured, and the underinsured. Provider Access Systems shall be required to report data related to the number of individuals served and the types of services provided from the LIP funding.*

The State has created separate and unique payment methodologies that recognize different PAS options. These PAS distributions will be used to contribute primarily toward health care services provided to the uninsured and underinsured, although the distributions alone will not totally fund such services. Providers will be asked to report the number of services made available through programs receiving LIP funding, and no LIP funding will exceed the cost of such services.

B. Due to the limitation of funds, the distribution methodology incorporates the above as follows:

1. Hospital services are prioritized in the distribution methodology;
2. Providers within a local area will not receive less than they would have received if they were to obtain funding directly from their local governments for services related to Medicaid, the uninsured, and the underinsured; and
3. Providers will receive less than 100% of the cost of services for the uninsured, underinsured, and Medicaid shortfalls.

C. The following is a detailed description of the State's Reimbursement and Funding Methodology document for LIP expenditures for State Fiscal Year (SFY) 2007-08. Appendix B provides CMS with a point of reference for the anticipated distribution of funds within the various PAS. The attachment details the distributions by provider type and provider name. The State asks that CMS please note that charity care and Medicaid days serve as the primary allocation statistics. The data represented in this document is for demonstration Year 2. A summary of the total distributions made during demonstration Year 1 is provided in Appendix H.

II. Reimbursement Methodology

The State's recommended distributions of the LIP funds are separated into seven distinct categories. Some of the providers may be eligible to receive a LIP distribution in more than one category. The categories vary based on type of provider and services offered. These categories include some funding for hospital providers that previously received hospital inpatient Upper Payment Limit (UPL) distributions. It is essential to these safety-net providers that AHCA maintain at least a portion of the vital levels of funding as part of the transition from UPL to the LIP. Below is a description of the five PAS categories as approved by the Florida Legislature in the General Appropriations Act (GAA) for SFY 2007-08 and proposed to CMS for inclusion in the LIP Reimbursement and Funding Methodology. Overall the PAS categories are the same for Year 2 as they were for Year 1 (as presented in the Reimbursement and Funding Methodology Document, May 29, 2007. Due to the decreased Federal Medical Assistance Percentage (FMAP) and the increased costs for local governments to fund the state, non-federal share for other Medicaid programs (e.g. DSH and the exemptions from ceilings hospital reimbursement program), there is a change in the amounts of funding provided for the various PAS. For your reference, Appendix B provides the anticipated distributions by provider and by category based on the methodologies discussed below. These distributions will be made to qualifying providers after the Agency receives executed Letters of Agreement with participating counties and health care taxing districts, appropriate copies of local agreements (between the local governments and providers), receipt of the state, non-federal share, and proper LIP Cost Limit and Milestone documentation by participating providers. Distributions for Year 2 may begin effective July 1, 2007.

A. The first PAS category represents distributions that existed during SFY 2005-2006 as part of the UPL program. The hospitals that receive these distributions are considered some of Florida's core safety-net providers serving a significant portion of Florida's Medicaid, uninsured, and underinsured population. There are five categories representing the transition from UPL to LIP which total $124,483,459 of the $1 billion. The transition programs are described below.

   1. The first category to receive a distribution representing the transition from UPL to LIP is rural hospitals. The total distribution for rural hospitals is $7,279,414 which shall be distributed in the same proportion as the rural Disproportionate Share (s. 409.9116, F.S.) Hospital payments. A primary element in the rural DSH formula is the sum of charity care days and Medicaid days divided by total patient days. In computing the total amount earned by each rural hospital, the agency uses the average of the 3 most recent years of actual data, from the Florida Hospital Uniform Reporting System (FHURS). In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602, F.S., and must meet the following additional requirements:

a) Agree to conform to all agency requirements to ensure high quality in the provision of services, including criteria adopted by agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the agency deems appropriate as specified by rule;

b) Agree to accept all patients, regardless of ability to pay, on a functional space-available basis;

c) Agree to provide backup and referral services to the county health departments and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital; and

d) For any hospital owned by a county government which is leased to a management company, agree to submit on a quarterly basis a report to the Agency, in a format specified by the Agency, which provides a specific accounting of how all funds dispersed under this act are spent.

2. Distributions to primary care hospitals will be made to the hospitals that participated in the Primary Care Disproportionate Share Hospital (DSH) program, s. 409.9117, F.S., in State Fiscal Year 2003-2004. They shall be paid $10,596,695 distributed in the same proportion as the Primary Care DSH payments for 2003-2004. Payments may not be made to a hospital unless the hospital agrees to:

a) Cooperate with a Medicaid prepaid health plan, if one exists in the community;
b) Ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians;
c) Coordinate and provide primary care services free of charge, except co-payments, to all persons with incomes up to 100 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital;
d) Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a

non-duplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours;

e) Cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries;
f) In cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area;
g) Provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay;
h) Work with the Florida Healthy Kids Corporation and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan;
i) Work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services; and
j) Work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until full compliance is achieved.

3. The Level I and II trauma hospitals shall receive a total distribution of $10,745,241. Of this amount, $4,649,757 shall be distributed equally among hospitals that are a Level I trauma center; $3,907,360 shall be distributed equally among hospitals that are either a Level II or pediatric trauma center; and $2,188,124 shall be distributed equally among hospitals that are both a Level II and pediatric trauma center.

4. Of the total amount, $94,125,241 is for distributions to hospitals that serve as a safety-net hospital in providing emergency, specialized pediatric trauma services and inpatient hospital care as part of the PAS.

5. AHCA recommends continuing distributions to specialty pediatric centers. To qualify for a specialty pediatric payment, a hospital must be licensed as a children's specialty hospital and its combined Medicaid managed care and fee for service days as a percentage to total inpatient days must equal or exceed 30 percent. The total distribution of $1,736,868 shall be distributed equally to the qualifying hospitals.

B. The second PAS category is designated for public, non-state owned, hospitals. The total distributions to the providers in this category are $606,628,878. The distributions are separated into four tiers described below.

  1. Public hospitals receiving local tax support and having greater than 150,000 Medicaid and charity care days shall be paid $333,832,769 to be allocated to each hospital based on its percentage of Medicaid and charity care days to the total.

  2. Public hospitals or systems receiving local tax support and the hospital or system having less than 150,000 Medicaid and charity care days, but the hospital or system having more than 45,000 Medicaid and charity care days shall be paid $210,453,803. These funds shall be allocated to the hospitals based on their percentage of Medicaid and charity care days to the total for all the hospitals in this group. If a system has more than 65,000 Medicaid and charity care days then the days for each of their hospitals shall receive a weight of 1.345.

  3. Public hospitals or systems receiving local tax support and having less than 45,000 Medicaid and charity care days, but the hospital or system having more than 8,500 Medicaid and charity care days shall be paid $52,817,108. These funds shall be allocated to the hospitals based on their percentage of Medicaid and charity care days to the total for all the hospitals in this group.

  4. Public hospitals or systems, except hospitals classified as rural, with no local tax support shall be paid $9,525,198. These funds shall be allocated to each of the hospitals based on each hospital's percentage of Medicaid and charity care days to the total for the hospitals in that group.

These payments are referred to as LIP 1 in Appendix B.

C. A third PAS category is for providers in communities where the local government support for health care expenditures for the uninsured or underinsured to hospitals is greater than $1,000,000. These providers will receive a total distribution of $180,000,000. To be included in this grouping, the local government must provide a minimum of $1,000,000 in financial support for the hospitals in its political boundary. Payments will be allocated to each of the hospitals based on its percentage of charity care days to the total charity care days for all the hospitals in the group. In allocating the payments, each hospital will be capped at 120 percent of the amount of local funding it would have received from its local government for uninsured and underinsured individuals without the low income pool program. Any funds that remain unspent after the first allocation shall then be reallocated to the hospitals based on their percentage of charity care days to the total charity care days for the group. These payments are referred to as LIP 2 in Appendix B.

   The local government support of a minimum of $1,000,000 is determined by the Letter of Agreement that each local government executes with the Agency for Health Care Administration. The Letter of Agreement (LOA) is the Agreement entered into by the Agency and the local government for the state share of funds used in the LIP and other Medicaid programs, such as DSH. The local governments provide the Agency with the names of the providers they are working with as part of their community provider access system. The LOAs are executed annually based on legislative appropriations and local government funding commitment for each State Fiscal Year.

D. The fourth PAS category is for hospitals that do not receive local government support for health care expenditures for the uninsured or underinsured or whose local governments provide $1,000,000 or less in support for the uninsured or underinsured. Additionally, to receive funds under this provision, a hospital's Medicaid days, charity care days and fifty percent of bad-debt days divided by the hospital's total days must equal or exceed ten percent. Payments shall be allocated to hospitals that qualify under this provision based on their percentage of Medicaid days, charity care days and fifty percent of bad-debt days to the total Medicaid days, charity care days and fifty percent of bad-debt days for all the hospitals that qualify under this provision. Payments made under this section are referred to as LIP 3 in Appendix B. The total distribution for this category shall be $67,438,599.

   There is no overlap with a PAS in LIP 1, LIP 2 or LIP 3.

E. The State recommends PAS distributions of $3,172,805 to hospitals that operate poison control programs. The Florida Poison Information Center Network (FPICN), which was created in 1989 by an act of the Florida Legislature (s.

395.1027, F.S), consists of Poison Control Centers in Tampa, Jacksonville, and Miami; and a data center located in Jacksonville. Pursuant to *s. 395.1027, F.S.:*

"There shall be created three certified regional poison control centers, one each in the north, central, and southern regions of the state. Each regional poison control center shall be affiliated with and physically located in a certified Level I trauma center. Each regional poison control center shall be affiliated with an accredited medical school or college of pharmacy. The regional poison control centers shall be coordinated under the aegis of the Division of Children's Medical Services Prevention and Intervention in the department.

Each regional poison control center shall provide the following services:

- *a. Toll-free access by the public for poison information;*
- *b. Case management of poison cases,*
- *c. Professional consultation to health care practitioners;*
- *d. Prevention education to the public; and*
- *e. Data collection and reporting."*

These three nationally accredited poison control centers provide emergency services to the entire state and are operational 24 hours a day, 7 days a week.

F. Distributions to the Federal Qualified Health Centers (FQHC), in the amount of $15,276,255 represent the sixth PAS recommended by the State. There are two ways an FQHC can qualify for a LIP distribution. One method is for the FQHC to qualify for matching funds from the Florida Department of Health (DOH). The total distribution for this method shall be $7,276,255.

Of the $7,276,255, DOH will match, up to a total per State Fiscal Year, of $1,500,000, any local government IGT provided to AHCA on behalf of an FQHC for a LIP distribution. The participating FQHCs must go through an intense competitive review process with DOH in order to qualify for these funds. The FQHCs must show that they are increasing access to primary care services in rural and underserved areas of Florida by expanding their services.

Eligible applicants include health centers funded by the federal government under Section 330 of the Public Health Service Act (42 U.S.C. 254b et seq.).

An FQHC must serve new patients by requesting funding for operating costs or for capital improvement projects. Applicants must provide comprehensive primary and preventive health services in compliance with federal laws and expectations and must meet the requirements outlined in s. 409.9125(5) F.S., the "Community Health Center Access Program Act".

Under the second method, which includes a total of $8,000,000, local governments will provide the full state share match. The funds shall be distributed to all Florida FQHCs through a methodology which allocates the funds proportionally by the relative number of uninsured visits (as a percent of all uninsured visits to Florida FQHCs) to an FQHC weighted by the Medicaid cost per visit or encounter.

The FQHCs must show that they are increasing access to primary care services for Medicaid and uninsured populations. They must provide comprehensive primary and preventative health services in compliance with federal laws and expectations and must meet the requirements outlined in s. 409.9125(5), Florida Statute (F.S.), the "Community Health Center Access Program Act."

G. The remaining $3,000,000 PAS is for distributions to county health initiatives emphasizing the expansion of primary care services. Of the $3,000,000, $1,000,000 is provided to St. Johns River Rural Health Network (SJRRHN) to develop and fund Provider Access Systems for Medicaid and the uninsured in rural areas.

The goal of the SJRRHN is to reduce the number and duration of inpatient admissions and ER visits for ambulatory sensitive conditions (ASC) among low income uninsured adults' by providing comprehensive outpatient services to adults who are at risk of avoidable hospital care. It is expected that the LIP funds will be targeted to secondary prevention as the most cost beneficial investment. The target population will be those with chronic disease that, if managed properly in an outpatient setting, will decrease the use of hospital inpatient and emergency room services. The target population will be identified and enrolled in the pilot program. Enrollment will be followed by a health status and resource assessment conducted by a Nurse Case Manager. Services that may be rendered to the participants include:

- Initial assessment, re: medical, dental and primary care history
- Lab
- Radiology
- Prescription medications
- Specialty care
- Behavioral health
- Oral health
- Disease management
- Transportation assistance

Services may be provided by the County Health Department, private sector physicians, hospitals, and other community providers. The SJRRHN will be responsible for the overall program design and implementation.

The remaining $2,000,000 is provided to expand primary care services to low income, uninsured individuals. Of the total, $1,000,000 is to be allocated as follows: $200,000 to Sarasota County, $200,000 to Charlotte County, $200,000 to Lee County, $200,000 to Okaloosa County and $200,000 to Walton County. A summary of the use of these funds is described below by county.

a) Sarasota County: Through the Sarasota Health Care Access program, uninsured patients who agree to participate in case management will be offered the opportunity to enroll in primary care and receive Emergency Department (ED) follow-up care (when required) at specific safety net provider programs in the community. All patients will receive counseling/education on available health care resources, access to ancillary care/services (including dental), and access to pharmacy patient assistance programs. Patients with ambulatory sensitive conditions opting to enroll in a network primary care program and case management services will receive disease specific interventions as a component of their primary care treatment plan.

   The overall goal is to reduce the number of unnecessary hospital ED encounters by the uninsured in Sarasota County, increase the enrollment in safety net provider primary care programs by the uninsured in Sarasota County, and increase access to low or no cost medications for the uninsured in Sarasota County. The primary methods for achieving these goals include the coordination of care and exchange of data with local hospital EDs, provision of nurse case management services for the uninsured with ambulatory sensitive conditions with greater than two ED visits in the past 12 months, provision of case management, including ED follow-up, for uninsured patients receiving care at EDs in Sarasota County, and providing education and linking uninsured patients with existing pharmaceutical company, generic and other patient assistance programs (including completion of required applications, paperwork and verifications). The coordination of the allocated LIP distribution will be through the Sarasota County Health Department.

b) Charlotte County: The intent of the Charlotte County initiative with the LIP program funds is to expand primary care services to low income, uninsured individuals through the use of a call center, case management, and the expansion of primary care service hours. The goal is to establish a multi-tiered health care access system that starts with better utilization of self-care healthcare services to those that require healthcare professional intervention. The plan is based upon three pillars of healthcare access starting from the easiest and most affordable delivery, self-care, to the most complex and expensive, face-to-face intervention with a healthcare provider. The coordination of the allocated LIP distributions will be through the Charlotte County Health Department.

c) Lee County: Uninsured and underinsured individuals in Lee County will have increased access to health services through a LIP distribution to Lee County Health Department. Specifically, expansion of access to pediatric patients and family planning services will be realized with the LIP funds. This will be achieved by increasing hours of operation including weekend and evening hours, the addition of a nurse midwife to allow for OB visits at one of the County's centers, increasing pediatric exam rooms at one location to accommodate sick and well children, the addition of another pediatric provider at a separate site, and the pediatric director working with all hospital emergency departments to divert any patients who are not appropriate for the Emergency Room. In addition, there are efforts in progress working with Lee Memorial Health System, d/b/a Lee Memorial Hospital, to divert non-emergent patients away from the Emergency Department.

d) Okaloosa County: The Okaloosa County Health Department (CHD) serves a large number of Medicaid, uninsured, and underinsured women of reproductive age. There are significant limitations as to the places where the scope of services necessary can be provided using current categorical federal and state funded family planning funds. This limits the providers' ability to provide a more comprehensive assessment of findings or treatment of findings, when potential problems are discovered on clinical exams or as a result of laboratory tests. The Okaloosa CHD has difficulty getting providers to take referrals of the uninsured, underinsured patients based solely on physical findings. In addition the Medicaid population in Okaloosa County has limited access family planning services such as colposcopy services.

   The LIP funds provided to the Okaloosa County Health Department will be used to expand the ability to assess, diagnose and treat, and follow-up the women seen in their Family Planning clinics for reproductive health abnormalities found in the course of providing family planning services. The ability to provide definitive treatment for abnormal PAP smears and the ability to work up other breast and pelvic findings will facilitate the CHD's ability to refer to local providers. The CHD has found that local providers are more willing to serve clients with limited resources when there is definitive evidence of a medical problem, such as can be provided by more extensive laboratory and radiological procedures.

e) Walton County: The Walton County Health Department (CHD) will increase the number of individuals served in its primary care program to include individuals whose income is up to 140% of the Federal Poverty Level (the previous limit was 100% of the Federal Poverty Level). In addition, they will implement a Women's Health Services program for women less than 200% of the Federal Poverty Level. This program will

provide breast and cervical cancer screening services for women age less than fifty who no longer qualify for family planning services.

The remaining $1,000,000 represents additional funding provided by the Florida Legislature for state fiscal year 2007-08 for county health initiatives, as approved by the Department of Health, for emphasizing the expansion of primary care services. The providers and the amounts awarded are listed below.

a) Duval County Health Department - $500,000
b) Sarasota County Health Department - $400,000
c) Okaloosa County Health Department - $100,000

Both the Duval and Sarasota initiatives will work towards increasing access to services for the Medicaid, uninsured, and underinsured populations in coordination with their local safety net providers (e.g. physicians, hospitals) via the following activities:

a. A governing body including all major participants that meets regularly and addresses operational issues;
b. "Navigators" who identify low income uninsured persons who are accessing services inappropriately (such as emergency rooms) and actively linking them to appropriate providers including primary care providers and volunteer specialists (We Care type networks);
c. Disease Management specialists who manage persons with serious illnesses but illnesses that by and large can be managed on an outpatient basis (diabetes, CVD, etc.);
d. Medication assistance services where specialists help indigent persons access needed medications from sources such as compassionate drug programs supported by pharmaceutical companies, reduced price 340B programs accessible through some hospitals and FQHCs, etc;
e. Outreach efforts to the uninsured to make them aware of the availability of appropriate safety net health care providers.

Okaloosa County Health Department's initiative is establishing a free medical clinic. This clinic will increase the county's ability to meet the needs of surrounding area uninsured individuals.

III. Low Income Pool Permissible Expenditures

In accordance with STCs 97, 98 and 100(a), the State is required to submit permissible expenditures for hospitals and non-hospital based providers to ensure services are paid at cost. The permissible expenditures are referred to by the State as the LIP Cost Limit. Below are the factors the State is recommending for inclusion in the LIP Cost Limits.

A. Hospital Expenditures

The following paragraphs are separated into two categories. The first category is eligible hospital Medicaid expenditures with the second focusing on hospital Uninsured/Underinsured expenditures. STC 97 requires;

> *"Hospital cost expenditures from the LIP will be paid at cost and will be further defined in the Reimbursement and Funding Methodology Document utilizing methodologies from the CMS-2552 cost report plus mutually agreed upon additional costs. The State agrees that it shall not receive FFP [Federal Financial Participation] for Medicaid and LIP payments to hospitals in excess of cost…."*

1. Hospital Medicaid Expenditures

Medicaid costs eligible for FFP will be broken out into components:

a. Hospital Base Costs
   - Determined by methodologies in the CMS-2552 report applicable to hospitals, and

b. Additional Hospital Provider Costs
   - Costs incurred by the hospital provider, but excluded from the calculation of fee for service (FFS) reimbursement rates using cost reporting methodologies, or
   - An appropriate proxy for costs incurred but excluded from the calculation of the FFS rates.

The Agency will use each hospital's most recently filed CMS-2552 cost report and supporting documents for all of the calculations discussed in this section titled Hospital Expenditures (see Appendix C for a sample of provider cost reports).

2. Hospital Provider Additional Medicaid Costs

STC 97 requires that the Agency utilize methodologies from CMS-2552 cost report plus mutually agreed upon additional costs. Hospital providers may have costs incurred but excluded from the calculation of FFS reimbursement rates using cost reporting methodologies. Any net shortfall in Medicaid reimbursement below these costs should be included as additional costs. The additional costs for the Medicaid population may include;

a. Hospital-based physician services (not already included on Worksheet E-3, Part III, line 5)
   1) Part A provider component services in excess of Reasonable Compensation Exception (RCE) limits

2) Part B professional component services (not separately billable to individual patients)

b. Physician unmet guarantee amounts and other subsidies
c. Non-physician practitioner costs
d. Outpatient clinical laboratory services
e. Provider-based ambulance services
f. Provider-based transplant services indirect organ acquisition costs (not already included on Worksheet E-3, Part III, line 4)
g. Provider-based clinic services
h. Patient and community education programs, excluding cost of marketing activities
i. Services contracted to other providers.

These additional costs can be determined by one of the following methods:

- For additional <u>costs</u>, apply a ratio of Medicaid costs (before additions) to total costs (before additions) to the additional costs to obtain the Medicaid portion of the additional costs;
- For additional <u>services</u>, apply a ratio of the costs-to-charges for these services to Medicaid charges for these services to obtain the Medicaid portion of costs for these services.

It is anticipated that all additional costs can be appropriately accounted for through one of the above methods. Medicaid costs for LIP providers include the costs associated with providing services to Medicaid managed care individuals.

The total amount for Medicaid costs will be documented on worksheet E-3, Part III, column 1, line 6 of the CMS-2552 report submitted to the Agency. Additional costs will be documented in detail via the LIP Cost Limit Calculation worksheet (see Appendix D).

The costs represented on worksheet E-3, part III, column 1, line 6 of CMS-2552 are the total costs for each provider, based on the cost allocation established in the CMS-2552 report. The allocation of total costs is first performed through the initial worksheets. Costs of each of the components of the hospital are separately determined following a common step-down of all overhead costs. The appropriate cost to charge ratio (CCR) is applied to the various approved Medicaid cost centers. A summary of relevant worksheets is provided below.

- Worksheet S – Provider certification, settlement summary, and statistical information
- Worksheet A – Reclassification and Adjustment of Trial Balance expenses

- Worksheet B – Cost Allocation (General Services, Capital Related, & Statistical Basis)
- Worksheet C – Computation of Ratio of Cost to Charges
- Worksheet D – Apportionment of Inpatient Services Costs
- Worksheet E – Calculation of Medicare Settlement
- Worksheet G – Financial Statements

Worksheet (W/S) E-3, Part III, calculates reimbursement for Title XIX, Medicaid. Line 6 of W/S E-3, Part III, is the sum of the preceding lines, which includes interns and residents (line 3), organ acquisitions (line 4), and teaching physicians (line 5). These specific lines are costs that would otherwise have been removed from the allocation process due to Medicare reimbursement policies. Teaching costs, for example, are paid separately by Medicare and therefore these costs are adjusted out on W/S A-8. Medicaid reimburses for all these allowable costs centers and therefore they are added back into the cost report via W/S E-3, lines 3-5.

3. Hospital Provider Costs for Medicaid Eligibles

Some patients are eligible for Medicaid, but their services are not paid for by the Medicaid program. In some cases, patients have exhausted Medicaid benefit limits. Since qualification for Medicaid eligibility is the same as the State's charity definition for DSH allocation purposes, patients who qualify for Medicaid, but no longer have coverage, are typically accounted for as charity patients.

In other cases, some other form of insurance applies, such as Personal Injury Protection (PIP) insurance, which makes a full or partial payment for services. To the extent there is a shortfall in payments compared to the cost of these services, the shortfall should be included in the LIP Cost Limit.

4. Hospital Underinsured and Uninsured Costs

a. The LIP is established to "ensure continued government support for the provision of healthcare services to Medicaid, underinsured and uninsured populations" (STC 91). The LIP Medicaid expenditures have been identified above. Before defining the LIP expenditures for the underinsured and uninsured, it is important to understand how these expenditures are identified by hospitals.

b. A definition of "uninsured" is straightforward: the patient has no insurance whatsoever. Charges for services to uninsured patients are most often written off as charity care. However, some patients with no insurance coverage may not meet a provider's charity care

criteria; this may be due to having income or assets exceeding thresholds, or simply failure to submit information to qualify as a charity case. The conclusion is that not all uninsured (and unpaid) patient services become classified as charity care.

c. This definition also would exclude patients with insurance that does not cover their particular services, or patients with insurance who reach coverage limits. Those patients could be includable under the definition of "underinsured."

d. When a patient has some insurance coverage, portions of a claim may go unpaid for reasons other than contractual agreements between the provider and the payer (e.g., patient co-payment requirements, or coverage limitations). In some situations the unpaid balance of a claim for a patient who has some insurance coverage may qualify as charity. Due to the challenges in gathering documentation to justify the distinction between charity and bad debt, there may be cases where the unpaid balance may be written off as bad debt even though it could be charity. Hospitals account for the unpaid balance differently. Once the unpaid balance is written off, it is often not possible to differentiate how much of the total (total bad debt or total charity) is due to an inability to pay or an unwillingness to pay.

e. Section 112(b) of the 1999 Balanced Budget Refinement Act (BBRA) "requires hospitals to submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient services for which the hospital is not compensated." This is accomplished on Worksheet S-10 of the CMS-2552 hospital cost report. The definition of this uncompensated care amount includes charity and bad debt write-offs. Therefore, for purposes of the LIP, the definition of uninsured and underinsured will be consistent with CMS' requirements in reporting this information under the BBRA.

f. Costs of these services can be calculated by applying an average cost-to-charge ratio for the provider to the charges written off as bad debt or charity. This method is consistent with the method used by CMS in the CMS-2552 hospital cost report Worksheet S-10. Costs may include additional costs as noted above in the section titled "Hospital Provider Additional Medicaid Costs", applicable to the uninsured and underinsured populations. To the extent there are charges associated with the additional costs (e.g., outpatient clinical laboratory services); those charges should be included in the cost-to-charge ratio as well. Other additional costs (e.g., physician subsidies) do not have related charges to consider.

g. Providers may also incur costs that are strictly for programs of services furnished to uninsured and underinsured patients. To the extent that they are separately identifiable, these costs should be added in their entirety to the costs of underinsured and uninsured services. Examples of costs include:
   1) non-provider-based clinics under the provider's license
   2) services contracted to other providers, including services to treat uninsured patients
   3) costs associated with securing free drugs for indigent patients
   4) drugs and supplies furnished to non-Medicaid patients in inpatient and outpatient settings

h. It is recommended that the entirety of these costs be included in the LIP Cost Limit.

B. Expenditures for Non-Hospital Providers

1. Non-hospital providers – Medicaid

a. Not all providers of services to Medicaid, underinsured and uninsured populations are required to file cost reports with AHCA. Some providers file cost reports with their Medicare fiscal intermediary, but such cost reports may exclude any calculation of Medicaid reimbursable costs (e.g., Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)). Medicaid costs for providers filing Medicare-only cost reports may be determined using the average Medicare cost per patient visit, multiplied by the number of Medicaid visits reported in the cost report or as determined by ACHA Medicaid claims listings. For FQHCs, due to the fact that the established Medicare rate does not include all allowable Medicaid costs (such as, radiology, dental, obstetric, gynecologic) the Agency has approved that the calculation of the Medicaid shortfall will be performed through the application of a cost to charge ratio (CCR) to Medicaid charges.

b. The appropriate proxy for Medicaid costs for County Health Departments (CHDs) will be CHD Medicaid cost reimbursement rate, as established through the provider Medicaid cost report.

In the event the Florida Legislature appropriates LIP funding for Provider Access Systems not addressed under this section, the Agency will revise this section of the document to detail the expenditures for such Provider Access Systems. A timely review by CMS will be performed for approval of

the revised section(s) before processing LIP distributions to the new Provider Access Systems.

2. Non-Hospital Providers - Underinsured/Uninsured Costs

a. Providers may also incur costs that are strictly for programs of services furnished to uninsured patients. To the extent they are separately identifiable; these costs should be added in their entirety to the costs of underinsured and uninsured services. Examples of such costs include:

1) non-provider-based clinics under the provider's license
2) services contracted to other providers, including services to treat uninsured patients
3) costs associated with securing free drugs for indigent patients
4) drugs and supplies furnished to non-Medicaid patients in inpatient and outpatient settings

b. It is recommended that costs specifically identifiable for underinsured and uninsured patients should be fully included in the LIP Cost Limit.

In order to provide assurance and accountability on behalf of the non-hospital providers submitting permissible expenditure data to the Agency, the Agency will require these providers to submit a Permissible Expenditures Certification Form. A sample of this form is provided in Appendix E.

IV. Shortfall for Medicaid, Uninsured, and Underinsured Costs

A. Permissible expenditures from the LIP fund may be made for the uncompensated medical care costs of Medicaid, underinsured, and uninsured populations. The STCs explicitly indicate that the Medicaid portion would be the Medicaid "shortfall." The shortfall is the difference between Medicaid costs and Medicaid payments to the provider. In calculating the Medicaid shortfall, the costs will be reduced by the Medicaid payment.

B. The amount of charity and bad debt used to compute costs of services to underinsured and uninsured populations will be net of recoveries. Therefore, recoveries of bad debts or payments on charity accounts will be deducted from bad debt and charity write-offs, respectively, before application of any cost-to-charge ratio or inclusion in supplemental cost report forms.

C. The shortfall for Medicaid, uninsured, and underinsured costs is the LIP Cost Limit. All provider types will be required to complete the LIP Cost Limit

Calculation worksheet (see Appendix D for three separate LIP Cost Limit worksheets which include Hospitals, FQHCs, and CHDs). The data used for FQHCs will be the Uniform Data System (UDS) report. The data used for the CHDs includes the Medicaid cost based reimbursement and provider count for the uninsured and underinsured as provided for in the County Health Department Clinic Health Management System. The calculation of each provider's LIP Cost Limit worksheet is provided below.

LIP Cost Limit Worksheet – Hospital Providers

a. The provider will provide the basic information such as the provider name, Medicaid provider identification number and provider fiscal year period represented.

b. Calculation of the Medicaid shortfall.
    1. In accordance with Section III, A of this document, providers will document Medicaid reimbursable cost as provided on Worksheet E-3, Part III, Column 1, line 6 of the Form CMS-2552. This will be documented on line 1 of the LIP Cost Limit Calculation worksheet. The cost report used will be the same as the one used to establish the provider's July reimbursement rate of the most recent State Fiscal Year. For example, for State Fiscal Year 2006-2007, the cost report used to establish the July 2006 hospital reimbursement rate will be the report used to calculate the LIP Cost Limit.
    2. Additional costs will be documented in detail on the LIP Cost Limit Calculation worksheet and subtotaled on line 2.
    3. The additional costs represent total costs (or services, see Section III, A, 2 for the recommended calculation for additional services) to the provider. In order to capture the Medicaid portion of the additional costs, the provider will apply the ratio of Medicaid cost to total hospital cost. Line 3 of the LIP Cost Limit Calculation worksheet represents total hospital cost, from Worksheet C, Column 5, line 101 of the CMS-2552.
    4. Line 4 is the calculation of the ratio of Medicaid costs to total hospital costs (Worksheet E-3, Part III, Column 1, line 6 divided by Worksheet C, Column 5, line 101 of the Form CMS-2552), referred to as Medicaid utilization.
    5. Medicaid utilization is multiplied by additional costs to arrive at Medicaid additional costs, line 5.
    6. Line 5a is provided for situations where there is a need to calculate costs associated with additional services.
    7. Additional Medicaid costs (line 5 and 5a) are added to Medicaid costs (line 1) to arrive at total permissible Medicaid expenditures (line 6).

8. In order to arrive at a Medicaid shortfall, Medicaid payments for the same provider fiscal period are documented on line 7.
9. Total Medicaid costs (line 6) less Medicaid payments (line 7) represent the Medicaid shortfall, line 8.
10. LIP distributions are made based on estimated current year activities. Due to the fact that the data used to calculate the Medicaid cost shortfall is for prior period activity, an inflation factor is applied to the Medicaid shortfall. Where a cost report is used to determine a prospective payment rate for a provider, an inflation factor is included in the rate calculation to adjust historical costs to a current period level. The Agency will use this inflation factor as applicable for the LIP Cost Limit calculation.
11. The total Medicaid shortfall is documented on line 10 as the product of the inflation factor multiplied by the total Medicaid shortfall.

c. Calculation of the uninsured and underinsured shortfall:
   1. The provider's total charity care charges will be documented on line 11. The source of this information will be documented on the LIP Cost Limit Calculation worksheet.
   2. The provider's total bad debts charges (net of Medicare bad debts) will be reported in line 12. The sum of charity and bad debt should equal the total reported on Worksheet S-10 of the CMS-2552.
   3. Charges for other Medicaid eligibles (as discussed in Section III, A, 3 of this document) will be listed on line 13.
   4. Lines 14 and 15 provide additional space to provide a detailed breakdown of other Medicaid eligibles if applicable.
   5. The total of charity, bad debt and Medicaid eligible charges is calculated on line 16.
   6. The total hospital costs (the sum of lines 2 and 3) is reported on line 17. This will be used to obtain a total hospital cost-to-charge ratio which will be applied to the uninsured and underinsured charges.
   7. Total hospital charges, from Worksheet C, Column 8, line 101 of CMS-2552, will be documented on line 18.
   8. The charges related to additional costs (as noted on line 2, "Additional costs") are to be recorded on line 19.
   9. The sum of line 18 and 19 is the total adjusted hospital charges.
   10. Line 21 is adjusted ratio of costs to charges (line 17 divided by line 20).
   11. The cost of the uninsured and underinsured is obtained by multiplying line 16 x line 21.
   12. The amount of charity and bad debt used to compute costs of services to uninsured and underinsured populations will be net

of recoveries. Therefore, recoveries of bad debts or payments on charity accounts will be deducted from bad debt and charity write-offs respectively, before application of any cost-to-charge ratio or inclusion in supplemental cost report forms. Payments for Medicaid eligibles and any other identified applicable payment not already included in any of the above calculations will be documented on line 23.

13. Directly identified costs of services to the uninsured and underinsured patients (such as costs of medications provided through a provider-owned outpatient clinic) are noted on line 24.
14. LIP distributions are made based on estimated current year activities. Due to the fact that the data used to calculate the uninsured and underinsured cost shortfall is for prior period activity, an inflation factor is applied to the net uninsured and underinsured shortfall. Where a cost report is used to determine a prospective payment rate for a provider, an inflation factor is included in the rate calculation to adjust historical costs to a current period level. The Agency will use this inflation factor as applicable for the LIP Cost Limit calculation. The total in line 25 is the sum of line 22 (cost of uninsured and underinsured services) less line 23 (Medicaid eligible and other payments) plus line 24 (directly identified costs) multiplied by the inflation factor provided on line 9. The result is the total uninsured and underinsured shortfall.

d. The total LIP Cost Limit is the sum of line 10 (the Medicaid shortfall) and line 25 (the uninsured and underinsured shortfall).

LIP Cost Limit Worksheet – Federally Qualified Health Center Providers

a. The provider will provide the basic information such as the provider name and contact information. The FQHC LIP Cost Limit worksheet requests a UDS number. The Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA) collects data from health centers supported by HRSA Bureau of Primary Health Care grants through the Uniform Data System. Data is collected each February for the previous calendar year. The UDS number is unique for each main FQHC. Medicaid identification numbers are provided for every FQHC site. One FQHC may have multiple sites. Therefore, there may be one UDS number for several FQHC Medicaid provider numbers. The reimbursement rates calculated are by the main FQHC. As the UDS report is required by all FQHCs and reporting done in a standardized format, this is used as one of the main points of reference for the FQHC LIP Cost Limit.

b. Calculation of the Medicaid shortfall.
    1. The FQHC will record their total accrued cost per their most recently completed UDS report. For example, for State Fiscal Year 2006-2007, the most recently completed UDS report is for calendar year January – December 2005.
    2. The total FQHC charges per UDS report are documented on line 2.
    3. The total FQHC cost to charge ratio is calculated by taking the total FQHC costs and dividing them by the total FQHC charges.
    4. Total Medicaid charges for inpatient FQHC physician visits is documented on line 4. These charges are part of the FQHC's internal records. These charges will include the same period as the UDS report period. These charges are generated when a physician, primary care or obstetric for example, follow a patient during their inpatient admission in a hospital setting. These physicians are employed by or under contract with the FQHC. The costs of these physicians are not included in the FQHC encounter reimbursement rate. The FQHC bills and is reimbursed for these physician services at the Medicaid physician fee schedule.
    5. The Medicaid cost for inpatient FQHC physician visit is calculated by multiplying the Medicaid charges for inpatient FQHC physician visits by the FQHC cost to charge ratio.
    6. The total Medicaid inpatient FQHC physician visit reimbursement is documented on line 6.
    7. The difference between the Medicaid inpatient physician cost, on line 5 and the total Medicaid inpatient reimbursement, on line 6, is the Medicaid physician shortfall.

c. Calculation of the uninsured shortfall:
    1. The FQHC Medicaid PPS rate will be used to determine the uninsured shortfall. The Florida Medicaid PPS rate is established every October. The PPS rate used will be the one most recently established during the UDS data year. For example, if the UDS data year used is for calendar year ending December 31, 2005 then the PPS rate used will be the one established October 1, 2005. The Medicaid PPS rate serves as the proxy for the cost of uninsured individuals
    2. The total number of uninsured encounters is documented on line 9.
    3. The uninsured cost is calculated by multiplying the number of uninsured encounters by the Medicaid PPS rate.
    4. Collections received on behalf of the uninsured are recorded at the FQHCs and documented on line 11.

5. The difference between the uninsured costs and the collections received on behalf of the uninsured encounters is the uninsured shortfall.

d. The total LIP Cost Limit is the sum of line 7 (the Medicaid Inpatient FQHC Physician Shortfall) plus line 12 (the Uninsured Shortfall).

LIP Cost Limit Worksheet – County Health Department (CHD) Providers

a. The provider will provide the basic information such as the provider name, provider number, and contact information.

b. Calculation of the Medicaid shortfall.
   1. Total Medicaid encounters will be reported by the CHD. This information is obtained through the standardized local clinic health management system. This system maintains client encounter data in addition to multiple other client functions such as registration, billing, and eligibility determination. The data period used will be the most recently completed fiscal year used to establish the provider's annual reimbursement rate. The CHD annual reimbursement rate is calculated every July using the CHD's prior year Medicaid Cost Report. The CHD Medicaid cost report period for a rate established on July 1, 2006 is July 1, 2004 – June 30, 2005. All CHDs have the same fiscal year period.
   2. The July 1st, State calculated, Medicaid encounter rate reported on line 2 is used as the proxy for determining Medicaid costs.
   3. Total Medicaid costs are calculated by multiplying Medicaid encounters by the July Medicaid encounter rate.
   4. Total Medicaid reimbursement is documented on line 4.
   5. The Medicaid shortfall is the difference between total Medicaid costs and Total Medicaid reimbursement.

c. Calculation of the uninsured shortfall:
   1. The uninsured shortfall for CHDs is calculated in the same manner as the Medicaid shortfall. The total number of uninsured encounters, available through the clinic health management system, is documented on line 6.
   2. The July 1st, State calculated, Medicaid encounter rate is reported on line 7.
   3. Total uninsured costs are calculated by multiplying the uninsured encounters by the July encounter rate.
   4. Personal Health Fee Collections (payments made on behalf of the uninsured) are documented on line 9.

5. The uninsured shortfall is calculated by subtracting line 9 from line 8.

d. The total LIP Cost Limit is the sum of line 5 (the Medicaid Shortfall) plus line 10 (the Uninsured Shortfall).

V. Planning and Reconciliation

A. Planning

According to the STC number 97 and 98, "the State agrees that it shall not receive FFP for Medicaid and LIP payments to hospitals in excess of cost." The previous sections provide the methodology for the LIP distributions (Section II) and the calculation of the permissible expenditures (Section III) which will be used to calculate the providers' total allowable cost, referred to as the LIP Cost Limit. In order to assure no provider will receive greater than cost, the Agency will perform a cost/payment reconciliation prior to any LIP distributions as described below.

Provider LIP Cost Limits will be calculated once a year, prior to the initial annual LIP distributions. A PAS must submit the LIP Cost Limit and LIP Milestone documents annually in order to receive its calculated LIP distribution. On May 24, 2007, the Agency created a LIP web-reporting tool to allow PAS provider entities to submit the provider LIP Cost Limit and LIP Milestone data via a dedicated internet website. The LIP Cost Limit data for the existing SFY and the prior year LIP Milestone data must be completed prior to any LIP distributions in a subsequent fiscal year. LIP distributions are anticipated to be made monthly or quarterly. This could vary by provider type in a subsequent fiscal year. The LIP distributions for the five year demonstration period of this waiver are dependent upon the Agency receiving annual spending authority through the General Appropriations Act from the Florida legislature. The Agency, the Governor, and Florida legislature will receive recommendations from the Low Income Pool Council (LIP Council), but the legislature's final appropriation is based on decisions made during the annual legislative session.

In accordance with House Bill 3B (HB 3B), implemented during Special Session 2005, the legislature directed the Agency to create a LIP Council. The LIP Council is compromised of 17 members including representatives from public, non-profit, teaching, rural, and for-profit hospitals in addition to representatives from units of local government which contribute funding. The LIP Council's responsibility, in accordance with HB 3B is to:

"*(a) Make recommendations on the financing of the low-income pool and the disproportionate share hospital program and the distribution of their funds.*
(b) Advise the Agency for Health Care Administration on the development of the low-income pool plan required by the federal Centers for Medicare and Medicaid Services pursuant to the Medicaid reform waiver.
(c) Advise the Agency for Health Care Administration on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by intergovernmental transfers.
(d) Submit its findings and recommendations to the Governor and the Legislature no later than February 1 of each year."

The LIP Council works closely with the Agency with special consideration focused on all STCs related to the LIP. Due to the fact that the LIP is dependent upon annual appropriations by the State legislature, the Reimbursement and Funding Methodology document is subject to revision annually. Funding for existing PAS programs may continue, new PAS programs may be approved, and funding amounts among the PAS programs may be modified. As this occurs, the Agency will communicate the changes to CMS, through a revised Reimbursement and Funding Methodology document. It is unknown what the magnitude of the changes will be from year to year. However, it is anticipated that subsequent revisions will likely not be substantial. The total amount of the funding remains $1 billion per year for the five year demonstration period.

The State fiscal year begins July 1st. Upon the Governor's approval of the state's General Appropriations Act, which often occurs during the month prior to July 1st, the Agency will submit the revised Reimbursement and Funding Methodology document to CMS. Should the legislature appropriate funding to a new program, such as the St. John's River Rural Health Network (which initially received $1 million during state fiscal year 2006-07), the Agency might need additional time to submit the details of the methodology specific to that particular program in a subsequently revised document during the year. The Agency has communicated to all the providers eligible for LIP that distributions to PAS categories will not be made until CMS approves the methodology for that PAS. Although the state fiscal year begins July 1st, distributions are not anticipated to occur until the months following. The Agency will submit to CMS revisions to the Reimbursement and Funding Methodology document upon final state legislative funding authority, subject to the Governor's approval of the budget. The Agency requests CMS review the document and submit its comments within thirty-days upon receipt of the revised document.

B. Reconciliation

During the first quarter of the state fiscal year (July – September), the LIP Cost Limits will be determined for each provider receiving a LIP distribution. The LIP Cost Limits will be calculated using the data described in Section III and Section IV of this document. The LIP Cost Limit calculation is the total allowable expenditures less any reimbursement from Medicaid, the underinsured, or the uninsured. The reimbursement includes Medicaid claims payment for services rendered to Medicaid recipients to each provider and, for hospitals, DSH payments. Payments on behalf of the underinsured and uninsured are already included in the cost limit, as detailed in Section III and Section IV. The remaining amount is the Medicaid, underinsured and uninsured shortfall. This amount, referred to as the LIP Cost Limit, is the maximum amount a provider is eligible to receive in a LIP distribution.

Prior to making a LIP distribution, the LIP Cost Limit for each individual provider will be reviewed. The LIP distribution will be subtracted from the LIP Cost Limit. As long as there is a positive remaining balance of the LIP Cost Limit, there exists a Medicaid, underinsured, and uninsured shortfall. Should the resulting calculation show that the anticipated LIP distribution will exceed the LIP Cost Limit, the provider's distribution will be reduced accordingly. The Agency assures that no provider will receive a LIP distribution in excess of the Medicaid, underinsured, and uninsured shortfall.

Medicaid reimbursement for hospital providers is calculated every January and July, in accordance to the Florida Title XIX Inpatient Hospital Reimbursement Plan (the Plan). The reimbursement rate calculation places limitations on the calculated reimbursement, referred to as ceilings and targets. The limits are often below the provider's reported Medicaid cost. The use of provider reimbursement rates limited by ceilings and targets creates an immediate Medicaid shortfall. Some providers, such as statutory teaching hospitals and rural hospitals, are exempt from these limitations. For these providers, their Medicaid reimbursement represents their Medicaid cost, as allowed in the Plan. The Medicaid shortfall could therefore be minimal for these providers. A shortfall could still exist due to the fact that there may be legislative reductions to the reimbursement rate above and beyond the cost calculation as well as additional costs not routinely captured by the Plan, as detailed in Section III A(2) of this document. LIP distributions to hospital providers will allow for any calculated Medicaid shortfall in addition to the underinsured and uninsured shortfall.

VI. Forms

Data submitted to AHCA in support of the LIP Cost Limit calculations may be more extensive than the as-filed cost report forms would include. Examples include:

supplemental cost report pages used to compute costs of underinsured or uninsured services, or documentation of Medicaid eligible services. This additional documentation should be subject to attestation similar to the attestation applied to the filed cost report, and subject to audit at the discretion of AHCA. Providers will be required to submit the appropriate form shown in Appendix D which calculates their LIP Cost Limit. Appendix D includes the LIP Cost Limit worksheet for hospital providers, FQHCs, and CHDs. All providers that submit a LIP Cost Limit worksheet must also submit the LIP Permissible Expenditures Certification Form as shown in Appendix E.

VII. Source of non-Federal Funds for the LIP

Appendix F documents the total non-Federal funds for which the Agency is entering contracts for the Low Income Pool for Year 2. A copy of all executed Letters of Agreement, including any existing local government provider agreements, are being provided to the CMS staff as requested by CMS. For Year 2 of the LIP, a total of $51,117,531, non-recurring general revenue was provided by the Florida legislature as the state share for LIP expenditures. The total state, non-federal funds, provided by local governments, health care taxing districts and state general revenue funds for LIP expenditures for SFY 2007-08 is $431,700,000. Appendix I documents the total non-Federal funds the Agency received for the Low Income Pool for Year 1..

VIII. Reporting Methodology

In accordance with STC 101, the Reimbursement and Funding Methodology “document shall also include a reporting methodology for the number of individuals and types of services provided through the LIP. This methodology shall include a projection of these amounts for each current year of operation, and final reporting of historical demonstration periods.”

The Agency is requesting all providers who receive LIP distributions to complete a LIP Milestone Reporting Requirement document, see Appendix G. The report will be completed and submitted to the State no later than July 1st of each state fiscal year, beginning July 1, 2007 through the demonstration period of the waiver.

The reporting document requires providers to record an unduplicated count of Medicaid and uninsured/underinsured visits at their respective facilities funded by LIP resources. In addition, the recipients of LIP funds are required to document the number of services provided to these individuals as one individual may receive multiple services. The data submitted by the providers will exclude non-qualified aliens. The reporting document is to be completed by all providers receiving LIP funds as described in Section II of this document. This information will be used in conjunction with the Medicaid Reform / LIP evaluation by the University of Florida, for STC 102.

The reporting methodology requires the documentation of the number of individuals and types of services provided through the LIP. This will be achieved through the receipt of the LIP Milestone documents from the PAS. The Agency required the PAS to complete a LIP Milestone document based on SFY 2005-06 (referred to as the "Pre-LIP" year data) to establish a base year for comparison against LIP distribution years. The Pre-LIP year and Year 1 LIP Milestone data reports were due July 1, 2007 and August 15, 2007, respectively. The Agency, along with the University of Florida LIP Reform evaluation team, is currently reviewing the results of the submitted data. The data will be used in the Cost Effectiveness Study, required in STC #102. The cost effectiveness study will be reviewed with the Agency and CMS to determine the impact of the LIP on the PAS (STC #102). The cost effectiveness study information will be incorporated in this document upon completion of the review.

IX. Conclusion

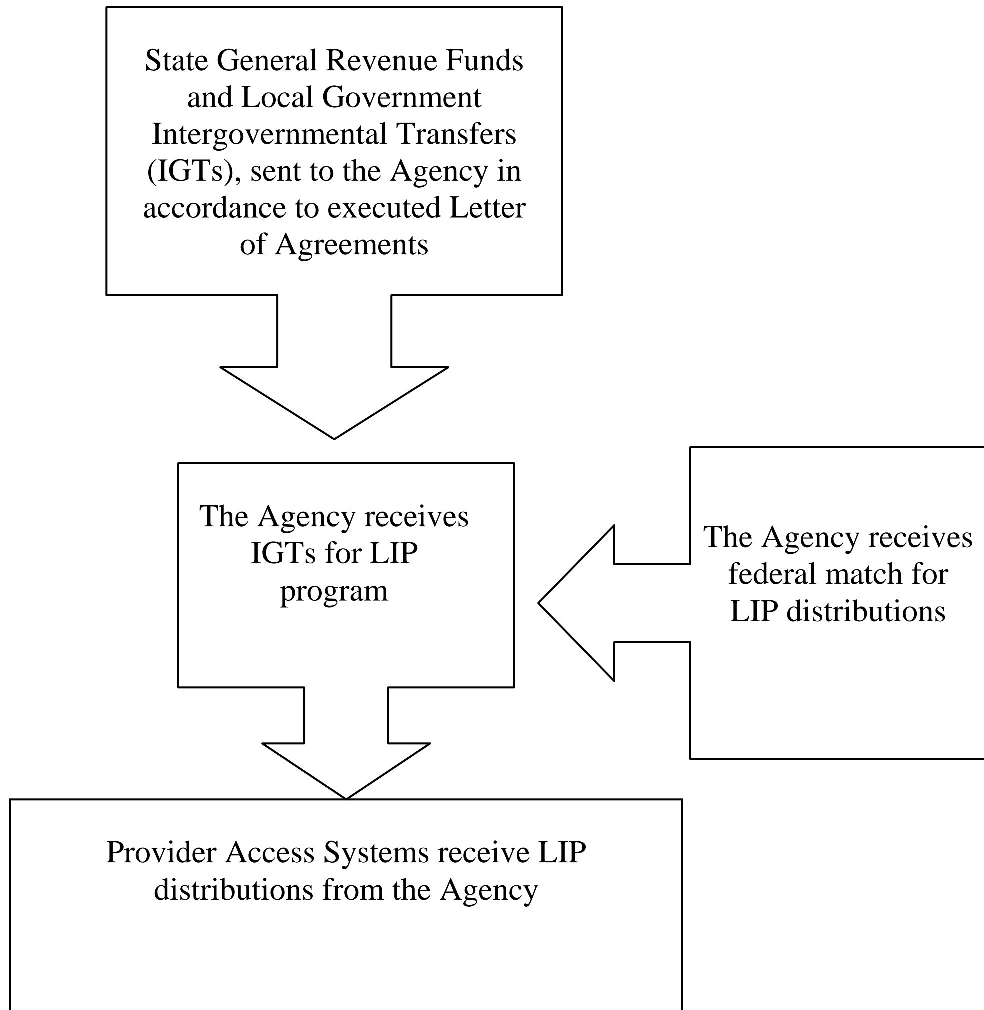
This LIP Reimbursement and Funding Methodology document is submitted to satisfy STCs 93, 97, 98, 100(a) and 101, set forth in the Medicaid Reform Section 1115 Demonstration. STC 100(a), the Pre-Implementation Milestones, calls for the "State's submission and CMS approval of a Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement." The State satisfied STC 101(a) through its original submission (and subsequent clarification) of this Reimbursement and Funding Methodology document. This document as submitted May 29, 2007 reflected the requirements in STC 101, by detailing the payment mechanisms for expenditures made from the LIP, and includes a reporting methodology for the number of individuals and types of services provided through the LIP.

This updated version is submitted to CMS in order to document the legislative appropriated LIP distributions and funding for Year 2 of the LIP program, and to address a series of questions raised by CMS.

APPENDIX A

Flow Chart of Local Government Funds Provided for the LIP Program

Flow of Local Government Funds Provided for the Florida Medicaid Low Income Pool Program



APPENDIX B

LIP DISTRIBUTIONS BY PROVIDER

Low Income Pool Anticipated Distributions State Fiscal Year 2007-2008

AHCA Number	Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Special LIP Payments Rural SEE NOTE	Primary Care	Designated Trauma Centers Level I	Level II or Pediatric	Level II and Pediatric	Tot. Trauma		Safety-Net	Specialty Pediatric	Provider Special LIP Sub-Total
100250	101516	ALL CHILDREN'S HOSPITAL	PINELLAS				390,736		390,736		2,899,731	868,434	4,158,901
100240	116483	ANN BATES LEACH EYE HOSPITAL	DADE						-				-
100131	120375	AVENTURA HOSPITAL & MEDICAL CEN	DADE						-				-
100117	102326	BAPTIST HOSPITAL - BEACHES	DUVAL						-				-
100008	100358	BAPTIST HOSPITAL - MIAMI	DADE						-				-
100093	100749	BAPTIST HOSPITAL OF PENSACOLA	ESCAMBIA				390,736		390,736		390,735		781,471
100088	100641	BAPTIST MEDICAL CENTER	DUVAL						-				-
100140	101231	BAPTIST MEDICAL CENTER - NASSAU	NASSAU	176,157					-				176,157
100121	120413	BARTOW MEMORIAL HOSPITAL	POLK						-				-
100026	100064	BAY MEDICAL CENTER	BAY						-				-
100032	101567	BAYFRONT MEDICAL CENTER	PINELLAS				390,736		390,736		187,531		578,267
100014	101834	BERT FISH MEDICAL CENTER	VOLUSIA										
100002	101401	BETHESDA MEMORIAL HOSPITAL	PALM BEACH						-				-
100243	118079	BRANDON REGIONAL HOSPITAL	HILLSBOROUG H						-				-
100071	100871	BROOKSVILLE REGIONAL HOSPITAL	HERNANDO						-				-
100039	100129	BROWARD GENERAL MEDICAL CENTER	BROWARD		1,710,581	664,251			664,251		286,857		2,661,689
100112	100269	CALHOUN LIBERTY HOSPITAL	CALHOUN	164,725					-				164,725
100138	101940	CAMPBELLTON-GRACEVILLE HOSPITAL	JACKSON	147,763					-				147,763
100177	100099	CAPE CANAVERAL HOSPITAL	BREVARD						-				-
100244	119717	CAPE CORAL HOSPITAL	LEE						-				-
100254	119806	CAPITAL REGIONAL MEDICAL CENTER	LEON						-				-
100009	100366	CEDARS MEDICAL CENTER	DADE						-				-
100161	101788	CENTRAL FLORIDA REGIONAL HOSPITAL	SEMINOLE						-				-
100023	102199	CITRUS MEMORIAL HOSPITAL	CITRUS						-				-
100234	120308	COLUMBIA HOSPITAL	PALM BEACH						-				-
100191	105520	COMMUNITY HOSPITAL OF	PASCO						-				-

AHCA Number	Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Special LIP Payments									
						Designated Trauma Centers							
				Rural SEE NOTE	Primary Care	Level I	Level II or Pediatric	Level II and Pediatric	Tot. Trauma		Safety-Net	Specialty Pediatric	Provider Special LIP Sub-Total
		NEW PORT RICHEY											
100183	109606	CORAL GABLES HOSPITAL	DADE						-				-
100276	120405	CORAL SPRINGS MEDICAL CENTER	BROWARD						-				-
100211	109592	DADE CITY HOSPITAL	PASCO						-				-
100258	120090	DELRAY MEDICAL CENTER	PALM BEACH					547,031	547,031				547,031
100175	101923	DESOTO MEMORIAL HOSPITAL	DESOTO	347,559					-				347,559
100078	101036	DOCTORS MEMORIAL HOSPITAL - BONIFAY	HOLMES	259,480					-				259,480
100106	101800	DOCTORS MEMORIAL HOSPITAL - PERRY	TAYLOR	191,008					-				191,008
100277	102776	DOUGLAS GARDENS HOSPITAL	DADE										-
100134	100048	ED FRASER MEMORIAL HOSPITAL	BAKER	1,139,175					-				1,139,175
100239	102598	EDWARD WHITE HOSPITAL	PINELLAS						-				-
100024	101206	FISHERMEN'S HOSPITAL	MONROE	153,667					-				153,667
100090	101711	FLAGLER HOSPITAL	ST JOHNS						-				-
100007	101290	FLORIDA HOSPITAL	ORANGE						-		47,819		47,819
100109	100901	FLORIDA HOSPITAL - WALKER	HIGHLANDS						-				-
100282	102601	FLORIDA HOSPITAL - WAUCHULA	HIGHLANDS	127,281					-				127,281
100118	101893	FLORIDA HOSPITAL FLAGLER	FLAGLER	258,174					-				258,174
100057	101095	FLORIDA HOSPITAL WATERMAN	LAKE						-				-
100046	101494	FLORIDA HOSPITAL ZEPHYRHILLS	PASCO						-				-
100210	102148	FLORIDA MEDICAL CENTER	BROWARD						-				-
100223	111325	FORT WALTON BEACH MEDICAL CENTER	OKALOOSA						-				-
100159	100811	GADSDEN COMMUNITY HOSPITAL	GADSDEN	131,723					-				131,723
100153	100803	GEORGE E. WEEMS MEMORIAL HOSPITAL	FRANKLIN	200,735					-				200,735
100130	101443	GLADES GENERAL HOSPITAL	PALM BEACH	378,894					-				378,894
100262	101524	GOOD SAMARITAN MEDICAL CENTER	PALM BEACH						-				-
100242	117617	GULF COAST HOSPITAL	BAY						-				-
100279	102253	GULF COAST HOSPITAL - FT. MYERS	LEE						-				-
100271	120324	H. LEE MOFFIT CANCER CENTER	HILLSBOROUG H						-				-
100252	119750	H.H. RAULERSON	OKEECHOBEE						-				-
100017	101842	HALIFAX MEDICAL CENTER	VOLUSIA				390,736		390,736				390,736

				Special LIP Payments									
						Designated Trauma Centers							
AHCA Number	Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Rural SEE NOTE	Primary Care	Level I	Level II or Pediatric	Level II and Pediatric	Tot. Trauma		Safety-Net	Specialty Pediatric	Provider Special LIP Sub-Total
100030	101354	HEALTH CENTRAL	ORANGE						-				-
100081	101885	HEALTHMARK REGIONAL MEDICAL CENTER	WALTON	157,814					-				157,814
100181	120057	HEALTHSOUTH LARKIN HOSPITAL-MIAMI	DADE						-				-
100137	102288	HEART OF FLORIDA REGIONAL MEDICAL CENTER	POLK						-				-
100055	101613	HELEN ELLIS MEMORIAL HOSPITAL	PINELLAS						-				-
100098	100862	HENDRY REGIONAL MEDICAL CENTER	HENDRY	128,806					-				128,806
100053	100412	HIALEAH HOSPITAL	DADE						-				-
100049	100897	HIGHLANDS REGIONAL MEDICAL CENTER	HIGHLANDS						-				-
100019	100081	HOLMES REGIONAL MEDICAL CENTER	BREVARD				390,736		390,736				390,736
100073	100188	HOLY CROSS HOSPITAL	BROWARD						-				-
100125	102261	HOMESTEAD HOSPITAL	DADE	401,296					-				401,296
100200	108219	IMPERIAL POINT HOSPITAL	BROWARD		618,360				-				618,360
100105	101044	INDIAN RIVER MEMORIAL HOSPITAL	INDIAN RIVER						-				-
100142	101061	JACKSON HOSPITAL	JACKSON	144,134					-				144,134
100022	100421	JACKSON MEMORIAL HOSPITAL	DADE		1,938,824	664,251			664,251		3,981,378		6,584,453
100048	101737	JAY HOSPITAL	SANTA ROSA	197,588					-				197,588
100080	101460	JFK MEDICAL CENTER	PALM BEACH						-				-
100253	120294	JUPITER MEDICAL CENTER	PALM BEACH						-				-
100209	120138	KENDALL REGIONAL MEDICAL CENTER	DADE						-				-
100241	108227	LAKE BUTLER HOSPITAL	UNION	597,910					-				597,910
100156	119768	LAKE CITY MEDICAL CENTER	COLUMBIA						-				-
100099	101664	LAKE WALES HOSPITAL ASSOCIATION	POLK						-				-
100157	101648	LAKELAND REGIONAL MEDICAL CENTER	POLK				390,736		390,736				390,736
100299	103420	LAKEWOOD RANCH MEDICAL CENTER	MANATEE						-				-
100248	119741	LARGO MEDICAL CENTER	PINELLAS						-				-
100246	119695	LAWNWOOD REGIONAL MEDICAL CENTER	ST. LUCIE						-				-
100012	101109	LEE MEMORIAL HOSPITAL	LEE				390,736		390,736		1,041,960		1,432,696
100084	101079	LEESBURG REGIONAL MEDICAL CENTER	LAKE						-				-
100107	101117	LEHIGH REGIONAL MEDICAL CENTER	LEE						-				-
100150	101192	LOWER KEYS HOSPITAL	MONROE						-				-

AHCA Number	Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Special LIP Payments									
						Designated Trauma Centers							
				Rural SEE NOTE	Primary Care	Level I	Level II or Pediatric	Level II and Pediatric	Tot. Trauma		Safety-Net	Specialty Pediatric	Provider Special LIP Sub-Total
100004	101150	MADISON COUNTY MEMORIAL HOSPITAL	MADISON	161,741					-				161,741
100035	101168	MANATEE MEMORIAL HOSPITAL	MANATEE						-				-
100160	101214	MARINERS HOSPITAL	MONROE	201,089					-				201,089
100044	101184	MARTIN MEMORIAL HOSPITAL	MARTIN						-				-
100043	101541	MEASE HOSPITAL - DUNEDIN	PINELLAS						-				-
100260	119971	MEDICAL CENTER-PORT ST. LUCIE	ST. LUCIE						-				-
100087	101761	MEMORIAL HOSPITAL - SARASOTA	SARASOTA						-				-
100045	101877	MEMORIAL HOSPITAL - WEST VOLUSIA	VOLUSIA						-				-
100230	102229	MEMORIAL HOSPITAL PEMBROKE	BROWARD						-				-
100281	102521	MEMORIAL HOSPITAL WEST	BROWARD						-				-
100179	101931	MEMORIAL MEDICAL CENTER - JACKSONVILLE	DUVAL						-				-
100038	100200	MEMORIAL REGIONAL HOSPITAL	BROWARD		1,901,503	664,251			664,251				2,565,754
100061	100439	MERCY HOSPITAL	DADE						-				-
110199	100609	MIAMI CHILDRENS HOSPITAL	DADE				390,736		390,736		728,325	868,434	1,987,495
100127	101583	MORTON F. PLANT HOSPITAL	PINELLAS						-				-
100034	100463	MT. SINAI MEDICAL CENTER	DADE						-		7,877,283		7,877,283
100062	101176	MUNROE REGIONAL MEDICAL CENTER	MARION						-				-
100018	100315	NAPLES COMMUNITY HOSPITAL	COLLIER						-		217,075		217,075
100139	101141	NATURE COAST REGIONAL HOSPITAL	LEVY	259,234					-				259,234
100063	101508	NORTH BAY MEDICAL CENTER	PASCO						-				-
100086	100218	NORTH BROWARD MEDICAL CENTER	BROWARD				390,736		390,736				390,736
100204	108626	NORTH FLORIDA REGIONAL MEDICAL CENTER	ALACHUA						-				-
100122	101265	NORTH OKALOOSA MEDICAL CENTER	OKALOOSA						-				-
100029	100498	NORTH SHORE MEDICAL CENTER	DADE						-				-
100238	115193	NORTHSIDE MEDICAL CENTER	PINELLAS						-				-
100147	101907	NORTHWEST FLORIDA COMMUNITY HOSPITAL	WASHINGTON	144,636					-				144,636

AHCA Number	Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Special LIP Payments									
						Designated Trauma Centers							
				Rural SEE NOTE	Primary Care	Level I	Level II or Pediatric	Level II and Pediatric	Tot. Trauma		Safety-Net	Specialty Pediatric	Provider Special LIP Sub-Total
100189	104591	NORTHWEST REGIONAL HOSPITAL	BROWARD						-				-
100212	109886	OCALA REGIONAL MEDICAL CENTER	MARION						-				-
100226	111741	ORANGE PARK MEDICAL CENTER	CLAY						-				-
100006	101338	ORLANDO REGIONAL MEDICAL CENTER	ORANGE			664,251			664,251		4,827,975		5,492,226
100110	101389	OSCEOLA REGIONAL MEDICAL CENTER	OSCEOLA						-				-
100176	102105	PALM BEACH GARDENS MEDICAL CENTER	PALM BEACH						-				-
100050	100536	PALM SPRINGS GENERAL HOSPITAL	DADE						-				-
100187	104604	PALMETTO GENERAL HOSPITAL	DADE						-				-
100126	120111	PALMS OF PASADENA HOSPITAL	PINELLAS						-				-
100269	120260	PALMS WEST HOSPITAL	PALM BEACH						-				-
100076	100544	PAN AMERICAN HOSPITAL	DADE						-				-
100114	102385	PARKWAY REGIONAL MEDICAL CENTER	DADE										
100028	100102	PARRISH MEDICAL CENTER	BREVARD						-				-
100286	103144	PHYSICAN'S REGIONAL MEDICAL CENTER	COLLIER						-				-
103030	120251	PINECREST REHABILITATION HOSPITAL	PALM BEACH						-				-
100167	120006	PLANTATION GENERAL HOSPITAL	BROWARD						-				-
100129	101311	PRINCETON HOSPITAL	ORANGE						-				-
100232	113514	PUTNAM COMMUNITY MEDICAL CENTER	PUTNAM						-				-
100025	100765	SACRED HEART HOSPITAL	ESCAMBIA					547,031	547,031		405,476		952,507
100292	103233	SACRED HEART OF THE EMERALD COAST	WALTON						-				-
100067	120227	SAINT ANTHONY'S HOSPITAL	PINELLAS						-				-
100077	100285	SAINT JOSEPH HOSPITAL OF PORT CHARLOTTE	CHARLOTTE										
100515	100722	SAINT LUKE'S HOSPITAL	DUVAL						-				-
100180	120103	SAINT PETERSBURG GENERAL HOSPITAL	PINELLAS						-				-
100040	100731	SAINT VINCENT'S HEALTH SYSTEM	DUVAL						-				-
100124	101745	SANTA ROSA MEDICAL CENTER	SANTA ROSA						-				-
100249	119989	SEVEN RIVERS COMMUNITY HOSPITAL	CITRUS						-				-

				Special LIP Payments									
						Designated Trauma Centers							
AHCA Number	Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Rural SEE NOTE	Primary Care	Level I	Level II or Pediatric	Level II and Pediatric	Tot. Trauma		Safety-Net	Specialty Pediatric	Provider Special LIP Sub-Total
100001	100676	SHANDS AT JACKSONVILLE	DUVAL		1,667,634	664,251			664,251		47,774,542		50,106,427
100102	100331	SHANDS AT LAKE SHORE	COLUMBIA	333,179					-				333,179
100146	101796	SHANDS AT LIVE OAK	SUWANNEE	432,921					-				432,921
100103	100072	SHANDS AT STARKE	BRADFORD	298,333					-				298,333
100113	100030	SHANDS TEACHING HOSPITAL & CLINIC	ALACHUA		851,890	664,251			664,251		6,688,734		8,204,875
100132	100986	SOUTH FLORIDA BAPTIST HOSPITAL	HILLSBOROUGH						-				-
100051	101087	SOUTH LAKE MEMORIAL HOSPITAL	LAKE						-				-
100154	100587	SOUTH MIAMI HOSPITAL	DADE						-				-
100220	111341	SOUTHWEST FLORIDA REGIONAL MEDICAL CENTE	LEE						-				-
100075	100978	ST. JOSEPH'S HOSPITAL	HILLSBOROUGH					547,031	547,031		45,877		592,908
100010	101486	ST. MARY'S HOSPITAL	PALM BEACH					547,031	547,031		253,288		800,319
100015	101591	SUN COAST HOSPITAL	PINELLAS						-				-
100135	101133	TALLAHASSEE MEMORIAL HEALTHCARE	LEON						-		47,237		47,237
100128	100994	TAMPA GENERAL HOSPITAL	HILLSBOROUGH		1,907,903	664,251			664,251		16,423,418		18,995,572
100255	119849	TOWN & COUNTRY HOSPITAL	HILLSBOROUGH						-				-
100108	100838	TRINITY COMMUNITY HOSPITAL	HAMILTON	144,392					-				144,392
100054	101257	TWIN CITIES HOSPITAL	OKALOSSA						-				-
100069	100943	UNIVERSITY COMMUNITY HOSP. - CARROLLWOOD	HILLSBOROUGH						-				-
100173	101028	UNIVERSITY COMMUNITY HOSPITAL - TAMPA	HILLSBOROUGH						-				-
100224	112801	UNIVERSITY HOSPITAL & MEDICAL C	BROWARD						-				-
100079	100471	UNIVERSITY OF MIAMI HOSPITAL & CLINICS	DADE						-				-
100072	101826	VOLUSIA MEDICAL CENTER	VOLUSIA						-				-
100275	102130	WELLINGTON REGIONAL MEDICAL CENTER	PALM BEACH						-				-
100268	120243	WEST BOCA MEDICAL CENTER	PALM BEACH						-				-
100231	113212	WEST FLORIDA REGIONAL MEDICAL CENTER	ESCAMBIA				390,736		390,736				390,736
100165	100625	WESTCHESTER GENERAL HOSPITAL	DADE						-				-
100052	101699	WINTER HAVEN HOSPITAL	POLK						-				-
100092	100111	WUESTHOFF HOSPITAL	BREVARD						-				-
100291	103209	WUESTHOFF MEDICAL CENTR - MELBOURNE	BREVARD						-				-
		Hospital Provider Access System Totals		7,279,414	10,596,695	4,649,757	3,907,360	2,188,124	10,745,241		94,125,241	1,736,868	124,483,459

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1	LIP 2	LIP 3	LIP OTHER	TOTAL OF LIP 1, 2, & 3 PAYMENTS
			Avg DSH (01,02,03)	Avg DSH (01,02,03)	Using FHURS '05 FYE		
101516	ALL CHILDREN'S HOSPITAL	PINELLAS			2,153,058		2,153,058
116483	ANN BATES LEACH EYE HOSPITAL	DADE			160,153		160,153
120375	AVENTURA HOSPITAL & MEDICAL CEN	DADE			631,002		631,002
102326	BAPTIST HOSPITAL - BEACHES	DUVAL			256,118		256,118
100358	BAPTIST HOSPITAL - MIAMI	DADE			2,211,975		2,211,975
100749	BAPTIST HOSPITAL OF PENSACOLA	ESCAMBIA			1,139,026		1,139,026
100641	BAPTIST MEDICAL CENTER	DUVAL			2,341,763		2,341,763
101231	BAPTIST MEDICAL CENTER - NASSAU	NASSAU			169,793		169,793
120413	BARTOW MEMORIAL HOSPITAL	POLK			94,554		94,554
100064	BAY MEDICAL CENTER	BAY	2,473,855				2,473,855
101567	BAYFRONT MEDICAL CENTER	PINELLAS		13,295,959			13,295,959
101834	BERT FISH MEDICAL CENTER	VOLUSIA					-
101401	BETHESDA MEMORIAL HOSPITAL	PALM BEACH		1,577,812			1,577,812
118079	BRANDON REGIONAL HOSPITAL	HILLSBOROUGH			1,252,924		1,252,924
100871	BROOKSVILLE REGIONAL HOSPITAL	HERNANDO			662,638		662,638
100129	BROWARD GENERAL MEDICAL CENTER	BROWARD	92,751,690				92,751,690
100269	CALHOUN LIBERTY HOSPITAL	CALHOUN					-
101940	CAMPBELLTON-GRACEVILLE HOSPITAL	JACKSON			11,758		11,758
100099	CAPE CANAVERAL HOSPITAL	BREVARD			267,539		267,539
119717	CAPE CORAL HOSPITAL	LEE	603,666				603,666
100366	CEDARS MEDICAL CENTER	DADE			1,735,647		1,735,647
101788	CENTRAL FLORIDA REGIONAL HOSPITAL	SEMINOLE			416,694		416,694
102199	CITRUS MEMORIAL HOSPITAL	CITRUS		9,255,860			9,255,860
120308	COLUMBIA HOSPITAL	PALM BEACH		646,869			646,869
105520	COMMUNITY HOSPITAL OF NEW PORT RICHEY	PASCO			651,721		651,721
109606	CORAL GABLES HOSPITAL	DADE			345,447		345,447
120405	CORAL SPRINGS MEDICAL CENTER	BROWARD	10,448,425				10,448,425
109592	DADE CITY HOSPITAL	PASCO			185,508		185,508
120090	DELRAY MEDICAL CENTER	PALM BEACH		5,948,061			5,948,061
101923	DESOTO MEMORIAL HOSPITAL	DESOTO			207,639		207,639
101036	DOCTORS MEMORIAL HOSPITAL - BONIFAY	HOLMES			68,341		68,341
101800	DOCTORS MEMORIAL HOSPITAL - PERRY	TAYLOR			169,237		169,237

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1	LIP 2	LIP 3	LIP OTHER	TOTAL OF LIP 1, 2, & 3 PAYMENTS
			Avg DSH (01,02,03)	Avg DSH (01,02,03)	Using FHURS '05 FYE		
102776	DOUGLAS GARDENS HOSPITAL	DADE					-
100048	ED FRASER MEMORIAL HOSPITAL	BAKER			42,488		42,488
102598	EDWARD WHITE HOSPITAL	PINELLAS		74,972			74,972
101206	FISHERMEN'S HOSPITAL	MONROE			52,307		52,307
101711	FLAGLER HOSPITAL	ST JOHNS			637,628		637,628
101290	FLORIDA HOSPITAL	ORANGE		7,398,676			7,398,676
100901	FLORIDA HOSPITAL - WALKER	HIGHLANDS			425,198		425,198
102601	FLORIDA HOSPITAL - WAUCHULA	HIGHLANDS			75,708		75,708
101893	FLORIDA HOSPITAL FLAGLER	FLAGLER			158,638		158,638
101095	FLORIDA HOSPITAL WATERMAN	LAKE		5,981,607			5,981,607
101494	FLORIDA HOSPITAL ZEPHYRHILLS	PASCO			387,894		387,894
102148	FLORIDA MEDICAL CENTER	BROWARD			763,559		763,559
111325	FORT WALTON BEACH MEDICAL CENTER	OKALOOSA			551,595		551,595
100811	GADSDEN COMMUNITY HOSPITAL	GADSDEN					-
100803	GEORGE E. WEEMS MEMORIAL HOSPITAL	FRANKLIN					-
101443	GLADES GENERAL HOSPITAL	PALM BEACH		1,700,579			1,700,579
101524	GOOD SAMARITAN MEDICAL CENTER	PALM BEACH		929,723			929,723
117617	GULF COAST HOSPITAL	BAY			554,229		554,229
102253	GULF COAST HOSPITAL - FT. MYERS	LEE	399,954				399,954
120324	H. LEE MOFFIT CANCER CENTER	HILLSBOROUGH			422,833		422,833
119750	H.H. RAULERSON	OKEECHOBEE			174,411		174,411
101842	HALIFAX MEDICAL CENTER	VOLUSIA	34,719,682				34,719,682
101354	HEALTH CENTRAL	ORANGE	1,200,482				1,200,482
101885	HEALTHMARK REGIONAL MEDICAL CENTER	WALTON			53,295		53,295
120057	HEALTHSOUTH LARKIN HOSPITAL-MIAMI	DADE			339,357		339,357
102288	HEART OF FLORIDA REGIONAL MEDICAL CENTER	POLK			585,669		585,669
101613	HELEN ELLIS MEMORIAL HOSPITAL	PINELLAS		194,408			194,408
100862	HENDRY REGIONAL MEDICAL CENTER	HENDRY			60,227		60,227
100412	HIALEAH HOSPITAL	DADE			933,918		933,918
100897	HIGHLANDS REGIONAL MEDICAL CENTER	HIGHLANDS			249,879		249,879
111791	HOLLYWOOD MED CNTR (incl. with Memorial Regional)	BROWARD					-
100081	HOLMES REGIONAL MEDICAL CENTER	BREVARD			1,468,999		1,468,999
100188	HOLY CROSS HOSPITAL	BROWARD			556,356		556,356
102261	HOMESTEAD HOSPITAL	DADE			909,448		909,448

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (01,02,03)	LIP 2 Avg DSH (01,02,03)	LIP 3 Using FHURS '05 FYE	LIP OTHER	TOTAL OF LIP 1, 2, & 3 PAYMENTS
108219	IMPERIAL POINT HOSPITAL	BROWARD	10,754,916				10,754,916
101044	INDIAN RIVER MEMORIAL HOSPITAL	INDIAN RIVER		11,894,226			11,894,226
101061	JACKSON HOSPITAL	JACKSON			244,876		244,876
100421	JACKSON MEMORIAL HOSPITAL	DADE	333,832,769				333,832,769
101737	JAY HOSPITAL	SANTA ROSA			91,666		91,666
101460	JFK MEDICAL CENTER	PALM BEACH		4,795,481			4,795,481
120294	JUPITER MEDICAL CENTER	PALM BEACH		427,079			427,079
120138	KENDALL REGIONAL MEDICAL CENTER	DADE			995,507		995,507
108227	LAKE BUTLER HOSPITAL	UNION			106,528		106,528
119768	LAKE CITY MEDICAL CENTER	COLUMBIA			114,855		114,855
101664	LAKE WALES HOSPITAL ASSOCIATION	POLK			168,127		168,127
101648	LAKELAND REGIONAL MEDICAL CENTER	POLK			2,408,318		2,408,318
103420	LAKEWOOD RANCH MEDICAL CENTER	MANATEE			68,426		68,426
119741	LARGO MEDICAL CENTER	PINELLAS		261,903			261,903
119695	LAWNWOOD REGIONAL MEDICAL CENTER	ST. LUCIE			1,067,608		1,067,608
101109	LEE MEMORIAL HOSPITAL	LEE	3,643,405				3,643,405
101079	LEESBURG REGIONAL MEDICAL CENTER	LAKE		5,431,676			5,431,676
101117	LEHIGH REGIONAL MEDICAL CENTER	LEE			249,613		249,613
101192	LOWER KEYS HOSPITAL	MONROE			469,060		469,060
101150	MADISON COUNTY MEMORIAL HOSPITAL	MADISON					-
101168	MANATEE MEMORIAL HOSPITAL	MANATEE			1,172,108		1,172,108
101214	MARINERS HOSPITAL	MONROE			87,561		87,561
101184	MARTIN MEMORIAL HOSPITAL	MARTIN			699,810		699,810
101541	MEASE HOSPITAL - DUNEDIN	PINELLAS		795,244			795,244
101851	MEDICAL CENTER-PENINSULA				417,955		417,955
119971	MEDICAL CENTER-PORT ST. LUCIE	ST. LUCIE			350,815		350,815
101761	MEMORIAL HOSPITAL - SARASOTA	SARASOTA	18,097,426				18,097,426
101877	MEMORIAL HOSPITAL - WEST VOLUSIA	VOLUSIA			375,265		375,265
102229	MEMORIAL HOSPITAL PEMBROKE	BROWARD	7,226,665				7,226,665
102521	MEMORIAL HOSPITAL WEST	BROWARD	10,065,575				10,065,575
101931	MEMORIAL MEDICAL CENTER - JACKSONVILLE	DUVAL			961,305		961,305
100200	MEMORIAL REGIONAL HOSPITAL	BROWARD	56,980,159				56,980,159
100439	MERCY HOSPITAL	DADE			720,698		720,698
100609	MIAMI CHILDRENS HOSPITAL	DADE			2,675,002		2,675,002

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (01,02,03)	LIP 2 Avg DSH (01,02,03)	LIP 3 Using FHURS '05 FYE	LIP OTHER	TOTAL OF LIP 1, 2, & 3 PAYMENTS
101583	MORTON F. PLANT HOSPITAL	PINELLAS		7,443,405			7,443,405
100463	MT. SINAI MEDICAL CENTER	DADE			983,466		983,466
101176	MUNROE REGIONAL MEDICAL CENTER	MARION		4,297,336			4,297,336
100315	NAPLES COMMUNITY HOSPITAL	COLLIER			1,505,706		1,505,706
101141	NATURE COAST REGIONAL HOSPITAL	LEVY			69,705		69,705
101508	NORTH BAY MEDICAL CENTER	PASCO			255,612		255,612
100218	NORTH BROWARD MEDICAL CENTER	BROWARD	22,226,373				22,226,373
108626	NORTH FLORIDA REGIONAL MEDICAL CENTER	ALACHUA			562,046		562,046
101265	NORTH OKALOOSA MEDICAL CENTER	OKALOOSA			249,583		249,583
100498	NORTH SHORE MEDICAL CENTER	DADE			1,612,774		1,612,774
115193	NORTHSIDE MEDICAL CENTER	PINELLAS		360,000			360,000
101907	NORTHWEST FLORIDA COMMUNITY HOSPITAL	WASHINGTON			71,261		71,261
104591	NORTHWEST REGIONAL HOSPITAL	BROWARD			466,542		466,542
109886	OCALA REGIONAL MEDICAL CENTER	MARION		3,289,042			3,289,042
111741	ORANGE PARK MEDICAL CENTER	CLAY			641,480		641,480
101338	ORLANDO REGIONAL MEDICAL CENTER	ORANGE		7,395,950			7,395,950
101389	OSCEOLA REGIONAL MEDICAL CENTER	OSCEOLA			767,910		767,910
102105	PALM BEACH GARDENS MEDICAL CENTER	PALM BEACH		421,185			421,185
100536	PALM SPRINGS GENERAL HOSPITAL	DADE			398,474		398,474
104604	PALMETTO GENERAL HOSPITAL	DADE			1,461,416		1,461,416
120111	PALMS OF PASADENA HOSPITAL	PINELLAS		28,662			28,662
120260	PALMS WEST HOSPITAL	PALM BEACH		778,639			778,639
100544	PAN AMERICAN HOSPITAL	DADE			386,795		386,795
102385	PARKWAY REGIONAL MED CNTR (incl with JMH)	DADE					-
100102	PARRISH MEDICAL CENTER	BREVARD	679,806				679,806
103144	PHYSICAN'S REGIONAL MEDICAL CENTER	COLLIER		3,433,189			3,433,189
120251	PINECREST REHABILITATION HOSPITAL	PALM BEACH		47,700			47,700
120006	PLANTATION GENERAL HOSPITAL	BROWARD			1,219,633		1,219,633
101311	PRINCETON HOSPITAL	ORANGE			93,124		93,124
113514	PUTNAM COMMUNITY MEDICAL CENTER	PUTNAM			384,908		384,908
100765	SACRED HEART HOSPITAL	ESCAMBIA			2,402,900		2,402,900
103233	SACRED HEART OF THE EMERALD COAST	WALTON			93,663		93,663
120227	SAINT ANTHONY'S HOSPITAL	PINELLAS		6,636,253			6,636,253
100285	SAINT JOSEPH HOSPITAL OF PORT CHARLOTTE	CHARLOTTE					-

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (01,02,03)	LIP 2 Avg DSH (01,02,03)	LIP 3 Using FHURS '05 FYE	LIP OTHER	TOTAL OF LIP 1, 2, & 3 PAYMENTS
100722	SAINT LUKE'S HOSPITAL	DUVAL					-
120103	SAINT PETERSBURG GENERAL HOSPITAL	PINELLAS		339,588			339,588
100731	SAINT VINCENT'S HEALTH SYSTEM	DUVAL			1,167,465		1,167,465
101745	SANTA ROSA MEDICAL CENTER	SANTA ROSA			302,297		302,297
120014	SEBASTIAN HOSPITAL	INDIAN RIVER			125,005		125,005
119989	SEVEN RIVERS COMMUNITY HOSPITAL	CITRUS			212,256		212,256
100676	SHANDS AT JACKSONVILLE	DUVAL		26,605,548			26,605,548
100331	SHANDS AT LAKE SHORE	COLUMBIA		3,446,608			3,446,608
101796	SHANDS AT LIVE OAK	SUWANNEE			88,516		88,516
100072	SHANDS AT STARKE	BRADFORD			97,133		97,133
100030	SHANDS TEACHING HOSPITAL & CLINIC	ALACHUA			5,274,199		5,274,199
103284	SISTER EMMANUEL HOSPITAL	DADE			51,623		51,623
100986	SOUTH FLORIDA BAPTIST HOSPITAL	HILLSBOROUGH		1,857,696			1,857,696
101087	SOUTH LAKE MEMORIAL HOSPITAL	LAKE			215,181		215,181
100587	SOUTH MIAMI HOSPITAL	DADE			768,517		768,517
111341	SOUTHWEST FLORIDA REGIONAL MEDICAL CENTE	LEE	524,030				524,030
100978	ST. JOSEPH'S HOSPITAL	HILLSBOROUGH		12,858,519			12,858,519
101486	ST. MARY'S HOSPITAL	PALM BEACH		8,370,991			8,370,991
101591	SUN COAST HOSPITAL	PINELLAS		181,488			181,488
119806	TALLAHASSEE COMM HSPTL (Capital Regional Med Ctr)	LEON			346,188		346,188
101133	TALLAHASSEE MEMORIAL HEALTHCARE	LEON			1,741,809		1,741,809
100994	TAMPA GENERAL HOSPITAL	HILLSBOROUGH		20,413,838			20,413,838
119849	TOWN & COUNTRY HOSPITAL	HILLSBOROUGH			204,078		204,078
100838	TRINITY COMMUNITY HOSPITAL	HAMILTON					-
101257	TWIN CITIES HOSPITAL	OKALOSSA			60,909		60,909
100943	UNIVERSITY COMMUNITY HOSP. - CARROLLWOOD	HILLSBOROUGH			209,062		209,062
101028	UNIVERSITY COMMUNITY HOSPITAL - TAMPA	HILLSBOROUGH			1,041,335		1,041,335
112801	UNIVERSITY HOSPITAL & MEDICAL C	BROWARD			422,741		422,741
100471	UNIVERSITY OF MIAMI HOSPITAL & CLINICS	DADE			57,933		57,933
101826	VOLUSIA MEDICAL CENTER	VOLUSIA			267,353		267,353
102130	WELLINGTON REGIONAL MEDICAL CENTER	PALM BEACH		976,595			976,595
120243	WEST BOCA MEDICAL CENTER	PALM BEACH		207,633			207,633
113212	WEST FLORIDA REGIONAL MEDICAL CENTER	ESCAMBIA			453,220		453,220
100625	WESTCHESTER GENERAL HOSPITAL	DADE			950,804		950,804

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (01,02,03)	LIP 2 Avg DSH (01,02,03)	LIP 3 Using FHURS '05 FYE	LIP OTHER	TOTAL OF LIP 1, 2, & 3 PAYMENTS
101699	WINTER HAVEN HOSPITAL	POLK			830,476		830,476
100111	WUESTHOFF HOSPITAL	BREVARD			699,686		699,686
103209	WUESTHOFF MEDICAL CENTR - MELBOURNE	BREVARD			242,541		242,541
	Totals		606,628,878	180,000,000	67,438,599		854,067,477

Medicaid	Provider Name	County	LIP 1	LIP 2	LIP 3	LIP-OTHER	Total
							All Payments
Number	(as contained in 1994 Audit Records)		Avg DSH (00,01,02)	Avg DSH (00,01,02)	Using FHURS '04 FYE	(Designated)	
LIP Distributions Non-Hospital Providers							
Federally Qualified Health Clinics (DOH)							
0291528-03	Miami Beach Community Health Center	Dade				250,000	250,000
6800050-00	Suncoast Community Health Center	Hillsborough				478,940	478,940
0295507-00	Thomas E. Langley Medical Center	Sumter				466,106	466,106
0295230-01	Community Health Centers of Pinellas	Pinellas				500,000	500,000
0295744-00	Tampa Community Health Center	Hillsborough				489,476	489,476
6800025-00	Citrus Health Network	Dade				435,161	435,161
060551401	Bond Community Health	Leon				262,685	262,685
6839550-03	Collier Health Services	Collier				700,000	700,000
0295230-01	Community Health Centers of Pinellas	Pinellas				0	0
0295728-00	Community Health of South Dade	Dade				500,000	500,000
0295612-00	Manatee County Rural Health Services	Manatee				500,000	500,000
0295612-00	Manatee County Rural Health Services	Manatee				242,575	242,575
0291528-03	Miami Beach Community Health Center	Dade				500,000	500,000
0295507-00	Premier HealthCare	Pasco				110,626	110,626
6800050-00	Treasure Coast Health Center	Indian River				85,500	85,500
0279595-01	Community Health Centers, Inc	Orange				216,422	216,422
0279269-00	Agape Duval-South Jacksonville	Duval				495,000	495,000
0279269-00	Agape Duval-West Jacksonville	Duval				498,002	498,002
	Remaining Balance - Providers to be Determined					545,762	545,762
Federally Qualified Health Clinics (8 Million)							
0295655-00	Agape Community Health Center	Duval				45,765	45,765
6860320-00	Bond Community Health Center	Leon				113,402	113,402
6800271-00	Borinquen Health Care Center	Dade				128,514	128,514
27926952	Broward Community FH	Broward				83,128	83,128
6867286-00	C.L. Brumback*	Palm Beach				163,039	163,039
52033191	Camillus Health Concern, Inc.	Dade				75,027	75,027
0295485-00	Central Florida Health Care - Frostproof	Polk				299,124	299,124
6896936-00	Central Florida Migrant & Comm. Hlth. Ctr.	Orange				247,034	247,034
6800025-00	Citrus Health Network	Dade				24,732	24,732
0605514-01	Collier Health Services, Inc	Collier				518,421	518,421

Medicaid	Provider Name	County	LIP 1	LIP 2	LIP 3	LIP-OTHER	Total All Payments
Number	(as contained in 1994 Audit Records)		Avg DSH (00,01,02)	Avg DSH (00,01,02)	Using FHURS '04 FYE	(Designated)	
0295230-01	Community HC Pinellas	Pinellas				142,250	142,250
0295493-00	Community Health Center S. Dade	Dade				1,233,122	1,233,122
27959501-00	Community Health Centers	Orange				576,536	576,536
0295515-00	Economic Opportunity FHC	Dade				222,547	222,547
0295540-00	Family Health Center of Columbia County	Columbia				42,400	42,400
295612-00	Family Hlth Ctr of SW Florida	Lee				546,767	546,767
0295477-00	Florida Community Health Centers	St. Lucie				380,730	380,730
295434-00	Healthcare For The Homeless	Orange				45,708	45,708
6885713-00	Helen B. Bentley Family Health Center	Dade				214,059	214,059
6874291-00	Hernando County Health Department	Hernando				112,841	112,841
0295728-00	I.M Solzbacher Ctr for the Homeless*	Duval				159,101	159,101
0295612-00	Manatee County Rural Health Services(1)	Manatee				583,232	583,232
0291528-03	Miami Beach Community Health Center	Dade				190,244	190,244
0295400-00	North Florida Med. Ctr -	Leon				73,705	73,705
0295060-01	Northeast FL Health Services*	Volusia				17,671	17,671
0295434-00	Osceola County Health Department	Osceola				25,873	25,873
0295523-00	PanCare Health Center	Bay				8,428	8,428
0295701-00	Premier HealthCare Group, Inc.	Pasco				157,057	157,057
0295442-00	Rural Health Care - FMDC	Palatka				93,389	93,389
0295451-00	St Joseph Care of Florida	Gulf				85,399	85,399
6800050-00	Suncoast Community HCC(3)	Hillsborough				595,411	595,411
0295744-00	Tampa Community Health Center (2)	Hillsborough				433,321	433,321
0295507-00	Thomas E. Langley	Sumter				60,020	60,020
0295531-00	Treasure Coast (Fellsmere)	Indian River				96,075	96,075
0295680-00	Trenton Medical Center, Inc.	Gilchrist				40,198	40,198
6886931-00	Brevard Health Alliance	Brevard				87,887	87,887
0603651-01	Escambia Community Clinic	Escambia				77,842	77,843
County Health Initiatives							
0279269-00	Duval County Health Department	Duval				500,000	500,000
0279561-01	Okaloosa County Health Department	Okaloosa				400,000	400,000
0279684-00	Sarasota County Health Department	Sarasota				100,000	100,000
0520446-00	Charlotte County Health Department	Charlotte				200,000	200,000
0279463-00	Lee County Health Department	Lee				200,000	200,000

Medicaid	Provider Name	County	LIP 1	LIP 2	LIP 3	LIP-OTHER	Total
							All Payments
Number	(as contained in 1994 Audit Records)		Avg DSH (00,01,02)	Avg DSH (00,01,02)	Using FHURS '04 FYE	(Designated)	
0279561-00	Okaloosa Health Department	Okaloosa				200,000	200,000
0279684-00	Sarasota Health Department	Sarasota				200,000	200,000
0279765-00	Walton County Health Department	Walton				200,000	200,000
	St. John's River Rural Health Network					1,000,000	1,000,000
Providers with Poison Control Programs							
100676	Shands at Jacksonville Poison Control Program	Duval				1,201,102	1,201,102
100994	Tampa General Hospital Poison Control Program	Hillsborough				1,971,703	1,971,703
	Total Non-Hospital		0	0	0	21,449,060	21,449,060
	Total LIP1, 2, 3, & Non-Hospital		606,628,878	180,000,000	67,438,599	21,449,060	875,516,537
	Special LIP Total						124,483,459
	Grand Total						1,000,000,000

APPENDIX C

SAMPLE COST REPORT FORMS

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER NO.: ________________ COMPONENT NO.: ________________	PERIOD: FROM ________ TO ___________	WORKSHEET E-3, PART III
Check Applicable Boxes	[ ] Title V [ ] Title XVIII [ ] Title XIX	[ ] Hospital [ ] Subprovider [ ] SNF	[ ] NF [ ] ICF/MR	[ ] PPS [ ] TEFRA [ ] Other

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

		Title V or Title XIX	Title XVIII SNF PPS	
		1	2	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Interns and residents (see instructions)			3
4	Organ acquisition (certified transplant centers only)			4
5	Cost of teaching physicians (see instructions)			5
6	Subtotal (sum of lines 1 through 5)			6
7	Inpatient primary payer payments			7
8	Outpatient primary payer payments			8
9	Subtotal (line 6 less sum of lines 7 and 8)			9
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
10	Routine service charges			10
11	Ancillary service charges			11
12	Interns and residents service charges			12
13	Organ acquisition charges, net of revenue			13
14	Teaching physicians			14
15	Incentive from target amount computation			15
16	Total reasonable charges (sum of lines 10 through 15)			16
	CUSTOMARY CHARGES			
17	Amount actually collected from patients liable for payment for services on a charge basis			17
18	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			18
19	Ratio of line 17 to line 18 (not to exceed 1.000000)			19
20	Total customary charges (see instructions)			20
21	Excess of customary charges over reasonable cost (complete only if line 20 exceeds line 9) (see instructions)			21
22	Excess of reasonable cost over customary charges (complete only if line 9 exceeds line 20) (see instructions)			22
23	Cost of covered services (line 9)			23
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
24	Other than outlier payments			24
25	Outlier payments			25
26	Program capital payments			26
27	Capital exception payments (see instructions)			27
28	Routine service other pass through costs			28
29	Ancillary service other pass through costs			29
30	Subtotal (sum of lines 23 through 29)			30
31	Customary charges (title XIX PPS covered services only)			31
32	Titles V or XIX PPS, lesser of lines 30 or 31; non PPS and title XVIII enter amount from line 30			32
33	Deductibles (exclude professional component)			33

FORM CMS-2552-96 (6/2003) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3633.3)

APPENDIX D

LIP COST LIMIT WORKSHEETS

LIP COST LIMIT CALCULATION
HOSPITAL PROVIDER TYPE State Fiscal Year - _____

Provider Name	HOSPITAL XYZ	**FYB**	02/02/22
Provider Number	0123456-00	**FYE**	02/02/22
Completed By	Preparer's Name	**Date**	02/02/22
Contact Phone Number	(222) 222-2222		

Medicaid Shortfall

1. Medicaid reimbursable cost (WS E-3, III, col. 1 line 6) ______

Additional Cost:

Description	Source	Amount
-	-	-

	Source	Amount
2. Total Additional Cost		-
3. Total hospital cost (WS C, col 5, line 101)		
4. Medicaid Utilization (line 1 / line 3)		%
5. Medicaid additional cost (line 2 x line 4)		-
5a. Other Medicaid additional cost (please attach detail)		
6. Total Medicaid cost (line 1 + line 5 + line 5a)		-
7. Current period Medicaid payments (All sources: PCL, Remits, etc.)		
8. Net Medicaid shortfall (Line 6 - Line 7)		-
9. 1 + Inflation factor (refer to Title XIX Rate Calculation)		
10. Medicaid shortfall (Line 8 x Line 9)		-

LIP COST LIMIT CALCULATION
HOSPITAL PROVIDER TYPE (continued)

Provider Name	**FYB**	02/02/22
HOSPITAL XYZ		
Provider Number	**FYE**	02/02/22
0123456-00		

Underinsured and Uninsured Unrecovered Cost

	Source	
11. Charity care		
12. Bad debts (net of Medicare bad debts)		
13. Charges for other Medicaid eligible patients		
14. ______________________________		
15. ______________________________		
16. Total Charges for underinsured and uninsured patients (sum of lines 11 through 15)		-
17. Total hospital costs, including additional costs (line 2 + line 3)		-
18. Total hospital charges (WS C, col. 8, line 101)		
19. Charges related to "Additional costs" on line 2		-
20. Total adjusted charges (line 18 + line 19)		
21. Adjusted ratio of costs to charges (line 17 / line 20)		
22. Costs of Underinsured and Uninsured Services (Line 16 x Line 21)		-
23. Medicaid eligible and other payments		
24. Directly-identified cost of services to uninsured and underinsured patients		-
25. Total Uninsured and Underinsured Shortfall [(line 22 - line 23 + line 24) x line 9]		-
26. LIP Cost Limit (Line 10 + Line 25)		**-**

LIP COST LIMIT WORKSHEET FQHC PROVIDERS

Provider Name
ABC Federally Qualified Health Center | **Date** Completed XX/XX/2006

UDS Number
0123456-99

UDS Calendar Year ending
December 31, 2005

Completed By
(Preparer's Name)

Contact Phone Number (222) 222-2222

	Medicaid Inpatient Shortfall			
1	Total Accrued Cost - per UDS Report (Table 8A, cell 17a)	a	10,000.00	
2	Total Charges per UDS Report (Table 9D, cell 14A)	b	20,000.00	
3	Cost/Charge Ratio	c	50.00%	a / b
4	Total Medicaid Charges for Inpatient FQHC Physician Visits	d	1,000.00	
5	Medicaid Cost for Inpatient FQHC Physician Visits	e	500.00	c x e
6	Total Medicaid Inpatient FQHC Physician Reimbursement	f	100.00	
7	Total Medicaid Inpatient FQHC Physician Shortfall	g	400.00	e – f
8	Medicare Economic Index (MEI) Inflation		2.8%	
9	**Total Medicaid Inpatient Shortfall Inflated**	g(1)	512.00	(g) x MEI
	Uninsured Component			
10	Medicaid PPS Rate as of 10/01/05	h	98.50	
11	Uninsured Encounters (based on UDS calendar year)	i	500.00	
12	Total Uninsured Cost	j	49,250.00	j x i
13	Collections on the uninsured	k	100.00	
14	Uninsured Shortfall	l	49,150.00	j – k
15	**Total Medicaid & Uninsured Shortfall**	m	**49,662.00**	g(1) + l

LIP COST LIMIT WORKSHEET CHD PROVIDERS

Provider Name		**FYB**		07/01/04
County Health Department Name				
Medicaid Provider Number		**FYE**		06/30/05
0123456-00				
Completed By		**Date**		XX/XX/2006
(Preparer's Name)				
Contact Phone Number				
(222) 222-2222				

	Medicaid Component			
1	Total Medicaid Encounters (FY 2004-05)	a	10,000	
2	Medicaid reimbursement rate as calculated on 7/01/06	b	$100.00	
3	Total Medicaid Cost	c	$1,000,000.00	a x b
4	Total Medicaid Reimbursement	d	$700,000.00	
5	Medicaid Shortfall	e	$300,000.00	c - d
	Uninsured Component			
6	Uninsured Encounters (FY 2004-05)	f	25,000	
7	Medicaid reimbursement rate as calculated on 7/01/06	g	$100.00	
8	Total Uninsured Cost	h	$2,500,000.00	f x g
9	Personal Health Fee Collections (FY 2004-05)	i	$300,000.00	
10	Uninsured Shortfall	j	$2,200,000.00	h - i
11	**Total Medicaid & Uninsured Shortfall (FY 2004-05)**	k	**$2,500,000.00**	e + j

APPENDIX E

LIP Permissible Expenditures Certification Form

Permissible Expenditures Certification Form

For the Florida Low Income Pool

____

(Provider name)

Provider name and address (include county):

Prepared by:

Contact Phone:

Contact email:

Medicaid Provider Number

Reporting Period: From______________________ To: ______________________

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF _________________
(Provider Type)

I Hereby Certify That I Have Examined The Accompanying Data (Permissible Expenditures) For The Reporting Period Beginning _________ and Ending ______ And That To The Best Of My Knowledge And Belief It Is A True, Correct And Complete Statement Prepared From The Books And Records Of The _________ (provider name) In Accordance With Applicable Instructions, Except As Noted:

I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services and expenditures identified in this report were provided in compliance with such laws and regulations.

____

Signature of Officer or Administrator

____

Title

____

Date

APPENDIX F

STATE, NON-FEDERAL, SOURCE OF LIP FUNDING
STATE FISCAL YEAR 2007-08

Source of Funding Available for the Low Income Pool State Fiscal Year 2007 – 2008

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2007-2008, Hospital LIP	Amount as Non-Federal Share for SFY 2007-2008, Other LIP	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Brevard County	General Fund	Appropriated once a year by the County		37,941	37,941	IGT	Yes	Yes
Broward County	General Fund	Appropriated once a year by the County		35,886	35,886	IGT	Yes	Yes
Charlotte County	Ad Valorem Property Tax	.0727 Mills		86,340	86,340	IGT	Yes	Yes
Children's Services Council of St. Lucie County	Ad Valorem Property Tax	Appropriated once a year by the County		164,361	164,361	IGT	Yes	Yes
Citrus County Hospital Board	Ad Valorem Property Tax	.95 Mills. The amount of taxes levied is determined by Trustees, based on the operating and capital needs of the Hospital. A budget is prepared each year that indicates the amount of tax support required. The Trustees evaluate and validate the budget need and set taxes appropriately. The Trustees are charged with providing for the appropriate level of health care in the community.	5,452,749		5,452,749	IGT	Yes	Yes
Collier County	Ad Valorem Property Tax	Appropriated once a year by the County	1,919,651	374,897	2,294,548	IGT	Yes	Yes
Columbia County	Ad Valorem Property Tax	Appropriated once a year by the County		18,304	18,304	IGT	Yes	Yes
Duval County	General Funds	The 3 major sources of revenue come from	12,117,697	518,629	12,626,326	IGT	Yes	Yes

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2007-2008, Hospital LIP	Amount as Non-Federal Share for SFY 2007-2008, Other LIP	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
	and General Revenue	Ad Valorem taxes, state revenue sharing and the operating contribution from the Jacksonville Electric Authority, which included both electric and water/sewer fees. Amount decided every year by the County.						
Escambia County	County General Revenue	Appropriated once a year by the County		33,605	33,605	IGT	Yes	Yes
Gulf County	Sales Tax	1/2 cent		36,867	36,867	IGT	Yes	Yes
Halifax Hospital Medical Center Taxing District	Ad Valorem Property Tax	3.0 Mills	16,378,520		16,378,520	IGT	Yes	Yes
Health Care District of Palm Beach County	Ad Valorem Property Tax	1.08 Mills	14,258,096	70,384	14,328,480	IGT	Yes	Yes
Hernando County	Ad Valorem Property Tax	0.1306 Mills		48,714	48,714	IGT	Yes	Yes
Hillsborough County	Sales Tax	1/2 Cent	15,692,228	839,974	16,532,202	IGT	Yes	Yes
Indian River Taxing District	Ad Valorem Property Tax	.66296 Mills	6,818,194	59,931	6,878,125	IGT	Yes	Yes
Jackson Public Health Trust	Ad Valorem Property Tax	There is a formula used to calculate the amount of property tax allocated to JPHT. There is a floor on the amount.				IGT	Yes	Yes
Lake Shore Hospital	Ad Valorem Property Tax	1.75 Mills, may levy up to 3 mills	1,854,866		1,854,866	IGT	Yes	Yes

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2007-2008, Hospital LIP	Amount as Non-Federal Share for SFY 2007-2008, Other LIP	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Authority								
Leon County	Ad Valorem Property Tax	.06 Mills		105,656	105,658	IGT	Yes	Yes
Manatee County	Ad Valorem Property Tax	Appropriated once a year by the County		412,066	412,066	IGT	Yes	Yes
Marion County	Ad Valorem Property Tax	Appropriated once a year by the County	4,092,805		4,902,805	IGT	Yes	Yes
Miami-Dade County	Sales Tax	1/2 Cent, budgeted at 95% of the total	154,613,175	1,265,237	155,878,412	IGT	Yes	Yes
Nassau		Appropriated once a year by the Council		87,662	87,662	IGT	Yes	Yes
North Broward Hospital District	Ad Valorem Property Tax	Levied by the District	59,308,657		59,308,657	IGT	Yes	Yes
North Lake Hospital Taxing District	Ad Valorem Property Tax	1 Mil on the dollar of the value of all nonexempt property within that area of Lake County which comprises the North Lake County Hospital District.	6,947,322		6,947,322	IGT	Yes	Yes
Okaloosa County	Ad Valorem Property Tax	Appropriated once a year by the County		129,510	129,510	IGT	Yes	Yes
Orange County	County General Revenue, Ad Valorem Tax	Appropriated once a year by the County	6,242,210	421,682	6,663,892	IGT	Yes	Yes
Osceola County	Ad Valorem Property Tax	Appropriated once a year by the County		11,169	11,169	IGT	Yes	Yes

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2007-2008, Hospital LIP	Amount as Non-Federal Share for SFY 2007-2008, Other LIP	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Pasco County	County General Revenue	Appropriated once a year by the County		23,879	23,879	IGT	Yes	Yes
Pinellas County	Ad Valorem Property Tax	.40 Mills	16,950,848	169,335	17,120,183	IGT	Yes	Yes
Polk County	County General Revenue	Appropriated once a year by the County		129,132	129,132	IGT	Yes	Yes
Sarasota County Public Hospital Board	Ad Valorem Property Tax	.80 Mills, authority to levy up to 2 mills	9,624,437		9,624,437	IGT	Yes	Yes
South Broward Hospital District	Ad Valorem Property Tax	Maximum limit 2.5 Mills	34,075,474		34,075,474	IGT	Yes	Yes
St. Lucie County	Ad Valorem Property Tax	.3915 Mills with a maximum of .50 Mills				IGT	Yes	Yes
St. Johns County	Ad Valorem Property Tax	Appropriated once a year by the County	225,675		225,675	IGT	Yes	Yes
Sumter County	County General Revenue	Appropriated once a year by the County		100,609	100,609	IGT	Yes	Yes
West Volusia Hospital Authority	Ad Valorem Property Tax	1.26190 Mills		7,629	7,629	IGT	Yes	Yes
Walton County	County General Revenue	Appropriated once a year by the County		86,340	86,340	IGT	Yes	Yes

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2007-2008, Hospital LIP	Amount as Non-Federal Share for SFY 2007-2008, Other LIP	Total as Non-Federal Share for SFY 2007-2008 LIP	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Total Local Governments			366,572,604	5,275,739	371,848,342	IGT	Yes	Yes
Department of Health	State General Revenue	From funds appropriated	4,750,306	3,865,717	8,616,023	IGT	Yes	Yes
Agency for Health Care Administration	State General Revenue	As appropriated	51,117,531		51,117,531	IGT	Yes	Yes
Undetermined Source of Funds	FQHC Program 1			118,103	118,103			
Total Proposed Source of Funds			**422,440,441**	**9,259,559**	**431,700,000**			

APPENDIX G

LIP MILESTONE REPORTING DOCUMENT

	LOW INCOME POOL MILESTONE REPORTING REQUIREMENTS					
			A	B		C
	HOSPITAL SERVICES:					
				(sample data)		
	UNDUPLICATED COUNT OF INDIVIDUALS SERVED:			Medicaid		Uninsured / Underinsured
1	Inpatient			22		21
2	Outpatient			20		32
3	Unduplicated (IP&OP Combined) Count			30		45
	Types of Hospital services provided			Medicaid		Uninsured / Underinsured
4	Hospital Discharges			3,500		3,000
5	Case Mix Index					
6	Hospital Inpatient (Days)			15,000		5,700
7	Emergency Care (encounters)			3,000		4,000
		Number of Outpatient ER visits All Payors:				
	7a	Level 1 (CPT 99281)				
	7b	Level 2 (CPT 99282)				
	7c	Level 3 (CPT 99283)				
	7d	Level 4 (CPT 99284)				
	7e	Level 5 (CPT 99285)				
	7f	Trauma/Critical Care (CPT 99291)				
8	Hospital Outpatient (OP)* (encounters)			1,500		1,789
9	Affiliated Services** (encounters)			2,300		165
10	Prescription Drugs (number of prescriptions filled)			5,000		25,000
	Hospital OP Care (Check those that apply to your facility)					
11	Diagnostic X-Ray and laboratory		X			
12	Surgical Care in Outpatient Facility		X			
13	Outpatient Facility Care		X			
14	Speech, Physical and Occupational Therapies		X			
	****Hospital Affiliated Services (Check those that apply to your facility)***					
15	Primary Care/Preventative Care Visit		X			
16	Specialist Visit		X			
17	Surgical Care in Provider's Office		X			
18	Home Health Care		X			
19	Durable Medical Equipment		X			
20	Prosthetic and Orthotic Devices		X			
21	Nursing Home		X			
22	**Additional Services Provided with LIP Distributions:**					
	NON-HOSPITAL PROVIDERS:					

	UNDUPLICATED COUNT OF INVIDUALS SERVED:	Medicaid		Uninsured / Underinsured
23	Federally Qualified Health Centers (FQHC)			
24	County Health Department (CHD)			
25	St John's River Rural Health Network (SJRRHN)			
26	Other ___________________________			
	Types of Non-Hospital Provider Services	Medicaid		Uninsured / Underinsured
27	Primary Care (encounters)			
28	OB / GYN (encounters)			
29	Disease Management (encounters)			
30	Mental Health/Substance Abuse (encounters)			
31	Dental Services (encounters)			
32	Prescription Drug (number of Prescriptions filled or encounters?)			
33	Laboratory Services (encounters)			
34	Radiology Services (encounters)			
35	Specialty Encounter (encounters)			
36	Care Coordination Encounter (encounters)			
37	**Additional Services Provided with LIP Distributions:**			

APPENDIX H

LIP Distributions State Fiscal Year 2006-2007

Low Income Pool Distributions to Provider Access Systems	
	State Fiscal Year 2006-07
LIP Categories	
Hospital PAS'	
Safety-Net	$106,098,400
LIP 1	578,000,000
LIP 2	180,000,000
LIP 3	80,291,769
Specialty Children's Pediatric	2,000,000
Primary Care	12,203,921
Rural	8,383,495
Trauma	12,375,000
Total Hospital	**$979,352,585**
Non-Hospital PAS'	
Hospitals Operating Poison Control Programs	3,172,979
FQHCs	14,549,320
CHDs	1,000,000
SJRRHN	583,333
Total Non-Hospital	**19,305,632**
Grand Total	**$998,658,217**

APPENDIX I

Prior Year LIP Source of Funds

Source of Funding Available for the Low Income Pool State Fiscal Year 2006 - 2007

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2006-2007	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Broward County	General Fund	Appropriated once a year by the County	32,845	IGT	Yes	Yes
Charlotte County	Ad Valorem Property Tax	.0727 Mills	82,480	IGT	Yes	Yes
Citrus County	Ad Valorem Property Tax	Appropriated once a year by the County		IGT	Yes	Yes
Citrus County Hospital Board	Ad Valorem Property Tax	.95 Mills. The amount of taxes levied is determined by Trustees, based on the operating and capital needs of the Hospital. A budget is prepared each year that indicates the amount of tax support required. The Trustees evaluate and validate the budget need and set taxes appropriately. The Trustees are charged with providing for the appropriate level of health care in the community.	4,487,211	IGT	Yes	Yes
Collier County	Ad Valorem Property Tax	Appropriated once a year by the County	2,317,300	IGT	Yes	Yes
Columbia County	Ad Valorem Property Tax	Appropriated once a year by the County	17,160	IGT	Yes	Yes

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2006-2007	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Duval County	General Funds and General Revenue	The 3 major sources of revenue come from Ad Valorem taxes, state revenue sharing and the operating contribution from the Jacksonville Electric Authority, which included both electric and water/sewer fees. Amount decided every year by the County.	13,829,553	IGT	Yes	Yes
Escambia County	County General Revenue	Appropriated once a year by the County		IGT	Yes	Yes
Gulf County	Sales Tax	1/2 cent	37,788	IGT	Yes	Yes
Halifax Hospital Medical Center Taxing District	Ad Valorem Property Tax	3.0 Mills	18,321,158	IGT	Yes	Yes
Health Care District of Palm Beach County	Ad Valorem Property Tax	1.08 Mills	16,515,262	IGT	Yes	Yes
Hernando County	Ad Valorem Property Tax	0.1306 Mills	13,303	IGT	Yes	Yes
Hillsborough County	Sales Tax	1/2 Cent	20,112,168	IGT	Yes	Yes

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2006-2007	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Indian River Taxing District	Ad Valorem Property Tax	.66296 Mills	6,305,907	IGT	Yes	Yes
Jackson Public Health Trust	Ad Valorem Property Tax	There is a formula used to calculate the amount of property tax allocated to JPHT. There is a floor on the amount.		IGT	Yes	Yes
Lake Shore Hospital Authority	Ad Valorem Property Tax	1.75 Mills, may levy up to 3 mills	2,113,980	IGT	Yes	Yes
Lee County	General Revenue Primary Care Fund	Appropriated once a year by the County	217,554	IGT	Yes	Yes
Leon County	Ad Valorem Property Tax	.06 Mills	152,060	IGT	Yes	Yes
Manatee County	General Revenue Funds, Ad Valorem Property Tax	Appropriated once a year by the County	599,030	IGT	Yes	Yes
Marion County	Ad Valorem Property Tax	Appropriated once a year by the County	4,664,545	IGT	Yes	Yes
Miami-Dade County	Sales Tax	1/2 Cent, budgeted at 95% of the total	173,400,674	IGT	Yes	Yes
North Broward Hospital District	Ad Valorem Property Tax	Levied by the District	65,203,844	IGT	Yes	Yes
North Lake Hospital Taxing District	Ad Valorem Property Tax	1 Mil on the dollar of the value of all nonexempt property within that area of Lake County which comprises the North Lake County Hospital District.	4,917,822	IGT	Yes	Yes

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2006-2007	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
Okaloosa County	Ad Valorem Property Tax	Appropriated once a year by the County	82,480	IGT	Yes	Yes
Orange County	County General Revenue, Ad Valorem Tax	Appropriated once a year by the County	7,499,577	IGT	Yes	Yes
Osceola County	Ad Valorem Property Tax	Appropriated once a year by the County	11,466	IGT	Yes	Yes
Pasco County	County General Revenue	Appropriated once a year by the County	45,611	IGT	Yes	Yes
Pinellas County	Ad Valorem Property Tax	.40 Mills	15,603,326	IGT	Yes	Yes
Polk County	County General Revenue	Appropriated once a year by the County	120,396	IGT	Yes	Yes
Sarasota County	County General Revenue	Appropriated once a year by the County	82,480	IGT	Yes	Yes
Sarasota County Public Hospital Board	Ad Valorem Property Tax	.80 Mills, authority to levy up to 2 mills	10,569,899	IGT	Yes	Yes
South Broward Hospital District	Ad Valorem Property Tax	Maximum limit 2.5 Mills	37,534,571	IGT	Yes	Yes
Southeast Volusia Hospital District	Ad Valorem Property Tax	Sets millage rates each year based upon upcoming year needs.		IGT	Yes	Yes

Source of Funding	Derivation of Funds	Funding Amount	Amount as Non-Federal Share for SFY 2006-2007	Funding Mechanism	Will the source identified in the first column be responsible for the transfer?	Will the transfer from the identified source be sent directly to the Agency?
St. Lucie County	Ad Valorem Property Tax	.3915 Mills with a maximum of .50 Mills	124,000	IGT	Yes	Yes
St. Johns County	Ad Valorem Property Tax	Appropriated once a year by the County	257,201	IGT	Yes	Yes
Sumter County	County General Revenue	Appropriated once a year by the County	64,074	IGT	Yes	Yes
Suwannee County	Ad Valorem Property Tax	.0025 Mill				
West Volusia Hospital Authority	Ad Valorem Property Tax	1.26190 Mills	6,553	IGT	Yes	Yes
Walton County	County General Revenue	Appropriated once a year by the County	82,480	IGT	Yes	Yes
Total Local Governments			**405,425,758**	**IGT**	**Yes**	**Yes**
Department of Health	State General Revenue	As appropriated	6,612,869	IGT	Yes	Yes
Department of Education	State General Revenue	As appropriated				
				IGT	Yes	Yes
Undetermined Source of Funds						
FQHC Program 1			361,373			
Total Proposed Source of Funds for LIP			412,400,000			