AMENDMENT TO AMENDED AND RESTATED AGREEMENT
BETWEEN
THE CITY OF JACKSONVILLE AND
SHANDS JACKSONVILLE MEDICAL CENTER, INC.

THIS AMENDMENT ("Amendment") is made and entered into in duplicate as of _____, 2025, (the "Effective Date"), by and between the CITY OF JACKSONVILLE, acting as Duval County, Florida, a consolidated county and municipal corporation existing under the Constitution and the laws of the State of Florida, (hereinafter the "County"), and SHANDS JACKSONVILLE MEDICAL CENTER, INC., a Florida not for profit corporation with principal offices at 655 W. 8th Street, Jacksonville, Florida 32209 (hereinafter the "Hospital").

RECITALS:

WHEREAS, County and Hospital previously entered into that certain Amended and Restated Agreement dated June 2d, 2005 (the "Agreement"); and

WHEREAS, the Council Auditor's Office conducted an audit of the Agreement and reported its findings to the City Council in Report #881 dated August 18, 2024; and

WHEREAS, County and Hospital desire to amend the Agreement based upon the findings in Report #881 and to address other changes requested by the County; and

WHEREAS, this Amendment is authorized by Ordinance _____.

NOW, THEREFORE, IN CONSIDERATION of the Agreement and of the mutual covenants contained below, the parties agree as follows:

1. The above-stated recitals are accurate, true and correct and are incorporated herein and made a part hereof by this reference.

2. The following statement from Section 2 of the Agreement is deleted:

> *Eligibility for coverage under this Agreement will be deferred until receipt of a denial from Medicaid for reasons other than noncompliance.*

And is replaced with the following:

> *Upon HOSPITAL's successful verification of: (1) no current Medicaid coverage; (2) proof of Duval County residency; and (3) qualifying income level, an individual will be deemed eligible for coverage for the subsequent 90-day period, during which time, the individual must file for Medicaid and provide the letter of denial of Medicaid coverage to the HOSPITAL's Financial Evaluation Department ("FED"). Provided the individual's Medicaid denial letter is not due*

to noncompliance with the Medicaid application process, once the Medicaid denial letter is provided to FED, the individual's eligibility will continue for the subsequent 9-month period (equaling 12 months of eligibility). If the individual fails to provide the Medicaid denial letter within the 90-day period, or if the individual's Medicaid coverage is denied because of noncompliance with the Medicaid application process, eligibility will expire at the end of the 90-day period. and any services provided during the initial 90 days will be assigned to Financial Assistance Policy. There will be only one 90-day grace period within a 12-month coverage period in which a patient can provide the Medicaid denial letter.

3. In the Appendix attached as Attachment A to the Agreement, the following statements on the fifth page, Paragraph 9, are deleted:

In general, outpatient financial evaluations will be effective for a 6 month period. Those patients who derive substantially all of their income from a pension or other fixed source of income will be evaluated on an annual basis. Self-pay patients will be evaluated on an annual basis or more frequently upon request.

And are replaced with the following:

Financial evaluations will be conducted on an annual basis.

4. In the Appendix attached as Attachment A to the Agreement, Schedules D, E, F, H, I, and J are deleted and replaced with the Schedule D attached hereto that is titled as follows:

SCHEDULE D
SHANDS JACKSONVILLE MEDICAL CENTER, INC.
FEE SCHEDULE
(DUVAL COUNTY PATIENTS ONLY)
AUGUST 1, 2024

5 To the extent this Amendment conflicts with the Agreement, this Amendment shall control. All other terms and conditions of the Agreement shall remain in full force and effect.

[Remainder of page left blank intentionally; signatures on following page.]

IN WITNESS WHEREOF, the parties hereto have executed this instrument the day and year first above written.

ATTEST:

By: _____
James R. McCain, Jr.
Corporation Secretary

CITY OF JACKSONVILLE

By: _____
Donna Deegan
Mayor

In accordance with the Ordinance Code of the City of Jacksonville, I do hereby certify that there is an unexpended, unencumbered, and unimpounded balance in the appropriation sufficient to cover the foregoing agreement, and that provision has been made for the payment of monies provided therein to be paid.

_____
Director of Finance

Form Approved:

_____
Office of General Counsel

WITNESS:

By: _____

Print Name:_____

Title: _____

SHANDS JACKSONVILLE MEDICAL CENTER, INC., a Florida not for profit corporation

By:_____

Print Name: _____

Title: _____

SCHEDULE D

SHANDS JACKSONVILLE MEDICAL CENTER, INC.

FEE SCHEDULE

(DUVAL COUNTY PATIENTS ONLY)

AUGUST 1, 2024

CITY CONTRACT FULL RATING

As a FULL CONTRACT, you are required to pay the following amounts when services are rendered:

Emergency Room	$0
Primary Care	$0
Specialty/Ancillary	$0
Series Visit: Mental Health, Physical Therapy, Radiation Oncology, Dialysis	$0
Inpatient	$0
Ambulatory Surgery	$0
Pharmacy	$0

YOU WILL BE RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH NON-COVERED SERVICES.

CITY CONTRACT PART PAY 1

As PART PAY 1, you are required to pay the following amounts when services are rendered:

Emergency Room	$10.00 co-pay with maximum of 30% of AGB (Amount Generally Billed)
Primary Care	$0 co-pay
Specialty/Ancillary	$10 co-pay
Series Visit: Mental Health, Physical Therapy, Radiation Oncology, Dialysis	$25/month
Pharmacy/Take home supplies	10% of charges
Inpatient Hospitalization	30% of AGB with maximum of $500.00
Ambulatory Surgery/Observation	30% of AGB with maximum of $300.00

YOU WILL BE RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH NON-COVERED SERVICES.

CITY CONTRACT PART PAY 2

As Part Pay 2, you are required to pay the following amounts when services are rendered:

Emergency Room	$10.00 co-pay with maximum of 44% of AGB (Amount Generally Billed)
Primary Care	$0 co-pay
Specialty/Ancillary	$10 co-pay
Series Visit: Mental Health, Physical Therapy, Radiation Oncology, Dialysis	$30/month
Pharmacy/Take home supplies	20% of charges
Inpatient Hospitalization	44% of AGB with maximum of $1,200.00
Ambulatory Surgery/Observation	44% of charges with maximum of $450.00

YOU WILL BE RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH NON-COVERED SERVICES.

CITY CONTRACT PART PAY 3

As Part Pay 3, you are required to pay the following amounts when services are rendered:

Emergency Room	$25.00 co-pay with maximum of 58% of AGB (Amount Generally Billed)
Primary Care	$0 co-pay
Specialty/Ancillary	$10 co-pay
Series Visit: Mental Health, Physical Therapy, Radiation Oncology, Dialysis	$40/month
Pharmacy/Take home supplies	40% of charges
Inpatient Hospitalization	58% of AGB with maximum of $2,000.00
Ambulatory Surgery/Observation	58% of AGB with maximum of $600.00

YOU WILL BE RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH NON-COVERED SERVICES.

CITY CONTRACT PART PAY 4

As Part Pay 4, you are required to pay the following amounts when services are rendered:

Emergency Room	$25.00 co-pay with maximum of 72% of AGB (Amount Generally Billed)
Primary Care	$0 co-pay
Specialty/Ancillary	$15 co-pay
Series Visit: Mental Health, Physical Therapy, Radiation Oncology, Dialysis	$55/month
Pharmacy/Take home supplies	60% of charges
Inpatient Hospitalization	72% of AGB with maximum of $3,000.00
Ambulatory Surgery/Observation	72% of AGB with maximum of $750.00

YOU WILL BE RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH NON-COVERED SERVICES.

CITY CONTRACT PART PAY 5

As Part Pay 5, you are required to pay the following amounts when services are rendered:

Emergency Room	$25.00 co-pay with maximum of 86% of AGB (Amount Generally Billed)
Primary Care	$0 co-pay
Specialty/Ancillary	$15 co-pay
Series Visit: Mental Health, Physical Therapy, Radiation Oncology, Dialysis	$70/month
Pharmacy/Take home supplies	80% of charges
Inpatient Hospitalization	86% of AGB with maximum of $4,000.00
Ambulatory Surgery/Observation	86% of AGB with maximum of $900.00

YOU WILL BE RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH NON-COVERED SERVICES.

CITY CONTRACT PART PAY 6

As Part Pay 6, you are required to pay the following amounts when services are rendered:

Emergency Room	$50.00 co-pay with maximum of 100% of AGB (Amount Generally Billed)
Primary Care	$0 co-pay
Specialty/Ancillary	$15 co-pay
Series Visit: Mental Health, Physical Therapy, Radiation Oncology, Dialysis	$85/month
Pharmacy/Take home supplies	100% of charges
Inpatient Hospitalization	100% of AGB with maximum of $5,000.00
Ambulatory Surgery/Observation	100% of AGB with maximum of $1,200.00

YOU WILL BE RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH NON-COVERED SERVICES.