Reimbursement and Funding Methodology

Florida Medicaid Reform Section 1115 Waiver

Low Income Pool

Submitted November 22, 2006

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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). The State has created separate and unique payment methodologies that recognize different PAS options. These PAS distributions will be used to contribute primarily toward healthcare 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 recommended Reimbursement and Funding Methodology document for LIP expenditures for state fiscal year (SFY) 2006-07. 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.

II. Recommended 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 who 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 2006-07 and proposed to CMS for inclusion in the LIP Reimbursement and Funding Methodology. For your reference Appendix B provides the anticipated distributions by provider and by category based on the methodologies discussed below.

A. The first PAS category represents distributions that existed during SFY 2005-2006 as part of the UPL. 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 $141,060,821 of the $1 billion. The transition programs are described below.

1. Of the total amount, $106,098,400 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.

2. 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 $2,000,000 shall be distributed equally to the qualifying hospitals.

3. The Level I and II trauma hospitals shall receive a total distribution of $12,375,000. Of this amount, $5,355,000 shall be distributed equally among hospitals that are a Level I trauma center; $4,500,000 shall be distributed equally among hospitals that are either a Level II or pediatric trauma center; and $2,520,000 shall be distributed equally among hospitals that are both a Level II and pediatric trauma center.

4. 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 $12,203,921 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 copayments, 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 nonduplicative 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.

5. The final category to receive a distribution representing the transition from UPL to LIP is for rural hospitals. The total distribution for rural hospitals is $8,383,500 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.

B. The second PAS category is designated for public, non-state owned, hospitals. The distributions are separated into four tiers described below. The total distributions to the providers in this category are $578,000,000.

1. Public hospitals receiving local tax support and having greater than 150,000 Medicaid and charity care days shall be paid $313,473,121 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 $204,526,879. 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 1.24.

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 $50,000,000. 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 $10,000,000. 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 on 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 on 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 on Appendix B. The total distribution for this category shall be $80,489,174.

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

E. The State recommends PAS distributions of $3,173,750 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 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 $2,000,000 PAS is for distributions to county health initiatives emphasizing the expansion of primary care services. Of the $2,000,000, $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. Of this amount, $600,000 will be designated for use in Baker, Clay and Nassau Counties, the rural component of the pilot for Medicaid Reform. An allocation of $200,000 for Bradford County and $200,000 for Union County will be designated for services to low income, uninsured adults.

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 $1,000,000 is provided to expand primary care services to low income, uninsured individuals 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 will receive the $200,000 LIP distribution appropriated for State Fiscal Year 2006-2007. The Walton County 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.

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 utilizes 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
   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
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 costs, 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 services, 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).

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, have been treated as charity patients.

In other cases, some other form of insurance applies, such as Personal Injury Protection (PIP) insurance, which makes a nominal 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 (eg., 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.

b. Some providers are not required to file any cost reports at all. Examples include practitioners, freestanding diagnostic centers, durable medical equipment suppliers, pharmacies, and assisted living facilities participating in the Medicaid waiver. These providers are paid at rates that are independent of individual provider costs. For these providers, an appropriate proxy for costs is needed.

c. The appropriate proxy for Medicaid costs for health care practitioners (psychiatrists, clinical psychologists, physician assistants, clinical social workers, nurse practitioners, nurse midwives, certified registered nurse anesthetists), freestanding diagnostic centers, and for durable medical equipment suppliers will

be determined by applying the applicable Medicare fee schedule to the services furnished by such practitioners to Medicaid eligible individuals.

d. The appropriate proxy for Medicaid costs for pharmacies will be determined by applying the lesser of: the average wholesale price (AWP) minus 15.4 percent, the wholesaler acquisition cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the state maximum allowable cost (SMAC), or the usual and customary (UAC) charge billed by the provider, s. 409.912(39)(a)2., F.S.

e. The appropriate proxy for Medicaid costs for assisted living facilities in the Medicaid waiver should be the Medicaid waiver fee schedule rate.

f. 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.

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 may be obtained from a cost report, such as Form CMS 2552 for hospitals, plus any other additional reporting documentation (such as Audited Financial Statements or the provider's trial balance). 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. The provider will exclude from cost reporting any costs for the provision of health care to non-qualified aliens.
    4. Charges for other Medicaid eligibles (as discussed in Section III, A, 3 of this document) will be listed on line 13.
    5. Lines 14 and 15 provide additional space to provide a detailed breakdown of other Medicaid eligibles if applicable.

6. The total of charity, bad debt and Medicaid eligible charges is calculated on line 16.
7. 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.
8. Total hospital charges, from Worksheet C, Column 8, line 101 of CMS-2552, will be documented on line 18.
9. The charges related to additional costs (as noted on line 2, "Additional costs") are to be recorded on line 19.
10. The sum of line 18 and 19 is the total adjusted hospital charges.
11. Line 21 is adjusted ratio of costs to charges (line 17 divided by line 20).
12. The cost of the uninsured and underinsured is obtained by multiplying line 16 x line 21.
13. 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.
14. 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.
15. 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 undinsured 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 (UDS). 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. The provider will exclude any costs for the provision of health care to non-qualified aliens.
5. Collections received on behalf of the uninsured are recorded at the FQHCs and documented on line 11.
6. 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. The provider will exclude any costs for the provision of health care to non-qualified aliens.
    5. Personal Health Fee Collections (payments made on behalf of the uninsured) are documented on line 9.
    6. 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 annual LIP distributions. LIP distributions are anticipated to be made monthly or quarterly, this could vary by provider type. The LIP distributions for the five year demonstration period of this waiver are dependent upon the Agency receiving 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 Servcies 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 will work 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 current Reimbursement and Funding Methodology document is subject to revision annually. Funding for existing PAS may continue, new PAS 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 at this time. However, it is anticipated that subsequent revisions will likely not be substantial. The total amount of the funding remains $1billion 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 (appropriated to receive $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 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. Form

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 provider's who 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

The table below documents the total non-Federal funds for which the Agency is currently contracting with for the Low Income Pool. A copy of all executed Letters of Agreement, including any existing local government provider agreements, are being provided to the Federal Centers for Medicare and Medicaid (CMS) staff as requested by CMS. There remains approximately $700,000 in total non-Federal funds that have not yet been determined. Of the this total, $350,000 will come from DOH, the remaining balance will be provided by local governments and/or taxing districts. DOH has scheduled their final Intent To Negotiate (ITN) process for these remaining LIP funds for December 2006. The Agency will update this document upon confirmation from DOH of the remaining local government sources.

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

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?
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
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
Indian River Taxing District	Ad Valorem Property Tax	.66296 Mills	6,305,907	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?
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
Okaloosa County	Ad Valorem Property Tax	Appropriated once a year by the County	82,480	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?
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
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				
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?
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			

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 F. 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 LIP Council, established by the legislature, is currently reviewing the reporting methodology document. The first quarter of distributions for the LIP will not be complete until the end of the 2006 calendar year. The current year of operation is, therefore, just beginning. The reporting methodology is required to document the number of individuals and types of services provided through the LIP. This report is not due until July 1, 2007, after the completion of the first year of LIP distributions. Therefore, there is no information to project as of November 2006. Upon updating this document every year, as indicated in Section V, A, Planning and Reconciliation, 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."

IX. Conclusion

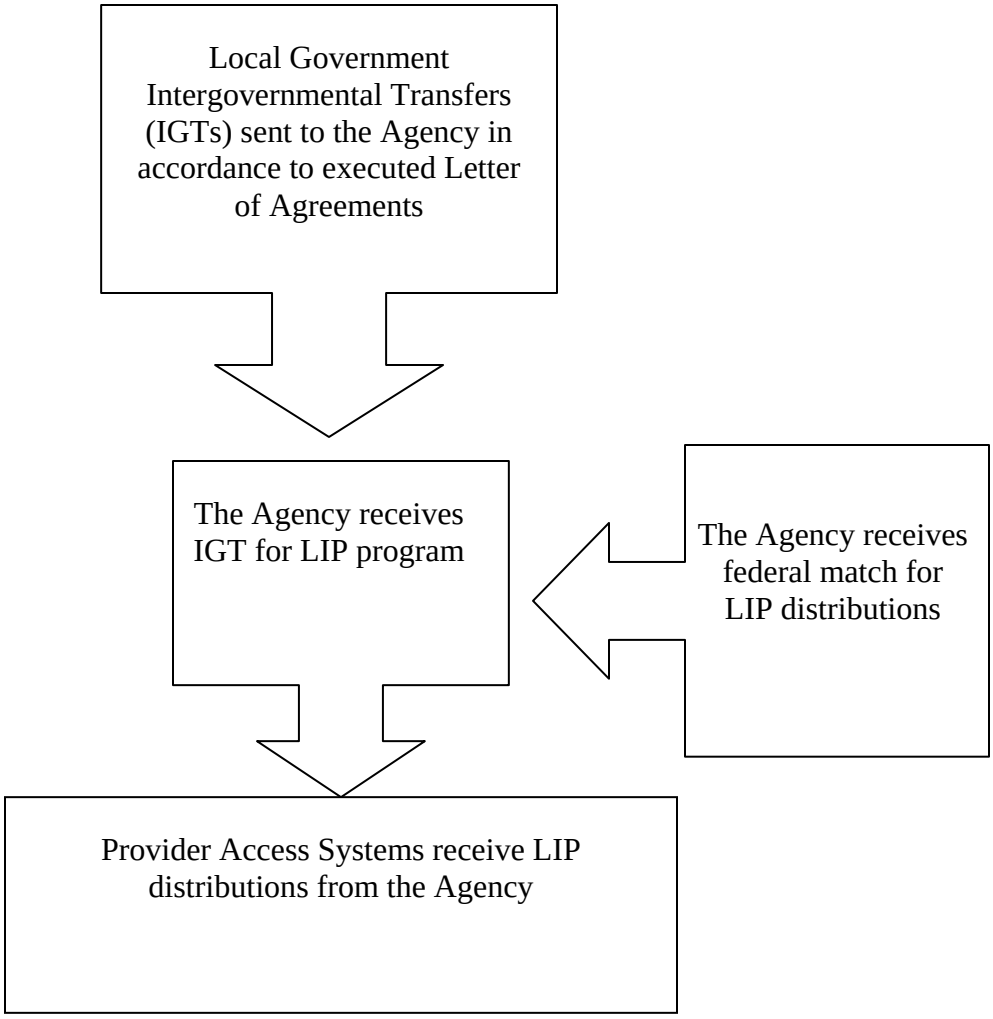
This LIP Reimbursement and Funding Methodology document is submitted to satisfy STCs 93, 97, 98, 100(a) and 101, set forth in the Medicaid Reform Section 1115 Demonstration. STC 100(a), the Pre-Implementation Milestones, calls for the "State's submission and CMS approval of a Reimbursement and Funding 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 now reflects 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.

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 Distributions State Fiscal Year 2006-2007

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Safety-Net	Pediatric	Primary Care	Rural	Trauma	Total Base Distributions
102610	A.G. HOLLY STATE HOSPITAL	PALM BEACH						0
101516	ALL CHILDREN'S HOSPITAL	PINELLAS	6,637,413	1,000,000			450,000	8,087,413
116483	ANNE BATES LEACH EYE HOSPITAL	Dade						0
102326	Baptist Hospital - Beaches	Duval						0
100358	Baptist Hospital - Miami	Dade						0
100749	BAPTIST HOSPITAL OF PENSACOLA	ESCAMBIA	450,000				450,000	900,000
100641	BAPTIST MEDICAL CENTER	Duval						0
101231	BAPTIST MEDICAL CENTER - NASSAU	NASSAU				295,455		295,455
120413	Bartow Healthcare	Polk						0
100064	BAY MEDICAL CENTER	Bay						0
101567	BAYFRONT MEDICAL CENTER	PINELLAS	215,975				450,000	665,975
119881	Bayonet Point Regional Medical Center	Pasco						0
101834	BERT FISH MEDICAL CENTER	VOLUSIA						0
101401	BETHESDA MEMORIAL HOSPITAL	PALM BEACH						0
110213	Blake Medical Center	Manatee						0
101419	Boca Raton Community	PALM BEACH						0
120022	Bon Secours Hsp - Villa Maria Rehab - St. Catherine's							0
118079	Brandon Regional Hospital	HILLSBOROUGH						0
100871	Brooksville Regional Hospital	Hernando						0
100129	BROWARD GENERAL MEDICAL CENTER	BROWARD	330,366		1,970,029		765,000	3,065,395
100269	CALHOUN LIBERTY HOSPITAL	CALHOUN				259,919		259,919
101940	CAMPBELLTON-GRACEVILLE HOSPITAL	JACKSON				58,909		58,909
100099	Cape Canaveral	Brevard						0
119717	Cape Coral	Lee						0
119806	Capital Regional Medical Center	Leon						0
100366	CEDARS MEDICAL CENTER	Dade						0
101788	Central Florida Regional	Seminole						0
100277	Charlotte Regional Medical	Charlotte						0
102199	CITRUS MEMORIAL HOSPITAL	CITRUS						0
102202	Cleveland Clinic AHCA #100056	BROWARD						0
103144	Physicians Regional (formerly Cleveland Clinic FL Hospital Naples AHCA#23960025)	Collier						0

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Safety-Net	Pediatric	Primary Care	Rural	Trauma	Total Base Distributions
120375	**Columbia - Aventura Hospital**	**Dade**						**0**
109592	**Columbia Dade City / Pasco Regional Hospital**	**Pasco**						**0**
102253	**COLUMBIA GULF COAST HOSPITAL**	**Lee**						**0**
120308	**COLUMBIA HOSPITAL**	**PALM BEACH**						**0**
101851	**Columbia Medical Ctr Penninsula**							**0**
119971	**Columbia Medical Ctr Port ST. Lucie**							**0**
115193	**COLUMBIA NORTHSIDE MEDICAL CENTER**	**PINELLAS**						**0**
120006	**COLUMBIA PLANTATION HOSPITAL**	**BROWARD**						**0**
105520	**Community Hospital of New Port Richey**							**0**
109606	**Coral Gables**	**DADE**						**0**
120405	**CORAL SPRINGS MEDICAL CENTER**	**BROWARD**						**0**
120090	**DELRAY MEDICAL CENTER**	**PALM BEACH**					**630,000**	**630,000**
101923	**DESOTO MEMORIAL HOSPITAL**	**DESOTO**				**539,605**		**539,605**
119954	**Doctor's Hospital of Sarasota**	**SARASOTA**						**0**
101036	**DOCTORS MEMORIAL HOSPITAL - BONIFAY**	**HOLMES**				**400,600**		**400,600**
101800	**DOCTORS MEMORIAL HOSPITAL - PERRY**	**TAYLOR**				**287,052**		**287,052**
120286	**Doctor's Memorial Hospital Coral Gables**							**0**
111522	**Doctor's Osteopathic**							**0**
102776	**Douglas Gardens Hospital**							**0**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Safety-Net	Pediatric	Primary Care	Rural	Trauma	Total Base Distributions
101494	**East Pasco Med Ctr**	**Pasco**						**0**
100048	**ED FRASER MEMORIAL HOSPITAL**	**BAKER**				**0**		**0**
102598	**EDWARD WHITE HOSPITAL**	**PINELLAS**						**0**
102539	**Englewood Community**	**SARASOTA**						**0**
117463	**Fawcett Memorial**	**Charlotte**						**0**
101206	**FISHERMEN'S HOSPITAL**	**MONROE**				**260,532**		**260,532**
101711	**FLAGLER HOSPITAL**	**ST JOHNS**						**0**
100901	**Florida Hosp Walker**							**0**
101290	**FLORIDA HOSPITAL**	**ORANGE**	**55,072**					**55,072**
101095	**FLORIDA HOSPITAL - WATERMAN**	**LAKE**						**0**
102601	**FLORIDA HOSPITAL - WAUCHULA**	**HIGHLANDS**				**199,835**		**199,835**
101893	**FLORIDA HOSPITAL FLAGLER**	**FLAGLER**				**431,388**		**431,388**
100068	**Florida Hospital Ormond**							**0**
102148	**Florida Medical Center**	**BROWARD**						**0**
260011	**FLORIDA STATE HOSPITAL**	**GADSDEN**						**0**
111325	**FT. WALTON BEACH MEDICAL CENTER**	**Oka**						**0**
100811	**GADSDEN COMMUNITY HOSPITAL**	**GADSDEN**				**60,129**		**60,129**
102717	**Genesis Rehab**							**0**
100803	**GEORGE E. WEEMS MEMORIAL HOSPITAL**	**FRANKLIN**				**315,252**		**315,252**
101443	**GLADES GENERAL HOSPITAL**	**PALM BEACH**				**519,570**		**519,570**
101524	**GOOD SAMARITAN MEDICAL CENTER**	**PALM BEACH**						**0**
117617	**GULF COAST COMMUNITY HOSPITAL**	**Bay**						**0**
100820	**Gulf Pines Hospital**	**Gulf**						**0**
120324	**H. LEE MOFFIT CANCER CENTER**	**HILLSBOROUGH**						**0**
101842	**HALIFAX MEDICAL CENTER**	**VOLUSIA**					**450,000**	**450,000**
101354	**HEALTH CENTRAL**	**Orange**						**0**
101885	**HEALTHMARK REGIONAL MEDICAL CENTER**	**WALTON**				**258,995**		**258,995**
120057	**HealthSouth Larkin**	**Dade**						**0**
120421	**HealthSouth Rehab-**	**BREVARD**						**0**
102288	**Heart of Florida Regional**	**POLK**						**0**
101613	**HELEN ELLIS MEMORIAL HOSPITAL**	**PINELLAS**						**0**
100862	**HENDRY REGIONAL MEDICAL CENTER**	**HENDRY**				**242,127**		**242,127**
119750	**HH Raulerson**	**OKEECHOBEE**						**0**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Safety-Net	Pediatric	Primary Care	Rural	Trauma	Total Base Distributions
100412	**HIALEAH HOSPITAL**	**DADE**						**0**
100897	**Highlands Regional**	**HIGHLANDS**						**0**
111791	**Hollywood Med Ctr**	**BROWARD**						**0**
100081	**HOLMES REGIONAL MEDICAL CENTER**	**BREVARD**					**450,000**	**450,000**
100188	**Holy Cross**	**BROWARD**						**0**
102261	**HOMESTEAD HOSPITAL**	**DADE**				**582,395**		**582,395**
108219	**IMPERIAL POINT HOSPITAL**	**BROWARD**			**712,148**			**712,148**
101044	**INDIAN RIVER MEMORIAL HOSPITAL**	**INDIAN RIVER**						**0**
101061	**JACKSON HOSPITAL**	**JACKSON**				**226,960**		**226,960**
100421	**JACKSON MEMORIAL HOSPITAL**	**DADE**	**3,322,365**		**2,232,890**		**765,000**	**6,320,255**
101737	**JAY HOSPITAL**	**SANTA ROSA**				**278,394**		**278,394**
101460	**JFK MEDICAL CENTER**	**PALM BEACH**						**0**
120294	**JUPITER MEDICAL CENTER**	**PALM BEACH**						**0**
120138	**Kendall Regional**	**DADE**						**0**
100016	**Kindred AHCA#100016**							**0**
100042	**Kindred AHCA#100042**							**0**
100115	**Kindred AHCA#100115**							**0**
100120	**Kindred AHCA#100120**							**0**
100143	**Kindred AHCA#100143**							**0**
100152	**Kindred AHCA#100152**							**0**
23960011	**Kindred AHCA#23960011**							**0**
108227	**LAKE BUTLER HOSPITAL**	**UNION**				**98,181**		**98,181**
119768	**Lake City Medical Center**	**COLUMBIA**						**0**
101664	**Lake Wales Hosp Assoc**	**POLK**						**0**
101648	**LAKELAND REGIONAL MEDICAL CENTER**	**POLK**					**450,000**	**450,000**
103420	**Lakewood Ranch Medical Center**							**0**
119741	**LARGO MEDICAL CENTER**	**PINELLAS**						**0**
119695	**LAWNWOOD REGIONAL MEDICAL CENTER**	**ST. LUCIE**						**0**
101109	**LEE MEMORIAL HOSPITAL**	**LEE**	**1,200,000**				**450,000**	**1,650,000**
101079	**LEESBURG REGIONAL MEDICAL CENTER**	**LAKE**						**0**
101117	**Lehigh Regional**							**0**
101192	**LOWER KEYS HOSPITAL**	**MONROE**						**0**
101150	**MADISON COUNTY MEMORIAL HOSPITAL**	**MADISON**				**271,275**		**271,275**
101168	**MANATEE MEMORIAL HOSPITAL**	**Manatee**						**0**
101214	**MARINERS HOSPITAL**	**MONROE**				**347,240**		**347,240**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Safety-Net	Pediatric	Primary Care	Rural	Trauma	Total Base Distributions
101184	**Martin Memorial**	**MARTIN**						**0**
110041	**Meadowbrook Rehab**							**0**
120081	**Mease Hospital - Countryside**	**PINELLAS**						**0**
101541	**MEASE HOSPITAL - DUNEDIN**	**PINELLAS**						**0**
102229	**MEMORIAL HOSPITAL - PEMBROKE**	**BROWARD**						**0**
101761	**MEMORIAL HOSPITAL - SARASOTA**	**SARASOTA**						**0**
102521	**MEMORIAL HOSPITAL - WEST**	**BROWARD**						**0**
101931	**Memorial Hospital of ..AHCA#100179**							**0**
101869	**Memorial Hospital Ormond Beach**	**VOLUSIA**						**0**
112798	**Memorial Hospital Tampa**	**BROWARD**						**0**
101877	**Memorial Hospital W Volusia/FL Hospital Deland**							**0**
100200	**MEMORIAL REGIONAL HOSPITAL**	**BROWARD**			**2,189,909**		**765,000**	**2,954,909**
100439	**Mercy Hospital**	**DADE**						**0**
100609	**MIAMI CHILDRENS HOSPITAL**	**DADE**	**5,400,229**	**1,000,000**			**450,000**	**6,850,229**
101583	**MORTON F. PLANT HOSPITAL**	**PINELLAS**						**0**
101508	**Morton Plant NORTH BAY**	**Pasco**						**0**
100463	**MT. SINAI MEDICAL CENTER**	**DADE**	**9,072,075**					**9,072,075**
101176	**MUNROE REGIONAL MEDICAL CENTER**	**MARION**						**0**
100315	**NAPLES COMMUNITY HOSPITAL**	**COLLIER**	**250,000**					**250,000**
101141	**NATURE COAST REGIONAL HOSPITAL**	**LEVY**				**410,218**		**410,218**
100218	**NORTH BROWARD MEDICAL CENTER**	**BROWARD**					**450,000**	**450,000**
108626	**North Florida Regional AHCA#100204**	**ALACHUA**						**0**
101265	**North Okaloosa**	**OKALOOSA**						**0**
100498	**NORTH SHORE MEDICAL CENTER**	**DADE**						**0**
260029	**NORTHEAST FLORIDA STATE HOSPITAL**	**BAKER**						**0**
102571	**Northridge Medical Ctr**	**BROWARD**						**0**
101907	**NORTHWEST FLORIDA COMMUNITY HOSPITAL**	**WASHINGTON**				**225,870**		**225,870**
104591	**Northwest Regional**	**BROWARD**						**0**
120073	**Oak Hill Hospital**	**HERNANDO**						**0**
109886	**OCALA REGIONAL MEDICAL CENTER**	**MARION**						**0**
111741	**Orange Park Medical Center**	**CLAY**						**0**
101338	**ORLANDO REGIONAL MEDICAL CENTER**	**ORANGE**	**5,560,262**				**765,000**	**6,325,262**
101389	**Osceola Regional Hospital**	**OSCEOLA**						**0**
102105	**PALM BEACH GARDENS MEDICAL CENTER**	**PALM BEACH**						**0**
100536	**Palm Springs General**	**DADE**						**0**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Safety-Net	Pediatric	Primary Care	Rural	Trauma	Total Base Distributions
104604	**PALMETTO GENERAL HOSPITAL**	**DADE**						**0**
120111	**PALMS OF PASADENA HOSPITAL**	**PINELLAS**						**0**
120260	**PALMS WEST HOSPITAL**	**PALM BEACH**						**0**
100544	**Pan American**	**DADE**						**0**
102385	**PARKWAY REGIONAL MEDICAL CENTER**	**DADE**						**0**
100102	**PARRISH MEDICAL CENTER**	**BREVARD**						**0**
120251	**PINECREST REHABILITATION HOSPITAL**	**PALM BEACH**						**0**
101311	**PRINCETON HOSPITAL**	**PUTNAM**						**0**
113514	**PUTNAM HOSPITAL**	**PUTNAM**						**0**
103233	**Sacred Heart Emerald Coast**							**0**
100765	**SACRED HEART HOSPITAL**	**ESCAMBIA**	**466,977**				**630,000**	**1,096,977**
120227	**SAINT ANTHONY'S HOSPITAL**	**PINELLAS**						**0**
100722	**SAINT LUKE'S HOSPITAL**	**DUVAL**						**0**
120103	**SAINT PETERSBURG GENERAL HOSPITAL**	**PINELLAS**						**0**
100731	**SAINT VINCENT'S HEALTH SYSTEM**	**DUVAL**						**0**
101745	**Santa Rosa Medical Center**	**Santa Rosa**						**0**
120014	**Sebastian Hospital**	**Indian River**						**0**
103390	**Semper Care Hospital**							**0**
119989	**Seven River's Community**	**CItrus**						**0**
100676	**SHANDS AT JACKSONVILLE**	**DUVAL**	**46,121,019**		**1,920,568**		**765,000**	**48,806,587**
100331	**SHANDS AT LAKE SHORE**	**COLUMBIA**				**554,796**		**554,796**
101796	**SHANDS AT LIVE OAK**	**SUWANNEE**				**258,124**		**258,124**
100072	**SHANDS AT STARKE**	**BRADFORD**				**484,103**		**484,103**
100030	**SHANDS TEACHING HOSPITAL & CLINIC**	**ALACHUA**	**7,703,253**		**981,098**		**765,000**	**9,449,351**
103284	**Sister Emmanuel Hospital**							**0**
119946	**South Bay Hospital**	**HILLSBOROUGH**						**0**
100986	**SOUTH FLORIDA BAPTIST HOSPITAL**	**HILLSBOROUGH**						**0**
260045	**SOUTH FLORIDA STATE HOSPITAL**	**BROWARD**						**0**
101087	**SOUTH LAKE MEMORIAL HOSPITAL**	**LAKE**				**247,382**		**247,382**
100587	**South Miami Hospital**	**DADE**						**0**
111341	**Southwest Florida Regional**	**LEE**						**0**
23960028	**SSH-Miami AHCA#23960028**							**0**
102407	**St. John's Rehabilitation**	**BROWARD**						**0**
100978	**ST. JOSEPH'S HOSPITAL**	**HILLSBOROUGH**	**52,835**				**630,000**	**682,835**
100285	**St. Joseph's Port Charlotte**							**0**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	Safety-Net	Pediatric	Primary Care	Rural	Trauma	Total Base Distributions
101486	**ST. MARY'S HOSPITAL**	**PALM BEACH**	**291,706**				**630,000**	**921,706**
101591	**SUN COAST HOSPITAL**	**PINELLAS**						**0**
101133	**TALLAHASSEE MEMORIAL HEALTHCARE**	**LEON**	**54,402**					**54,402**
100994	**TAMPA GENERAL HOSPITAL**	**HILLSBOROUGH**	**18,914,451**		**2,197,279**		**765,000**	**21,876,730**
103179	**The Villages Regional**							**0**
119849	**Town and Country Hospital**	**HILLSBOROUGH**						**0**
100838	**TRINITY COMMUNITY HOSPITAL**	**HAMILTON**				**269,194**		**269,194**
101257	**Twin Cities Hospital**	**OKALOOSA**						**0**
101028	**University Comm Hosp Tampa**	**HILLSBOROUGH**						**0**
112801	**University Hospital AHCA#100224**							**0**
100943	**University Hospital Carrollwood**	**HILLSBOROUGH**						**0**
100471	**UNIVERSITY OF MIAMI HOSPITAL AND CLINIC**	**DADE**						**0**
102768	**VENCOR HOSPITAL - ST. PETERSBURG**							**0**
119733	**Venice Hospital**							**0**
101826	**Volusia Medical Ctr / FL Hospital Fish Memorial**							**0**
102130	**WELLINGTON REGIONAL MEDICAL CENTER**	**PALM BEACH**						**0**
120243	**WEST BOCA MEDICAL CENTER**	**PALM BEACH**						**0**
260053	**WEST FLORIDA COMMUNITY CARE CENTER**	**Santa Rosa**						**0**
113212	**WEST FLORIDA REGIONAL MEDICAL CENTER**	**ESCAMBIA**					**450,000**	**450,000**
100625	**WESTCHESTER GENERAL HOSPITAL**	**Dade**						**0**
112305	**Westside Regional AHCA#100228**	**Broward**						**0**
101699	**Winter Haven**	**Polk**						**0**
101362	**Winter Park Memorial Hospital**	**Orange**						**0**
100111	**WUESTHOFF HOSPITAL**	**Brevard**						**0**
103209	**Wuesthoff Medical Center AHCA#23960034**							**0**
	Total LIP Hospital Providers		**106,098,400**	**2,000,000**	**12,203,921**	**8,383,500**	**12,375,000**	**141,060,821**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (00,01,02)	LIP 2 Avg DSH (00,01,02)	LIP 3 Using FHURS '04 FYE	LIP-OTHER (Designated)	Total All Payments
102610	A.G. HOLLY STATE HOSPITAL	PALM BEACH					0
101516	ALL CHILDREN'S HOSPITAL	PINELLAS			2,527,640		2,527,640
116483	ANNE BATES LEACH EYE HOSPITAL	Dade			384,427		384,427
102326	Baptist Hospital - Beaches	Duval			308,696		308,696
100358	Baptist Hospital - Miami	Dade			2,404,628		2,404,628
100749	BAPTIST HOSPITAL OF PENSACOLA	ESCAMBIA			1,311,145		1,311,145
100641	BAPTIST MEDICAL CENTER	Duval			2,478,102		2,478,102
101231	BAPTIST MEDICAL CENTER - NASSAU	NASSAU			228,960		228,960
120413	Bartow Healthcare	Polk			250,329		250,329
100064	BAY MEDICAL CENTER	Bay	2,890,179		0		2,890,179
101567	BAYFRONT MEDICAL CENTER	PINELLAS		9,437,665			9,437,665
119881	Bayonet Point Regional Medical Center	Pasco			0		0
101834	BERT FISH MEDICAL CENTER	VOLUSIA			240,793		240,793
101401	BETHESDA MEMORIAL HOSPITAL	PALM BEACH		1,805,151			1,805,151
110213	Blake Medical Center	Manatee			0		0
101419	Boca Raton Community	PALM BEACH			0		0
120022	Bon Secours Hsp - Villa Maria Rehab - St. Catherine's						0
118079	Brandon Regional Hospital	HILLSBOROUGH			1,152,138		1,152,138
100871	Brooksville Regional Hospital	Hernando			905,438		905,438
100129	BROWARD GENERAL MEDICAL CENTER	BROWARD	84,117,944				84,117,944
100269	CALHOUN LIBERTY HOSPITAL	CALHOUN			30,514		30,514
101940	CAMPBELLTON-GRACEVILLE HOSPITAL	JACKSON			11,050		11,050
100099	Cape Canaveral	Brevard			277,548		277,548
119717	Cape Coral	Lee	736,462		0		736,462
119806	Capital Regional Medical Center	Leon			406,886		406,886
100366	CEDARS MEDICAL CENTER	Dade			2,451,696		2,451,696
101788	Central Florida Regional	Seminole			530,332		530,332
100277	Charlotte Regional Medical	Charlotte			0		0
102199	CITRUS MEMORIAL HOSPITAL	CITRUS		7,808,712			7,808,712
102202	Cleveland Clinic AHCA #100056	BROWARD			0		0
103144	Physicians Regional (formerly Cleveland Clinic FL Hospital Naples AHCA#23960025)	Collier		3,621,669			3,621,669
120375	Columbia - Aventura Hospital	Dade			631,926		631,926

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (00,01,02)	LIP 2 Avg DSH (00,01,02)	LIP 3 Using FHURS '04 FYE	LIP-OTHER (Designated)	Total All Payments
109592	**Columbia Dade City / Pasco Regional Hospital**	**Pasco**			**248,771**		**248,771**
102253	**COLUMBIA GULF COAST HOSPITAL**	**Lee**			**367,497**		**367,497**
120308	**COLUMBIA HOSPITAL**	**PALM BEACH**		**667,134**			**667,134**
101851	**Columbia Medical Ctr Penninsula**						**0**
119971	**Columbia Medical Ctr Port ST. Lucie**				**408,003**		**408,003**
115193	**COLUMBIA NORTHSIDE MEDICAL CENTER**	**PINELLAS**		**394,194**			**394,194**
120006	**COLUMBIA PLANTATION HOSPITAL**	**BROWARD**			**1,367,702**		**1,367,702**
105520	**Community Hospital of New Port Richey**				**936,902**		**936,902**
109606	**Coral Gables**	**DADE**			**449,583**		**449,583**
120405	**CORAL SPRINGS MEDICAL CENTER**	**BROWARD**	**10,324,747**				**10,324,747**
120090	**DELRAY MEDICAL CENTER**	**PALM BEACH**		**6,210,200**			**6,210,200**
101923	**DESOTO MEMORIAL HOSPITAL**	**DESOTO**			**240,806**		**240,806**
119954	**Doctor's Hospital of Sarasota**	**SARASOTA**			**0**		**0**
101036	**DOCTORS MEMORIAL HOSPITAL - BONIFAY**	**HOLMES**			**85,578**		**85,578**
101800	**DOCTORS MEMORIAL HOSPITAL - PERRY**	**TAYLOR**			**194,996**		**194,996**
120286	**Doctor's Memorial Hospital Coral Gables**						**0**
111522	**Doctor's Osteopathic**				**0**		**0**
102776	**Douglas Gardens Hospital**				**21,510**		**21,510**
101494	**East Pasco Med Ctr**	**Pasco**			**456,869**		**456,869**
100048	**ED FRASER MEMORIAL HOSPITAL**	**BAKER**			**69,878**		**69,878**
102598	**EDWARD WHITE HOSPITAL**	**PINELLAS**		**80,102**			**80,102**
102539	**Englewood Community**	**SARASOTA**			**0**		**0**
117463	**Fawcett Memorial**	**Charlotte**					**0**
101206	**FISHERMEN'S HOSPITAL**	**MONROE**			**63,320**		**63,320**
101711	**FLAGLER HOSPITAL**	**ST JOHNS**			**776,985**		**776,985**
100901	**Florida Hosp Walker**				**595,867**		**595,867**
101290	**FLORIDA HOSPITAL**	**ORANGE**		**8,232,905**			**8,232,905**
101095	**FLORIDA HOSPITAL - WATERMAN**	**LAKE**		**4,499,331**			**4,499,331**
102601	**FLORIDA HOSPITAL - WAUCHULA**	**HIGHLANDS**			**78,441**		**78,441**
101893	**FLORIDA HOSPITAL FLAGLER**	**FLAGLER**			**0**		**0**
100068	**Florida Hospital Ormond**						**0**
102148	**Florida Medical Center**	**BROWARD**			**1,275,497**		**1,275,497**
260011	**FLORIDA STATE HOSPITAL**	**GADSDEN**					**0**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (00,01,02)	LIP 2 Avg DSH (00,01,02)	LIP 3 Using FHURS '04 FYE	LIP-OTHER (Designated)	Total All Payments
111325	FT. WALTON BEACH MEDICAL CENTER	Oka			648,383		648,383
100811	GADSDEN COMMUNITY HOSPITAL	GADSDEN			27,843		27,843
102717	Genesis Rehab						0
100803	GEORGE E. WEEMS MEMORIAL HOSPITAL	FRANKLIN			23,280		23,280
101443	GLADES GENERAL HOSPITAL	PALM BEACH		2,460,143			2,460,143
101524	GOOD SAMARITAN MEDICAL CENTER	PALM BEACH		997,134			997,134
117617	GULF COAST COMMUNITY HOSPITAL	Bay			685,399		685,399
100820	Gulf Pines Hospital	Gulf					0
120324	H. LEE MOFFIT CANCER CENTER	HILLSBOROUGH			409,250		409,250
101842	HALIFAX MEDICAL CENTER	VOLUSIA	31,864,755				31,864,755
101354	HEALTH CENTRAL	Orange	1,300,714		0		1,300,714
101885	HEALTHMARK REGIONAL MEDICAL CENTER	WALTON			73,183		73,183
120057	HealthSouth Larkin	Dade			398,466		398,466
120421	HealthSouth Rehab-	BREVARD					0
102288	Heart of Florida Regional	POLK			696,010		696,010
101613	HELEN ELLIS MEMORIAL HOSPITAL	PINELLAS		226,828			226,828
100862	HENDRY REGIONAL MEDICAL CENTER	HENDRY			81,737		81,737
119750	HH Raulerson	OKEECHOBEE			191,733		191,733
100412	HIALEAH HOSPITAL	DADE			1,182,226		1,182,226
100897	Highlands Regional	HIGHLANDS			269,570		269,570
111791	Hollywood Med Ctr	BROWARD			0		0
100081	HOLMES REGIONAL MEDICAL CENTER	BREVARD			1,608,982		1,608,982
100188	Holy Cross	BROWARD			672,119		672,119
102261	HOMESTEAD HOSPITAL	DADE			1,084,698		1,084,698
108219	IMPERIAL POINT HOSPITAL	BROWARD	11,715,778				11,715,778
101044	INDIAN RIVER MEMORIAL HOSPITAL	INDIAN RIVER		10,775,273			10,775,273
101061	JACKSON HOSPITAL	JACKSON			255,514		255,514
100421	JACKSON MEMORIAL HOSPITAL	DADE	313,473,121				313,473,121
101737	JAY HOSPITAL	SANTA ROSA			118,070		118,070
101460	JFK MEDICAL CENTER	PALM BEACH		4,973,185			4,973,185
120294	JUPITER MEDICAL CENTER	PALM BEACH		459,091			459,091
120138	Kendall Regional	DADE			1,257,483		1,257,483
100016	Kindred AHCA#100016						0

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (00,01,02)	LIP 2 Avg DSH (00,01,02)	LIP 3 Using FHURS '04 FYE	LIP-OTHER (Designated)	Total All Payments
100042	Kindred AHCA#100042						0
100115	Kindred AHCA#100115						0
100120	Kindred AHCA#100120						0
100143	Kindred AHCA#100143						0
100152	Kindred AHCA#100152						0
23960011	Kindred AHCA#23960011						0
108227	LAKE BUTLER HOSPITAL	UNION			37,848		37,848
119768	Lake City Medical Center	COLUMBIA			129,622		129,622
101664	Lake Wales Hosp Assoc	POLK			172,330		172,330
101648	LAKELAND REGIONAL MEDICAL CENTER	POLK			2,316,116		2,316,116
103420	Lakewood Ranch Medical Center				23,223		23,223
119741	LARGO MEDICAL CENTER	PINELLAS		291,026			291,026
119695	LAWNWOOD REGIONAL MEDICAL CENTER	ST. LUCIE			1,370,886		1,370,886
101109	LEE MEMORIAL HOSPITAL	LEE	4,285,250				4,285,250
101079	LEESBURG REGIONAL MEDICAL CENTER	LAKE		3,931,369			3,931,369
101117	Lehigh Regional				196,543		196,543
101192	LOWER KEYS HOSPITAL	MONROE			497,791		497,791
101150	MADISON COUNTY MEMORIAL HOSPITAL	MADISON			86,780		86,780
101168	MANATEE MEMORIAL HOSPITAL	Manatee			1,295,298		1,295,298
101214	MARINERS HOSPITAL	MONROE			112,790		112,790
101184	Martin Memorial	MARTIN			866,030		866,030
110041	Meadowbrook Rehab						0
120081	Mease Hospital - Countryside	PINELLAS					0
101541	MEASE HOSPITAL - DUNEDIN	PINELLAS		846,532			846,532
102229	MEMORIAL HOSPITAL - PEMBROKE	BROWARD	6,891,699				6,891,699
101761	MEMORIAL HOSPITAL - SARASOTA	SARASOTA	18,135,245				18,135,245
102521	MEMORIAL HOSPITAL - WEST	BROWARD	9,246,469				9,246,469
101931	Memorial Hospital of ..AHCA#100179				1,177,437		1,177,437
101869	Memorial Hospital Ormond Beach	VOLUSIA					0
112798	Memorial Hospital Tampa	BROWARD			0		0
101877	Memorial Hospital W Volusia/FL Hospital Deland				472,080		472,080
100200	MEMORIAL REGIONAL HOSPITAL	BROWARD	58,673,914				58,673,914
100439	Mercy Hospital	DADE			712,325		712,325

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100609	MIAMI CHILDRENS HOSPITAL	DADE			2,861,623		2,861,623
101583	MORTON F. PLANT HOSPITAL	PINELLAS		7,736,458			7,736,458
101508	Morton Plant NORTH BAY	Pasco			229,755		229,755
100463	MT. SINAI MEDICAL CENTER	DADE			1,209,284		1,209,284
101176	MUNROE REGIONAL MEDICAL CENTER	MARION		4,607,670			4,607,670
100315	NAPLES COMMUNITY HOSPITAL	COLLIER			1,744,625		1,744,625
101141	NATURE COAST REGIONAL HOSPITAL	LEVY			104,951		104,951
100218	NORTH BROWARD MEDICAL CENTER	BROWARD	23,556,328				23,556,328
108626	North Florida Regional AHCA#100204	ALACHUA			643,510		643,510
101265	North Okaloosa	OKALOOSA			289,496		289,496
100498	NORTH SHORE MEDICAL CENTER	DADE			1,902,224		1,902,224
260029	NORTHEAST FLORIDA STATE HOSPITAL	BAKER					0
102571	Northridge Medical Ctr	BROWARD			0		0
101907	NORTHWEST FLORIDA COMMUNITY HOSPITAL	WASHINGTON			18,130		18,130
104591	Northwest Regional	BROWARD			508,190		508,190
120073	Oak Hill Hospital	HERNANDO					0
109886	OCALA REGIONAL MEDICAL CENTER	MARION		3,539,896			3,539,896
111741	Orange Park Medical Center	CLAY			803,129		803,129
101338	ORLANDO REGIONAL MEDICAL CENTER	ORANGE		8,433,972			8,433,972
101389	Osceola Regional Hospital	OSCEOLA			848,978		848,978
102105	PALM BEACH GARDENS MEDICAL CENTER	PALM BEACH		439,596			439,596
100536	Palm Springs General	DADE			538,165		538,165
104604	PALMETTO GENERAL HOSPITAL	DADE			1,699,646		1,699,646
120111	PALMS OF PASADENA HOSPITAL	PINELLAS		29,550			29,550
120260	PALMS WEST HOSPITAL	PALM BEACH		806,737			806,737
100544	Pan American	DADE			377,501		377,501
102385	PARKWAY REGIONAL MEDICAL CENTER	DADE			1,918,239		1,918,239
100102	PARRISH MEDICAL CENTER	BREVARD	787,395		0		787,395
120251	PINECREST REHABILITATION HOSPITAL	PALM BEACH		50,205			50,205
101311	PRINCETON HOSPITAL	PUTNAM			61,089		61,089
113514	PUTNAM HOSPITAL	PUTNAM			447,079		447,079
103233	Sacred Heart Emerald Coast				103,657		103,657
100765	SACRED HEART HOSPITAL	ESCAMBIA			2,634,556		2,634,556

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120227	SAINT ANTHONY'S HOSPITAL	PINELLAS		6,945,859			6,945,859
100722	SAINT LUKE'S HOSPITAL	DUVAL			0		0
120103	SAINT PETERSBURG GENERAL HOSPITAL	PINELLAS		356,654			356,654
100731	SAINT VINCENT'S HEALTH SYSTEM	DUVAL			1,328,796		1,328,796
101745	Santa Rosa Medical Center	Santa Rosa			324,899		324,899
120014	Sebastian Hospital	Indian River			0		0
103390	Semper Care Hospital				0		0
119989	Seven River's Community	CItrus			194,215		194,215
100676	SHANDS AT JACKSONVILLE	DUVAL		27,449,742			27,449,742
100331	SHANDS AT LAKE SHORE	COLUMBIA		3,705,978			3,705,978
101796	SHANDS AT LIVE OAK	SUWANNEE			86,755		86,755
100072	SHANDS AT STARKE	BRADFORD			118,658		118,658
100030	SHANDS TEACHING HOSPITAL & CLINIC	ALACHUA			5,685,380		5,685,380
103284	Sister Emmanuel Hospital				0		0
119946	South Bay Hospital	HILLSBOROUGH					0
100986	SOUTH FLORIDA BAPTIST HOSPITAL	HILLSBOROUGH		1,938,861			1,938,861
260045	SOUTH FLORIDA STATE HOSPITAL	BROWARD					0
101087	SOUTH LAKE MEMORIAL HOSPITAL	LAKE			277,913		277,913
100587	South Miami Hospital	DADE			909,424		909,424
111341	Southwest Florida Regional	LEE			502,575		502,575
23960028	SSH-Miami AHCA#23960028						0
102407	St. John's Rehabilitation	BROWARD					0
100978	ST. JOSEPH'S HOSPITAL	HILLSBOROUGH		14,200,041			14,200,041
100285	St. Joseph's Port Charlotte				430,293		430,293
101486	ST. MARY'S HOSPITAL	PALM BEACH		8,797,387			8,797,387
101591	SUN COAST HOSPITAL	PINELLAS		211,979			211,979
101133	TALLAHASSEE MEMORIAL HEALTHCARE	LEON			2,212,018		2,212,018
100994	TAMPA GENERAL HOSPITAL	HILLSBOROUGH		21,783,425			21,783,425
103179	The Villages Regional				0		0
119849	Town and Country Hospital	HILLSBOROUGH			247,381		247,381
100838	TRINITY COMMUNITY HOSPITAL	HAMILTON			79,082		79,082
101257	Twin Cities Hospital	OKALOOSA			74,078		74,078
101028	University Comm Hosp Tampa	HILLSBOROUGH			1,142,780		1,142,780
112801	University Hospital AHCA#100224				535,829		535,829

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (00,01,02)	LIP 2 Avg DSH (00,01,02)	LIP 3 Using FHURS '04 FYE	LIP-OTHER (Designated)	Total All Payments
100943	**University Hospital Carrollwood**	**HILLSBOROUGH**			**187,613**		**187,613**
100471	**UNIVERSITY OF MIAMI HOSPITAL AND CLINIC**	**DADE**			**71,461**		**71,461**
102768	**VENCOR HOSPITAL - ST. PETERSBURG**						**0**
119733	**Venice Hospital**				**0**		**0**
101826	**Volusia Medical Ctr / FL Hospital Fish Memorial**				**324,573**		**324,573**
102130	**WELLINGTON REGIONAL MEDICAL CENTER**	**PALM BEACH**		**1,019,704**			**1,019,704**
120243	**WEST BOCA MEDICAL CENTER**	**PALM BEACH**		**228,642**			**228,642**
260053	**WEST FLORIDA COMMUNITY CARE CENTER**	**Santa Rosa**					**0**
113212	**WEST FLORIDA REGIONAL MEDICAL CENTER**	**ESCAMBIA**			**555,167**		**555,167**
100625	**WESTCHESTER GENERAL HOSPITAL**	**Dade**			**1,093,197**		**1,093,197**
112305	**Westside Regional AHCA#100228**	**Broward**					**0**
101699	**Winter Haven**	**Polk**			**892,088**		**892,088**
101362	**Winter Park Memorial Hospital**	**Orange**					**0**
100111	**WUESTHOFF HOSPITAL**	**Brevard**			**743,189**		**743,189**
103209	**Wuesthoff Medical Center AHCA#23960034**				**206,485**		**206,485**
	Total LIP Hospital Providers		**578,000,000**	**180,000,000**	**80,489,174**	**0**	**838,489,174**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (00,01,02)	LIP 2 Avg DSH (00,01,02)	LIP 3 Using FHURS '04 FYE	LIP-OTHER (Designated)	Total All Payments
LIP Distributions Non-Hospital Providers							
Federally Qualified Health Clinics (DOH)							
0291528-03	**Miami Beach Community Health Center**	**Dade**				**333,333**	**333,333**
6800050-00	**Suncoast Community Health Center**	**Hillsborough**				**328,747**	**328,747**
0295507-00	**Thomas E. Langley Medical Center**	**Sumter**				**310,737**	**310,737**
0295230-01	**Community Health Centers of Pinellas**	**Pinellas**				**333,333**	**333,333**
0295744-00	**Tampa Community Health Center**	**Hillsborough**				**326,317**	**326,317**
6800025-00	**Citrus Health Network**	**Dade**				**290,107**	**290,107**
060551401	**Bond Community Health**	**Leon**				**525,370**	**525,370**
0605514-01	**Collier Health Services**	**Collier**				**700,000**	**700,000**
0295230-01	**Community Health Centers of Pinellas**	**Pinellas**				**250,000**	**250,000**
029572800	**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**				**485,150**	**485,150**
0291528-03	**Miami Beach Community Health Center**	**Dade**				**250,000**	**250,000**
029550700	**Premier HealthCare**	**Pasco**				**221,252**	**221,252**
680005000	**Treasure Coast Health Center**	**Indian River**				**171,000**	**171,000**
	Remaining Balance - Providers to be Determined					**1,750,908**	**1,750,908**
Federally Qualified Health Clinics (8 Million)							
0295655-00	**Agape Community Health Center**	**Duval**				**30,860**	**30,860**
6860320-00	**Bond Community Health Center**	**Leon**				**106,124**	**106,124**
6800271-00	**Borinquen Health Care Center**	**Dade**				**215,028**	**215,028**
27926952	**Broward Community FH**	**Broward**				**73,094**	**73,094**
6867286-00	**C.L. Brumback***	**Palm Beach**				**176,569**	**176,569**
52033191	**Camillus Health Concern, Inc.**	**Dade**				**147,467**	**147,467**
0295485-00	**Central Florida Health Care - Frostproof**	**Polk**				**292,010**	**292,010**
6896936-00	**Central Florida Migrant & Comm. Hlth. Ctr.**	**Orange**				**249,306**	**249,306**
6800025-00	**Citrus Health Network**	**Dade**				**23,763**	**23,763**
0605514-01	**Collier Health Services, Inc**	**Collier**				**561,443**	**561,443**
0295230-01	**Community HC Pinellas**	**Pinellas**				**151,541**	**151,541**
0295493-00	**Community Health Center S. Dade**	**Dade**				**808,068**	**808,068**

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (00,01,02)	LIP 2 Avg DSH (00,01,02)	LIP 3 Using FHURS '04 FYE	LIP-OTHER (Designated)	Total All Payments
27959501-00	Community Health Centers	Orange				624,380	624,380
0295515-00	Economic Opportunity FHC	Dade				437,520	437,520
0295540-00	Family Health Center of Columbia County	Columbia				41,620	41,620
295612-00	Family Hlth Ctr of SW Florida	Lee				527,659	527,659
0295477-00	Florida Community Health Centers	St. Lucie				323,029	323,029
295434-00	Healthcare For The Homeless	Orange				60,994	60,994
6885713-00	Helen B. Bentley Family Health Center	Dade				235,854	235,854
6874291-00	Hernando County Health Department	Hernando				32,265	32,265
0295728-00	I.M Solzbacher Ctr for the Homeless*	Duval				15,430	15,430
0295612-00	Manatee County Rural Health Services(1)	Manatee				794,605	794,605
0291528-03	Miami Beach Community Health Center	Dade				418,406	418,406
0295400-00	North Florida Med. Ctr -	Leon				88,333	88,333
0295060-01	Northeast FL Health Services*	Volusia				15,894	15,894
0295434-00	Osceola County Health Department	Osceola				27,809	27,809
0295523-00	PanCare Health Center	Bay				8,682	8,682
0295701-00	Premier HealthCare Group, Inc.	Pasco				81,647	81,647
0295442-00	Rural Health Care - FMDC	Palatka				105,602	105,602
0295451-00	St Joseph Care of Florida	Gulf				91,652	91,652
6800050-00	Suncoast Community HCC(3)	Hillsborough				639,803	639,803
0295744-00	Tampa Community Health Center (2)	Hillsborough				426,613	426,613
0295507-00	Thomas E. Langley	Sumter				66,440	66,440
0295531-00	Treasure Coast (Felllsmere)	Indian River				55,626	55,626
0295680-00	Trenton Medical Center, Inc.	Gilchrist				44,864	44,864
County Health Initiatives							
0520446	Charlotte County Health Department	Charlotte				200,000	200,000
0279463	Lee County Health Department	Lee				200,000	200,000
0279561	Okaloosa Health Department	Okaloosa				200,000	200,000
0279684	Sarasota Health Department	Sarasota				200,000	200,000
0279765	Walton County Health Department	Walton				200,000	200,000

Medicaid Number	Provider Name (as contained in 1994 Audit Records)	County	LIP 1 Avg DSH (00,01,02)	LIP 2 Avg DSH (00,01,02)	LIP 3 Using FHURS '04 FYE	LIP-OTHER (Designated)	Total All Payments
	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**				**1,201,938**	**1,201,938**
100994	**Tampa General Hospital Poison Control Program**	**Hillsborough**				**1,971,812**	**1,971,812**
	TOTAL		**0**	**0**	**0**	**20,450,005**	**20,450,005**
	GRAND TOTAL		**578,000,000**	**180,000,000**	**80,489,174**	**20,450,005**	**858,939,179**

APPENDIX C

SAMPLE COST REPORT FORMS

3690 (Cont.) FORM CMS-2552-96 05-04

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET E-3, PART III

Check Applicable Boxes	[ ] Title V	[ ] Hospital	[ ] NF	[ ] PPS
	[ ] Title XVIII	[ ] Subprovider	[ ] ICF/MR	[ ] TEFRA
	[ ] Title XIX	[ ] SNF		[ ] 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)

06-01 **FORM HCFA 1728-94** **3290 (Cont.)**

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO.: | PERIOD: From: To: | WORKSHEET C PARTS III, IV & V

PART III - SUPPLIES AND DRUGS COST COMPUTATION

	Other Patient Services	From Wkst B, Col. 6, Line:	Total Cost	Total Charges from HHA Record)	Ratio (Col 2 ÷ 3)	Medicare Covered Charges			Cost of Services			
							Part B			Part B		
						Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	5	6	7	8	9	10	
15	Cost of Medical Supplies - Pre 10/1/2000	12										15
15.01	Cost of Medical Supplies - Post 9/30/2000	12										15.01
16	Cost of Drugs - Pre 10/1/2000	13										16
16.01	Cost of Drugs - Post 9/30/2000	13										16.01

PART IV - COMPARISON OF THE LESSER OF THE AGGREGATE MEDICARE COST, THE AGGREGATE OF THE MEDICARE COST PER VISIT LIMITATION AND THE AGGREGATE PER BENEFICIARY COST LIMITATION

		Medicare Program Unduplicated Census Count For Each MSA Pre 10/1/2000 (4)	Per Beneficiary Annual Limitation Per MSA/Non-MSA (From Your Intermediary)	Cost of Medicare Services			Total (Sum of Cols 3 & 4	
					Part B			
				Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		1	2	3	4	5	6	
17	Total Cost of Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 & 11, respectively, lines 1-6 (exculsive of subscripts))							17
18	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))							18
19	Total (Sum of lines 17 and 18)							19
20	Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. C, Pt. II, cols. 8, 9 &11, respectively, line 14)							20
21	Cost of Medical Supplies (from Part III, columns 8 and 9, line 15 (exclusive of line 15.01))							21
22	Total (Sum of lines 20 and 21)							22

		MSA Code (3)						(Col 1 x 2)	
		0	1	2	3	4	5	6	
23	Per Beneficiary Cost Limitation for MSA:								23
23.01	Per Beneficiary Cost Limitation for MSA:								23.01
23.02	Per Beneficiary Cost Limitation for MSA:								23.02
23.03	Per Beneficiary Cost Limitation for MSA:								23.03
23.04	Per Beneficiary Cost Limitation for MSA:								23.04
23.05	Per Beneficiary Cost Limitation for MSA:								23.05
23.06	Per Beneficiary Cost Limitation for MSA:								23.06
23.07	Per Beneficiary Cost Limitation for MSA:								23.07
23.08	Per Beneficiary Cost Limitation for MSA:								23.08
23.09	Per Beneficiary Cost Limitation for MSA:								23.09
24	Aggregate Per Beneficiary Cost Limitation (Sum of lines 23 and subscripts thereof)								24

PART V - OUTPATIENT THERAPY REDUCTION COMPUTATION

	Patient Services	From Wkst. C, Part I, Col. 4, Line:	Average Cost Per Visit	Part B Subject to Deductibles and Coinsurance								
				Medicare Program Visits for Services Before 1/1/98	Medicare Program Costs for Services Before 1/1/98	Medicare Program Visits for Services 1/1/98-12/31/98	Medicare Program Visits for Services 1/1/99-9/30/00	Medicare Program Visits for Services on or after 10/1/00	Medicare Program Costs for Services 1/1/98-12/31/98	Application of the Reasonable Cost Reduction	Reasonable Costs Net of Adjustments	
		1	2	3	4	5	5.01	5.02	6	7	8	
25	Physical Therapy	2										25
26	Occupational Therapy	3										26
27	Speech Pathology	4										27
28	Total (Sum of lines 25-27)											28

(3) The MSA codes flow from Worksheet S-3, Part III, line 29 and subscripts as indicated.
(4) The sum of column 1, line 24 must equal Worksheet S-3, Part I, column 2, line 10.01.

FORM HCFA-1728-94-C (6-2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SEC. 3215 - 3215.5)

Rev. 10 **32-321**

09-00 FORM CMS-1984-99 3890 (Cont.)

CALCULATION OF PER DIEM COST	PROVIDER NO. _____	PERIOD: FROM _____ TO _____	WORKSHEET D

	COMPUTATION OF PER DIEM COST	TITLE XVIII (1)	TITLE XIX (2)	OTHER (3)	TOTAL (4)	
1	Total cost (Worksheet B, line 100, col 7, less line 53, col. 7)					1
2	Total Unduplicated Days (Worksheet S-1, line 12, col. 6)					2
3	Average cost per diem (line 1 divided by line 2)					3
4	Unduplicated Medicare Days (Worksheet S-1, line 12, col.1)					4
5	Average Medicare cost (line 3 times line 4)					5
6	Unduplicated Medicaid Days (Worksheet S-1, line 12, col. 2)					6
7	Average Medicaid cost (line 3 times line 6)					7
8	Unduplicated SNF days (Worksheet S-1, line 12, col. 3)					8
9	Average SNF cost (line 3 times line 8)					9
10	Unduplicated NF days (Worksheet S-1, line 12, col. 4)					10
11	Average NF cost (line 3 times line 10)					11
12	Other Unduplicated days (Worksheet S-1, line 12, col. 5)					12
13	Average cost for other days (line 3 times line 12)					13
14	Total cost (see instructions)					14
15	Total days (see instructions)					15

DIALYSIS FACILITY

3490 (Cont.) Form CMS-265-94 12-05

COMPUTATION OF AVERAGE COST PER TREATMENT | FACILITY NO.: _____ | REPORTING PERIOD FROM_____ TO_____ | WORKSHEET C

		TOTAL				MEDICARE					
		NUMBER OF TREATMENTS	COSTS (TRANSFERRED FROM WKST. B., COL.11)	AVERAGE COST OF TREATMENTS (COL.2/COL.1)	NUMBER OF TREATMENTS (Pre 4/1/2005, see instructions)	NUMBER OF TREATMENTS (Post 4/1/2005, see instructions)	TOTAL EXPENSES (COL.4 x COL.3)	PAYMENT RATE (Pre 4/1/2005, see instructions)	PAYMENT RATE (Post 4/1/2005, see instructions)	TOTAL PAYMENT DUE (COL.4 x COL.6)	
		1	2	3	4	4.01	5	6	6.01	7	
1	Maintenance-Hemodialysis		Line 7								1
2	Maintenance-Peritoneal Dialysis		Line 8								2
3	Training-Hemodialysis		Line 9								3
4	Training-Peritoneal Dialysis		Line 10								4
5	Training-CAPD		Line 11								5
6	Training-CCPD		Line 12								6
7	Home Program-Hemodialysis		Line 13								7
8	Home Program-Peritoneal Dialysis		Line 14								8
9	Home Program-CAPD	Patient Wks	Line 15								9
10	Home Program-CCPD	Patient Wks	Line 16								10
11	Totals Sum of Lines 1-8 (Cols. 1 & 4) Sum of Lines 1-10 (Cols. 2,5, & 7)										11

FORM CMS-265-94 (12-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3412)

34-312 Rev. 9

OUTPATIENT THERAPY/CORF

12-04 **FORM CMS 2088-92** **1890 (Cont.)**

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR OUTPATIENT REHABILITATION SERVICES-TITLE XVIII	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET D

CORF OPT CMHC

PART I - COMPUTATION OF REIMBURSEMENT SETTLEMENT

	DESCRIPTION	1	1.01	
1	Cost of provider services (see instructions)			1
1.01	CMHC PPS payments including outlier payments			1.01
1.02	1996 CMHC specific payment to cost ratio (obtain this ratio from your intermediary)			1.02
1.03	Line 1, column 1.01 times 1.02			1.03
1.04	Line 1.01 divided by line 1.03			1.04
1.05	CMHC transitional corridor payment			1.05
1.1	Cost of CORF services prior to 1/1/1998 (see instructions)			1.1
2	Adjustment for the cost of services covered by Workers' Compensation, and other primary payers (see instructions)			2
3	Subtotal (line 1 plus line 1.1 minus line 2) (For CMHCs see instructions)			3
4	Deductibles billed to program patients. (Do not include coinsurance)			4
5	Total amount reimbursable to provider prior to application of Lesser of reasonable cost or customary charges (line 3 minus line 4)			5
6	Excess of reasonable cost over customary charges (see instructions)			6
7	Subtotal (line 5 minus line 6)			7
8	80 percent of costs (line 7 x 80 percent)			8
9	Coinsurance billed to program patients (see instructions)			9
10	Net cost for comparison (line 7 minus line 9)			10
11	Reimbursable bad debts (see instructions)			11
11.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			11.01
12	TOTAL COST-- (line 11 plus the lesser of line 8 or line 10)			12
13	Recovery of unreimbursed cost under the lesser of cost or charges (from Worksheet D-1, Part I, line 3)			13
14	80% of recovery of unreimbursed cost under the lesser of cost or charges (line 13 X 80 percent)			14
15	Total cost (line 12 plus line 14) (see instructions)			15
16	Sequestration adjustment (see Instructions)			16
16.5	Other Adjustments (see instructions) (specify)			16.5
17	Adjusted total cost (line 15 minus the sum of lines 16 and 16.5) (see instructions)			17
18	Interim Payments			18
18.5	Tentative settlement (For intermediary use only)			18.5
19	Balance due Provider/Program (line 17 minus line 18) (Indicate overpayment in brackets)			19

NOTE: FOR CORF SERVICES RENDERED PRIOR TO JANUARY 1, 1998 CORFS COMPLETE LINE 22.1 ONLY AS THESE SERVICES ARE NOT SUBJECT TO THE LESSER OF REASONABLE COSTS OR CUSTOMARY CHARGES, BUT ARE REIMBURSED BASED ON REASONABLE COSTS. FOR CORF RENDERED ON OR AFTER JANUARY 1, 1998, COMPLETE LINE 21 THROUGH 29 AS THESE SERVICES AS SUBJECT TO LCC.

PART II -COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES		1	
20	Reasonable cost of services		20
21	Cost of services (from Part I, line 1) (from Part I, line 1, column 1 for CMHCs) (see instructions)		21
21.1	Cost of services (from Part I, line 1.1 for CORFs) (see instructions)		21.1
22	TOTAL charges for medicare services		22
22.1	TOTAL CORF charges for medicare services prior to 1/1/1998		22.1
23	Customary Charges		23
24	Aggregate amount actually collected from patients liable for payment for services on a charge basis.		24
25	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)		25
26	Ratio of line 24 to line 25 (not to exceed 1.000000)		26
27	Total customary charges (line 22 x line 26)		27
27.1	Total customary CORF charges prior to 1/1/1998 (line 22.1 x line 26)		27.1
28	Excess of customary charges over reasonable cost (Complete only if line 27 exceeds line 21) (see instructions)		28
29	Excess of reasonable cost over customary charges (Complete only if line 21 exceeds line 27) (see instructions)		29

FORM CMS-2088-92 (12-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15 - II, SEC. 1810, 1810.1 AND 1810.2)

Rev. 7 **18-319**

SCHEDULE H

FLORIDA MEDICAID PROGRAM
NURSING HOME SERVICE PROVIDERS

COMPUTATION OF ALLOWABLE MEDICAID COSTS

Provider Name:
D/B/A:
Provider No.:

Reporting Period
From To

LINE		
	CALCULATION OF MEDICAID PROPERTY COST PER DIEM:	
1	Total Property Cost (Sch F, Line 35)	-
2	Total Patient Days (Sch A, Line 5 (a) - Total)	-
3	Property Cost Per Diem (Line 1 / Line 2)	-
4	Total Medicaid Patient Days (Sch A, Line 5(b) - Total)	-
5	Medicaid Property Cost (Line 3 x Line 4)	-

	CALCULATION OF MEDICAID OPERATING COST PER DIEM:	
1	Patient Care Operating Costs (Sch G, Col 2, Line 4 + Col 4, Line 4)	-
2	Laundry and Linen (Sch G, Col 5, Line 5)	-
3	Total Operating Cost (Line 1 + Line 2)	-
4	Total Patient Days (Sch A, Line 5(a) - Total)	-
5	Total Operating Cost Per Diem (Line 3 / Line 4)	-
6	Total Medicaid Patient Days (Sch A, Line 5(b) - Total)	-
7	Medicaid Operating Cost (Line 5 x Line 6)	-
8	Medicaid Indirect Ancillary Cost (Sch H, Sec A, Col 6, Line 11)	-
9	Medicaid Bad Debts	-
10	Total Medicaid Operating Cost (Lines 7 + 8 + 9)	-
11	Medicaid Operating Cost Per Diem (Line 10 / Line 6)	-

	APPORTIONMENT OF ALLOWABLE RETURN ON EQUITY CAPITAL OR USE ALLOWANCE	
1	Total Allowable Return on Equity Capital (Sch J, Line 20 or 21)	-
2	Total Cost Subject to Allocation (Sch F, Line 48)	-
3	Ratio of Allowable Equity to Total Costs (Line 1 / Line 2)	-
4	**Medicaid Program Cost:**	
5	Direct Medicaid Patient Care Costs (Sch H, Sec B, Line 7, Col 1)	-
6	Indirect Medicaid Patient Care Costs (Sch H, Sec B, Line 7, Col 2)	-
7	Medicaid Operating Cost (Sch H, Sec D, Line 10)	-
8	Medicaid Property Cost (Sch H, Sec C, Line 5)	-
9	Total Medicaid Program Cost (Lines 5 + 6 + 7 + 8)	-
10	Medicaid Allowable Return on Equity (Line 3 x Line 9)	-
11	Medicaid Return on Equity Per Diem (Line 9 / Sec D, Line 6)	-

	INITIAL MEDICAID PER DIEM:	
1	Medicaid Patient Direct Care Per Diem (Sch H, Sec B, Line 8, Col 1)	-
2	Medicaid Patient Indirect Care Per Diem (Sch H, Sec B, Line 8, Col 2)	-
3	Medicaid Property Cost Per Diem (Sch H, Sec C, Line 3)	-
4	Medicaid Operating Cost Per Diem (Sch H, Sec D, Line 11)	-
5	Mediciad Return on Equity Capital Use Allowance Per Diem (Sch H, Sec E, Line 10)	-
6	Initial Medicaid Per Diem (Lines 1 + 2 + 3 + 4 + 5)	-

APPENDIX D

LIP COST LIMIT WORKSHEETS

LIP COST LIMIT CALCULATION
HOSPITAL PROVIDER TYPE SFY0607

Provider Name		**FYB**	02/02/22
HOSPITAL XYZ			
Provider Number		**FYE**	02/02/22
0123456-00			
Completed By		**Date**	02/02/22
Preparer's Name			
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
-		-	-
-		-	-
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

10. Medicaid shortfall (Line 8 x Line 9) -

LIP COST LIMIT CALCULATION
HOSPITAL PROVIDER TYPE SFY0607

Provider Name HOSPITAL XYZ

Provider Number 0123456-00

FYB 02/02/22

FYE 02/02/22

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

Uninsured Component

8	Medicaid PPS Rate as of 10/01/05	h	98.50	
9	Uninsured Encounters (based on UDS calendar year)	i	500.00	
10	Total Uninsured Cost	j	49,250.00	j x i
11	Collections on the uninsured	k	100.00	
12	Uninsured Shortfall	l	49,150.00	j - k

13	**Total Medicaid & Uninsured Shortfall**	m	**49,550.00**	q + m

Please Provide the Informatio Below for Medicaid Provider's Associated With Your UDS Number

	Medicaid Provider Name	Medicaid ID Number	Medicaid FFS October Rate
1	Fellsmere		98.50
2	Indian River2		98.50
3	Indian River3		98.50
4	Indian River4		98.50
5	Indian River5		98.50
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
	Total		492.50
	Average		98.50

LIP COST LIMIT WORKSHEET CHD PROVIDERS

Provider Name		**FYB**	07/01/04
Mosquito County Health Department			
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 Adminstrator

_____

Title

_____

Date

APPENDIX F

LIP MILESTONE REPORTING REQUIREMENTS

LOW INCOME POOL MILESTONE REPORTING REQUIREMENTS

HOSPITAL SERVICES:

UNDUPLICATED COUNT OF MEDICAID, UNINSURED, AND UNDERINSURED INDIVIDUALS SERVED:	Medicaid	Uninsured/ Underinsured
Inpatient		
Outpatient		
TOTAL		

Types of Hospital services provided	Medicaid	Uninsured/ Underinsured
Hospital Inpatient (Days)		
Hospital Outpatient (OP)* (encounters)		
Emergency Care (encounters)		
Ancillary Care** (encounters)		
Prescription Drug (number of Prescriptions)		

Hospital OP Care Includes (Check those that apply to your facility)

Primary Care/Preventative Care Visit		
Specialist Visit		
Surgical Care in Provider's Office		
Surgical Care in Outpatient Facility		
Outpatient Facility Care		
Speech, Physical and Occupational Therapies		
Other_____		

Hospital Ancillary Care (Check those that apply to your facility)

Home Health Care		
Durable Medical Equipment		
Prosthetic and Orthotic Devices		
Diagnostic X-Ray and laboratory		

NON-HOSPITAL PROVIDERS:

UNDUPLICATED COUNT OF MEDICAID, UNINSURED, AND UNDERINSURED INVIDUALS SERVED:	Medicaid	Uninsured/ Underinsured
Federally Qualified Health Centers (FQHC)		
County Health Department (CHD)		
St John's River Rural Health Network (SJRRHN)		

Other _____		
TOTAL		

Types of Non-Hospital Provider Services	Medicaid	Uninsured/ Underinsured
Primary Care (encounters)		
OB / GYN (encounters)		
Disease Management (encounters)		
Mental Health/Substance Abuse (encounters)		
Dental Services (encounters)		
Preventive Services (encounters)		
Pharmacy Services (encounters)		