

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



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]	$(C \times .25) = (E)$	\$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.



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.



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



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]	$(C \times .25) = (E)$	\$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.





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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

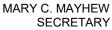
Medicaid Number: 010123100

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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$63,823



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

Baptist Medical Center - Nassau

Agency for Health Care Administration

Medicaid 010123100

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

	 •
Account Category	Amounts
Salaries and Benefits	
Equipment Other - (Specify)	
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.



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



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]	$(C \times .25) = (E)$	\$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.





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.



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



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]	$(C \times .25) = (E)$	\$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.





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.



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



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]	$(C \times .25) = (E)$	\$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.



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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

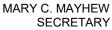
Medicaid Number: 010180000

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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$61,988



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

Doctors' Memorial Hospital

Agency for Health Care Administration

Medicaid 010180000

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

Doctors Wemorian Hospitan	Wicarcara 010100000	That Quarter Amount \$013200
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.



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



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]	$(C \times .25) = (E)$	\$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.



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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

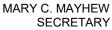
Medicaid Number: 010120600

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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$85,132



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

Fishermen's Community Hospital

Agency for Health Care Administration

Medicaid 010120600

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

	(
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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

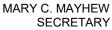
Medicaid Number: 010080300

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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$124,976



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

George E. Weems Memorial Hospital

Agency for Health Care Administration

Medicaid 010080300

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

8	. ,
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.



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



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]	$(C \times .25) = (E)$	\$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.

First Quarter Amount \$36,288



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

Healthmark Regional Medical Center

Agency for Health Care Administration

Medicaid 010188500

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

and the second s	()
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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

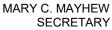
Medicaid Number: 010086200

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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$131,509



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

Hendry Regional Medical Center

Agency for Health Care Administration

Medicaid 010086200

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

J . g	
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.



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



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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$70,487



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

Jackson Hospital

Agency for Health Care Administration

Medicaid 010106100

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

ouckson 1105 pital	Miculaid 010100100	That Quarter Amount \$70,107
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.



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



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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$62,098



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

Jay Hospital

Agency for Health Care Administration

Medicaid 010173700

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

oay nospitai	Wicultaid 010175700	That Quarter Amount \$02,070
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.



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



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]	$(C \times .25) = (E)$	\$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.



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.



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



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]	$(C \times .25) = (E)$	\$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.





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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

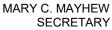
Medicaid Number: 010115000

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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$72,769



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

Madison County Memorial Hospital

Agency for Health Care Administration

Medicaid 010115000

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

	()
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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

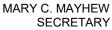
Medicaid Number: 010121400

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]	$(C \times .25) = (E)$	\$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.





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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

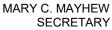
Medicaid Number: 010190700

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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$515,903



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

Northwest Florida Community Hospital Medicaid 010190700

Agency for Health Care Administration

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

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.



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



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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$62,814



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

Shands Lake Shore Regional Medical

Agency for Health Care Administration

Medicaid 010033100

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

Center	
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.



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



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]	$(C \times .25) = (E)$	\$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.

First Quarter Amount \$55,789



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

Shands Live Oak Regional Medical Center | Medicaid 010179600

Agency for Health Care Administration

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

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.



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



Rural Disproportionate Share Hospital Distribution

State Fiscal Year 2019 - 2020 Payment

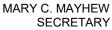
Medicaid Number: 010007200

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]	$(C \times .25) = (E)$	\$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.



First Quarter Amount \$60,213



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

Shands Starke Regional Medical Center Medicaid 010007200

Agency for Health Care Administration

Medicaid Cost Reimbursement 2727 Mahan Drive, Mail Stop 23

Tallahassee Florida 32308

Uses of Funds

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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.