STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SOUTH BROWARD HOSPITAL DISTRICT D/B/A MEMORIAL HOSPITAL PEMBROKE,

Respondent.
_____/

DOAH CASE NO.: 15-3113MPI
MPI CASE NO.: 2015-0002434
C.I. NO.: 11-2566-000
PROVIDER NO.: 010222900
NPI NO.: 1063495836
LICENSE NO.: 4121

RENDITION NO.: AHCA- 20 - 064 **-S-MDO**

FINAL ORDER

THE PARTIES resolved all disputed issues and executed a Settlement Agreement. The parties are directed to comply with the terms of the attached settlement agreement. Based on the foregoing, this file is **CLOSED**.

DONE and ORDERED on this the 29 day of January 2020, in Tallahassee, Leon County, Florida.

for
MARY C. MAYHEW, SECRETARY
Agency for Health Care Administration

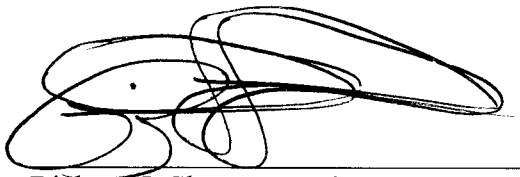
A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

South Broward Hospital District d/b/a Memorial Hospital Pembroke Attn: Hospital Administrator 7800 Sheridan Street Pembroke Pines, FL 33024-2536 (U.S. Mail)	Joanne B. Erde, P.A. Duane Morris LLP 200 South Biscayne Boulevard, Suite 3400 Miami, Florida 33131 jerde@duanemorris.com (Electronic Mail)
Joseph M. Goldstein, Esquire Shutts & Bowen, LLP 200 East Broward Blvd, Suite 2100 Fort Lauderdale, FL 33301 jgoldstein@shutts.com (Electronic Mail)	Division of Health Quality Assurance Bureau of Central Services CSMU-86@ahca.myflorida.com
Stefan R. Grow, Esquire General Counsel (Electronic Mail)	Division of Health Quality Assurance Bureau of Health Facility Regulation BHFR@ahca.myflorida.com (Electronic Mail)
Shena L. Grantham, Esquire MAL & MPI Chief Counsel (Electronic Mail)	Bureau of Financial Services (Electronic Mail)
Kelly Bennett, Chief, MPI (Electronic Mail)	

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the above named addressees by U.S. Mail or other designated method on this the 29th day of January 2020.



Richard J. Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308-5403
(850) 412-3689/FAX (850) 921-0158

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

SOUTH BROWARD HOSPITAL DISTRICT d/b/a MEMORIAL HOSPITAL PEMBROKE,

Respondent.

_____ /

MPI C.I. NO.:	11-2566-000
PROVIDER NO.:	010222900
NPI NO.:	1063495836
LICENSE NO.:	4121
MPI CASE NO:	2015-0002434
DOAH CASE NO.:	15-3113MPI

SETTLEMENT AGREEMENT

Petitioner, the **STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION** ("AHCA" or "Agency"), and Respondent, **SOUTH BROWARD HOSPITAL DISTRICT d/b/a MEMORIAL HOSPITAL PEMBROKE** ("PROVIDER"), by and through the undersigned, hereby stipulate and agree as follows:

1. The parties enter into this agreement for the purpose of memorializing the resolution of this matter.

2. PROVIDER is a Medicaid provider in the State of Florida, provider number 010222900, and was a provider during the audit period.

3. In its Final Audit Report (attached as Exhibit A), dated April 14, 2015, the Agency notified PROVIDER that a review of Medicaid claims performed by the Agency's Bureau of Medicaid Program Integrity ("MPI"), during the period January 1, 2007, through December 31, 2007, indicated that certain claims, in whole or in part, were inappropriately paid by Medicaid. The Agency sought repayment of this overpayment, in the amount fifty

thousand three hundred eleven dollars and nine cents ($50,311.09). A fine of two thousand five hundred dollars ($2,500.00) was also applied. Additionally, the Agency applied costs in the amount one thousand seven hundred eleven dollars and fifty-eight cents ($1,711.58) pursuant to section 409.913(23)(a), Florida Statutes. The total amount due was fifty-four thousand five hundred twenty-two dollars and sixty-seven cents ($54,522.67).

4. In response to the Final Audit Report dated April 14, 2015, PROVIDER filed a Petition for Formal Administrative Hearing.

5. On November 6, 2015, *State of Florida, Agency of Health Care Administration v. South Broward Pembroke, Case No. 15-3113* and *State of Florida, Agency of Health Care Administration v. South Broward Memorial West, Case No. 15-3118* were consolidated. On January 3, 2017, and several dates thereafter, an Order was issued placing the case in abeyance during the litigation of *Lee Memorial Health System Gulf Coast Medical Center v. Agency for Health Care Administration*, DOAH Case No. 15-3876, First District Court of Appeal Case No. 1D16-1969 ("*Gulf Coast*"), *AHCA v. Lee Memorial Health System d/b/a Lee Memorial Hospital, Case No. 14-4171MPI & 15-3271MPI, First DCA No. 1D16-3975 (Lee Memorial)* and *AHCA v. Cape Memorial Hospital, Inc. d/b/a Cape Coral Hospital, Case No. 14-3606MPI, First DCA No. 1D16-5310 (Cape Memorial)*. On February 27, 2019, the First District Court of Appeal issued its Opinion in the cases mentioned above finding in favor of the hospitals. The Mandate for each case was issued on June 18, 2019.

6. In light of the ruling of the First District Court of Appeal, PROVIDER and AHCA agree as follows:

i. The Final Audit Report dated April 14, 2015 is rescinded.

ii. As of October 7, 2019, AHCA has collected monies from PROVIDER totaling fifty-four thousand five hundred twenty-two dollars and sixty-seven cents ($54,522.67).

iii. Within thirty (30) days of AHCA's receipt of this Settlement Agreement executed by PROVIDER, AHCA shall issue a Final Order adopting this Settlement Agreement.

iv. Within thirty (15) days following issuance of a Final Order, the Revenue Section of AHCA's Financial Services ("Financial Services") shall forward PROVIDER a Refund Application reflecting the refund of fifty-four thousand five hundred twenty-two dollars and sixty-seven cents ($54,522.67) is due to PROVIDER.

v. Once Financial Services has received a complete, correct, and original signed Refund Application, the Refund Application will be processed and transmitted to the Department of Financial Services within fifteen days of receipt.

vi. Payment of the refund shall be made within thirty (30) days of Financial Services' submission of and the Florida Department of Financial Services' ("DFS") approval of the signed Refund Application.

7. PROVIDER and AHCA agree that full payment, as set forth above, resolves and settles this case completely and releases both parties from any administrative or civil

liabilities, costs, penalties or fines arising from the findings referenced in audit C.I. Number 11-2566-000 (MPI Case No.: 2015-0002434).

8. AHCA and PROVIDER reserve the right to enforce this Agreement under the laws of the State of Florida, the Rules of the Medicaid Program, and all other applicable rules and regulations.

9. This settlement does not constitute an admission of wrongdoing or error by either party with respect to this case or any other matter.

10. The signatories to this Agreement, acting in a representative capacity, represent that they are duly authorized to enter into this Agreement on behalf of the respective parties.

11. This Agreement shall be construed in accordance with the provisions of the laws of Florida. Exclusive venue for any action arising from this Agreement shall be in Leon County, Florida.

12. This Agreement constitutes the entire agreement between PROVIDER and AHCA, including anyone acting for, associated with, or employed by the parties, concerning this matter and supersedes any prior discussions, agreements, or understandings. There are no promises, representations, or agreements between PROVIDER and AHCA other than as set forth herein. No modification or waiver of any provision shall be valid unless a written amendment to the Agreement is completed and properly executed by the parties.

13. This is an Agreement of Settlement and Compromise, made in recognition that the parties may have different or incorrect understandings, information, and contentions as to facts and law, and with each party compromising and settling any potential correctness or incorrectness of its understandings, information, and contentions as to facts and law, so that no

misunderstanding or misinformation shall be a ground for rescission hereof.

14. PROVIDER expressly waives in this matter its right to any hearing pursuant to sections 120.569 or 120.57, Florida Statutes; the making of findings of fact and conclusions of law by the Agency; all further and other proceedings to which it may be entitled by law or rules of the Agency regarding this proceeding; and any and all issues raised herein. PROVIDER further agrees that it shall not challenge or contest any Final Order entered in this matter, which is consistent with the terms of this Settlement Agreement in any forum now or in the future available to it, including the right to any administrative proceeding, circuit or federal court action, or any appeal.

15. PROVIDER does hereby discharge the State of Florida, Agency for Health Care Administration, and its employees, agents, representatives, and attorneys of and from all claims, demands, actions, causes of action, suits, damages, losses, and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter, AHCA's actions herein, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement.

16. The parties agree to bear their own attorney's fees and costs.

17. This Agreement is and shall be deemed jointly drafted and written by all parties to it and shall not be construed or interpreted against the party originating or preparing it.

18. To the extent that any provision of this Agreement is prohibited by law for any reason, such provision shall be effective to the extent not so prohibited, and such prohibition shall not affect any other provision of this Agreement.

19. This Agreement shall inure to the benefit of and be binding on each party's successors, assigns, heirs, administrators, representatives, and trustees.

20. All times stated herein are of the essence of this Agreement.

21. This Agreement shall be in full force and effect upon execution by the respective parties in counterpart.

[SIGNATURE PAGES FOLLOW]

SOUTH BROWARD HOSPITAL DISTRICT d/b/a MEMORIAL HOSPITAL PEMBROKE

BY: _____ Date: 1/15, 2019
(Print Name and Title)

Aurelio M. Fernandez, III
BY: President and CEO
(Print Name and Title)

AGENCY FOR HEALTH CARE ADMINISTRATION
2727 Mahan Drive, Bldg. 3, Mail Stop #3
Tallahassee, FL 32308-5403

_____ Date: 1/29, 2020
Molly McKinstry
Deputy Secretary for HQA

_____ Date: 1/24, 2019
Stefan R. Grow, Esquire
General Counsel

_____ Date: 1/21, 2020
Shena L. Grantham, Esquire
MAL & MPI Chief Counsel

_____ Date: 12/26, 2019
Joseph M. Goldstein
Shutts & Bowen, AHCA Outside Counsel

EXHIBIT "A"

RL-19748

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

FILED
2015 JUN -1 AM 11:21
DIVISION OF
ADMINISTRATIVE HEARINGS

CERTIFIED MAIL No.: 7012 1010 0003 2495 3738

April 14, 2015

15-3113MPI

Provider No.: 010222900
NPI No.: 1063495836
License No.: 4121

SOUTH BROWARD HOSP DISTRICT
MEMORIAL HOSP. PEMBROKE
7800 SHERIDAN ST
PEMBROKE PINES, FL 33024

In Reply Refer to
FINAL AUDIT REPORT
C.L. No. 11-2566-000

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period January 1, 2007, through December 31, 2007. A preliminary audit report dated October 8, 2014 was sent to you indicating that we had determined you were overpaid $52,005.85. Based upon a review of all documentation submitted, we have determined that you were overpaid $50,311.09 for services that in whole or in part are not covered by Medicaid. A fine of $2,500.00 has been applied. The cost assessed for this audit is $1,711.58. The total amount due is $54,522.67.

Be advised of the following:

(1) In accordance with Sections 409.913(15), (16), and (17), Florida Statutes (F.S.), and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. This letter shall serve as notice of the following sanction(s):

- A fine of $2,500.00 for violation(s) of Rule Section 59G-9.070(7)(c), F.A.C.

(2) Pursuant to Section 409.913(23)(a) F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.

This review and the determinations of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining payment pursuant to Medicaid policy, the Medicaid program utilizes descriptions, policies and the limitations and exclusions found in the Medicaid provider handbooks. In applying for Medicaid reimbursement, providers are required to follow the guidelines set

forth in the applicable rules and Medicaid fee schedules, as promulgated in the Medicaid policy handbooks, bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

Emergency Medicaid for Aliens (EMA) is a Medicaid limited coverage program in which coverage is only for the duration of the emergency. Definitions for Emergency Medical Condition, Emergency Services and Care or Medical Necessity, may be found in the Florida Medicaid Provider General Handbook. Other relevant definitions may be found in the Florida Administrative Codes, Florida Statutes and in federal law.

Below is a discussion of the particular guidelines related to the review of EMA claims and an explanation of why these claims do not meet Medicaid requirements. A list of the paid claims affected by this determination is attached.

REVIEW DETERMINATION(S)

The Florida Medicaid Provider General Handbook(s), 2004, 2007, pages 3-19, establishes Limited Coverage Categories and Program Codes for programs with limited Medicaid benefits. Medicaid policy related to the program, Emergency Medicaid for Aliens, is further described. The Florida Hospital Services Coverage and Limitations Handbook, 2005, page 2-7, also refers to Emergency Medicaid for Aliens policy. These policy references state: "Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated." The Florida Medicaid Provider Reimbursement Handbooks UB-92, 2004, page 2-9 and UB-04, 2007, page 2-7 state: "Medicaid coverage of inpatient services for non-qualified, non-citizens is limited to emergencies, newborn delivery services and dialysis services."

A medical record review was performed by a medical review team including a peer physician reviewer who determined the point at which the alien recipient's emergent complaint was alleviated. Medicaid policy does not allow payment of claims for services rendered beyond the date the emergency has been alleviated. Although medical necessity may continue to exist, Medicaid is not responsible for payment of those continuing services. Consequently, the inpatient services billed to and paid by Medicaid beyond the peer reviewer's determined date of alleviation are identified as an overpayment and are subject to recoupment.

In instances where hospital observation days were allowed, claims were adjusted to allow the outpatient per diem for observations, and the difference was identified as an overpayment and subject to recoupment.

In instances where the medical record was not received or was incomplete, the related claim was denied. The Provider General Handbook(s) 2004, 2007, pages 5-8, states the following:

> "Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid may recover payment for services or goods when the provider has incomplete records or cannot locate the records."

In accordance with Medicaid policies, those claims not supported by documentation are identified as overpayments and subject to administrative sanction and recoupment.

The Medicaid Provider General Handbook, 2003, page 5-3, defines "Overpayment" as:

"Overpayment includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse or mistake."

If you are currently involved in a bankruptcy, you should notify your attorney immediately and then provide them a copy of this letter. Please advise your attorney that we require the following information immediately:

1) the date of filing of the bankruptcy petition;
2) the case number;
3) the court name and the division in which the petition was filed (e.g., Northern District of Florida, Tallahassee Division);
4) the name, address, and telephone number of your attorney.

If you are not in bankruptcy and you concur with our findings, remit by certified check in the amount of $54,522.67, which includes the overpayment amount as well as any fines imposed and assessed costs.

The check must be payable to the **Florida Agency for Health Care Administration.**

To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report. Please mail payment to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901.

Pursuant to section 409.913(25)(d), F.S., the Agency may collect money owed by all means allowable by law, including, but not limited to, exercising the option to collect money from Medicare that is payable to the provider. Pursuant to section 409.913(27), F.S., if within 30 days following this notice you have not either repaid the alleged overpayment amount or entered into a satisfactory repayment agreement with the Agency, your Medicaid reimbursements will be withheld; they will continue to be withheld, even during the pendency of an administrative hearing, until such time as the overpayment amount is satisfied. Pursuant to section 409.913(30), F.S., the Agency shall terminate your participation in the Medicaid program if you fail to repay an overpayment or enter into a satisfactory repayment agreement with the Agency, within 35 days after the date of a final order which is no longer subject to further appeal. Pursuant to sections 409.913(15)(q) and 409.913(25)(c), F.S., a provider that does not adhere to the terms of a repayment agreement is subject to termination from the Medicaid program.

Finally, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C. and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be received by the Agency within twenty-one (21) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.**

Section 409.913(12), F.S., provides exemptions from the provisions of Section 119.07(1), F.S. All information obtained pursuant to this review is confidential and exempt from the provisions of Section 119.07(1), F.S., until the Agency takes final agency action with respect to the provider and requires repayment of any overpayment or imposes an administrative sanction by Final Order.

Any questions you may have about this matter should be directed to: **Sonya Graves**, AHCA Investigator, Agency for Health Care Administration, Office of Inspector General, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 412-4596, facsimile (850) 410-1972.

Sincerely,

Johnnie L. Shepherd
AHCA Administrator
Office of Inspector General
Medicaid Program Integrity
JS/MS/cnl

Enclosure(s):
Provider Overpayment Remittance Voucher
Medical Peer Review Worksheets
Claims Analysis Spreadsheets

Copies furnished to:

Finance & Accounting
(interoffice mail)

Health Quality Assurance
(E-mail)

NOTICE OF ADMINISTRATIVE HEARING AND MEDIATION RIGHTS

You have the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If you disagree with the facts stated in the foregoing Final Audit Report (hereinafter FAR), you may request a formal administrative hearing pursuant to Section 120.57(1), Florida Statutes. If you do not dispute the facts stated in the FAR, but believe there are additional reasons to grant the relief you seek, you may request an informal administrative hearing pursuant to Section 120.57(2), Florida Statutes. Additionally, pursuant to Section 120.573, Florida Statutes, mediation may be available if you have chosen a formal administrative hearing, as discussed more fully below.

The written request for an administrative hearing must conform to the requirements of either Rule 28-106.201(2) or Rule 28-106.301(2), Florida Administrative Code, and must be received by the Agency for Health Care Administration, by 5:00 P.M., no later than 21 days after you received the FAR. The address for filing the written request for an administrative hearing is:

Richard J. Shoop, Esquire
Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 3
Tallahassee, Florida 32308
Fax: (850) 921-0158
Phone: (850) 412-3630
E-File Website: http://apps.ahca.myflorida.com/Efile

Petitions for hearing filed pursuant to the administrative process of Chapter 120, Florida Statutes may be filed with the Agency by U.S. mail or courier sent to the Agency Clerk at the address listed above, by hand delivery at the address listed above, by facsimile transmission to (850) 921-0158, or by electronic filing through the Agency's website at http://apps.ahca.myflorida.com/Efile.

The request must be legible, on 8 ½ by 11-inch white paper, and contain:

1. Your name, address, telephone number, any Agency identifying number on the FAR, if known, and name, address, and telephone number of your representative, if any;
2. An explanation of how your substantial interests will be affected by the action described in the FAR;
3. A statement of when and how you received the FAR;
4. For a request for formal hearing, a statement of all disputed issues of material fact;
5. For a request for formal hearing, a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle you to relief;
6. For a request for formal hearing, whether you request mediation, if it is available;
7. For a request for informal hearing, what bases support an adjustment to the amount owed to the Agency; and
8. A demand for relief.

A formal hearing will be held if there are disputed issues of material fact. Additionally, mediation may be available in conjunction with a formal hearing. Mediation is a way to use a neutral third party to assist the parties in a legal or administrative proceeding to reach a settlement of their case. If you and the Agency agree to mediation, it does not mean that you give up the right to a hearing. Rather, you and the Agency will try to settle your case first with mediation.

If you request mediation, and the Agency agrees to it, you will be contacted by the Agency to set up a time for the mediation and to enter into a mediation agreement. If a mediation agreement is not reached within 10 days following the request for mediation, the matter will proceed without mediation. The mediation must be concluded within 60 days of having entered into the agreement, unless you and the Agency agree to a different time period. The mediation agreement between you and the Agency will include provisions for selecting the mediator, the allocation of costs and fees associated with the mediation, and the confidentiality of discussions and documents involved in the mediation. Mediators charge hourly fees that must be shared equally by you and the Agency.

If a written request for an administrative hearing is not timely received you will have waived your right to have the intended action reviewed pursuant to Chapter 120, Florida Statutes, and the action set forth in the FAR shall be conclusive and final.

FAR

Provider Overpayment Remittance Voucher

If you choose to make payment, please return this form along with your check.

Complete this form and send along with your check to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

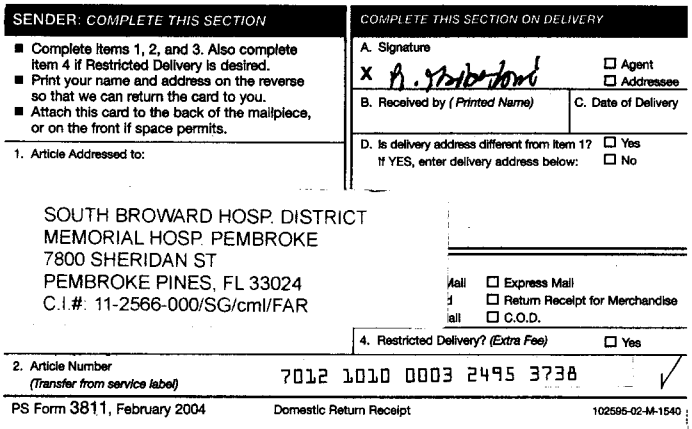
CHECK MUST BE MADE PAYABLE TO: FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Provider Name:	SOUTH BROWARD HOSP DISTRICT
Provider ID:	010222900
MPI Case #:	11-2566-000
Overpayment Amount:	$50,311.09
Costs:	$1,711.58
Fines:	$2,500.00
Total Due:	$54,522.67
Check Number:	#_____

A final order will be issued that will include the final identified overpayment, applied Sanctions, and assessed costs, taking into consideration any information or documentation that you have already submitted. Any amount due will be offset by any amount already received by the Agency in this matter.

Payment for Medicaid Program Integrity Audit

RL-19748



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

SOUTH BROWARD HOSP. DISTRICT
MEMORIAL HOSP. PEMBROKE
7800 SHERIDAN ST
PEMBROKE PINES, FL 33024
C.I.#: 11-2566-000/SG/cml/FAR

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

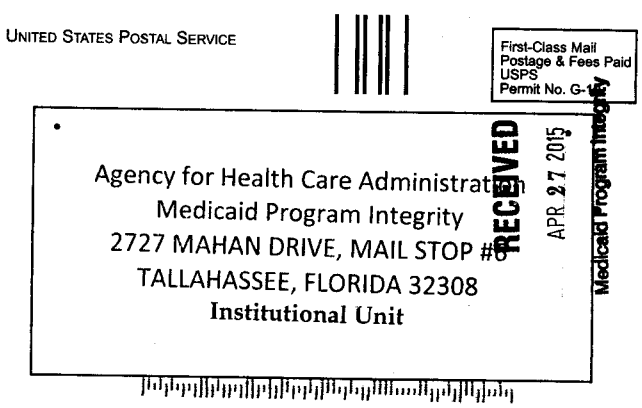
D. Is delivery address different from Item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

☐ Express Mail
☐ Return Receipt for Merchandise
☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7012 1010 0003 2495 3738 ✓

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540



UNITED STATES POSTAL SERVICE

First-Class Mail
Postage & Fees Paid
USPS
Permit No. G-10

Agency for Health Care Administration
Medicaid Program Integrity
2727 MAHAN DRIVE, MAIL STOP #6
TALLAHASSEE, FLORIDA 32308
Institutional Unit

RECEIVED
APR 27 2015
Medicaid Program Integrity

EXHIBIT 2