MSL MOORE STEPHENS LOVELACE, P.A.

CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT ACCOUNTANTS' REPORT ON APPLYING AGREED-UPON PROCEDURES TO INDIGENT CARE REIMBURSEMENT SUBMISSIONS

To the Trustees of
North Lake County Hospital District:

We have performed the agreed-upon procedures enumerated below with respect to the compliance of submissions received under HB 1299 (the "Bill") for the period July 1, 2013 through September 30, 2013.

The Board of Trustees (the "Trustees") of the North Lake County Hospital District (the "District") is responsible for the approval and disbursement of funds under the Bill.

This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures is solely the responsibility of the Trustees. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Purpose of the Procedures

Any provider receiving funds from the District is subject to a verification of its records related to the patients for whom payment is sought to ensure compliance with the Bill. The District must conduct verification procedures of providers receiving payments in excess of ten percent of the District's tax revenue in each year and may perform verifications of any other provider submissions under the Bill to ensure compliance and accountability to the taxpayers. If, upon completion of the verification procedures, it is determined that payments were made by the District that are not in compliance, the District is entitled to a recoupment of the amounts in question. We were engaged by the District to perform certain agreed-upon procedures designed to meet these verification requirements of the Bill.

Agreed-Upon Procedures

It was agreed that our engagement would be limited to the following procedures:

1) Determine a statistically valid sample size (producing results that could be extrapolated with a 95% confidence level) for each healthcare provider.

2) Interview the provider personnel responsible for the preparation of the indigent care report and update our understanding of the sources of information used to prepare the report and the controls used by the provider to ensure that each eligible indigent encounter is recorded and that each recorded indigent encounter is eligible, properly valued, and medically necessary.

3) Obtain the quarterly report submitted by each provider identifying their indigent care encounters. Verify the accuracy of any mathematical calculations in the reports and, on a test basis, agree the report information to the provider's source documents.

4) For each sample encounter, agree the encounter information to its source in the provider's system. Additionally, obtain the patient file and review it for:

   a) Documentation supporting patient eligibility - that is, qualification pursuant to the provisions of the Florida Health Care Responsibility Act, Section 154.304(9), Florida Statutes, and the Florida Health Care Indigency Eligibility Certification Standards, Florida Administrative Code, Rule 59H-1.0035(30).

   b) Documentation that the recipient of the indigent care for which payment is sought is a resident of the District.

   c) Documentation supporting medical eligibility - that is, the presence in the file of an appropriately authorized script or order from an appropriately licensed healthcare practitioner.

5) For each sample encounter, look up the procedure code on the Medicare fee screen. Using the cost-to-charge ratio from the provider's most recently filed cost report, determine the lower of the Medicare reimbursement rate for identical or substantially similar care in the territory of the District or the cost incurred by the provider in the delivery of such care.

6) Communicate with the provider's compliance officer regarding the results and findings of the provider's most recently completed accreditation and peer reviews and audits by government agencies or others that may indicate that unnecessary procedures may have been performed and report such findings, if any, to the District's management.

7) Obtain a written representation letter from the provider's management stating that they have reviewed the quarterly indigent care report, accept responsibility for it and certify, under penalty of perjury, that the eligibility verification procedures adopted by the District have been complied with and that they, in good faith, believe that the persons for which they are claiming indigent care reimbursement from the District are qualified under the Bill.

8) Report to the District the results from performing these agreed-upon procedures.

9) Annually, report to the District summarizing the results of the agreed-upon procedures and present the extrapolation of any payments that were made by the District that were not in compliance with the provisions of the Bill.

Findings

The following providers submitted funding requests under the Bill for the period July 1, 2013 through September 30, 2013:

- Florida Hospital Waterman
- Central Florida Health Alliance - d/b/a Leesburg Regional Medical Center
- St. Luke's Medical Clinic
- Central Florida Health Alliance - d/b/a Community Medical Care Center
- Florida Hospital Waterman - d/b/a FHW Community Primary Health Clinic
- Community Health Center
- LifeStream Behavioral Center

We performed the agreed-upon procedures to the sampled claims and noted no verified exceptions. However, the results of our testing noted certain as yet unresolved matters that require further analysis and may potentially result in exceptions. The dollar amounts involved are not significant to the amount earned by the providers. We plan to resolve those matters during our testing for the quarter ended December 31, 2013. If necessary, a true-up adjustment will be made in next quarter's report.

During the quarter, certain charges submitted in previous quarters were retrospectively approved by Medicaid. These charges have been deducted from the preliminary amounts below. In addition, providers sometimes treat patients who are eligible under the Medicaid program but who have exhausted the benefits available. The total of the Medicaid claims denied under these circumstances are added below at the lower of cost or the Medicare reimbursement rate for such claims.

Amounts earned by provider are as follows:

Provider	Preliminary Amount	Medicaid Retro	Medicaid Exhausted	Final Amount
Florida Hospital Waterman	$ 1,401,362	$ (85,204)	$ 85,494	$ 1,401,652
Leesburg Regional Medical Center	1,310,906	(115,585)	87,087	1,282,408
St. Luke's Medical Clinic	27,806	-	-	27,806
Community Medical Care Center	104,022	-	-	104,022
Community Health Center	19,138	-	-	19,138
FHW Community Primary Health Clinic	58,049	-	-	58,049
LifeStream Behavioral Center	204,386	-	-	204,386
Totals	$ 3,125,669	$ (200,789)	$ 172,581	$ 3,097,461

Other Matters

Attached to this report is Schedule A which includes information about the number of cases, year-to-date cumulative amounts for each provider, percentage of encounters per provider, and a calculation of the average cost per provider per case/encounter.

Comments on Scope Limitations of our Work

Our work consisted of the performance of agreed-upon procedures. We were not engaged to, and did not, conduct an audit or examination, the objective of which would be the expression of an opinion. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

Pursuant to Florida law, this report is a public record and its distribution is not limited. Auditing standards generally accepted in the United States of America require us to indicate that this report is intended solely for the information and use of the District's Trustees and is not intended to be, and should not be, used by anyone other than the District's Trustees.

Moore Stephens Lovelace, P.A.

MOORE STEPHENS LOVELACE, P.A.
Certified Public Accountants

Orlando, Florida
January17, 2014

North Lake County Hospital District
Schedule A
Quarter Ended September 30, 2013

Provider	Fiscal Year July 1, 2013 - June 30, 2014				Quarter Ended 9/30/2013				
	Annual Budgeted Amounts	Amount Submitted to Date	Amount Remaining in Budget	Amount over Budget	Approved Submissions	Number of Encounters/ Days	Reimburse per Encounter	Avg. Reimburse per Encounter	% of Total Encounters
Acute Care									
Florida Hospital Waterman	$ 3,479,462	$ 1,401,652	$ 2,077,810	$ -	$ 1,401,652	1,034	$ 1,356	$ 1,356	24%
Central Florida Health Alliance	$ 3,532,010	$ 1,282,408	$ 2,249,602	$ -	$ 1,282,408	822	$ 1,560	$ 1,560	19%
Mental Health Hospital									
LifeStream Behavioral Center	$ 563,000	$ 204,386	$ 358,614	$ -	$ 204,386	508	$ 402	$ 402	12%
Clinics									
St. Luke's Medical Clinic	$ 50,000	$ 27,806	$ 22,194	$ -	$ 27,806	251	$ 111	$ 111	6%
Community Medical Care Center (Leesburg)	$ 160,000	$ 104,022	$ 55,978	$ -	$ 104,022	939	$ 111	$ 111	21%
FHW Community Primary Health Clinic	$ 180,000	$ 58,049	$ 121,951	$ -	$ 58,049	524	$ 111	$ 111	12%
Community Health Center	$ 100,000	$ 19,138	$ 80,862	$ -	$ 19,138	321	$ 60	$ 60	7%
LifeStream Primary Care Clinic	$ 250,000	$ -	$ 250,000	$ -	$ -	-	-	$ -	0%
Totals	$ 8,314,472				$ 3,097,461	4,399			