



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

March 12, 2019

Jared Smith
Broward Health Coral Springs
3000 Coral Hill Drive Coral Springs Florida
Fort Lauderdale, Florida 33316-2564

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

Dear Mr. Smith:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$132,044 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa Smith", is positioned above the typed name.

Lisa Smith, Bureau Chief,
Medicaid Program Finance

LS:rp

Enclosure:



State of Florida
Agency for Health Care Administration
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **012040500**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$132,044
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$132,044
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$66,022
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$33,011

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



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

March 12, 2019

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

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

Dear Ms. Newton:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$251,922 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

Sincerely,

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Lisa Smith, Bureau Chief,
Medicaid Program Finance

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Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010821900**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$251,922
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$251,922
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$125,961
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$62,981

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



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

March 12, 2019

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

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

Dear Ms. Todd-Atkinson:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$1,906,006 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

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Medicaid Program Finance

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State of Florida
Agency for Health Care Administration
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010012900**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$1,906,006
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$1,906,006
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$953,003
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$476,502

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



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MARY C. MAYHEW
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March 12, 2019

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

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

Dear Ms. Taylor:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$213,898 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

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Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010021800**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$213,898
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$213,898
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$106,949
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$53,475

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



RON DESANTIS
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March 12, 2019

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

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

Dear Mr. Migoya:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$2,138,155 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

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State of Florida
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Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010042100**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$2,138,155
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$2,138,155
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$1,069,078
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$534,538

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



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

March 12, 2019

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

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

Dear Ms. Fernandez-Bravo:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$43,002 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

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Medicaid Program Finance

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State of Florida
Agency for Health Care Administration
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010345400**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$43,002
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$43,002
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$21,501
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$10,751

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



RON DESANTIS
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MARY C. MAYHEW
SECRETARY

March 12, 2019

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

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

Dear Mr. Doyle:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$86,001 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

Sincerely,

Lisa Smith, Bureau Chief,
Medicaid Program Finance

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State of Florida
Agency for Health Care Administration
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010222900**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$86,001
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$86,001
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$43,001
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$21,500

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



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

March 12, 2019

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

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

Dear Ms. Carpenter:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$198,274 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

Sincerely,

Lisa Smith, Bureau Chief,
Medicaid Program Finance

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State of Florida
Agency for Health Care Administration
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010252100**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$198,274
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$198,274
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$99,137
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$49,569

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



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

March 12, 2019

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

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

Dear Mr. Ross:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$1,338,422 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

Sincerely,

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Lisa Smith, Bureau Chief,
Medicaid Program Finance

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Enclosure:



State of Florida
Agency for Health Care Administration
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010020000**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$1,338,422
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$1,338,422
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$669,211
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$334,606

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



RON DESANTIS
GOVERNOR

MARY C. MAYHEW
SECRETARY

March 12, 2019

Ed Jimenez
UF Health Shands Hospital
1600 Southwest Archer Road
Gainesville, Florida 32610-3001

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

Dear Mr. Jimenez:

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

The enclosed payment and previously disbursed payments represent 75% of your annual appropriation of \$218,600 for state fiscal year 2018 - 2019. The formula used to determine the amount of your payment is shown on the enclosed calculation sheet.

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

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

Sincerely,

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Lisa Smith, Bureau Chief,
Medicaid Program Finance

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State of Florida
Agency for Health Care Administration
Medicaid Program Finance

Provider Service Network Disproportionate Share Payment

State Fiscal Year 2018 - 2019 Second Payment

Medicaid Number : **010003000**

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

Annual Provider Service Network Payment Distribution to your facility	(A)	\$218,600
Amount being withheld from distribution in anticipation of funding reductions	(B)	\$0
Total of your facility's annual Provider Service Network payments	(A – B) = (C)	\$218,600
Total of your Provider Service Network payments previously paid in this fiscal year	(D)	\$109,300
Second Scheduled Provider Service Network payment [1]	((C x .75) – D) = (E)	\$54,650

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