



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Jared Smith  
Broward Health Coral Springs  
3000 Coral Hill Drive Coral Springs Florida  
Coral Springs, Florida 33065

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 012040500**

Dear Mr. Smith:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$132,044 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

LS:rp

Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **012040500**

Facility Name (current) : **Broward Health Coral Springs**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$132,044
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	(A - B) = (C)	\$132,044
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$99,033
<b>Your Scheduled Provider Service Network payment [1]</b>	(C - D) = (E)	<b>\$33,011</b>

[1] This payment may be made by check or transferred electronically.



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Susan Newton  
Broward Health Imperial Point  
6401 North Federal Highway  
Fort Lauderdale, Florida 33308-1427

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010821900**

Dear Ms. Newton:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$251,922 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa Smith".

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

LS:rp

Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010821900**

Facility Name (current) : **Broward Health Imperial Point**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$251,922
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	(A - B) = (C)	\$251,922
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$188,942
<b>Your Scheduled Provider Service Network payment [1]</b>	(C - D) = (E)	<b>\$62,980</b>

[1] This payment may be made by check or transferred electronically.



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Sandra Todd-Atkinson  
Broward Health Medical Center  
1600 South Andrews Avenue  
Fort Lauderdale, Florida 33316-2564

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010012900**

Dear Ms. Todd-Atkinson:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$1,906,006 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

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Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010012900**

Facility Name (current) : **Broward Health Medical Center**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$1,906,006
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	(A - B) = (C)	\$1,906,006
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$1,429,505
<b>Your Scheduled Provider Service Network payment [1]</b>	(C - D) = (E)	<b>\$476,501</b>

[1] This payment may be made by check or transferred electronically.



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Alice Taylor  
Broward Health North  
201 East Sample Road  
Deerfield Beach, Florida 33064-3596

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010021800**

Dear Ms. Taylor:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$213,898 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

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State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010021800**

Facility Name (current) : **Broward Health North**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$213,898
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	<b>(A - B) = (C)</b>	<b>\$213,898</b>
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$160,424
<b>Your Scheduled Provider Service Network payment [1]</b>	<b>(C - D) = (E)</b>	<b>\$53,474</b>

[1] This payment may be made by check or transferred electronically.





RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Carlos Migoya  
Jackson Memorial Hospital  
1611 Northwest 12th Avenue  
Miami, Florida 33136-1096

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010042100**

Dear Mr. Migoya:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$2,138,155 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

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Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010042100**

Facility Name (current) : **Jackson Memorial Hospital**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$2,138,155
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	<b>(A - B) = (C)</b>	<b>\$2,138,155</b>
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$1,603,616
<b>Your Scheduled Provider Service Network payment [1]</b>	<b>(C - D) = (E)</b>	<b>\$534,539</b>

[1] This payment may be made by check or transferred electronically.



RON DESANTIS  
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MARY C. MAYHEW  
SECRETARY

June 5, 2019

Grisel Fernandez-Bravo  
Memorial Hospital Miramar  
1901 Southwest 172nd Avenue  
Miramar, Florida 33029

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010345400**

Dear Ms. Fernandez-Bravo:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$43,002 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

LS:rp

Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010345400**

Facility Name (current) : **Memorial Hospital Miramar**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$43,002
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	(A - B) = (C)	\$43,002
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$32,252
<b>Your Scheduled Provider Service Network payment [1]</b>	(C - D) = (E)	<b>\$10,750</b>

[1] This payment may be made by check or transferred electronically.



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Mark Doyle  
Memorial Hospital Pembroke  
7800 Sheridan Street  
Pembroke Pines, Florida 33024-2536

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010222900**

Dear Mr. Doyle:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$86,001 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

LS:rp

Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010222900**

Facility Name (current) : **Memorial Hospital Pembroke**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$86,001
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	(A - B) = (C)	\$86,001
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$64,501
<b>Your Scheduled Provider Service Network payment [1]</b>	(C - D) = (E)	<b>\$21,500</b>

[1] This payment may be made by check or transferred electronically.



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Leah Carpenter  
Memorial Hospital West  
703 North Flamingo Road  
Pembroke Pines, Florida 33028-1006

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010252100**

Dear Ms. Carpenter:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$198,274 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

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Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010252100**

Facility Name (current) : **Memorial Hospital West**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$198,274
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	(A - B) = (C)	\$198,274
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$148,706
<b>Your Scheduled Provider Service Network payment [1]</b>	(C - D) = (E)	<b>\$49,568</b>

[1] This payment may be made by check or transferred electronically.





RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Zeff Ross  
Memorial Regional Hospital  
3501 Johnson Street  
Hollywood, Florida 33021-5487

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010020000**

Dear Mr. Ross:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$1,338,422 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

LS:rp

Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010020000**

Facility Name (current) : **Memorial Regional Hospital**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$1,338,422
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	(A - B) = (C)	\$1,338,422
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$1,003,817
<b>Your Scheduled Provider Service Network payment [1]</b>	(C - D) = (E)	<b>\$334,605</b>

[1] This payment may be made by check or transferred electronically.



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

June 5, 2019

Ed Jimenez  
UF Health Shands Hospital  
1600 Southwest Archer Road  
Gainesville, Florida 32608

**RE: State Fiscal Year 2018 - 2019  
Third Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010003000**

Dear Mr. Jimenez:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$218,600 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

LS:rp

Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Third Payment

Medicaid Number : **010003000**

Facility Name (current) : **UF Health Shands Hospital**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$218,600
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	(A - B) = (C)	\$218,600
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$163,950
<b>Your Scheduled Provider Service Network payment [1]</b>	(C - D) = (E)	<b>\$54,650</b>

[1] This payment may be made by check or transferred electronically.



RON DESANTIS  
GOVERNOR

MARY C. MAYHEW  
SECRETARY

January 14, 2019

Leon Haley  
UF Health Jacksonville  
655 West 8th Street  
Jacksonville, Florida 32209-6596

**RE: State Fiscal Year 2018 - 2019  
Second Scheduled Provider Service Network Disproportionate Share Payment  
Medicaid Number: 010067600**

Dear Mr. Haley:

Your facility has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2018 - 2019. This proviso language directs payments to be made to facilities meeting eligibility criteria. The amounts of such payments are calculated according to the distribution methodology defined in the proviso.

The enclosed payment and previously disbursed payments represent 100% of your annual appropriation of \$1,828,852 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

I would like to take this opportunity to thank you for your ongoing commitment to Medicaid beneficiaries and indigent persons in Florida. Your contributions to the provision of adequate and appropriate health care to Floridians in need are truly appreciated.

If you have any questions regarding the above, please call Ryan Perry of my staff at (850) 412-4132.

Sincerely,

Lisa Smith, Bureau Chief,  
Medicaid Program Finance

LS:rp

Enclosure:



State of Florida  
Agency for Health Care Administration  
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010067600**

Facility Name (current) : **UF Health Jacksonville**

Annual Provider Service Network Payment Distribution to your facility	(A)	\$1,828,852
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
<b>Total of your facility's annual Provider Service Network payments</b>	<b>(A - B) = (C)</b>	<b>\$1,828,852</b>
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$914,426
<b>Second Scheduled Provider Service Network payment [1]</b>	<b>(C - D) = (E)</b>	<b>\$914,426</b>

[1] This payment may be made by check or transferred electronically.