1. **Title of Project:** Baptist Hospital Disproportionate Share Hospital Funding Funding

2. **Senate Sponsor:** Doug Broxson

3. **Date of Submission:** 02/19/2019

4. **Project/Program Description:**
   To provide Disproportionate Share Hospital (DSH) funds for Baptist Health Care Pensacola. Baptist Health Care Pensacola provides a high volume of Medicaid and uncompensated charity care. These funds will assist the hospital in caring for our most vulnerable patients.

5. **State Agency to receive requested funds:** Agency for Health Care Administration
   State Agency Contacted? No

6. **Amount of the Nonrecurring Request for Fiscal Year 2019-2020**

<table>
<thead>
<tr>
<th>Type of Funding</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operations</td>
<td>3,853,571</td>
</tr>
<tr>
<td>Fixed Capital Outlay</td>
<td></td>
</tr>
<tr>
<td><strong>Total State Funds Requested</strong></td>
<td><strong>3,853,571</strong></td>
</tr>
</tbody>
</table>

7. **Total Project Cost for Fiscal Year 2019-2020 (including matching funds available for this project)**

<table>
<thead>
<tr>
<th>Type of Funding</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total State Funds Requested (from question #6)</td>
<td>3,853,571</td>
<td>100.00%</td>
</tr>
<tr>
<td>Federal</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>State (excluding the amount of this request)</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Local</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Total Project Costs for Fiscal Year 2019-2020</strong></td>
<td><strong>3,853,571</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

8. **Has this project previously received state funding?** No

<table>
<thead>
<tr>
<th>Fiscal Year (yyyy-yy)</th>
<th>Recurring Amount</th>
<th>NonRecurring Amount</th>
<th>Specific Appropriation #</th>
<th>Vetoed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

9. **Is future-year funding likely to be requested?** No

10. **Details on how the requested state funds will be expended**

<table>
<thead>
<tr>
<th>Spending Category Administrative Costs:</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Director/Project Head Salary and Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Salary and Benefits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
expense/equipment/travel/supplies/other
consultants/contracted services/study

operational costs:

salary and benefits

expense/equipment/travel/supplies/other

DSH funds will be used to provide charity and uncompensated care to residents in NW Florida.

fixed capital construction/major renovation:

donations

engineering

Total State Funds Requested (must equal total from question #6) 3,853,571

11. Program Performance:

a. What is the specific purpose or goal that will be achieved by the funds requested?

To provide for health care services, including within the hospital, clinics, and affiliated entities.

b. What are the activities and services that will be provided to meet the intended purpose of these funds?

Health care services related to charity and uncompensated care.

c. What are the direct services to be provided to citizens by the appropriations project?

Health care services related to charity and uncompensated care.

d. Who is the target population served by this project? How many individuals are expected to be served?

The majority of funds will serve the general population.

e. What is the expected benefit or outcome of this project? What is the methodology by which this outcome will be measured?

Overall improved health to the community measured via the impact to ED visits, readmission data, and outpatient visits.

f. What are the suggested penalties that the contracting agency may consider in addition to its standard penalties for failing to meet deliverables or performance measures provided for in the contract?

N/A

12. The owner(s) of the facility to receive, directly or indirectly, any fixed capital outlay funding. Include the relationship between the owner(s) of the facility and the entity.

N/A

13. Requestor Contact Information:

a. Name: Liz Callahan

b. Organization: Baptist Hospital, Inc. d/b/a Baptist Hospital

c. E-mail Address: liz.callahan@bhcpns.org

d. Phone Number: (850)469-2345
14. **Recipient Contact Information:**
   a. **Organization:** Baptist Hospital, Inc. d/b/a Baptist Hospital
   b. **County:** Escambia
   c. **Organization Type:**
      - For Profit
      - Non Profit 501(c) (3)
      - Non Profit 501(c) (4)
      - Local Entity
      - University or College
      - Other (Please specify)
   d. **Contact Name:** Liz Callahan
   e. **E-mail Address:** liz.callahan@bhcpns.org
   f. **Phone Number:** (850)469-2345

15. **Lobbyist Contact Information**
   a. **Name:** Teye Reeves
   b. **Firm Name:** Smith, Bryan and Myers
   c. **E-mail Address:** treeves@smithbryanandmyers.com
   d. **Phone Number:** (850)224-5081