RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Ronald Jimenez
Adventhealth Palm Coast
60 Memorial Medical Pkwy
Palm Coast, FL 32164

RE: State Fiscal Year 2019 - 2020
FirstRural Disproportionate Share Hospital Payments
Medicaid Number: 010189300

Dear Mr. Jimenez:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $60,361 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 First Payment

Medicaid Number : **010189300**

Facility Name (current) : **Adventhealth Palm Coast**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$212,029	$29,416
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$212,029**	**$29,416**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$53,007**	**$7,354**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Adventhealth Palm Coast	**Medicaid 010189300**	**First Quarter Amount $60,361**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Randall Surber
Adventhealth Wauchula
735 S 5th Ave
Wauchula, FL 33873

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010260100

Dear Mr. Surber:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $38,964 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010260100**

Facility Name (current) : **Adventhealth Wauchula**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$136,867	$18,989
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$136,867**	**$18,989**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$34,217**	**$4,747**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Adventhealth Wauchula	**Medicaid 010260100**	**First Quarter Amount $38,964**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Adrian Hugh Greene
Baptist Medical Center - Nassau
1250 S 18th St.
Fernandina Beach, FL 32034

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010123100

Dear Mr. Greene:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $63,823 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010123100**

Facility Name (current) : **Baptist Medical Center - Nassau**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$224,189	$31,104
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$224,189**	**$31,104**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$56,047**	**$7,776**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Baptist Medical Center - Nassau	**Medicaid 010123100**	**First Quarter Amount $63,823**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Janet D. Kinney
Calhoun-Liberty Hospital
20370 NE Burns Ave
Blountstown, FL 32424

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010026900

Dear Ms. Kinney:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $73,318 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010026900**

Facility Name (current) : **Calhoun-Liberty Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$257,538	$35,731
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$257,538**	**$35,731**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$64,385**	**$8,933**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Calhoun-Liberty Hospital	**Medicaid 010026900**	**First Quarter Amount $73,318**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Vincent Sica
Desoto Memorial Hospital
900 N Robert Ave
Arcadia, FL 34266

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010192300

Dear Mr. Sica:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $81,812 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010192300**

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

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$287,375	$39,871
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$287,375**	**$39,871**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$71,844**	**$9,968**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Desoto Memorial Hospital	**Medicaid 010192300**	**First Quarter Amount $81,812**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Joann M. Baker
Doctors Memorial Hospital
2600 Hospital Drive
Bonifay, FL 32425

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010103600

Dear Ms. Baker:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $62,468 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010103600**

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

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$219,427	$30,444
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$219,427**	**$30,444**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$54,857**	**$7,611**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Doctors Memorial Hospital	**Medicaid 010103600**	**First Quarter Amount $62,468**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Thomas Joseph Stone
Doctors' Memorial Hospital
333 N Byron Butler Pkwy
Perry, FL 32348

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010180000

Dear Mr. Stone:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $61,988 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010180000**

Facility Name (current) : **Doctors' Memorial Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$217,741	$30,210
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$217,741**	**$30,210**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$54,435**	**$7,553**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Doctors' Memorial Hospital	**Medicaid 010180000**	**First Quarter Amount $61,988**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Edward Anderson
Ed Fraser Memorial Hospital
159 N 3rd St.
Macclenny, FL 32063

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010004800

Dear Mr. Anderson:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $441,774 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010004800**

Facility Name (current) : **Ed Fraser Memorial Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$1,551,797	$215,298
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$1,551,797**	**$215,298**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$387,949**	**$53,825**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Ed Fraser Memorial Hospital	**Medicaid 010004800**	**First Quarter Amount $441,774**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Richard L. Freeburg
Fishermen's Community Hospital
3301 Overseas Hwy
Marathon, FL 33050

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010120600

Dear Mr. Freeburg:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $85,132 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010120600**

Facility Name (current) : **Fishermen's Community Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$299,039	$41,489
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$299,039**	**$41,489**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$74,760**	**$10,372**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Fishermen's Community Hospital	**Medicaid 010120600**	**First Quarter Amount $85,132**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

David Walker
George E. Weems Memorial Hospital
135 Ave G
Apalachicola, FL 32320

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010080300

Dear Mr. Walker:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $124,976 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010080300**

Facility Name (current) : **George E. Weems Memorial Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$438,996	$60,907
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$438,996**	**$60,907**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$109,749**	**$15,227**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

George E. Weems Memorial Hospital	**Medicaid 010080300**	**First Quarter Amount $124,976**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

James H. Thompson
Healthmark Regional Medical Center
4413 US Hwy 331 S
Defuniak Springs, FL 32435

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010188500

Dear Mr. Thompson:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $36,288 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010188500**

Facility Name (current) : **Healthmark Regional Medical Center**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$127,469	$17,684
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$127,469**	**$17,684**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$31,867**	**$4,421**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Healthmark Regional Medical Center	**Medicaid 010188500**	**First Quarter Amount $36,288**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Raymond D. Williams
Hendry Regional Medical Center
524 W Sagamore Ave
Clewiston, FL 33440

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010086200

Dear Mr. Williams:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $131,509 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010086200**

Facility Name (current) : **Hendry Regional Medical Center**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$461,944	$64,091
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$461,944**	**$64,091**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$115,486**	**$16,023**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Hendry Regional Medical Center	**Medicaid 010086200**	**First Quarter Amount $131,509**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Carrol James Platt
Jackson Hospital
4250 Hospital Dr.
Marianna, FL 32446

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010106100

Dear Mr. Platt:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $70,487 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010106100**

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

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$247,596	$34,352
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$247,596**	**$34,352**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$61,899**	**$8,588**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Jackson Hospital	**Medicaid 010106100**	**First Quarter Amount $70,487**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Michael T. Hutchins
Jay Hospital
14114 Alabama St.
Jay, FL 32565

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010173700

Dear Mr. Hutchins:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $62,098 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010173700**

Facility Name (current) : **Jay Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$218,127	$30,263
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$218,127**	**$30,263**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$54,532**	**$7,566**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Jay Hospital	**Medicaid 010173700**	**First Quarter Amount $62,098**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Pamela B. Howard
Lake Butler Hospital
850 E Main St.
Lake Butler, FL 32054

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010822700

Dear Ms. Howard:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $200,715 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010822700**

Facility Name (current) : **Lake Butler Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$705,039	$97,818
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$705,039**	**$97,818**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$176,260**	**$24,455**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Lake Butler Hospital	**Medicaid 010822700**	**First Quarter Amount $200,715**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Darcy Davis
Lakeside Medical Center
39200 Hooker Hwy
Belle Glade, FL 33430

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010144300

Dear Ms. Davis:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $89,727 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010144300**

Facility Name (current) : **Lakeside Medical Center**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$315,179	$43,728
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$315,179**	**$43,728**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$78,795**	**$10,932**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Lakeside Medical Center	**Medicaid 010144300**	**First Quarter Amount $89,727**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Tammy Wells Stevens
Madison County Memorial Hospital
224 NW Crane Ave
Madison, FL 32340

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010115000

Dear Ms. Wells Stevens:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $72,769 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010115000**

Facility Name (current) : **Madison County Memorial Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$255,611	$35,464
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$255,611**	**$35,464**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$63,903**	**$8,866**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Madison County Memorial Hospital	**Medicaid 010115000**	**First Quarter Amount $72,769**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Richard L. Freeburg
Mariners Hospital
91500 Overseas Hwy
Tavernier, FL 33070

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010121400

Dear Mr. Freeburg:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $112,124 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010121400**

Facility Name (current) : **Mariners Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$393,851	$54,643
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$393,851**	**$54,643**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$98,463**	**$13,661**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Mariners Hospital	**Medicaid 010121400**	**First Quarter Amount $112,124**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Michael A. Kozar
Northwest Florida Community Hospital
1360 Brickyard Rd.
Chipley, FL 32428

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010190700

Dear Mr. Kozar:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $515,903 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010190700**

Facility Name (current) : **Northwest Florida Community Hospital**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$1,812,185	$251,426
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$1,812,185**	**$251,426**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$453,046**	**$62,857**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Northwest Florida Community Hospital	**Medicaid 010190700**	**First Quarter Amount $515,903**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Rhonda Sherrod
Shands Lake Shore Regional Medical Center
368 NE Franklin St.
Lake City, FL 32055

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010033100

Dear Ms. Sherrod:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $62,814 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010033100**

Facility Name (current) : **Shands Lake Shore Regional Medical Center**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$220,644	$30,612
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$220,644**	**$30,612**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$55,161**	**$7,653**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Shands Lake Shore Regional Medical Center	**Medicaid 010033100**	**First Quarter Amount $62,814**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Rhonda Sherrod
Shands Live Oak Regional Medical Center
1100 SW 11th St.
Live Oak, FL 32060

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010179600

Dear Ms. Sherrod:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $55,789 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010179600**

Facility Name (current) : **Shands Live Oak Regional Medical Center**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$195,969	$27,188
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$195,969**	**$27,188**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$48,992**	**$6,797**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Shands Live Oak Regional Medical Center	**Medicaid 010179600**	**First Quarter Amount $55,789**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

November 25, 2019

Jack Montois
Shands Starke Regional Medical Center
922 E Call St.
Starke, FL 32091

RE: State Fiscal Year 2019 - 2020
Rural Disproportionate Share Hospital Payments
Medicaid Number: 010007200

Dear Mr. Montois:

Your hospital has been deemed eligible to receive the associated payment under proviso language contained in the General Appropriations Act for state fiscal year 2019 - 2020. This proviso language directs payments to be made to hospitals 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 25% (rounded) of your annual appropriation of $60,213 for state fiscal year 2019 - 2020. 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

Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

Medicaid Number : **010007200**

Facility Name (current) : **Shands Starke Regional Medical Center**

		Rural Payment	Rural St. Only Payment
Annual Rural DSH distribution to your facility	(A)	$211,508	$29,345
Amount being withheld from distribution in anticipation of funding reductions	(B)		
Total of your facility's scheduled Rural DSH Distribution	(C)	**$211,508**	**$29,345**
Total of your "Rural DSH" Payments previously paid in this fiscal year	(D)	$0	$0
Your Scheduled Rural DSH Payments [1] [2]	(C x .25) = (E)	**$52,877**	**$7,336**

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

[2] This amount may be explicit instead of being based on quarterly distribution calculations.

RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

RURAL DISPROPORTIONATE SHARE/FINANCIAL ASSISTANCE PROGRAM
STATE FISCAL YEAR 2019 - 2020

Hospital Classification

Please check one

True	False	Hospital Description
		Owned by a county government and leased to a management company

If **true** fill out "Uses of Funds", sign and return form. If **false**, sign and return form

Please return to: Ryan Perry
Agency for Health Care Administration
Medicaid Cost Reimbursement
2727 Mahan Drive, Mail Stop 23
Tallahassee Florida 32308

Uses of Funds

Shands Starke Regional Medical Center	**Medicaid 010007200**	**First Quarter Amount $60,213**

Account Category	Amounts
Salaries and Benefits	
Equipment	
Other - (Specify)	
Total (1)	

Certification

I certify that the above information is true and correct to the best of my knowledge.

Please Sign & Print Name	Title & email address	Date

Signature and Title of individual completing form.

(1) - The total amount should equal the amount of the previous distribution.