

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Alachua County	achua County Health Department					Provider Number: 0279111-00				
224 SE 24th Str	eet730 N	N.E. Waldo Roa	d, Sui	ite 500			Date:	07/01/202	22	
Gainesville, FL	32641					Fiscal Year End: 06/30/2021				
							Audit Status:	Unaudited	d Cost	
<u>Provider Typ</u>	<u>)e</u>				Current	t Rate	New	Rate	Effective Date	
<u> </u>	<u>CHD</u>			-	164.	28	163	3.96	07/01/2022	
Rate Type	<u>nterim</u>				X	Prospec	tive			
_		Total Interim				Χ	Total P	rospective		
_		Settlement Bas	sed or	n Cost			Prospe	ctive Adjus	sted For New Costs	
		l	BAS	<u>IS:</u>						
				Budget						
		-	Х	Unaudited	Cost					
		-		Desk Revie	ewed Cost					
		-		Desk Audit	ted Cost					
		-		Field Audit	ed Cost					
DISTRIBUTION Fiscal Agen							F			
Contract Ma		ent					Rydell Samu	el. Admini	strator	

Rydell Samuel, Administrator Medicaid Program Finance

For Information Only (No Change In Rate)

Program Finance State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Alachua County	achua County Health Department					Provider Number: 0279111-93				
224 SE 24th St	reet730 l	N.E. Waldo Roa	ad, Si	uite 500			Date:	07/01/2022	2	
Gainesville, FL	32641					Fis	cal Year End:	06/30/2021		
							Audit Status:	Unaudited	Cost	
Provider Ty	<u>pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			-	164	.28	163	3.96	07/01/2022	
Rate Type										
ļ	<u>Interim</u>				Х	Prospec	<u>tive</u>			
		Total Interim				- x	Total P	rospective		
Settlement Based on Cost			Prospective Adjusted For		ed For New Costs					
			BAS	<u>SIS:</u>						
				Budget						
		-	Х	_ Unaudited	Cost					
		-		_ Desk Revi	ewed Cost					
		-		_ Desk Audi	ted Cost					
		-		- Field Audi	ted Cost					
		-		_						
DISTRIBUTION	<u>N:</u>						TR			
Fiscal Age	nt						1 N			
Contract M	lanageme	ent					Rydell Samu	el, Administ	rator	
Program Fi	inance						Medicaid Pro	ogram Finan	ice	

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(No Change In Rate)



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Medicaid Reimbursement Rate Change Form for CHDs

Baker County Hea	ker County Health Department					Provider Number: 0279129-00				
480 West Lowder	Street						Date:	07/01/2022		
Macclenny, FL 32	2063				F	Fiscal Y	ear End:	06/30/2021		
						Audi	t Status:	Unaudited (Cost	
Provider Type	<u>•</u>			<u>Curre</u>	nt Rate		New	Rate	Effective Date	
<u>CI</u>	HD			16	5.26		161	.06	07/01/2022	
Rate Type					_					
<u>Int</u>	<u>erim</u>	T . (.]] . (X	_		Talab			
		Total Interim				<	-	ospective		
		Settlement Base	ed on Cost				Prospe -	ctive Adjuste	ed For New Costs	
		B	ASIS:							
			Budget							
			X Unaudi	ted Cost						
			Desk R	eviewed Cos	st					
			 Desk A	udited Cost						
			Field A	udited Cost						
DISTRIBUTION:						-	R			
Fiscal Agent						f	V			
Contract Man	agemer	nt				Rvd	ell Samu	el, Administi	rator	
Program Fina	ance							gram Finan		

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford Coun	adford County Health Department					Provider Number: 0279145-00				
1801 North Te	mple Ave	nue					Date	07/01/202	22	
Starke, FL 320	091					Fis	cal Year End:	06/30/202	21	
							Audit Status:	Unaudited	d Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				165	.26	16;	3.96	07/01/2022	
<u>Rate Type</u>										
	Interim				X	Prospect	<u>tive</u>			
		Total Interim				- X	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs	
			BAS	SIS:						
				Budget						
			Х	_ Unaudited	l Cost					
				– Desk Revi	iewed Cost					
				– Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				_						
<u>DISTRIBUTIO</u>	<u>N:</u>						TR			
Fiscal Age	ent						PN .			
Contract N	Managemo	ent					Rydell Samu	uel, Adminis	strator	
Program F	inance						Medicaid Pro	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Departmen	ht	Provider Number: 0279145-04				
1801 North Temple Avenue		-	Date: 07/01/202	2		
Starke, FL 32091		- Fisca	I Year End: 06/30/202	1		
		- A	udit Status: Unaudited	Cost		
Provider Type	Curr	ent Rate	New Rate	Effective Date		
CHD	16	65.26	163.96	07/01/2022		
Rate Type						
<u>Interim</u>	>	Prospectiv	<u>'e</u>			
Total Inter	im	x	Total Prospective			
Settlemen	t Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed Co	ost				
	Desk Audited Cost					
	Field Audited Cost					
DISTRIBUTION:			IF			
Fiscal Agent			/ N			
Contract Management		R	ydell Samuel, Adminis	strator		
Program Finance		N	ledicaid Program Fina	nce		
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health D	epartment		Provider Number: 0279161-00				
780 SW 24th Street				Date:	07/01/2022		
Fort Lauderdale, FL 333	15		Fiscal Year End: 06/30/2021				
			Au	dit Status:	Unaudited Cos	st	
Provider Type		Curren	t Rate	New	Rate	Effective Date	
<u>CHD</u>		125	.03	163	.96	07/01/2022	
Rate Type							
Interim		X	Prospective	<u>)</u>			
	Total Interim		Х	Total Pr	ospective		
	Settlement Based on Cos	t		Prospec	ctive Adjusted F	For New Costs	
	BASIS:						
	Budg	jet					
	X Unau	idited Cost					
	Desk	Reviewed Cost					
	Desk	Audited Cost					
	Field	Audited Cost					
DISTRIBUTION:			-	TR			
Fiscal Agent				rv,			
Contract Managemer	nt		Ry	dell Samue	el, Administrato	or	
Program Finance			Me	edicaid Pro	gram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun County Health Departm	nent	Prov	Provider Number: 0279170-91				
19611 S.R. 20 West			Date: 07/01/202	2			
Blountstown, FL 32424		Fise	cal Year End: 06/30/202	1			
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		165.26	163.96	07/01/2022			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total I	nterim	X	Total Prospective				
Settler	nent Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	 Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			ſN				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

State Health Office



Office of Medicaid Program Finance

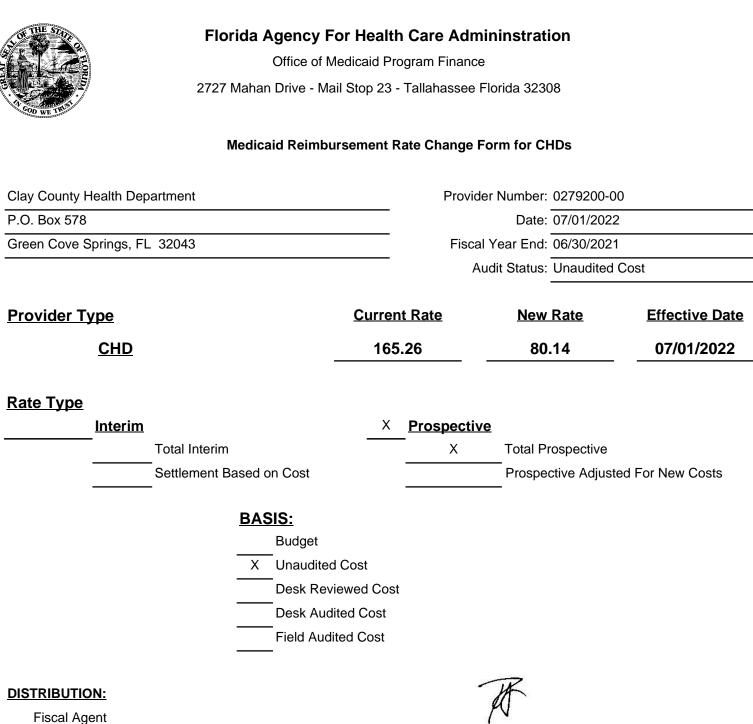
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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department	Prov	Provider Number: 0279196-00				
3700 Sovereign Path		Date: 07/01/202	22			
Lecanto, FL 34461-8071	Fis	cal Year End: 06/30/202	21			
		Audit Status: Unaudited	d Cost			
Provider Type	Current Rate	New Rate	Effective Date			
CHD	165.27	163.96	07/01/2022			
Rate Type						
Interim	X Prospect					
Total Interim	X	Total Prospective				
Settlement Based on Co		Prospective Adjus	sted For New Costs			
BASIS:						
Bud	lget					
X Una	audited Cost					
Des	k Reviewed Cost					
Des	k Audited Cost					
Field	d Audited Cost					
DISTRIBUTION:		TR				
Fiscal Agent		PU				
Contract Management		Rydell Samuel, Adminis	strator			
Program Finance		Medicaid Program Fina				

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Contract Management

Program Finance

State Health Office

Rydell Samuel, Administrator Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Departme	ent		Provider Number: 0279218-00				
P.O. Box 429			Date: 07/01/202	22			
Naples, FL 34106-0429			Fiscal Year End: 06/30/202	21			
			Audit Status: Unaudited Cost				
Provider Type		Current Rate	Rate <u>New Rate</u> Effec				
CHD	_	165.26	163.96	07/01/2022			
Rate Type							
<u>Interim</u>		X <u>Pros</u>	<u>pective</u>				
Total I	nterim		X Total Prospective				
Settler	nent Based on Cost		Prospective Adjus	sted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audite	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			R				
Fiscal Agent			PU				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	ince			
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Columbia Cou	lumbia County Health Department					Provider Number: 0279226-00				
217 North Eas	st Franklin S	Street					Date	07/01/202	2	
Lake City, FL	32055					Fise	cal Year End	06/30/202	1	
							Audit Status	Unaudited	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				165	.27	16	3.96	07/01/2022	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost			Prospective Adjusted Fo		ted For New Costs					
			BAS	<u>SIS:</u>						
				Budget						
			X	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Aud	ited Cost					
				- Field Audi	ted Cost					
				_						
DISTRIBUTIO							TR			
Fiscal Age							/ N			
	Manageme	nt					Rydell Samu			
Program	Finance						Medicaid Pro	ogram Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Department		Prov	Provider Number: 0279234-00				
1350 N.W. 14th Street			Date: 07/01/202	2			
Miami, FL 33125		Fisc	al Year End: 06/30/202	21			
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	165.26	163.96	07/01/2022			
Rate Type							
<u>Interim</u>		X Prospect	<u>ive</u>				
Total Inter	im	X	Total Prospective				
Settlemen	t Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲۷ ا				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Dep	partment	Prov	Provider Number: 0279242-00				
34 South Baldwin Avenue			Date: 07/01/202	22			
Arcadia, FL 33821		Fiso	Fiscal Year End: 06/30/2021				
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		121.40	123.69	07/01/2022			
Rate Type							
<u>Interim</u>		X Prospect	ive				
То	otal Interim	X	Total Prospective				
S	ettlement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	l Cost					
	Desk Revi	iewed Cost					
	Desk Audi	ited Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			R				
Fiscal Agent			(N				
Contract Management	:		Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Dixie County Health Departme		Provider Number: 0279251-00			
149 NE 241ST			Date: 07/01/2022	2	
Cross City, FL 32628		Fiscal Yea	r End: 06/30/202	1	
			Audit S	Status: Unaudited	Cost
Provider Type		Current Rate	2	New Rate	Effective Date
<u>CHD</u>	-	165.26		163.96	07/01/2022
Rate Type					
<u>Interim</u>		X <u>Pros</u>	pective		
Total	l Interim		х т	otal Prospective	
Settle	ement Based on Cost		F	Prospective Adjust	ed For New Costs
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ed Cost			
	Field Audite	ed Cost			
DISTRIBUTION:			H	Z	
Fiscal Agent			M		
Contract Management			Rydell	Samuel, Adminis	trator
Program Finance				aid Program Finar	
State Health Office					



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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	Prov	ider Number: 0279269-0	00	
515 West Sixth Street		Date: 07/01/202	: 07/01/2022	
Jacksonville, FL 32206	 Fisc	al Year End: 06/30/202	1	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	_	165.26	163.96	07/01/2022
Rate Type				
Interim		X Prospect	ive	
Total	Interim	X	Total Prospective	
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	ewed Cost		
	Desk Audite	ed Cost		
	Field Audite	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

State Health Office

For Information Only

(No Change In Rate)



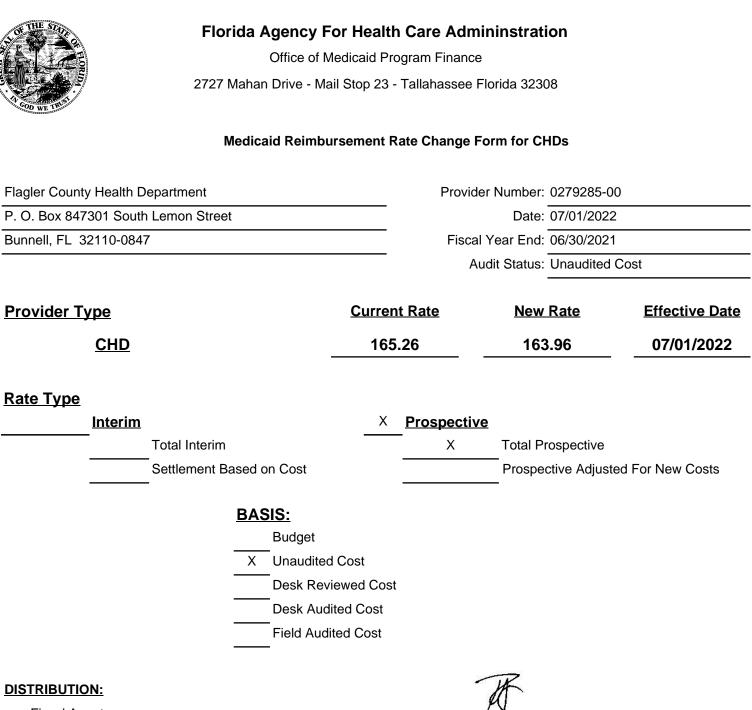
Office of Medicaid Program Finance

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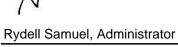
Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department	t	Prov	vider Number: 0279269-	43
515 West Sixth Street			Date: 07/01/202	2
Jacksonville, FL 32206	Fis	cal Year End: 06/30/202	21	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	165.26	163.96	07/01/2022
Rate Type				
<u>Interim</u>		X Prospect		
Total In		X	Total Prospective	
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			T	
Fiscal Agent			1	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Fina	nce

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- Fiscal Agent Contract Management Program Finance
- State Health Office



Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Department		Provider	Number:	0279293-00	
139 12th Street		Date:		: 07/01/2022	
Apalachicola, FL 32320		Fiscal Y	ear End:	06/30/2021	
		Auc	lit Status:	Unaudited Cos	st
Provider Type	Current	Rate	New	Rate	Effective Date
<u>CHD</u>	165.	27	163	.96	07/01/2022
Rate Type Interim	х	Prospective			
Total Interim		X	Total Pr	ospective	
Settlement Based on Cost			_	ctive Adjusted F	For New Costs
BASIS: Budget X Unaudited Composition Desk Reviewer Desk Audited Field Audited	ed Cost Cost		_		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance				el, Administrato gram Finance	or

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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department P. O. Box 1000 Quincy, FL 32353-1000			Provide	r Number:	0279307-00	
			Date:		: 07/01/2022	
			Fiscal	Year End:	06/30/2021	
			Au	dit Status:	Unaudited Cos	st
Provider Type	<u>C</u>	Curren	t Rate	New	Rate	Effective Date
CHD		146.	.96	163	8.96	07/01/2022
Rate Type						
<u>Interim</u>		Х	Prospective	<u>)</u>		
Total Interim			Х	Total P	ospective	
Settlement Ba	used on Cost			Prospe	ctive Adjusted I	For New Costs
	BASIS:					
	Budget					
	X Unaudited Cos	st				
	 Desk Reviewe	d Cost				
	Desk Audited	Cost				
	Field Audited (Cost				
DISTRIBUTION:			~	TR		
Fiscal Agent				pl]		
Contract Management			D		ol Adminiatrati	~
Program Finance					el, Administrato	
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Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Departme	Prov	ider Number: 0279315-0	00	
119 N.E. First Street		Date: 07/01/202	: 07/01/2022	
Trenton, FL 32693-3459	Fisc	cal Year End: 06/30/202	1	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	165.26	163.96	07/01/2022
Rate Type				
Interim		X Prospect	ive	
Total Int	erim	X	Total Prospective	
Settlement Based on Cost			Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			7	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Department					Prov	/ider Number:	0279323-0	00
P. O. Box 489					Date:		: 07/01/2022	
Moore Haven, FL 33471					Fis	cal Year End:	06/30/202	21
						Audit Status:	Unaudited	d Cost
Provider Type				<u>Curren</u>	t Rate	New	Rate	Effective Date
CHE	<u>)</u>		-	165	.26	93	.32	07/01/2022
Rate Type								
Inter	<u>im</u>			Х	Prospect	<u>tive</u>		
	Total Interim				- x	Total P	rospective	
	Settlement B	ased or	n Cost			Prospe	ctive Adjus	ted For New Costs
		BAS	<u>IS:</u>					
			Budget					
		X	Unaudited	Cost				
			Desk Revi	ewed Cost				
			Desk Audi	ted Cost				
			Field Audit	ted Cost				
DISTRIBUTION:						TR		
Fiscal Agent						γv		
Contract Manag	ement					Rydell Samu	iel, Adminis	strator
Program Financ	e					Medicaid Pro	ogram Fina	ince

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(No Change In Rate)

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Prov	ider Number: 0279331-	00	
2475 Garrison Avenue		Date: 07/01/202	: 07/01/2022	
Port St. Joe, FL 32456-5265	Fiso	cal Year End: 06/30/202	21	
		Audit Status: Unaudited	d Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	165.26	163.96	07/01/2022	
Rate Type				
Interim	X Prospect	ive		
Total Interim	X	Total Prospective		
Settlement Based on Cost		Prospective Adjus	sted For New Costs	
BASIS:				
Budget				
X Unaudit	ed Cost			
Desk Re	eviewed Cost			
Desk Au	udited Cost			
Field Au	udited Cost			
DISTRIBUTION: Fiscal Agent		T		
Contract Management		Rydell Samuel, Adminis	strator	
Program Finance		Medicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Depart	Provider Number: 0279331-07				
2475 Garrison Avenue			Date: 07/01/2022		
Port St. Joe, FL 32456-52	Fiscal Y	'ear End: 06/30/202'	1		
			Aud	it Status: Unaudited	Cost
Provider Type		Curren	t Rate	New Rate	Effective Date
<u>CHD</u>		165.	.26	163.96	07/01/2022
Rate Type					
<u>Interim</u>		Х	Prospective		
Te	otal Interim		×	Total Prospective	
Settlement Based on Cost				ted For New Costs	
				_	
	BASIS:				
	Budget	t			
	X Unaudi	ited Cost			
	Desk R	Reviewed Cost			
	Desk A	Audited Cost			
	Field A	udited Cost			
DISTRIBUTION:			-	R	
Fiscal Agent			1	W.	
Contract Management	t		Rvc	lell Samuel, Adminis	trator
Program Finance				dicaid Program Finar	
State Health Office					



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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Departme	Prov	ider Number: 0279340-0	00		
P. O. Box 267			Date: 07/01/202	: 07/01/2022	
Jasper, FL 32052	Fisc	al Year End: 06/30/202	21		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	165.26	163.96	07/01/2022	
Rate Type					
Interim		X Prospect	<u>ive</u>		
Total Inte	erim	X	Total Prospective		
Settlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ed Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			7 N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Department 115 K.D. Revell Road Wauchula, FL 33873						Prov	vider Numbe	r: 0279358-	-00
				Date: 07/0		e: 07/01/202	22		
				Fis	cal Year En	d: 06/30/202	21		
							Audit Statu	s: Unaudite	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	Ne	w Rate	Effective Date
	<u>CHD</u>				165	.26	1	63.96	07/01/2022
Rate Type					X	_			
	_ <u>Interim</u> _	-			X	_ <u>Prospec</u>			
		Total Interim		_		Χ		Prospective	
		Settlement Ba	ised oi	n Cost			Prosp	ective Adju	sted For New Costs
			BAS	SIS:					
				Budget					
			Х	Unaudited	Cost				
				Desk Revi	iewed Cost				
				Desk Audi	ited Cost				
				Field Audi	ted Cost				
				-					
DISTRIBUTIO	<u>DN:</u>						TR		
Fiscal Ag	ent						M		
Contract	Managem	ent					Rydell San	nuel, Admini	strator
Program	Finance							rogram Fina	

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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Department	Prov	ider Number: 0279366-	00	
P. O. Box 70		Date: 07/01/202	: 07/01/2022	
LaBelle, FL 33975	Fise	cal Year End: 06/30/202	21	
		Audit Status: Unaudited	d Cost	
Provider Type	Current Rate	New Rate	Effective Date	
<u>CHD</u>	165.26	163.96	07/01/2022	
Rate Type				
Interim	X Prospect	ive		
Total Interim	x	Total Prospective		
Settlement Based on Cost		Prospective Adjus	sted For New Costs	
BASIS:				
Budge	ət			
X Unauc	lited Cost			
Desk I	Reviewed Cost			
Desk /	Audited Cost			
Field A	Audited Cost			
DISTRIBUTION:		TR		
Fiscal Agent		r v		
Contract Management		Rydell Samuel, Admini	strator	
Program Finance		Medicaid Program Fina	ance	

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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Hea	alth Department			Provide	er Number:	0279374-00	
300 S. Main St.			Date:	07/01/2022			
Brooksville, FL 3460		Fiscal Year End: 06/30/2021					
				A	udit Status:	Unaudited Co	st
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date
<u>CHD</u>			165.2	26	163	.96	07/01/2022
Rate Type							
<u>Interii</u>	<u>n</u>		<u> </u>	Prospectiv	<u>e</u>		
	Total Interim			Х	Total Pre	ospective	
	Settlement Ba	sed on Cost			Prospec	tive Adjusted	For New Costs
		BASIS:					
		Budget					
	-	X Unaudited	d Cost				
	-	Desk Rev	iewed Cost				
	-	Desk Aud	ited Cost				
	-	Field Audi	ited Cost				
	-						
DISTRIBUTION:				-	TR		
Fiscal Agent					M		
Contract Manage	ement			R	ydell Samue	el, Administrat	or
Program Finance		N	ledicaid Pro	gram Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Hea	Ith Department			Provide	er Number:	0279374-91	
300 S. Main St.	Date: 07/01/2022						
Brooksville, FL 34601			Fiscal	Year End:	06/30/2021		
			Αι	udit Status:	Unaudited C	ost	
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>			165	.26	163	8.96	07/01/2022
Rate Type							
Interin	<u>1</u>		Х	Prospective	<u>e</u>		
	Total Interim			- x	Total P	rospective	
Settlement Based on Cost					Prospe	ctive Adjusted	For New Costs
		BASIS:					
		Budget					
	-	X Unaudited	Cost				
	-	Desk Revi	ewed Cost				
	-	Desk Audi	ted Cost				
	-	Field Audi	ted Cost				
DISTRIBUTION:				-	IK		
Fiscal Agent					74		
Contract Manager	ment			R	ydell Samu	el, Administra	itor
Program Finance				М	edicaid Pro	gram Finance	e
State Health Offic	е						



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Medicaid Reimbursement Rate Change Form for CHDs

Highlands County Health Departm	ient	Prov	ider Number: 0279382-0	00	
7205 South George Boulevard			Date: 07/01/202	07/01/2022	
Sebring, FL 33872		Fisc	al Year End: 06/30/202	1	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	162.89	163.96	07/01/2022	
Rate Type					
Interim		X Prospect	ive		
Total Inte	erim	X	Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audit	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			۲ ۷		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health	Department	Provi	der Number: 0279412-0	00	
1900 27th Street			Date: 07/01/202	2	
Vero Beach, FL 32960		Fisc	Fiscal Year End: 06/30/2021		
			Audit Status: Unaudited	Cost	
Provider Type	Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	165.26	163.96	07/01/2022	
Rate Type					
<u>Interim</u>		X <u>Prospecti</u>	ve		
Tot	al Interim	X	Total Prospective		
Set	tlement Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			rv,		
Contract Management		_	Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River C	County Hea	Ith Department			Prov	ider Number:	0279412-9	1
1900 27th Street					Date: 07/01/2022			2
Vero Beach, FL 32960					Fisc	al Year End	06/30/2021	1
						Audit Status	Unaudited	Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			165	.26	16	3.96	07/01/2022
Rate Type								
	Interim			X	Prospect	ive		
		Total Interim			X	Total P	rospective	
		Settlement Base	ed on Cost			Prospe	ctive Adjust	ed For New Costs
		<u>B</u>	ASIS:					
			Budget					
			X Unaudited	d Cost				
			Desk Rev	iewed Cost				
		_	Desk Aud	ited Cost				
			Field Aud	ited Cost				
DISTRIBUTIC	<u>DN:</u>					TR		
Fiscal Ag	ent					7N		
Contract	Manageme	ent				Rydell Samu	uel, Administ	trator
Program	Finance					Medicaid Pro	ogram Finar	nce

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River C	ounty Hea	Ith Department			Provid	der Number:	0279412-	92
1900 27th Street						Date	07/01/202	22
Vero Beach, FL 32960					Fisca	al Year End:	06/30/202	21
					P	Audit Status:	Unaudited	d Cost
Provider Ty	<u>/pe</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			165	.26	16	3.96	07/01/2022
Rate Type								
	Interim			X	Prospectiv			
		Total Interim			Χ	Total P	rospective	
		Settlement Based	on Cost			Prospe	ctive Adjus	ted For New Costs
		BA	SIS:					
			Budget					
		X	Unaudited	d Cost				
			 Desk Rev	iewed Cost				
			Desk Aud	ited Cost				
			Field Audi	ited Cost				
DISTRIBUTIO	N·					R		
Fiscal Age						p()		
Contract N		ant			r		ol Adminis	strator
						Rydell Samu Medicaid Pro		
Program Finance					I		giuni ina	

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Depart	ment	Provi	der Number: 0279421-0	00	
P. O. Box 310			Date: 07/01/202	2	
Marianna, FL 32447		Fisc	Fiscal Year End: 06/30/2021		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		165.26	163.96	07/01/2022	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total	Interim	X	Total Prospective		
Settle	ment Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	l Cost			
	Desk Rev	iewed Cost			
	Desk Aud	ited Cost			
	Field Audi	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			rv,		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

State Health Office

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson Cou	inty Health	Department				Prov	vider Number	: 0279439-	-00
1255 W. Washington Street							Date	: 07/01/202	22
Monticello, FL 32344						Fiscal Year End: 06/30/2021			
							Audit Status	: Unaudite	d Cost
Provider T	<u>ype</u>				<u>Currer</u>	nt Rate	New	<u> Rate</u>	Effective Date
	<u>CHD</u>				165	.26	16	3.96	07/01/2022
Rate Type									
	Interim				Х	Prospec	tive		
	-	Total Interim				X	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ective Adju	sted For New Costs
			BAS	<u>SIS:</u>					
				Budget					
			Х	Unaudited	d Cost				
				_ Desk Rev	iewed Cost	t			
				_ Desk Aud	ited Cost				
				– Field Audi	ited Cost				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						γv		
Contract	Managem	ent					Rydell Samu	uel, Admini	strator
Program Finance							Medicaid Pr	ogram Fina	ance

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Medicaid Reimbursement Rate Change Form for CHDs

Lee County Health Department 3920 Michigan Avenue Fort Myers, FL 33916						Provide	er Number:	0279463-0	0
						Date: 07/01/2022			2
						Fiscal	Year End:	06/30/2021	
						Αι	udit Status:	Unaudited	Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				165	.27	163	3.96	07/01/2022
Rate Type									
	<u>Interim</u>				Х	Prospective	<u>e</u>		
		Total Interim				- X	Total P	rospective	
		Settlement B	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs
			BAS	SIS:					
				Budget					
			Х	– Unaudited	d Cost				
				_ Desk Rev	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ited Cost				
				_					
DISTRIBUTIO							T		
Fiscal Age							/ 1		
Contract N	-	ent						el, Administ	
Program F	Finance					M	edicaid Pro	ogram Finan	се

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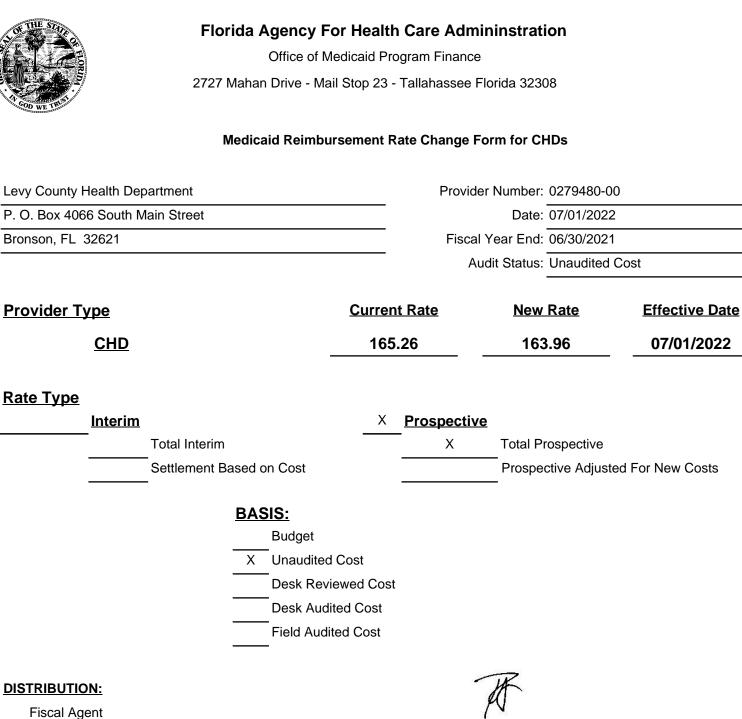
Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Department		Prov	ider Number: 0279471-0	00		
2965 Municipal Way			Date: 07/01/202	07/01/2022		
Tallahassee, FL 32304		Fisc	Fiscal Year End: 06/30/2021			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		156.94	163.96	07/01/2022		
Rate Type						
Interim		X Prospect	ive			
Total In	terim	X	Total Prospective			
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	d Cost				
	Desk Rev	iewed Cost				
	Desk Aud	ited Cost				
	Field Audi	ited Cost				
DISTRIBUTION:			TR			
Fiscal Agent			[N]			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina	nce		

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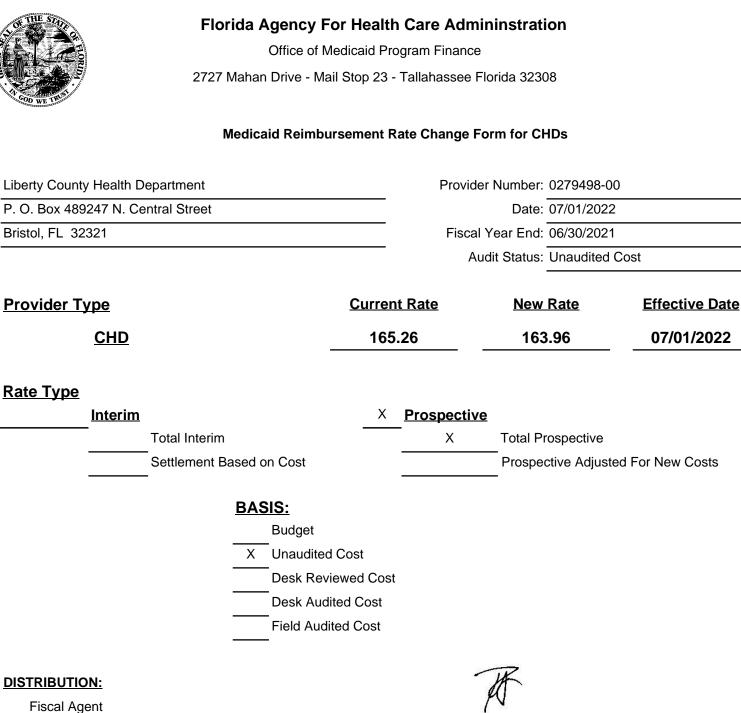


Contract Management Program Finance

State Health Office

Rydell Samuel, Administrator

Medicaid Program Finance



Contract Management Program Finance

State Health Office

Rydell Samuel, Administrator Medicaid Program Finance



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County H	anatee County Health Department					Provider Number: 0279510-00				
410 Six Avenue E	ast					Date: 0		07/01/202	07/01/2022	
Bradenton, FL 34	208					Fiscal Year End: 06/30/2021			21	
							Audit Status:	Unaudited	d Cost	
Provider Type	<u>)</u>				<u>Curren</u>	it Rate	New	Rate	Effective Date	
<u>CI</u>	HD				126	.36	132	2.41	07/01/2022	
Rate Type										
Int	<u>erim</u>				Х	Prospec	<u>tive</u>			
		Total Interim				- x	Total P	rospective		
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	- Unaudited	Cost					
				- Desk Revi	iewed Cost					
				- Desk Aud	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTION:							TR			
Fiscal Agent							rv,			
Contract Man	ageme	ent					Rydell Samu	uel, Adminis	strator	
Program Fina	ance						Medicaid Pro	ogram Fina	ince	

State Health Office



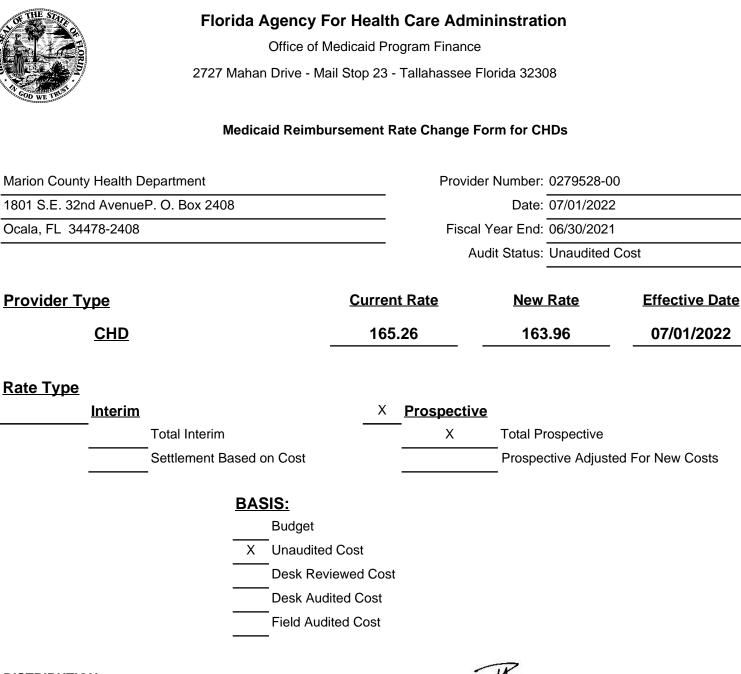
Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee Cou	anatee County Health Department					Provider Number: 0279510-01				
410 Six Avenu	ue East						Date	07/01/202	22	
Bradenton, FL	34208					Fiscal Year End: 06/30/2021			21	
							Audit Status:	Unaudited	d Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	it Rate	New	Rate	Effective Date	
	<u>CHD</u>				126	.36	132	2.41	07/01/2022	
Rate Type	last o nivos				v	Ducanaa	11. c			
	Interim	Total Interim			X	_ <u>Prospect</u> X		rospective		
		- Settlement Bas	cod c	n Cost				•	sted For New Costs	
		-	seu c	II COSI			F105pe	clive Aujus	Sied FOI New Cosis	
			BAS	SIS:						
				Budget						
		-	Х	Unaudited	l Cost					
		-		- Desk Revi	iewed Cost					
		-		Desk Audi	ited Cost					
		-		Field Audi	ted Cost					
		-		-						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						M			
Contract	Managem	ent					Rydell Samu	iel, Adminis	strator	
Program	Finance						Medicaid Pro	ogram Fina	ance	

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DISTRIBUTION:

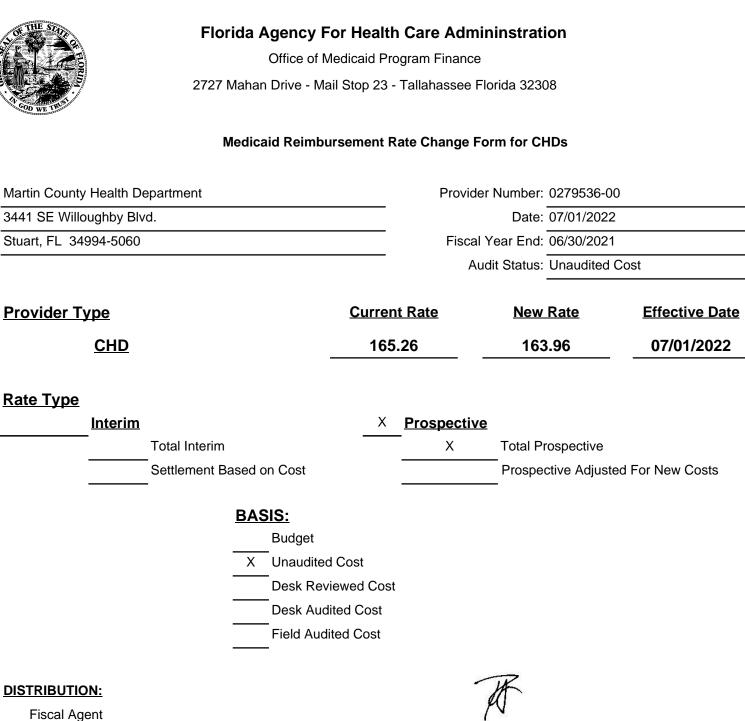
- **Fiscal Agent Contract Management**
- **Program Finance**

State Health Office

Rydell Samuel, Administrator Medicaid Program Finance

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07/01/2022



Contract Management

Program Finance

State Health Office

Rydell Samuel, Administrator Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Monroe Coun	onroe County Health Department					Provider Number: 0279544-00			
5100 College	Road					Date: 07/01/2022 Fiscal Year End: 06/30/2021		: 07/01/2022	
Key West, FL	33040							1	
							Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				165	.26	16;	3.96	07/01/2022
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	-	Total Interim				x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs
			BAS	SIS:					
				Budget					
			X	Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						[N]		
Contract	Managem	ent					Rydell Samu	el, Adminis	trator
Program	Finance						Medicaid Pro	ogram Finar	nce

State Health Office



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Medicaid Reimbursement Rate Change Form for CHDs

Monroe Count	onroe County Health Department					Provider Number: 0279544-93				
5100 College	Road					Date:		: 07/01/2022		
Key West, FL	33040					Fiscal Year End: 06/30/2021			1	
							Audit Status:	Unaudited	Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				165	.26	16:	3.96	07/01/2022	
Rate Type										
	<u>Interim</u>				Х	Prospect	<u>tive</u>			
	•	Total Interim				- x	Total P	rospective		
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	- Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>N:</u>						TR			
Fiscal Age	ent						7V			
Contract N	Managemo	ent					Rydell Samu	iel, Adminis	strator	
Program I	Finance						Medicaid Pro	ogram Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department	assau County Health Department				Provider Number: 0279552-00				
P. O. Box 517				Date: 07/01/2022	2				
Fernandina Beach, FL 32035-0517			Fiscal Year End: 06/30/2021						
			Aud	Audit Status: Unaudited Cost					
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date				
CHD	-	113	.06	162.12	07/01/2022				
Rate Type									
Interim		Х	Prospective						
Total Interin	n		- X	Total Prospective					
Settlement	Based on Cost			Prospective Adjust	ted For New Costs				
				_					
	BASIS:								
	Budget								
	X Unaudited	Cost							
	Desk Revi	ewed Cost							
	Desk Audi	ted Cost							
	Field Audit	ted Cost							
DISTRIBUTION:			-	R					
Fiscal Agent			1	N .					
Contract Management			Ryc	lell Samuel, Adminis	trator				
Program Finance			Med	dicaid Program Finar	nce				
State Health Office									



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Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health Depa	artment	Prov	Provider Number: 0279561-00			
221 Hospital Drive, N.E.			Date: 07/01/202	: 07/01/2022		
Ft. Walton Beach, FL 32548		Fise	Fiscal Year End: 06/30/2021			
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		165.26	163.96	07/01/2022		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Tota	l Interim	X	Total Prospective			
Settlement Based on Cost			Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	d Cost				
	Desk Rev	iewed Cost				
	Desk Aud	lited Cost				
	Field Aud	ited Cost				
DISTRIBUTION:			TR			
Fiscal Agent			r v			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Dep	artment	Prov	Provider Number: 0279579-00			
P.O. Box 18791728 N.W. 9th Ave	enue		Date: 07/01/202	07/01/2022		
Okeechobee , FL 34973-1879		Fiso	Fiscal Year End: 06/30/2021			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		104.70	108.04	07/01/2022		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total In	terim	X	Total Prospective			
Settlement Based on Cost			Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Rev	iewed Cost				
	Desk Aud	ited Cost				
	Field Audi	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			ſN			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

State Health Office



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Medicaid Reimbursement Rate Change Form for CHDs

Orange County Health Depar	rtment	Provi	Provider Number: 0279587-00				
6101 Lake Ellenor Drive			Date: 07/01/202	: 07/01/2022			
Orlando, FL 32804		Fisc	al Year End: 06/30/202	1			
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	165.27	163.96	07/01/2022			
Rate Type							
<u>Interim</u>		X Prospect	ve				
Tota	al Interim	X	Total Prospective				
Sett	lement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			rv,				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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(No Change In Rate)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola Cour	sceola County Health Department					Provider Number: 0279595-00			
P. O. Box 450	3091875 E	Boggy Creek R	load				Date:	: 07/01/2022	
Kissimmee, F	L 34745-0	309				Fiscal Year End: 06/30/2021			
							Audit Status:	Unaudited (Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				165	.26	134	4.81	07/01/2022
Rate Type									
	Interim				Х	Prospec	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cost			Prospe		ctive Adjuste	ed For New Costs			
			BAS	SIS:					
				Budget					
			Х	_ Unaudited	l Cost				
				– Desk Revi	iewed Cost				
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				_					
DISTRIBUTIC	<u>)N:</u>						TR		
Fiscal Ag	ent						^N		
Contract I	Manageme	ent					Rydell Samu	iel, Administr	ator
Program	Finance						Medicaid Pro	ogram Financ	ce

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Departmen	ıt	Provi	Provider Number: 0279617-00				
10841 Little Road			Date: 07/01/202	07/01/2022			
New Port Richey, FL 34654		Fisc	Fiscal Year End: 06/30/2021				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		165.26	163.96	07/01/2022			
Rate Type		X Prospecti					
<u>Interim</u> Total In	terim	X Prospecti X	Total Prospective				
	ent Based on Cost			ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			PV				
Contract Management		_	Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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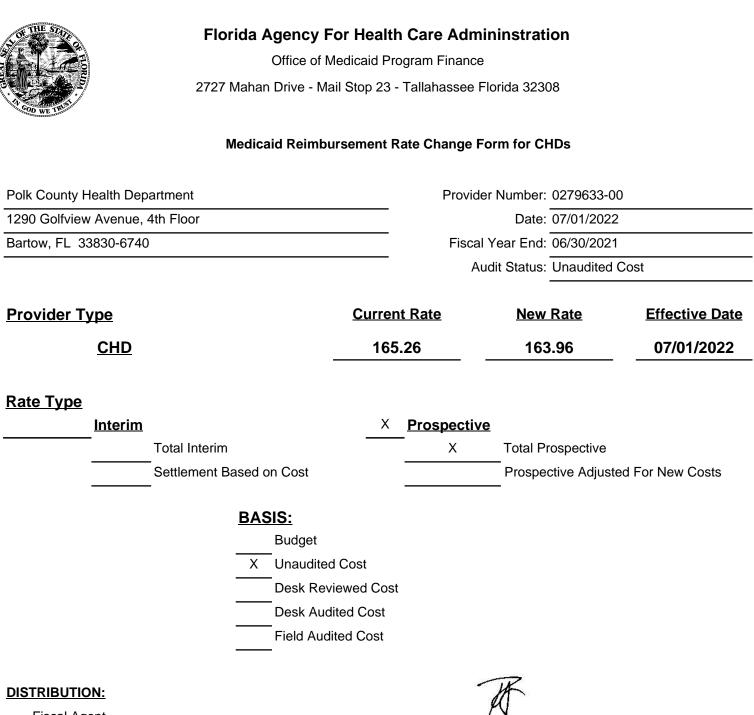
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Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County Health Depart	tment	Prov	Provider Number: 0279625-00				
500 7th Avenue South			Date: 07/01/202	: 07/01/2022			
St. Petersburg, FL 33701		 Fisc	Fiscal Year End: 06/30/2021				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		165.26	163.96	07/01/2022			
Rate Type							
<u>Interim</u>		X Prospect	<u>ive</u>				
Total	Interim	X	Total Prospective				
Settlement Based on Co			Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	l Cost					
	Desk Revi	iewed Cost					
	Desk Audi	ited Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			7 N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Fiscal Agent Contract Management Program Finance

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Rydell Samuel, Administrator

Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Depart	tment	Provi	Provider Number: 0279641-00				
2801 Kennedy Street			Date: 07/01/202	: 07/01/2022			
Palatka, FL 32177		Fisc	Fiscal Year End: 06/30/2021				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		165.27	163.96	07/01/2022			
Rate Type							
Interim		X Prospect	ive				
Total	Interim	X	Total Prospective				
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	l Cost					
	Desk Rev	iewed Cost					
	Desk Aud	ited Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

St. Johns Cou	. Johns County Health Department					Provider Number: 0279650-00				
1955 US 1 So	uth							Date:	07/01/2022	
St. Augustine,	FL 32086	6				Fiscal Year End: 06/30/2021				
							Audit	Status:	Unaudited C	ost
Provider Ty	<u>/pe</u>				<u>Currer</u>	nt Rate		New	<u>Rate</u>	Effective Date
	<u>CHD</u>				165	.26		163	.96	07/01/2022
Rate Type							_			
	Interim	-			X	- Prospec	<u>ctive</u>	T () D		
		Total Interim		_		Χ			ospective	
		Settlement Ba	ised c	on Cost				Prospec	ctive Adjusted	d For New Costs
			BAS	SIS:						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost	t				
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>N:</u>						1	R		
Fiscal Age	ent						p	V		
Contract N	Manageme	ent					Ryde	ell Samue	el, Administra	ator
Program F	-inance								gram Financ	

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Healt	. Lucie County Health Department				Provider Number: 0279668-00				
5150 NW Milner Drive					Date:	07/01/2022			
Port Saint Lucie, FL 3	4963			Fiscal Year End: 06/30/2021					
					Audit Status:	Unaudited C	Cost		
Provider Type			<u>Curren</u>	Current Rate No.		<u>Rate</u>	Effective Date		
<u>CHD</u>			165	.26	163	8.96	07/01/2022		
Rate Type									
Interin	<u>n</u>		Х	Prospecti	ve				
	Total Interim			- X	Total P	rospective			
	Settlement Base	ed on Cost			Prospe	ctive Adjuste	d For New Costs		
	B	ASIS:							
		Budget							
		X Unaudited	d Cost						
		Desk Rev	viewed Cost						
		Desk Aud	lited Cost						
		Field Aud	ited Cost						
DISTRIBUTION:					TR				
Fiscal Agent					74				
Contract Manager	ment			_	Rydell Samu	el, Administra	ator		
Program Finance				_	Medicaid Pro	gram Financ	e		

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	anta Rosa County Health Department					Pro	vider Number:	0279676-0	00	
P.O. Box 929							Date	07/01/202	2	
Milton, FL 32	572-0929					Fiscal Year End: 06/30/2021				
							Audit Status:	Unaudited	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				152	.71	163	3.96	07/01/2022	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs	
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				Budget						
			X	– Unaudited	d Cost					
				– Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						71			
Contract	Managem	ent					Rydell Samu	iel, Adminis	strator	
Program	Finance						Medicaid Pro	ogram Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health	arasota County Health Department					Provider Number: 0279684-00				
P. O. Box 2658					Date:	07/01/2022				
Sarasota, FL 34230-26	58			Fiscal Year End: 06/30/2021						
					Audit Status:	Unaudited (Cost			
Provider Type		<u>(</u>	Curren	t Rate	New	Rate	Effective Date			
<u>CHD</u>			165	.26	163	3.96	07/01/2022			
Rate Type			х	Dreeneet						
<u>Interim</u>	Total Interim			_ <u>Prospecti</u> X		rospective				
	_ Settlement Based o	on Cost		X		-	ed For New Costs			
	-	10031			i iospe					
	BAS	SIS:								
		Budget								
	X	Unaudited Co	st							
		Desk Reviewe	ed Cost							
		Desk Audited	Cost							
		Field Audited	Cost							
		-								
DISTRIBUTION:					TR					
Fiscal Agent					M					
Contract Manageme	ent				Rydell Samu	iel, Administr	ator			
Program Finance				-	Medicaid Pro	ogram Finano	ce			

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Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Hea	eminole County Health Department					0279692-00		
400 West Airport Bou	levard				Date:	07/01/2022		
Sanford, FL 32773				Fiscal Year End: 06/30/2021				
				Au	dit Status:	Unaudited Co	st	
Provider Type Cu			Current R	<u>ate</u>	New I	Rate	Effective Date	
<u>CHD</u>			165.26	;	163.	.96	07/01/2022	
Rate Type								
Interi	<u>m</u>		Х <u>Р</u>	rospective	2			
	Total Interim			Х	Total Pro	ospective		
	Settlement Ba	ased on Cost	_		Prospec	tive Adjusted	For New Costs	
		BASIS:						
		Budget						
		X Unaudited	d Cost					
		Desk Rev	viewed Cost					
		Desk Aud	lited Cost					
		Field Aud	ited Cost					
DISTRIBUTION:				-	TR			
Fiscal Agent					r v			
Contract Manage	ement			Ry	dell Samue	el, Administrato	or	
Program Finance	9			Me	edicaid Prog	gram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health Departmen	t	Provider Number: 0279706-01				
P. O. Box 98			Date: 07/01/202	2		
Bushnell, FL 33513		Fiscal Y	/ear End: 06/30/202	1		
		Auc	lit Status: Unaudited	Cost		
Provider Type	Curre	nt Rate	Rate <u>New Rate</u> Effect			
CHD	165	5.26 _	163.96	07/01/2022		
Rate Type						
Interim	Х	Prospective				
Total Inte	erim	— x	Total Prospective			
Settleme	nt Based on Cost		Prospective Adjust	ted For New Costs		
			_			
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed Cos	it				
	Desk Audited Cost					
	Field Audited Cost					
DISTRIBUTION:		-	R			
Fiscal Agent		1	ev.			
Contract Management		Ryc	dell Samuel, Adminis	trator		
Program Finance			dicaid Program Finar			
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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County	aylor County Health Department					Prov	vider Numbe	er: 0279722-	-01	
1215 Peacock	< Street						Dat	e: 07/01/202	22	
Perry, FL 323	347					Fiscal Year End: 06/30/2021				
							Audit Statu	s: Unaudite	d Cost	
Provider Ty	Provider Type		<u>Curren</u>	t Rate	Ne	w Rate	Effective Date			
	<u>CHD</u>				165	.26	1	63.96	07/01/2022	
Rate Type	Intorim				х	Broonoo	tivo			
	Interim	Total Interim				-Prospec X		Prospective		
		- Settlement Ba	sed o	n Cost		X		•	sted For New Costs	
		-	360 0	11 0031						
			BAS	IS:						
				Budget						
		-	Х	Unaudited	Cost					
		-		Desk Revi	ewed Cost					
		-		Desk Audi	ted Cost					
		-		Field Audi	ted Cost					
		-								
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						M			
Contract	Manageme	ent					Rydell Sar	nuel, Admini	strator	
Program	Finance						Medicaid F	Program Fina	ance	

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department		Provider	Number: 0279731-0	00		
495 East Main Street			Date: 07/01/2022	2		
Lake Butler, FL 32054		Fiscal Year End: 06/30/2021				
		Aud	it Status: Unaudited	Cost		
Provider Type	Current	Rate	New Rate	Effective Date		
CHD	165.	27	163.96	07/01/2022		
Rate Type						
Interim	Х	Prospective				
Total Interim		Х	Total Prospective			
Settlement Based on C	Cost		Prospective Adjust	ed For New Costs		
BASIS	<u>):</u>					
В	udget					
	naudited Cost					
D	esk Reviewed Cost					
D	esk Audited Cost					
Fi	ield Audited Cost					
DISTRIBUTION:		-	R			
Fiscal Agent		[V			
Contract Management		Ryd	ell Samuel, Adminis	trator		
Program Finance		Med	licaid Program Finar	nce		

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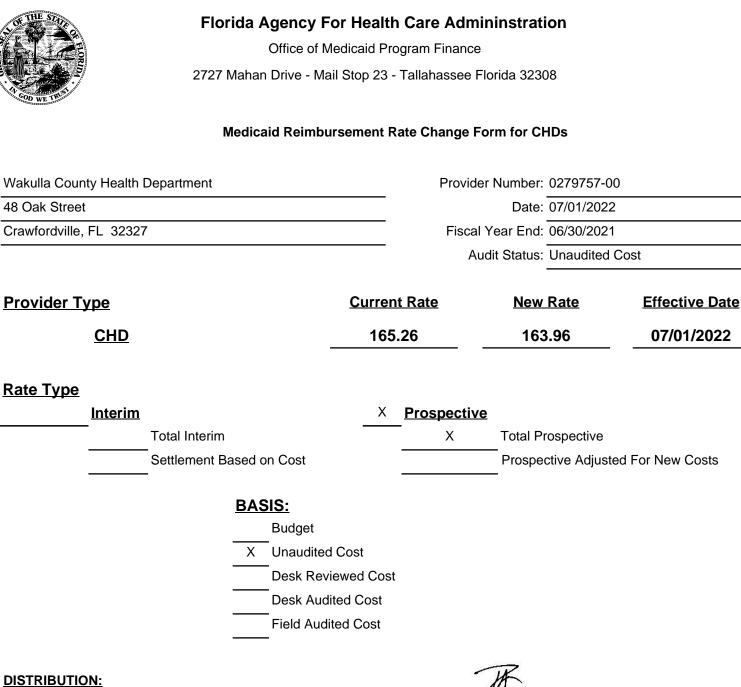
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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Depart	ment	Provi	der Number: 0279749-0	00			
P. O. Box 9190			Date: 07/01/202	2			
Daytona Beach, FL 32120		Fisc	Fiscal Year End: 06/30/2021				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		165.26	163.96	07/01/2022			
Rate Type							
Interim		X Prospecti	ive				
Tota	Interim	X	Total Prospective				
Settl	ement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	l Cost					
	Desk Rev	iewed Cost					
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DISTRIBUTION:			TR				
Fiscal Agent			7N				
Contract Management		_	Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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- **Fiscal Agent**
 - **Contract Management**
 - **Program Finance**
 - State Health Office

Rydell Samuel, Administrator Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Depart	tment	Prov	Provider Number: 0279773-00				
1338 South Boulevard			Date: 07/01/202	2			
Chipley, FL 32428		Fisc	Fiscal Year End: 06/30/2021				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	165.26	163.96	07/01/2022			
Rate Type							
Interim		X Prospect	<u>ive</u>				
Total Inte	erim	X	Total Prospective				
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health I	Department		Provider Number: 0290068-00				
597 West 11th Stree	et				Date: 0	7/01/2022	
Panama City, FL 32	2401-2330			Fiscal Year End: 06/30/2021			
				Auc	lit Status: L	Inaudited Cos	st
Provider Type			Current Ra	Current Rate		ate	Effective Date
<u>CHI</u>	<u>D</u>		165.26		146.:	32	07/01/2022
Rate Type							
Inter	<u>'im</u>		X <u>Pro</u>	ospective			
	Total Interim			Х	Total Pro	spective	
	Settlement B	ased on Cost			Prospecti	ve Adjusted F	For New Costs
		BASIS:					
		Budget					
		X Unaudite	ed Cost				
		Desk Re	viewed Cost				
		Desk Au	dited Cost				
		Field Au	dited Cost				
DISTRIBUTION:				~	R		
Fiscal Agent				/	-V		
Contract Manag	Contract Management			Ryc	lell Samuel	, Administrato	or
Program Finance	ce			Me	dicaid Prog	ram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Lafayette County Health Departme	ent	Prov	ider Number: 0290343-0	00	
P.O. Box 1806			Date: 07/01/202	2	
Mayo, FL 32066		Fisc	Fiscal Year End: 06/30/2021		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	165.26	163.96	07/01/2022	
Rate Type					
<u>Interim</u>		X Prospect	<u>ive</u>		
Total Inte	erim	X	Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			R		
Fiscal Agent			1 N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Department 801 S.W. Smith Street Madison, FL 32340						Provider Number: 0290408-00				
							Date	07/01/2022		
						Fiscal Year End: 06/30/2021			21	
					Audit Status:			Unaudited Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				165	.27	163	3.96	07/01/2022	
Rate Type										
	<u>Interim</u>				Х	Prospect	tive			
	-	Total Interim				- x	Total P	rospective		
Settlement Base			ased o	on Cost			Prospe	ctive Adjus	sted For New Costs	
			BAS	SIS:						
				Budget						
			Х	– Unaudited	d Cost					
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				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						74			
Contract Management							Rydell Samu	uel, Adminis	strator	
Program Finance							Medicaid Pr	ogram Fina	ance	

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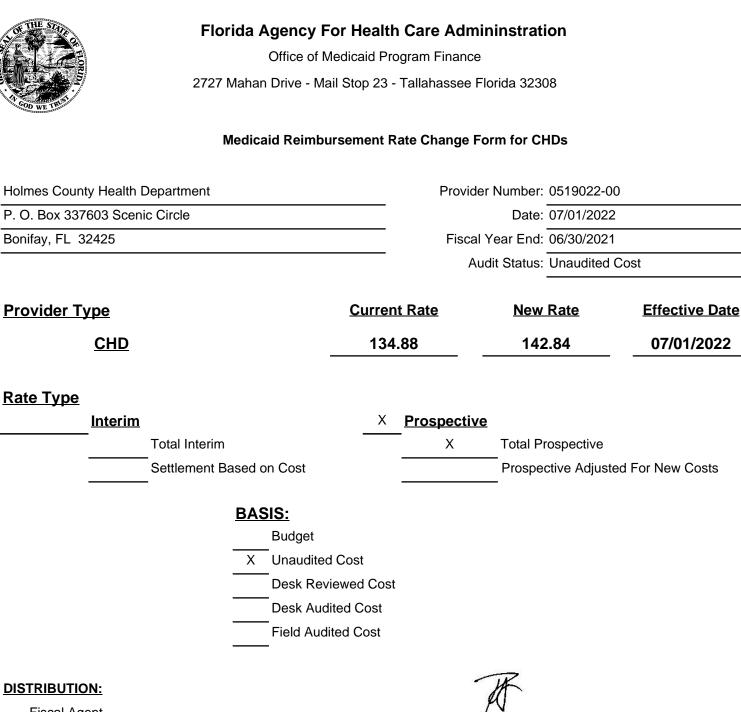
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Medicaid Reimbursement Rate Change Form for CHDs

Suwannee County Health Department P. O. Box 6030 Live Oak, FL 32060						Provider Number: 0518328-00					
							Date:	07/01/2022			
						Fiscal Year End: 06/30/		06/30/202	30/2021		
						Audit Status:			Unaudited Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				165	.26	16:	3.96	07/01/2022		
Rate Type											
	<u>Interim</u>				Х	Prospect	tive				
	-	Total Interim				- x	Total P	rospective			
Settlement Ba			ased o	on Cost			Prospe	ctive Adjus	ted For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	Unaudited	l Cost						
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				- Field Audi	ted Cost						
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DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						/ N				
Contract Management							Rydell Samu	iel, Adminis	trator		
Program Finance							Medicaid Pro	ogram Final	nce		

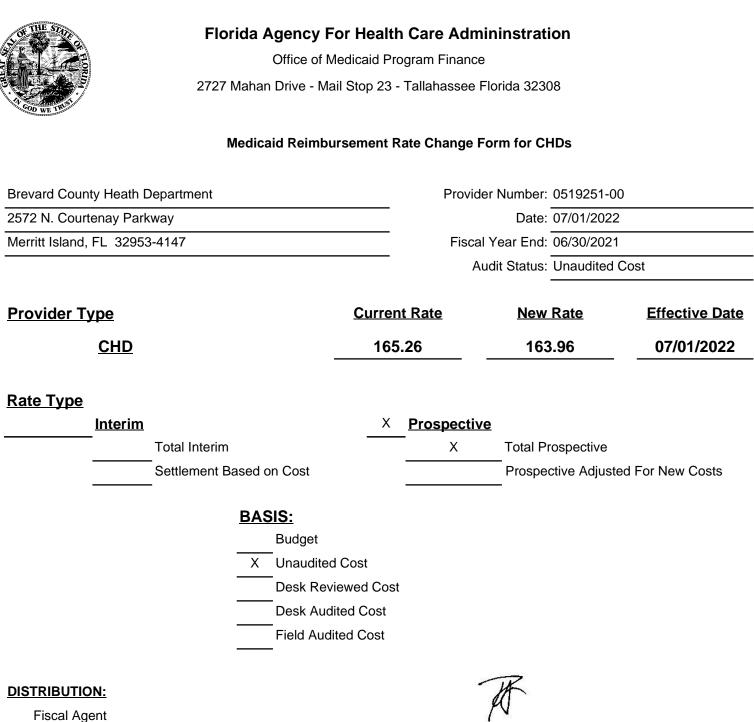
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- **Fiscal Agent Contract Management**
- **Program Finance** State Health Office



Rydell Samuel, Administrator Medicaid Program Finance



Contract Management

Program Finance

State Health Office

Rydell Samuel, Administrator Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health	Department		Provider Number: 0520331-00				
P. O. Box 29				Date: 07	07/01/2022		
West Palm Beach, FL 3340	02		Fiscal Year End: 06/30/2021		6/30/2021		
			Audit Status: Unaudited Cost				
Provider Type		<u>Current</u>	Rate	<u>New Ra</u>	ate	Effective Date	
<u>CHD</u>	-	165.2	26	163.9	6	07/01/2022	
Rate Type							
Interim		X	Prospective				
To	otal Interim		Х	Total Pros	spective		
Se	ettlement Based on Cost			Prospectiv	ve Adjusted F	or New Costs	
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audit	ted Cost					
DISTRIBUTION:			/	TR			
Fiscal Agent			1	ev.			
Contract Management		Rye	dell Samuel,	Administrato	r		
Program Finance			dicaid Progr		-		

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Departm	nent	Provider Number: 0520331-45						
P. O. Box 29		Date: 07/01/2022						
West Palm Beach, FL 33402		Fiscal Year End: 06/30/2021						
			Audit Status: Unaudited Cost					
Provider Type		Current Rate		New Rate	Effective Date			
CHD	-	165.	26	163.96	07/01/2022			
Rate Type								
<u>Interim</u>		Х	Prospective					
Total Interin	m		Х	Total Prospective				
Settlement	Based on Cost		Prospective Adjusted For New Cost					
				_				
	BASIS:							
	Budget							
	X Unaudited	Cost						
	Desk Revi	ewed Cost						
	Desk Audit	ted Cost						
	Field Audit	ted Cost						
			/	TR				
DISTRIBUTION: Fiscal Agent			1					
Contract Management		Ryc	lell Samuel, Adminis	trator				
Program Finance			dicaid Program Finar					
State Health Office								



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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte Cou	harlotte County Health Department						/ider Number:	0520446-0	00	
514 East Grad	ce Street						Date	07/01/202	2	
Punta Gorda,	FL 33950)				Fiscal Year End: 06/30/2021				
							Audit Status	Unaudited	l Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			148.20		163	3.96	07/01/2022		
Rate Type										
	<u>Interim</u>				Х	Prospect	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						/ N			
Contract Management							Rydell Samu	iel, Adminis	strator	
Program	Finance						Medicaid Pro	ogram Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Depar	tment	Pr	Provider Number: 0520446-09					
514 East Grace Street			Date: 07/01/202	2				
Punta Gorda, FL 33950		F	iscal Year End: 06/30/202	1				
			Audit Status: Unaudited Cost					
Provider Type		Current Rate	te <u>New Rate</u> <u>Effec</u>					
CHD	_	148.20	163.96	07/01/2022				
Rate Type								
<u>Interim</u>		X <u>Prospe</u>	ective					
Total I	Interim	x	Total Prospective					
Settle	ment Based on Cost		Prospective Adjus	ted For New Costs				
	BASIS:							
	Budget							
	X Unaudited	Cost						
	Desk Revie	ewed Cost						
	Desk Audite	ed Cost						
	Field Audite	ed Cost						
DISTRIBUTION:			TR					
Fiscal Agent			pq					
Contract Management			Rydell Samuel, Adminis	strator				
Program Finance			Medicaid Program Fina	nce				
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Medicaid Reimbursement Rate Change Form for CHDs

Hillsborough C	lillsborough County Health Department						vider Number:	0557269-0	00	
1105 E. Kenne	edy Boule	vard					Date	07/01/202	2	
Tampa, FL 33	3602					Fiscal Year End: 06/30/2021				
							Audit Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>				Curren	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			165.26		16	3.96	07/01/2022		
Rate Type										
	Interim				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				_						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						7V			
Contract Management						Rydell Samu	iel, Adminis	strator		
Program	Program Finance						Medicaid Pro	ogram Finai	nce	

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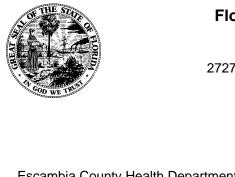
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Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health	Department			Provid	er Number:	0563234-00		
P. O. Box 1305421 W	/est Main Street				Date:	07/01/2022		
Tavares, FL 32778-1	305			Fisca	I Year End:	06/30/2021		
				A	udit Status:	Unaudited Co	ost	
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date	
<u>CHD</u>			165.26		163.96		07/01/2022	
Rate Type								
Interi	<u>m</u>		Х	Prospectiv	<u>′e</u>			
	Total Interim			- x	Total Pr	ospective		
	Settlement Bas	ed on Cost			Prospec	ctive Adjusted	For New Costs	
	Ē	BASIS:						
		Budget						
	-	X Unaudited	d Cost					
	-	Desk Rev	viewed Cost					
	-	Desk Aud	lited Cost					
	-	Field Aud	ited Cost					
	-							
DISTRIBUTION:				,	TR			
Fiscal Agent					1 N			
Contract Manage	ement			R	ydell Samu	el, Administra	tor	
Program Finance	;			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	scambia County Health Department						Provider Number: 0600181-00					
1295 West Fa	airfield Driv	'e						Date: 07/01/	2022			
Pensacola, Fl	L 32501					Fis	scal `	Year End: 06/30/	2021			
							Aud	dit Status: Unaud	ited Co	st		
Provider T	<u>ype</u>				Curren	nt Rate		New Rate		Effective Date		
	<u>CHD</u>				165	.26	_	163.96		07/01/2022		
Rate Type												
	<u>Interim</u>				Х	Prospec	tive					
	_	Total Interim				- x		Total Prospect	ive			
		Settlement Ba	ased o	on Cost				Prospective A	djusted	For New Costs		
			BAS	SIS:								
				Budget								
			X	– Unaudited	l Cost							
				_ Desk Revi	iewed Cost	t						
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DISTRIBUTIC	<u>DN:</u>						-	TR				
Fiscal Ag	lent						- 1	r V				
Contract Management							Ry	dell Samuel, Adm	ninistrate	or		
Program	Program Finance							dicaid Program F	inance			

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County	scambia County Health Department						ider Number:	0600181-03		
1295 West Fairfie	eld Drive	Э					Date:	07/01/2022		
Pensacola, FL 3	2501					Fiscal Year End: 06/30/2021				
							Audit Status:	Unaudited Co	ost	
Provider Type	<u>e</u>				Current	t Rate	New	Rate	Effective Date	
<u>c</u>	HD			165.26		163	163.96 07/01/2			
Rate Type										
<u>ln</u>	<u>terim</u>				X	Prospect				
		Total Interim				X		rospective		
		Settlement Ba	ased c	on Cost			Prospe	ctive Adjusted	For New Costs	
			BAS	SIS:						
				Budget						
			Х	- Unaudited	l Cost					
				– Desk Revi	iewed Cost					
				- Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTION:							TR			
Fiscal Agent							PN .			
Contract Management							Rydell Samu	iel, Administra	itor	
Program Fina	ance						Medicaid Pro	ogram Finance	Э	

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Healt	h Department			Provi	der Number:	0600181-09	
1295 West Fairfield Driv	/e				Date:	07/01/2022	
Pensacola, FL 32501				Fisc	al Year End:	06/30/2021	
					Audit Status:	Unaudited Co	ost
Provider Type			<u>Current</u>	t Rate	New	<u>Rate</u>	Effective Date
<u>CHD</u>		165.26		163.96 07/01/		07/01/2022	
Rate Type							
Interim			Х	<u>Prospecti</u>	ve		
	Total Interim			Х	Total P	rospective	
	Settlement Based	on Cost			Prospe	ctive Adjusted	For New Costs
	BA	SIS:					
		Budget					
	X	_ Unaudited	Cost				
		_ Desk Revie	ewed Cost				
		 Desk Audit	ted Cost				
		Field Audit	ed Cost				
DISTRIBUTION:					TR		
Fiscal Agent					۲N N		
Contract Managem	ent			-	-	el, Administrat	
Program Finance				I	Medicaid Pro	gram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	scambia County Health Department						vider Number:	0600181-	16
1295 West Fa	irfield Driv	'e					Date	07/01/202	22
Pensacola, Fl	32501					Fis	cal Year End:	06/30/202	21
							Audit Status:	Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			165.26		163	163.96 07/01/2		
Rate Type									
	<u>Interim</u>				Х	Prospect	tive		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs
			BAS	SIS:					
			<u></u>	Budget					
			X	_ Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Agent							M		
Contract Management							Rydell Samu	iel, Adminis	strator
Program	Finance						Medicaid Pro	ogram Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County	scambia County Health Department						ider Number:	0600181-20		
1295 West Fairfie	eld Drive	Э					Date:	07/01/2022		
Pensacola, FL 32	2501					Fiscal Year End: 06/30/2021				
							Audit Status:	Unaudited C	ost	
Provider Type	<u>e</u>				Current	t Rate	New	Rate	Effective Date	
<u>c</u>	HD			165.26		163	163.96 07/01/2			
Rate Type										
<u>In</u> t	<u>terim</u>				X	Prospect				
		Total Interim				X		rospective		
		Settlement Ba	ased c	on Cost			Prospe	ctive Adjustec	For New Costs	
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DISTRIBUTION:							TR			
Fiscal Agent							M			
Contract Management							Rydell Samu	iel, Administra	itor	
Program Fina	ance						Medicaid Pro	ogram Finance	Э	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	scambia County Health Department						vider Number:	0600181-2	25
1295 West Fa	irfield Driv	'e					Date	07/01/202	2
Pensacola, Fl	32501					Fis	cal Year End:	06/30/202	1
							Audit Status:	Unaudited	l Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			165.26		163	163.96 07/01/2		
Rate Type									
	<u>Interim</u>				Х	Prospect	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs
			BAS	SIS:					
			<u></u>	Budget					
			X	_ Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Agent							M		
Contract Management							Rydell Samu	iel, Adminis	strator
Program	Finance						Medicaid Pro	ogram Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	scambia County Health Department						/ider Number:	0600181-2	26
1295 West Fa	irfield Driv	e					Date	07/01/202	22
Pensacola, Fl	32501					Fis	cal Year End	06/30/202	21
							Audit Status:	Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			165.26		163	163.96 07/01/		
Rate Type									
	<u>Interim</u>				Х	Prospec	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs
			BAS	SIS:					
			<u></u>	Budget					
			X	 Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
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DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Agent							PV.		
Contract Management							Rydell Samu	iel, Adminis	strator
Program	Program Finance						Medicaid Pro	ogram Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	scambia County Health Department						ider Number:	0600181-29		
1295 West Fa	irfield Driv	e					Date:	07/01/2022		
Pensacola, FL	32501					Fiscal Year End: 06/30/2021				
							Audit Status:	Unaudited C	ost	
Provider Ty	<u>/pe</u>				Current	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			165.26		163	163.96 07/01/2			
Rate Type										
	Interim				X	Prospect				
		Total Interim				X		rospective		
		Settlement Ba	ased c	on Cost			Prospe	ctive Adjustec	For New Costs	
			BAS	SIS:						
				Budget						
			X	- Unaudited	l Cost					
				- Desk Revi	iewed Cost					
				- Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						rv.			
Contract Management							Rydell Samu	iel, Administra	itor	
Program I	Finance						Medicaid Pro	ogram Finance	Э	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department 1295 West Fairfield Drive						Provider Number: 0600181-31						
							Date	07/01/2022				
Pensacola, Fl	32501					Fiscal Year End:		06/30/202	1			
						Audit Status: Unaudited Cost						
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date			
CHD				165.26			163.9		07/01/2022			
Rate Type												
	<u>Interim</u>				Х	Prospect	tive					
	-	Total Interim				- x	Total P	rospective				
	Settlement Based on Cost				Prospective Adjusted For New Costs							
			BAS	SIS:								
			<u></u>	Budget								
			X	_ Unaudited	l Cost							
				_ Desk Revi	iewed Cost							
				_ Desk Audi	ited Cost							
				- Field Audi	ted Cost							
				-								
DISTRIBUTIC	<u>DN:</u>						TR					
Fiscal Ag	ent						M					
Contract Management							Rydell Samu	iel, Adminis	strator			
Program Finance							Medicaid Pro	ogram Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department 1295 West Fairfield Drive						Provider Number: 0600181-32					
							Date:	07/01/202	07/01/2022		
Pensacola, Fl	_ 32501					Fiscal Year End: 06/3		06/30/202	21		
						Audit Status: Unaudited Cost					
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
CHD				165.26			163.96		07/01/2022		
Rate Type											
	<u>Interim</u>				Х	Prospect	tive				
	-	Total Interim				- x	Total P	rospective			
	Settlement Based on Cost				Prospective Adjusted For New Costs						
			BAS	SIS:							
			<u></u>	Budget							
			X	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
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DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						M				
Contract Management							Rydell Samu	iel, Adminis	strator		
Program Finance							Medicaid Pro	ogram Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department 1295 West Fairfield Drive						Provider Number: 0600181-33				
							Date:	07/01/2022		
Pensacola, Fl	_ 32501					Fiscal Year End: 06/30/2021				
							Audit Status:	Unaudited Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
CHD				165.26			163	3.96	07/01/2022	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
	Settlement Based on Cost			on Cost			Prospe	ective Adjusted For New Costs		
			BAS	SIS:						
				Budget						
			X	 Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
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DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						7N			
Contract Management							Rydell Samu	iel, Administ	rator	
Program Finance							Medicaid Pro	ogram Finan	се	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department 1295 West Fairfield Drive Pensacola, FL 32501						Provider Number: 0600181-92				
							Date:	07/01/2022		
						- Fiscal Year End:		06/30/2021		
							Audit Status:	Unaudited Cost		
Provider Ty	<u>ype</u>				Current	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				165.	26	163	3.96	07/01/2022	
Rate Type										
	Interim	Tatal lataria			X	Prospect				
		Total Interim		A (X		rospective		
		Settlement Ba	ased c	on Cost			Prospe	ctive Adjustec	For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			X	Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				Desk Audi	ited Cost					
				- Field Audi	ted Cost					
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DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						ſŇ			
Contract Management							Rydell Samu	iel, Administra	itor	
Program Finance							Medicaid Pro	ogram Finance	e	

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