



The Florida Senate

Local Funding Initiative Request

Fiscal Year 2022-2023

LFIR # 1860

1. Project Title

2. Senate Sponsor

3. Date of Request

4. Project/Program Description

5. State Agency to receive requested funds

State Agency contacted?

6. Amount of the Nonrecurring Request for Fiscal Year 2022-2023

Type of Funding	Amount
Operations	1,000,000
Fixed Capital Outlay	0
Total State Funds Requested	1,000,000

7. Total Project Cost for Fiscal Year 2022-2023 (including matching funds available for this project)

Type of Funding	Amount	Percentage
Total State Funds Requested (from question #6)	1,000,000	100%
Matching Funds		
Federal	0	0%
State (excluding the amount of this request)	0	0%
Local	0	0%
Other	0	0%
Total Project Costs for Fiscal Year 2022-2023	1,000,000	100%

8. Has this project previously received state funding?

Fiscal Year (YYYY-YY)	Amount		Specific Appropriation #	Vetoed
	Recurring	Nonrecurring		

9. Is future funding likely to be requested?

a. If yes, indicate nonrecurring amount per year.

b. Describe the source of funding that can be used in lieu of state funding.

10. Has the entity requesting this project received any federal assistance related to the COVID-19 pandemic?

If yes, indicate the amount of funds received and what the funds were used for.



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11. Details on how the requested state funds will be expended

Spending Category	Description	Amount
Administrative Costs:		
Executive Director/Project Head Salary and Benefits		0
Other Salary and Benefits	Assist with the costs associated with providing medical care to indigent patients. This can include more healthcare staff.	1,000,000
Expense/Equipment/Travel/Supplies/Other		0
Consultants/Contracted Services/Study		0
Operational Costs: Other		
Salary and Benefits		0
Expense/Equipment/Travel/Supplies/Other		0
Consultants/Contracted Services/Study		0
Fixed Capital Construction/Major Renovation:		
Construction/Renovation/Land/Planning Engineering		0
Total State Funds Requested (must equal total from question #6)		1,000,000

12. Program Performance

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

Supplement indigent care funding lost from hospital district. We have received funding from the North Lake Hospital District for the past few years through property taxes. The district voted to eliminate the mileage increase for indigent care. If we receive state funding we can attempt to use it as a federal match to draw down more funding if a program exists to do so.

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

Acute Care Hospital Services

c. What direct services will be provided to citizens by the appropriation project?

Acute Care Hospital Services

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

Uninsured and Medicaid patients

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

Every hospital in Florida is required to report to the state Agency for Health Care Administration the amount of charity care that is delivered to indigent populations. This information is audited by the Agency. This project will benefit Leesburg and its community hospital by providing funding for indigent care. To measure the outcome, the hospital will report to the Agency the amount of indigent care delivered to patients. The amount of indigent care delivered to patients will be equal to or greater than the \$1,000,000 requested appropriation.

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 the contract?

If the Leesburg Hospital fails to deliver \$1,000,000 or greater amount of indigent care to patients of the hospital, as audited by the Agency, the hospital will return the un-used funds to the state.



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13. The owners of the facility to receive, directly or indirectly, any fixed capital outlay funding. Include the relationship between the owners of the facility and the entity.

N/A



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14. Requestor Contact Information

a. First Name Last Name

b. Organization

c. E-mail Address

d. Phone Number Ext.

15. Recipient Contact Information

a. Organization

b. Municipality and County

c. Organization Type

For Profit Entity

Non Profit 501(c)(3)

Non Profit 501(c)(4)

Local Entity

University or College

Other (please specify)

d. First Name Last Name

e. E-mail Address

f. Phone Number

16. Lobbyist Contact Information

a. Name

b. Firm Name

c. E-mail Address

d. Phone Number