

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
AHCA
AGENCY CLERK
2018 APR 18 A 9:44

STATE OF FLORIDA,
AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs.

MGM CASE MANAGEMENT SERVICES,
INC. D/B/A MGM BEHAVIORAL,

MPI CASE No.: 2017-0007978

Provider No.: 017452900

NPI No.: 1922391721

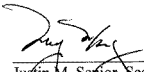
RENDITION NO.: AHCA-18-0218-S-MDG

Respondent.

FINAL ORDER

THE PARTIES resolved all disputed issues and executed a repayment agreement, which is attached and incorporated by reference. The parties are directed to comply with the terms of the attached repayment agreement. Based on the foregoing, this case is closed.

DONE AND ORDERED this 17 day of April, 2018, in Tallahassee,
Florida.


Justin M. Senior, 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:

MGM Case Management Services, Inc.
D/B/A MGM Behavioral
8040 NW 155th Street
Miami Lakes, FL 33016-5880
(U.S. mail)

Kelly Bennett, Chief, MPI
(Interoffice mail)

Division of Health Quality Assurance
Bureau of Health Facility Regulation
(Electronic Mail)

Division of Health Quality Assurance
Bureau of Central Services
(Electronic Mail)
CSMU-86@ahca.myflorida.com

Bureau of Financial Services
(Interoffice mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served on the above-named persons by U.S. Mail or interoffice mail as indicated on this the 18th day of

April, 2018.



Richard J. Shoop, Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, Building #3
Tallahassee, Florida 32308-5403
(850) 412-3630

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION**

**MGM CASE MANAGEMENT SERVICES,
INC. D/B/A MGM BEHAVIORAL**

Respondent,

PROVIDER NO. 0174529-00

AND

CASE NO. 2017-0007978

**STATE OF FLORIDA,
AGENCY FOR HEALTH CARE
ADMINISTRATION,**

Petitioner,

_____ /

PAYMENT PLAN AGREEMENT

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION ("AHCA" or "the Agency"), and MGM CASE MANAGEMENT SERVICES, INC. D/B/A MGM BEHAVIORAL, ("PROVIDER"), by and through the undersigned, hereby stipulate and agree as follows:

1. This Agreement is entered into for the purpose of memorializing the resolution of the matters set forth in this Agreement.
2. PROVIDER is a Medicaid provider in the State of Florida.
3. This will confirm the payment agreement for the Provider Self Audit and regarding the refunding of Medicaid overpayments totaling **\$1,047,839.51** for Medicaid Provider **0174529-00** and audit C. I. # **2017-0007978**.
4. The Agency and you are agreeing to all the following:

- (A) AHCA agrees to accept the payment arrangements set forth in the payment plan agreement for the overpayment issues arising from the MPI Case No. 2017-0007978;
- (B) The payment agreement is for five (5) monthly payments of **\$178,125.91** and one final payment of **\$178,125.68** beginning **03/01/18** until balance is resolved; Payment must be received on or by the **1ST** of each month;
- (C) Claims not covered by Medicaid which are the subject of the aforementioned audit, may not be re-billed to the Medicaid Program in any manner;
- (D) Interest at 10% per annum will begin 03/10/18;
- (E) Failure to meet this obligation will result in the Agency recouping 100% of your Medicaid payments and/or other collection activities allowed by law in addition to potential sanctions as provided under (F. S. 409.913).

By signing this agreement:

- (A) You confirm that you are duly authorized to enter into this repayment plan on behalf of the entity you are signing for below;
- (B) You expressly waive your right to a hearing pursuant to Sections 120.569 or 120.57, Florida Statutes, the making of findings fact and conclusions of law by the Agency, and all further and other proceedings to which you and any and all issues raised herein;
- (C) You agree that if you cease to be a Medicaid provider before the full amount is paid, that the Agency may enter a final order of default, and that the remaining amount will become immediately due and payable;

- (D) You agree that you owe at least \$1,047,839.51 plus 10% interest (If this amount is less than 100% of the Final Order, it is your responsibility to contact the Program Specialist to submit additional information within the original 30 days);
 - (E) You will immediately notify the Agency of any non-renewal, suspension or termination of your Medicaid or Medicare provider agreements;
 - (F) AHCA has the right if you fail to make payments, to lien Medicaid billings, or if Medicaid billings do not meet the payment amounts established in paragraph 4 (B) above, to lien Medicare to recoup any monies owed;
 - (G) You will immediately notify the Agency if you file bankruptcy.
5. Payment shall be made to:

AGENCY FOR HEALTHCARE ADMINISTRATION
Medicaid Accounts Receivable MS #14
Post Office Box 13749
Tallahassee, Florida 32317-3749

6. PROVIDER agrees that failure to pay any monies due and owing under the terms of this Agreement shall constitute PROVIDER'S authorization for the Agency, without further notice, to withhold the total remaining amount due plus interest under the terms of this agreement from any monies due and owing to PROVIDER for any Medicaid and Medicare claims. If you cannot make payments, or stop billing Medicaid or Medicare you are required to contact the Agency to establish a new payment schedule.

7. AHCA reserves 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.

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

9. 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.

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

11. This Agreement constitutes the entire agreement between PROVIDER and the AHCA, including anyone acting for, associated with or employed by them, concerning all matters and supersedes any prior discussions, agreements or understandings; there are no promises, representations or agreements between PROVIDER and the 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. This agreement does not affect the previous final order entered for this audit.

12. 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.

13. 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, and 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.

14. 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.

15. 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.

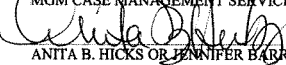
16. This Agreement shall inure to the benefit of and be binding on each party's successors, assigns, heirs, administrators, representatives and trustees.

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

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

19. This Agreement does not override any Settlement Agreement or Final Order issued prior to signing this agreement.

 Dated: 2/4, 2018
MGM CASE MANAGEMENT SERVICES, INC. D/B/A MGM/BEHAVIORAL

 Dated: 2/15, 2018
ANITA B. HICKS OR JENNIFER BARRETT
ACTING DEPUTY SECRETARY FOR OPERATIONS
AGENCY FOR HEALTH CARE ADMINISTRATION

**AGENCY FOR HEALTH CARE ADMINISTRATION
AMORTIZATION SCHEDULE**

MGM CASE MANAGEMENT SERVICES D/B/A MGM BEHAVIORAL /Provider # 0174529-00 /C. I. 2017-0007978

LOAN DATA		
Past Due Balance:	\$1,047,839.51	Table starts at date: 3/1/2018 or payment number: 1
Annual Int rate:	10.00%	
Term in years:	0.5	
Payments per year:	12	MAR # 23163
First payment due:	3/1/2018	
CALCULATED PAYMENT		
Entered payment:		
Calculated payment:	\$179,768.81	
AMOUNT USED		
Monthly Pmt Used:	\$178,125.91	\$1,047,839.51
1st Pmt in Table:	1	Cumulative interest prior to payment 1:

Table

Pmt No.	Payment Due Date	Beginning Balance	Interest	Principal	Ending Balance	Cumulative Interest	Payment Amount	Date Paid
1	3/1/2018	1,047,839.51	0.00	178,125.91	869,713.60	0.00	178,125.91	
2	4/1/2018	869,713.60	6,315.74	171,810.17	697,903.43	6,315.74	178,125.91	
3	5/1/2018	697,903.43	5,815.86	172,310.06	525,593.38	12,131.60	178,125.91	
4	6/1/2018	525,593.38	4,379.94	173,745.97	351,847.42	16,511.55	178,125.91	
5	7/1/2018	351,847.42	2,932.06	175,193.85	176,653.57	19,443.61	178,125.91	
6	8/1/2018	176,653.57	1,472.11	176,653.57	0.00	20,915.72	178,125.68	



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

CERTIFIED MAIL NO.: 9489 0090 0027 6030 9970 40

March 2, 2018

Exhibit 1

Provider No.: 017452900
NPI No.: 1922391721

MGM Case Management Services, Inc. d/b/a MGM Behavioral
8040 NW 155th Street
Miami Lakes, FL 33016-5880

In Reply Refer to:
SELF-AUDIT FINAL AUDIT REPORT
MPI Case No.: 2017-0007978

Dear Provider:

The Agency for Health Care Administration (Agency), Medicaid Program Integrity (MPI) has completed the review of your self-audit, pursuant to Sections 409.907 and 409.913, Florida Statutes (F.S.), Rules 59G-9.070, 56G-5.020, and 59G-4.125, Florida Administrative Code (F.A.C.), the Florida Medicaid Provider General Handbook, and the Florida Medicaid Behavior Analysis Services Coverage Policy. Your documentation indicated you billed Medicaid for services utilizing ineligible and/or unqualified service providers for dates of service during the period of March 1, 2017 through January 3, 2018. After a review of the documentation that you submitted, in the absence of fraud or misrepresentation, your overpayment amount totaled \$1,047,839.51. (Refer to the audit work papers.) Please note that the claims that were at issue during this review remain subject to further audit by the Agency. Furthermore, you are advised that you should continue to maintain documentation regarding these claims in accordance with applicable provisions of law.

Please remit payment by check in the amount of \$1,047,839.51. The check must be payable to the Florida Agency for Health Care Administration. Questions regarding payment should be directed to Medicaid Accounts Receivable, (850) 412-3858. To ensure proper credit, be certain your provider number and the MPI case number are shown on your check.

Please mail payment to:

Medicaid Accounts Receivable – MS # 14
Agency for Health Care Administration
2727 Mahan Drive, Building 2, Suite 200
Tallahassee, FL 32308



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. The Final Audit Report constitutes a probable cause determination by the Agency that you were overpaid by the Medicaid program. This correspondence is being sent to the address last shown on your provider enrollment file in compliance with Section 409.913(6), F.S. Thus, 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 Rule 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 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., for the complaint and all information obtained pursuant to an investigation of a Medicaid provider relating to an allegation of fraud, abuse, or neglect. The Agency has made the determination that your violation(s) of Medicaid policy constitute abuse as referenced in Section 409.913, F.S. Thus, 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: Vicki Stiles, Medical/Health Care Program Analyst, Agency for Health Care Administration, Medicaid Program Integrity, 921 N. Davis Street, Building A, Suite #160, Jacksonville, Florida 32209-6806, telephone (904) 798-4295, Vicki.Stiles@ahca.myflorida.com, facsimile (904) 353-2114.

Sincerely,



Sonya Graves
AHCA Administrator
Medicaid Program Integrity

Enclosure(s)

Copies furnished to:

Bureau of Financial Services
(Electronic Mail)

Division of Health Quality Assurance
Bureau of Health Facility Regulation
(Electronic Mail)

Division of Health Quality Assurance
Bureau of Central Services
CSMU-86@ahca.myflorida.com

Notice: Section 409.913(16), F.S., provides the authority for the Agency to impose the sanction of termination for cause if a provider voluntarily relinquishes its Medicaid provider number or an associated license, or allows the associated licensure to expire after receiving written notice that the Agency is conducting, or has conducted, an audit, survey, inspection, or investigation and that a sanction of suspension or termination will or would be imposed for noncompliance discovered as a result of the audit, survey, inspection, or investigation. This is notice that the Agency is conducting an audit, survey, inspection, or investigation within the meaning of 409.913(16), F.S. Accordingly, if you voluntarily terminate your Medicaid provider number, voluntarily relinquish an associated license, or allow an associated license to expire following receipt of this notice but prior to the conclusion of this audit, survey, inspection, or investigation, said action will result in the imposition of the sanction of termination for cause from the Medicaid program.

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.

**FLORIDA MEDICAID
PROVIDER SELF AUDIT PROTOCOL**

1. Introduction

The purpose of this Protocol is to provide guidance to providers regarding self audits. Self audits may be performed either:

- (a) Voluntarily by a provider, unsolicited by the Agency for Health Care Administration (Agency); or
- (b) In response to a request by the Agency pursuant to an amnesty program under Section 409.913(25)(e), Florida Statutes (F.S.).

The Agency's process for validating a self audit shall be consistent regardless of the means by which the self audit was initiated. Self audits will be forwarded to the Office of the Inspector General/Medicaid Program Integrity (OIG/MPI) for analysis, validation, and acceptance.

- a. **Voluntary self audits.** A provider has an obligation to ensure that claims submitted to the Medicaid program are proper. When a provider determines that payments made to the provider were in excess of the amount due from the Medicaid program, the provider is obligated to return the improper amounts to the state. Providers should return the improper amounts to the Agency along with supporting information that will allow OIG/MPI to validate the overpayment amount. Examples and an explanation of the necessary supporting information are set forth in this protocol.
- b. **Amnesty programs.** The Agency recognizes that by conducting a self-audit, a Medicaid provider has more control over the parameters of the audit; also, the process is generally more educational for the provider, which results in a greater likelihood of future compliance and less opportunity for future overpayments and sanctions; the expense of the audit process is generally less for the provider who conducts a self-audit as opposed to when the Agency conducts the audit and investigative costs are recovered.

Furthermore, Section 409.913, F.S., obligates the Agency to impose a sanction on providers when the Agency has discovered certain specified violations of Medicaid laws, including the laws governing the provider's profession. These sanctions are imposed in accordance with Rule 59G-9.070, F.A.C. (Administrative Sanctions of Providers, Entities and Persons). Section 409.913, F.S., however, also authorizes the Agency to institute amnesty programs, wherein Medicaid providers may repay an overpayment without sanctions being imposed.

Therefore, pursuant to Section 409.913(25)(e), F.S., the Agency may provide opportunities for providers to conduct self audits. Providers will receive notice from the Agency of a specific matter to be addressed via the self audit, along with other pertinent audit parameters (time period for review, specific claims to review, etc.) and will be afforded a specified period of time in which to conduct the self audit. Providers who avail themselves of this opportunity within the timeframe afforded by the Agency will benefit from the amnesty provisions. Providers who do not avail themselves of this opportunity will be subject to audit by the Agency, and will be subject to sanctions that may follow as a result of violations discovered during the audit.

Additionally, self audits conducted on a voluntary basis, upon acceptance by the Agency, shall be included in an amnesty program pursuant to Section 409.913(25)(e), F.S.

2. Self Audit Submission.

In order to ensure that the Agency can validate the audit findings and properly document the overpayment as well as the provider's correction of the overpayment, the Agency needs the following information:

- a. Billing Provider information:
 - (1) Name;
 - (2) Address;
 - (3) Provider type;
 - (4) Provider identification number(s);
 - (5) Tax identification number(s);
 - (6) Name, address, and telephone number of the designated contact for the provider regarding the self audit.

- b. Claims information (for the claims reviewed):
 - (1) Date of Service;
 - (2) Type of Service (e.g., procedure code; units of service);
 - (3) Treating Provider;
 - (4) Recipient Name and ID number
 - (5) Internal control number (ICN);
 - (6) Description of the non-compliance¹;
 - (7) And any other information that would allow the Agency to verify the claim(s).

¹ Descriptions may include such issues as "services not rendered", "up-coding", "brand drugs for generics", "unqualified staff performing service", "incorrect dates of service", "incorrect recipient", "duplicate services", "unbundling", "services not documented", etc.

Self Audit submissions shall be directed to:

**Attn: Vicki Stiles
Agency for Health Care Administration
Medicaid Program Integrity, Medicaid Area Four
921 N. Davis Street, Building A, Suite #160
Jacksonville, FL 32209-6806**

3. Agency Verification

The extent of the Agency's verification effort will depend, in large part, upon the quality and thoroughness of the internal investigative and self-audit reports. During the self-audit process, providers may have questions and concerns; the Agency will work closely with providers to answer any questions that they may have. Providers or their representatives that have questions regarding this protocol may contact the provider self-audit coordinator, whose name and contact information is included in the letter that initiated the self-audit or was identified following the provider's notice of intent to submit a self audit.

Upon completion of the Agency's review of the self-audit, the audit will either be accepted or declined. Accepted audits will result in the issuance of a final agency action letter stating the amount of money to be repaid and providing repayment instructions.

Audits that are not accepted will be returned to the provider for corrections, with an explanation regarding why the audit could not be accepted.

Participation in a self audit does not eliminate the possibility of further review by the Agency and does not affect in any manner the Agency or other regulatory or law enforcement agencies ability to pursue criminal, civil, or administrative remedies.

Provider shall maintain copies of all self-audit information and documentation for future reference.

MGM Case Management Services, Inc - 017452900

	Provider ID	Rendering Provider Name	Amount identified as paid to Provider
1	019080100	YESSICA DELGADO	\$96,593.56
2	019684800	ADIS MORALES	\$76,650.72
3	017808200	MARIAM PINERO	\$64,216.92
4	019082500	SILVIA PUIG	\$55,488.88
5	020007400	GLENDA GARRIDO	\$53,002.12
6	020020800	YILIANA TORNA	\$51,539.32
7	018563800	KAMILA DIAZ	\$48,808.76
8	019652100	MAYELIN SANTANA	\$45,103.00
9	020426800	ELIANY HERNANDEZ MARTINEZ	\$43,701.15
10	019684700	IRINA BAVARESCO	\$40,239.19
11	018020700	BELKYS TAMARGO	\$37,642.72
12	020427400	ERIKA S CERPA VELAZQUEZ	\$37,106.36
13	020427900	YUNIA SAN ROMAN MORENO	\$34,595.22
14	020778000	MARITZA MARRERO	\$34,522.08
15	020576500	NATACHA CONCEPCION	\$34,375.80
16	020448300	YITSEL HERNANDEZ	\$30,475.00
17	020009200	YANELIS PANTOJA	\$28,913.98
18	019086200	CAMILA MANERO	\$27,963.86
19	019651300	ROSA E HERNANDEZ	\$27,525.02
20	020295400	SAHYLI ROJAS	\$25,720.90
21	019877500	VANESSA BALLESTER	\$21,052.13
22	021023500	MARILEY PADRON BRITO	\$20,137.88
23	020511200	ISIS GALAN GARCIA	\$17,968.06
24	021157400	REYNIER SANTOS DE ARMAS	\$17,553.60
25	021648900	ANA L BENITEZ	\$15,603.20
26	020792800	LOURDES ARIAS ANEIRO	\$14,542.67
27	020746500	YANITH SOLER VALDES	\$11,507.36
28	020911900	DAYANA ROJAS RAMOS	\$11,458.60
29	019683900	SAILEIXIS ROJAS VIZCAINO	\$10,288.36
30	020788600	SAIBELYS PEDRAZA VIZCAINO	\$8,386.72
31	020033000	CAROLINA PEREZ DEL SOL	\$3,839.85
32	021217600	ALBERTO FACHADO	\$1,316.52
			\$ 1,047,839.51

USPS Tracking®

[FAQs > \(http://faq.usps.com/?articleId=220900\)](http://faq.usps.com/?articleId=220900)[Track Another Package +](#)**EXHIBIT 2****Tracking Number:** 9489009000276030997040[Remove X](#)

Your item was delivered to the front desk or reception area at 1:09 pm on March 6, 2018 in HIALEAH, FL 33016.

Delivered

March 6, 2018 at 1:09 pm
Delivered, Front Desk/Reception
HIALEAH, FL 33016

[Get Updates](#) 

[Text & Email Updates](#)

[Tracking History](#)

[Product Information](#)

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Go to our [FAQs](#) section to find answers to your tracking questions.