The Florida Senate

Local Funding Initiative Request - Fiscal Year 2018-2019

1. **Title of Project:** Health Central Disproportionate Share Hospital Funding
2. **Senate Sponsor:** Randolph Bracy
3. **Date of Submission:** 12/15/2017
4. **Project/Program Description:**

   Provides disproportionate share hospital funds (DSH) for Health Central. Historically, this hospital received DSH funding as a public hospital. When the hospital lost its public status, it was not eligible for DSH, however, its level of charity care and uncompensated care did not decrease. These funds will assist the hospital in providing care to our most vulnerable. Local IGT funds may be available to cover the match requirement. This request does not increase total DSH funding for the state.

5. **State Agency Contacted?** No

   a. If yes, which state agency?

   b. If no, which is the most appropriate state agency to place an appropriation for the issue being requested? Agency for Health Care Administration

6. **Amount of Non-recurring Requested for fiscal year 2018-19:**

Amount Requested for Operations	Amount Requested for Fixed Capital Outlay	Total Amount of Requested State Funds
2,700,000		2,700,000

7. **Type, amount and percent of matching funds available for this project for fiscal year 2018-19:**

Type	Amount	Percent
Federal	0	0.0%
State (excluding the amount of this request)	0	0.0%
Local	0	0.0%
Other	0	0.0%
TOTAL	0	0.0 %

8. **Total Project Cost for fiscal year 2018-19 (including the Total Amount of Requested State Funds):** 2,700,000

9. **Previous Year Funding Details:**

   a. Has funding been provided in a previous state budget for this activity? Yes
   b. In the previous 5 fiscal years, how many years was funding provided? (Optional) 3
   c. What is the most recent fiscal year the project was funded? 2015-16

d. Were the funds provided in the most recent fiscal year subsequently vetoed? No

e. Complete the following Worksheet.

FY:	Input Prior FY Appropriation for this project for FY 2017-18 (If appropriated in FY 2017-18 enter the appropriated amount, even if vetoed.)		
Column:	**A**	**B**	**C**
Funds Description:	**Prior Year Recurring Funds ***	**Prior Year Nonrecurring Funds ***	**Total Funds Appropriated (Column A + Column B)**
Input Amounts:			

10. Is future-year funding likely to be requested?

No

11. Program Performance:

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

State funding will be used to provide charity and uncompensated care for inpatient care and ER services

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

Hospital and emergency services.

c. How will the funds be expended?

Spending Category	Description	Amount
Administrative Costs		
☐Executive Director/Project Head Salary and Benefits		
☐Other Salary and Benefits		
☐Expense/Equipment/Travel/Supplies/Other		
☐Consultants/Contracted Services/Study		
Operational Costs		
☐Salary and Benefits		
☑Expense/Equipment/Travel/Supplies/Other	Funding will be used to provide hospital and	2,700,000

	emergency services	
☐Consultants/Contracted Services/Study		
Fixed Capital Construction/Major Renovation		
☐Construction/Renovation/Land/Planning Engineering		
TOTAL		2,700,000

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

Hospital and emergency services

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

Citizens in Lake, Orange and Osceola Counties.

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

Improve physical and mental health as well as reduce substance abuse by provider outcomes.

g. **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?**

No funding in future years.

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:** Michelle Strenth
    b. **Organization:** Orlando Health
    c. **Email:** Michelle.Strenth@orlandohealth.com
    d. **Phone Number:** (407)694-9910

14. **Recipient Contact Information:**
    a. **Organization:** Health Central Hospital
    b. **County:** Orange
    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: Michael Mueller
e. E-mail Address: michael.mueller@healthcentral.org
f. Phone Number: (407)296-1802

15. If there is a registered lobbyist, fill out the lobbyist information below.

a. Name: Eric Prutsman
b. Firm: Prutsman and Associates
c. Email: eric@prutsmanlaw.com
d. Phone Number: (850)210-2525