

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Alachua Cour	lachua County Health Department					Provider Number: 0279111-00				
224 SE 24th S	Street730 N	I.E. Waldo Ro	ad, Suite 500		Date: 07/01/2023					
Gainesville, F	L 32641				Fiscal Year End: 06/30/2022					
						Audit Status: Unaudited	Cost			
Provider T	<u>ype</u>			Currer	nt Rate	New Rate	Effective Date			
	CHD			163.96		163.27	07/01/2023			
Rate Type										
	<u>Interim</u>			X	Prospecti					
		Total Interim			X	Total Prospective				
		Settlement Ba	ased on Cost			Prospective Adjust	ed For New Costs			
DISTRIBUTIC Fiscal Ag			Desk /	et dited Cost Reviewed Cost Audited Cost Audited Cost	· (CD				
•	Manageme	ent				CE Jackson, Financial S	Specialist			
Program Finance				_	Medicaid Program Finar	<u>· </u>				
State Hea	alth Office									
						For Information On	nly			
					_	—— (No Change In Rat	te)			



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Baker County Health Depa	artment		Provid	ler Number: 0279129-0	00			
480 West Lowder Street				Date: 07/01/202	3			
Macclenny, FL 32063			Fiscal Year End: 06/30/2022					
			P	audit Status: Unaudited	Cost			
Provider Type		<u>Current Rate</u>		New Rate	Effective Date			
<u>CHD</u>		161.06		163.27	07/01/2023			
Rate Type								
<u>Interim</u>		X_ <u>P</u>	rospectiv	<u>/e</u>				
Т	Total Interim		Χ	Total Prospective				
s	Settlement Based on Cost	_		Prospective Adjus	ted For New Costs			
	BASIS:							
	Budget							
	X Unaudite	d Cost						
	Desk Rev	viewed Cost						
	Desk Aud	dited Cost						
	Field Aud	lited Cost						
DISTRIBUTION:				_				
Fiscal Agent			(D				
Contract Managemen	nt		(CE Jackson, Financial S	Specialist			
Program Finance			_	/ledicaid Program Final				
State Health Office								
				For Information Or	nly			
			_	—— (No Change In Ra	te)			



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Medicaid Reimbursement Rate Change Form for CHDs

Bradford Cou	ford County Health Department					Provider Number: 0279145-00					
1801 North Te	emple Ave	nue				Date: 07/01/2023					
Starke, FL 32	2091					Fi	scal Y	ear End: 06/30/2022	2		
							Aud	it Status: Unaudited	Cost		
Provider T	уре				Curren	t Rate		New Rate	Effective Date		
	CHD				163	.96	_	163.27	07/01/2023		
Rate Type	Interim				X	Prospec	rtive				
	_ 	Total Interim				_ 1103pc(X	<u> </u>	Total Prospective			
		- Settlement Ba	ased o	n Cost				Prospective Adjust	ed For New Costs		
			<u>X</u>	Budget Unaudited	iewed Cost ited Cost						
Program	jent Managem	ent						Jackson, Financial S licaid Program Finar			
								For Information Or	nly		
								(No Change In Rat	te)		



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Medicaid Reimbursement Rate Change Form for CHDs

Broward Coun	ty Health Department			Provid	der Number: 0279161-0	00		
780 SW 24th S	Street				Date: 07/01/202	3		
Fort Lauderda	le, FL 33315			Fiscal Year End: 06/30/2022				
				A	Audit Status: Unaudited	Cost		
Provider Ty	<u>/pe</u>		Current	Rate	New Rate	Effective Date		
	<u>CHD</u>		163.9	6	163.27	07/01/2023		
Rate Type								
	<u>Interim</u>		X_ <u>_</u>	Prospecti	<u>ve</u>			
	Total Interi	m		X	Total Prospective			
	Settlement	Based on Cost	_		Prospective Adjus	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	l Cost					
			iewed Cost					
		Desk Aud						
		Field Audi						
<u>DISTRIBUTIO</u>	<u>N:</u>				0 0			
Fiscal Age	ent			(-EL			
Contract N	Management				CE Jackson, Financial S	Specialist		
Program F	Finance			1	Medicaid Program Fina	nce		
State Hea	alth Office							
					For Information Or	nly		
				_	—— (No Change In Ra	te)		



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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun County Health Depa	rtment		Provid	er Number:	0279170-91	
19611 S.R. 20 West				Date:	07/01/2023	
Blountstown, FL 32424			Fisca	l Year End:	06/30/2022	
			A	udit Status:	Unaudited (Cost
Provider Type		Current	<u>Rate</u>	New	<u>Rate</u>	Effective Date
<u>CHD</u>	-	163.9	06	163	.27	07/01/2023
Rate Type						
<u>Interim</u>		Х	Prospectiv	<u>'e</u>		
 Tota	l Interim		Χ	Total Pr	ospective	
Settl	ement Based on Cost	_		Prospec	ctive Adjuste	ed For New Costs
DISTRIBUTION:	BASIS: Budget X Unaudited Desk Revie Desk Audit Field Audit	ewed Cost ted Cost				
Fiscal Agent			(-84		
Contract Management				E Jackson,		
Program Finance			M	ledicaid Pro	gram Finano	ce
State Health Office						
				For Info	rmation Onl	y
				— (No Cha	ange In Rate))



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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health I	Department			Provider Number: 0279196-00					
3700 Sovereign Path				Date: 07/01/2023					
Lecanto, FL 34461-80	071			Fiscal Year End: 06/30/2022					
				A	Audit Status: Unaudited	Cost			
Provider Type			Current	<u>Rate</u>	New Rate	Effective Date			
<u>CHD</u>			163.96		163.27	07/01/2023			
Rate Type									
<u>Interin</u>	<u>n</u>		X <u>I</u>	Prospectiv	<u>/e</u>				
	Total Interim			X	Total Prospective				
	Settlement Ba	sed on Cost	_		Prospective Adjust	ted For New Costs			
		BASIS:							
		Budget							
	•	X Unaudited	l Cost						
		Desk Rev	iewed Cost						
	•	Desk Aud	ited Cost						
		Field Audi	ted Cost						
DISTRIBUTION:									
Fiscal Agent				((19)				
Contract Manage	ment			(CE Jackson, Financial S	Specialist			
Program Finance				_	Medicaid Program Finar				
State Health Office	e								
					For Information Or	nly			
					(No Change In Ra	te)			



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Medicaid Reimbursement Rate Change Form for CHDs

Clay County H	ay County Health Department					Provider Number: 0279200-00					
P.O. Box 578								Date:	07/01/2023		
Green Cove S	Springs, FL	32043				Fis	cal Ye	ar End:	06/30/2022		
							Audit	Status:	Unaudited (Cost	
Provider T	<u>ype</u>				Current Rate			New Rate		Effective Date	
	<u>CHD</u>				80.	14		117	.04	07/01/2023	
Rate Type											
	<u>Interim</u>				X	Prospect	<u>tive</u>				
		Total Interim				X		Total Pro	ospective		
		Settlement Ba	ased c	on Cost				Prospec	tive Adjuste	ed For New Costs	
			BAS	SIS:							
				Budget							
			X	- Unaudited	l Cost						
				- Desk Revi	iewed Cost						
				- Desk Aud	ited Cost						
				Field Audi	ted Cost						
				_							
DISTRIBUTIO	ON:										
Fiscal Ag	ent						0	90			
Contract	Manageme	ent					CE J	ackson,	Financial S _l	pecialist	
Program	Finance						Medi	caid Pro	gram Finan	ce	
State Hea	alth Office										
								For Info	rmation Onl	ly	
								(No Cha	ange In Rate	e)	



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Medicaid Reimbursement Rate Change Form for CHDs

Collier County	/ Health De	epartment			Prov	ider Number:	0279218-0	00	
P.O. Box 429						Date	07/01/202	3	
Naples, FL 34	4106-0429				Fiscal Year End: 06/30/2022				
						Audit Status:	Unaudited	Cost	
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			163	.96	165	3.27	07/01/2023	
Rate Type	<u>Interim</u>			X	<u>Prospect</u>	<u>ive</u>			
	_	Total Interim			X	Total P	rospective		
		- Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs	
			Desk Aud	d Cost viewed Cost dited Cost dited Cost					
Program	ent Manageme	ent				CE Jackson Medicaid Pro		-	
					-		ormation Or ange In Ra	-	



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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Department			Provider Number: 0279226-00					
217 North East Franklin Street				Date: 07/01/2023	3			
Lake City, FL 32055			Fiscal Year End: 06/30/2022					
			,	Audit Status: Unaudited	Cost			
Provider Type		Current	Rate	New Rate	Effective Date			
<u>CHD</u>	_	163.	96	163.27	07/01/2023			
Rate Type								
<u>Interim</u>		X	Prospecti	<u>ve</u>				
Total Interim			X	Total Prospective				
Settlement Ba	sed on Cost			Prospective Adjust	ted For New Costs			
DISTRIBUTION:	BASIS: Budget X Unaudited C Desk Review Desk Audited Field Audited	ved Cost d Cost						
Fiscal Agent Contract Management Program Finance State Health Office			_	CE Jackson, Financial S Medicaid Program Finar				
			_	For Information Or (No Change In Rat	•			



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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health D	Department			Provider Number: 0279234-00				
1350 N.W. 14th Street	t				3			
Miami, FL 33125				Fiscal Year End: 06/30/2022				
					Audit Status:	Unaudited	Cost	
Provider Type			Current Rate		New Rate		Effective Date	
CHD			163.	.96	163	3.27	07/01/2023	
Rate Type								
<u>Interin</u>	<u>n</u>		X	Prospect	ive			
	Total Interim			X	Total P	rospective		
	Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs	
		BASIS: Budget Unaudited Desk Revi Desk Audi Field Audi	ewed Cost ted Cost					
DISTRIBUTION: Fiscal Agent				(10			
Contract Manager	ment			(E Jackson, I	inancial S	necialist	
Program Finance				•	Medicaid Pro			
State Health Offic	e					<i>y</i>		
					For Inf	ormation Or	nly	
				_	(No Ch	ange In Rat	te)	



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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department	:	Prov	Provider Number: 0279242-00					
34 South Baldwin Avenue			Date: 07/01/2023					
Arcadia, FL 33821		Fis	Fiscal Year End: 06/30/2022					
			Audit Status: Unaudited	l Cost				
Provider Type		Current Rate	New Rate	Effective Date				
<u>CHD</u>		123.69	163.27	07/01/2023				
Rate Type								
<u>Interim</u>		X Prospec	<u>tive</u>					
Total Inte	rim	X	Total Prospective					
Settlemer	nt Based on Cost		Prospective Adjus	ted For New Costs				
	BASIS:							
	Budget							
	X Unaudited	d Cost						
	Desk Rev	iewed Cost						
	Desk Aud	ited Cost						
	Field Aud	ited Cost						
DISTRIBUTION:								
Fiscal Agent			(0)					
Contract Management			CE lockeon Financial S	Propiolist				
Program Finance			CE Jackson, Financial S Medicaid Program Fina					
State Health Office								
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			(No Change In Ra					



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Medicaid Reimbursement Rate Change Form for CHDs

Dixie County I	e County Health Department					Provider Number: 0279251-00				
149 NE 241S	Т					Date	07/01/2023			
Cross City, FL	32628				Fiscal Year End: 06/30/2022					
						Audit Status	Unaudited 0	Cost		
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date		
	CHD			163	.96	16	3.27	07/01/2023		
Rate Type										
	Interim -			X	Prospec					
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs		
DISTRIBUTIO Fiscal Ag Contract		ent	BASIS: Budget X Unaudited Desk Rev Desk Aud Field Aud	viewed Cost lited Cost		CEJ_ CE Jackson	, Financial S	pecialist		
Program	_						ogram Financ	<u>- </u>		
	alth Office						Č			
						For Inf	ormation Only	у		
						—— (No Ch	ange In Rate	e)		



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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departm	ent	Pro	vider Number: 0279269-0	00			
515 West Sixth Street			Date: 07/01/2023				
Jacksonville, FL 32206			Fiscal Year End: 06/30/2022				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		163.96	163.27	07/01/2023			
Rate Type							
<u>Interim</u>		X Prospec	<u>ctive</u>				
Total	Interim	X	Total Prospective				
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs			
DISTRIBUTION:	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	iewed Cost ited Cost					
Fiscal Agent Contract Management Program Finance State Health Office			CE Jackson, Financial S Medicaid Program Financial	<u> </u>			
			For Information Or	nly			
			(No Change In Ra	ite)			



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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County	agler County Health Department				Provider Number: 0279285-00			
P. O. Box 847	301 South	Lemon Street				Date	07/01/2023	
Bunnell, FL 3	2110-0847	7			Fis	scal Year End	06/30/2022	
						Audit Status	Unaudited C	Cost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			163	.96	16	3.27	07/01/2023
Rate Type				V	_			
	<u>Interim</u> -	Tatal lutaria		X	<u>Prospec</u>			
		Total Interim	and an Coat		X		rospective	d For New Cooks
		Settlement Ba	ased on Cost			——— Prospe	ctive Adjusted	d For New Costs
DISTRIBUTIC Fiscal Ag Contract I		ent	BASIS: Budget Unaudited Desk Rev Desk Aud Field Aud	viewed Cost dited Cost		CEJ CE Jackson,	Financial Spe	ecialist
Program	_						ogram Financ	
State Hea	alth Office							
						For Info	ormation Only	,
						(No Ch	ange In Rate)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Franklin Cour	ranklin County Health Department					Provider Number: 0279293-00				
139 12th Stre	et							Date: 07/01/2023	3	
Apalachicola,	FL 32320					Fis	scal Ye	ar End: 06/30/2022	2	
							Audit	Status: Unaudited	Cost	
Provider T	<u>ype</u>				Curren	t Rate		New Rate	Effective Date	
	<u>CHD</u>				163	.96		163.27	07/01/2023	
Rate Type										
	<u>Interim</u>				X	Prospec				
		Total Interim				X		Total Prospective		
		Settlement Ba	ased o	n Cost				Prospective Adjust	ted For New Costs	
			BAS	IS:						
				Budget						
			X	Unaudited	l Cost					
				Desk Revi	iewed Cost					
				Desk Aud	ited Cost					
				Field Audi	ted Cost					
DISTRIBUTION Fiscal Ag							C	2		
_	Managem	ent					CE Ja	ackson, Financial S	Specialist	
Program								caid Program Finar	<u> </u>	
_	alth Office							-		
								For Information Or	nly	
								(No Change In Rat	te)	



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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Departn	nent	Prov	vider Number: 0279307-	00		
P. O. Box 1000			Date: 07/01/202	23		
Quincy, FL 32353-1000		 Fis	Fiscal Year End: 06/30/2022			
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		163.96	152.31	07/01/2023		
Rate Type						
<u>Interim</u>		X Prospec	<u>tive</u>			
Total In	terim	X	Total Prospective			
Settlem	ent Based on Cost		Prospective Adjus	sted For New Costs		
	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	iewed Cost ited Cost				
DISTRIBUTION: Fiscal Agent			CEL			
Contract Management			CE Jackson, Financial S	Specialist		
Program Finance			Medicaid Program Fina	ince		
State Health Office						
			For Information O	nly		
			(No Change In Ra	ate)		



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Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County He	christ County Health Department			Provider Number	: 0279315-0	00	
119 N.E. First Stree	et			Date	: 07/01/202	3	
Trenton, FL 32693	3-3459			Fiscal Year End: 06/30/2022			
				Audit Status	: Unaudited	Cost	
Provider Type			Current Rat	e <u>New</u>	v Rate	Effective Date	
<u>CH</u>	<u>ID</u>		163.96	16	3.27	07/01/2023	
Rate Type							
Inte	<u>erim</u>		X Pros	<u>spective</u>			
	Total Interin	า		X Total F	Prospective		
	Settlement	Based on Cost		Prospe	ective Adjust	ted For New Costs	
		BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	ewed Cost				
DISTRIBUTION:				(9)			
Fiscal Agent				CE lasks	· Einopoio! (Propiniint	
Contract Mana					n, Financial S	<u> </u>	
Program Finar				Medicald Pr	rogram Finai	nce	
State Health C	лисе						
				For Inf	ormation Or	nly	
				(No Cl	hange In Ra	te)	



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Medicaid Reimbursement Rate Change Form for CHDs

Glades County	ades County Health Department			vider Number: 0279323	-00		
P. O. Box 489				Date: 07/01/20	23		
Moore Haven, F	FL 33471		 Fis	Fiscal Year End: 06/30/2022			
				Audit Status: Unaudite	ed Cost		
Provider Ty _l	<u>pe</u>		Current Rate	New Rate	Effective Date		
	<u>CHD</u>		93.32	39.50	07/01/2023		
Rate Type							
<u> </u>	<u>nterim</u>		X Prospec	<u>tive</u>			
	Total I	nterim	x	Total Prospective	e		
_	Settle	ment Based on Cost		Prospective Adju	sted For New Costs		
DISTRIBUTION	<u>1:</u>	Desk Aud	d Cost viewed Cost dited Cost dited Cost				
Fiscal Ager	nt			CEL			
Contract M	anagement			CE Jackson, Financial	Specialist		
Program Fi	inance			Medicaid Program Fin	ance		
State Healt	th Office						
				For Information (Only		
				(No Change In R	tate)		



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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Depar	rtment	Pro	vider Number: 0279331-	-00		
2475 Garrison Avenue			Date: 07/01/2023			
Port St. Joe, FL 32456-5	265	 Fis	Fiscal Year End: 06/30/2022			
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		163.96	163.27	07/01/2023		
Rate Type						
<u>Interim</u>		X Prospec	<u>ctive</u>			
-	Total Interim	X	Total Prospective			
;	Settlement Based on Cost		Prospective Adjus	sted For New Costs		
DISTRIBUTION:	BASIS: Budget X Unaudited Desk Rev Desk Aud Field Audi	iewed Cost ited Cost				
DISTRIBUTION: Fiscal Agent			CEL			
Contract Managemer	nt		CE Jackson, Financial	Specialist		
Program Finance			Medicaid Program Fina	<u> </u>		
State Health Office						
			For Information C	Only		
			(No Change In Ra	ate)		



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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton Cour	amilton County Health Department				Prov	ider Number:	0279340-0	00
P. O. Box 267	•					Date	07/01/202	3
Jasper, FL 32	2052				Fise	cal Year End:	06/30/2022	2
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			163	.96	163	3.27	07/01/2023
Rate Type	<u>Interim</u>			X	Prospect	<u>iive</u>		
	-	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs
			Desk F	t lited Cost Reviewed Cost Audited Cost Audited Cost				
Program I	ent Manageme Finance	ent				CE Jackson Medicaid Pro		<u> </u>
State Hea	alth Office						ormation Or	-



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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County H	ardee County Health Department				der Number: 0279358-0	00		
115 K.D. Revell F	Road			Date: 07/01/2023				
Wauchula, FL 33	3873			Fiscal Year End: 06/30/2022				
				,	Audit Status: Unaudited	Cost		
Provider Type	<u>e</u>		Current	Rate	New Rate	Effective Date		
<u>C</u>	:HD		163.9	6	159.45	07/01/2023		
Rate Type								
<u>ln</u>	<u>terim</u>		X <u> </u>	Prospecti	<u>ve</u>			
	Total Interim	1		Χ	Total Prospective			
	Settlement E	Based on Cost	_		Prospective Adjust	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		Desk Revi	iewed Cost					
		Desk Aud	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:					0 0			
Fiscal Agent				((2)			
Contract Mar				(CE Jackson, Financial S	Specialist		
Program Fina				-	Medicaid Program Finai	nce		
State Health	Office							
					For Information Or	nly		
				_	(No Change In Ra	te)		



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Medicaid Reimbursement Rate Change Form for CHDs

Hendry Count	endry County Health Department				Provider Number: 0279366-00			
P. O. Box 70						Date	07/01/202	3
_aBelle, FL 3	33975				Fiscal Year End: 06/30/2022			
						Audit Status:	Unaudited	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			163	.96	16	3.27	07/01/2023
Rate Type	<u>Interim</u>			X	Prospect	<u>:ive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ective Adjust	ted For New Costs
			BASIS: Budget X Unaudited Desk Rev Desk Aud Field Aud	viewed Cost lited Cost				
Fiscal Ag Contract Program	ent Manageme	ent				CE Jackson Medicaid Pro		
State Hea	alth Office							
						For Infe	ormation Or	nly
						(No Ch	ange In Ra	te)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

ernando County Health Department			Provider Number: 0279374-00				
300 S. Main St.			Date: 07/01/2023				
Brooksville, FL 34601			Fisca	l Year End: 06/30/202	2		
			А	udit Status: Unaudited	Cost		
Provider Type		Current	Rate	New Rate	Effective Date		
<u>CHD</u>		163.9	6	163.27	07/01/2023		
Rate Type							
<u>Interim</u>		X <u>I</u>	Prospectiv	<u>′e</u>			
Total Inte	rim	_	X	Total Prospective			
Settlemer	t Based on Cost	_		Prospective Adjust	ted For New Costs		
DISTRIBUTION	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	iewed Cost ited Cost					
DISTRIBUTION: Fiscal Agent			(10			
Contract Management			C	E Jackson, Financial S	Specialist		
Program Finance			_	Medicaid Program Finar	<u> </u>		
State Health Office				-			
				For Information O	nly		
			_	(No Change In Ra	ate)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Highlands County Health	Department		Prov	ider Number: 0279382-	-00	
7205 South George Boul	evard			Date: 07/01/202	23	
Sebring, FL 33872			Fiscal Year End: 06/30/2022			
				Audit Status: Unaudite	d Cost	
<u>Provider Type</u>		Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>		163.	.96	163.27	07/01/2023	
Rate Type						
<u>Interim</u>		X	Prospect	<u>ive</u>		
	Total Interim		X	Total Prospective		
	Settlement Based on Cost			Prospective Adjus	sted For New Costs	
DISTRIBUTION:	Desk Au	ed Cost viewed Cost dited Cost dited Cost				
Fiscal Agent Contract Manageme	nt			CE Jackson, Financial	l Specialist	
Program Finance				Medicaid Program Fina	ance	
State Health Office						
				For Information C	Only	
			-	(No Change In R	ate)	



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Medicaid Reimbursement Rate Change Form for CHDs

ndian River C	an River County Health Department				Provider Number: 0279412-00				
1900 27th Stre	eet					Date:	07/01/202	3	
Vero Beach, F	L 32960				Fis	cal Year End:	06/30/202	2	
						Audit Status:	Unaudited	Cost	
Provider Ty	<u>/pe</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			163.	.96	163	3.27	07/01/2023	
Rate Type									
	<u>Interim</u>			X	Prospec	<u>tive</u>			
	-	Total Interim			X	Total P	rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs	
DISTRIBUTIO	<u> </u>		BASIS: Budget Unaudited Desk Revi Desk Audi Field Audi	ewed Cost ted Cost		22			
Fiscal Age	ent					CEL			
Contract N	Manageme	ent				CE Jackson	, Financial S	Specialist	
Program F	Finance					Medicaid Pro	ogram Finai	nce	
State Hea	alth Office								
						For Info	ormation Or	nly	
						(No Ch	ange In Ra	te)	



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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County	Health Department			Provider Number: 0279421-00				
P. O. Box 310					Date: 07/01/202	3		
Marianna, FL 32	2447			Fisc	al Year End: 06/30/202	2		
				A	Audit Status: Unaudited	Cost		
<u>Provider Typ</u>	<u>e</u>		Current	<u>Rate</u>	New Rate	Effective Date		
<u>c</u>	CHD		163.9	06	163.27	07/01/2023		
Rate Type								
<u>In</u>	<u>nterim</u>		X_ <u>_I</u>	Prospecti	<u>ve</u>			
	Total Interim	l		Χ	Total Prospective			
_	Settlement E	Based on Cost	_		Prospective Adjus	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	Cost					
		Desk Revi	ewed Cost					
		Desk Aud	ted Cost					
		Field Audi	ted Cost					
DISTRIBUTION:								
Fiscal Agent				(282			
Contract Ma	nagement			(CE Jackson, Financial S	Specialis <u>t</u>		
Program Fin	ance			ī	Medicaid Program Fina	nce		
State Health	Office							
					For Information Or	nly		
				_	 (No Change In Ra	te)		



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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson Cou	ferson County Health Department					Provider Number: 0279439-00				
1255 W. Wasl	hington St	reet						Date: 07/01/202	3	
Monticello, FL	32344					Fi	iscal Yea	r End: 06/30/202	2	
							Audit S	Status: Unaudited	Cost	
Provider Ty	ype				Curren	t Rate		New Rate	Effective Date	
	CHD				163	.96		163.27	07/01/2023	
Rate Type										
	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>			
		Total Interim				X	T	otal Prospective		
		Settlement Ba	ased o	on Cost			F	Prospective Adjus	ted For New Costs	
			D.4.6	210						
			BAS							
				Budget						
			X	Unaudited						
				_	iewed Cost					
				Desk Audi						
				Field Audi -	ted Cost					
DISTRIBUTIO	ON:						_			
Fiscal Ag	ent						C	2		
Contract I	Managem	ent					CE Ja	ckson, Financial S	Specialist	
Program	Finance						Medic	aid Program Fina	nce	
State Hea	alth Office									
							i	For Information O	nly	
								No Change In Ra	ate)	



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Medicaid Reimbursement Rate Change Form for CHDs

_ee County Health Depa	e County Health Department					Provider Number: 0279463-00				
3920 Michigan Avenue					Date:	07/01/202	3			
Fort Myers, FL 33916				Fisc	al Year End:	06/30/2022	2			
				,	Audit Status:	Unaudited	Cost			
Provider Type			Curren	t Rate	<u>New</u>	Rate	Effective Date			
<u>CHD</u>		-	163	.96	163	3.27	07/01/2023			
Rate Type										
<u>Interim</u>			X	<u>Prospecti</u>	<u>ve</u>					
	Total Interim			X	Total P	rospective				
	Settlement Bas	sed on Cost			Prospe	ctive Adjust	ted For New Costs			
DISTRIBUTION:	<u> </u> - - - -	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audit	ewed Cost ted Cost		0.0					
Fiscal Agent				(CEL					
Contract Manageme	ent				CE Jackson	, Financial S	Specialist			
Program Finance				-	Medicaid Pro	ogram Finar	nce			
State Health Office										
					For Info	ormation Or	nly			
				_	— (No Ch	ange In Ra	te)			



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Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Departm	ent	Pro	Provider Number: 0279471-00				
2965 Municipal Way			Date: 07/01/202	3			
Tallahassee, FL 32304		Fi	scal Year End: 06/30/202	2			
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		163.96	163.27	07/01/2023			
Rate Type							
<u>Interim</u>		X Prospec	<u>ctive</u>				
Tota	al Interim	X	Total Prospective				
Sett	lement Based on Cost		Prospective Adjust	ted For New Costs			
	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audit	ewed Cost ted Cost					
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office			CE Jackson, Financial S Medicaid Program Finan				
			For Information Or	nly			
			(No Change In Ra	te)			



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Medicaid Reimbursement Rate Change Form for CHDs

_evy County F	y County Health Department				Provider Number: 0279480-00				
P. O. Box 406	6 South M	lain Street				Date:	07/01/202	3	
Bronson, FL 3	32621				Fis	cal Year End:	06/30/2022	2	
						Audit Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			163.	.96	163	3.27	07/01/2023	
Rate Type									
	<u>Interim</u>			X	Prospect	<u>ive</u>			
		Total Interim			X	Total P	rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs	
DISTRIBUTIO	<u>ON:</u>		BASIS: Budget Unaudited Desk Revi Desk Audi Field Audi	ewed Cost		0 0			
Fiscal Age						CEL			
Contract I	Manageme	ent				CE Jackson,	Financial S	Specialist	
Program I	Finance					Medicaid Pro	ogram Finar	nce	
State Hea	alth Office								
						For Info	ormation Or	nly	
					•	(No Ch	ange In Ra	te)	



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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department		Prov	Provider Number: 0279498-00				
P. O. Box 489247 N. Central Street	t		Date: 07/01/202	3			
Bristol, FL 32321		 Fis	cal Year End: 06/30/202	2			
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		163.96	163.27	07/01/2023			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
Total Inter	im	X	Total Prospective				
Settlemen	t Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS: Budget X Unaudited Desk Rev Desk Aud Field Audi	iewed Cost ited Cost					
DISTRIBUTION:			00				
Fiscal Agent			CEX				
Contract Management			CE Jackson, Financial S				
Program Finance State Health Office			Medicaid Program Fina	nce			
State Health Office							
			For Information O	nly			
			(No Change In Ra	ate)			



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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County Healt	natee County Health Department				Provider Number: 0279510-00				
410 Six Avenue East					Date:	07/01/2023	3		
Bradenton, FL 34208				Fisca	al Year End:	06/30/2022	2		
				A	Audit Status:	Unaudited	Cost		
Provider Type			Current R	<u>late</u>	<u>New</u>	<u>Rate</u>	Effective Date		
CHD			132.41	<u> </u>	163	3.27	07/01/2023		
Rate Type									
<u>Interim</u>	<u>1</u>		X_ <u>P</u>	<u>rospecti</u>	<u>ve</u>				
	Total Interim			X	Total Pı	rospective			
	Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs		
DISTRIBUTION:		BASIS: Budget Unaudited Desk Revi Desk Audi Field Audit	ewed Cost		0 0				
Fiscal Agent				(13				
Contract Manager	ment			_	E Jackson,	Financial S _l	pecialist		
Program Finance				1	Medicaid Pro	gram Finan	ce		
State Health Office	е								
					For Info	ormation On	ly		
				_	—— (No Ch	ange In Rat	e)		



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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	ion County Health Department				Provider Number: 0279528-00				
1801 S.E. 32r	nd Avenuel	P. O. Box 2408	3			Date	: 07/01/2023		
Ocala, FL 34	478-2408				Fi	scal Year End	: 06/30/2022		
						Audit Status	: Unaudited (Cost	
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	<u>r Rate</u>	Effective Date	
	CHD			163	.96	16	3.27	07/01/2023	
Rate Type	<u>Interim</u>			X	Prospec	etivo.			
	- mterim	Total Interim			_ FTOSPEC X		Prospective		
	-	Settlement Ba	ased on Cost				·	ed For New Costs	
		-	3004 011 0001				ou vo v lajuote	ou i di i i di i di di di di di di di di d	
			BASIS:						
			Budget						
			X Unaudited	d Cost					
			Desk Rev	viewed Cost					
			Desk Aud	dited Cost					
			Field Aud	lited Cost					
DISTRIBUTIO	ON.					_			
Fiscal Ag						CA			
_	Manageme	ent				CE Jackson	, Financial S _l	pecialist	
Program	_						ogram Finan		
State Hea	alth Office								
						For Inf	ormation Onl	У	
							nange In Rate		



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Medicaid Reimbursement Rate Change Form for CHDs

Martin County	tin County Health Department				Provider Number: 0279536-00				
3441 SE Willo	ughby Blv	d.				Date:	07/01/202	3	
Stuart, FL 349	994-5060				Fis	cal Year End:	06/30/202	2	
						Audit Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			163.	.96	163	3.27	07/01/2023	
Rate Type									
	<u>Interim</u>			X	Prospec	<u>tive</u>			
	-	Total Interim			X	Total P	rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs	
			BASIS: Budget Unaudited Desk Revi Desk Audi Field Audi	ewed Cost					
DISTRIBUTIO Fiscal Age						CA			
_	o Manageme	ent				CE Jackson,	Financial S	Specialist	
Program I	_					Medicaid Pro		<u></u>	
State Hea									
						For Info	ormation Or	nly	
						(No Ch	ange In Ra	te)	



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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County	nroe County Health Department				Provider Number: 0279544-00				
5100 College Ro	oad				Date:	07/01/2023			
Key West, FL 3	33040			Fisc	al Year End:	06/30/2022			
				,	Audit Status:	Unaudited (Cost		
Provider Typ	<u>oe</u>		<u>Currer</u>	nt Rate	<u>New</u>	<u>Rate</u>	Effective Date		
<u>(</u>	<u>CHD</u>		163	3.96	163	3.27	07/01/2023		
Rate Type									
<u>lı</u>	<u>nterim</u>		X	<u>Prospecti</u>	<u>ve</u>				
_	Total	Interim		X	Total Pr	ospective			
_	Settle	ement Based on Co	st		Prospec	ctive Adjuste	ed For New Costs		
DISTRIBUTION	<u>l:</u>	Des Des	get nudited Cost ik Reviewed Cost ik Audited Cost d Audited Cost	t					
Fiscal Agen					(19)				
Contract Ma	anagement			(CE Jackson,	Financial St	oecialist		
Program Fi	nance			_	Medicaid Pro				
State Healtl	h Office								
					For Info	rmation Onl	у		
				_	—— (No Cha	ange In Rate	e)		



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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Departr	ment	Prov	Provider Number: 0279552-00				
P. O. Box 517			Date: 07/01/202	23			
ernandina Beach, FL 32035-	0517	Fis	cal Year End: 06/30/202	22			
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	162.12	153.73	07/01/2023			
Rate Type							
<u>Interim</u>		X Prospect	<u>tive</u>				
Total	Interim	X	Total Prospective				
Settle	ement Based on Cost		Prospective Adjus	sted For New Costs			
	BASIS: Budget X Unaudited Desk Revie Desk Audit Field Audit	ewed Cost red Cost					
DISTRIBUTION:			00				
Fiscal Agent			CCY				
Contract Management			CE Jackson, Financial				
Program Finance			Medicaid Program Fina	ince			
State Health Office							
			For Information O	only			
			—— (No Change In Ra	ate)			



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Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health Department					Pr	ovider N	Number: 0279561-0	00	
221 Hospital [Drive, N.E.							Date: 07/01/202	3
Ft. Walton Bea	ach, FL 3	2548				Fiscal Year End: 06/30/2022			
							Audit	Status: Unaudited	Cost
Provider Ty	ype				Curren	Current Rate Nev		New Rate	Effective Date
	CHD				163	.96		163.27	07/01/2023
Rate Type									
	<u>Interim</u>				X	<u>Prospe</u>	ctive		
	_	Total Interim				_ x		Total Prospective	
		Settlement Ba	ased o	on Cost				Prospective Adjust	ted For New Costs
			D.4.6	210					
			BAS						
				Budget 					
			X	Unaudited					
				_	iewed Cost				
				Desk Aud					
				Field Audi -	ted Cost				
DISTRIBUTIO	ON:						0	2	
Fiscal Ag	ent						C	EL_	
Contract I	Manageme	ent					CE J	ackson, Financial S	Specialist
Program	Finance						Medi	caid Program Finai	nce
State Hea	alth Office								
								For Information Or	nly
								(No Change In Ra	te)



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Medicaid Reimbursement Rate Change Form for CHDs

keechobee County Health Department					Provider Number: 0279579-00			
P.O. Box 187	91728 N.W	V. 9th Avenue				Date:	07/01/202	3
Okeechobee	, FL 3497	3-1879			Fiscal Year End: 06/30/2022			
						Audit Status:	Unaudited	Cost
Provider T	уре			Curren	Current Rate		Rate	Effective Date
	<u>CHD</u>			108	.04	134	4.29	07/01/2023
Rate Type	Interim			X	Prospect	<u>tive</u>		
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs
			Desk Aud	d Cost viewed Cost dited Cost dited Cost				
DISTRIBUTIO Fiscal Ag						00		
•	Manageme	ent				CE Jackson,	Financial S	specialist
Program	_					Medicaid Pro		
State Hea	alth Office							
						For Info	ormation Or	nly
						(No Ch	ange In Ra	te)



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Medicaid Reimbursement Rate Change Form for CHDs

Orange County Health Departme	nt	Pro	Provider Number: 0279587-00			
6101 Lake Ellenor Drive			Date: 07/01/202	3		
Orlando, FL 32804		Fis	Fiscal Year End: 06/30/2022			
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	163.96	163.27	07/01/2023		
Rate Type						
<u>Interim</u>		X Prospec	<u>tive</u>			
Total Int	erim	X	Total Prospective			
Settleme	ent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audit	ewed Cost ted Cost				
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office			CE Jackson, Financial S Medicaid Program Financial	<u> </u>		
			For Information Or	nly		
			(No Change In Ra	ite)		



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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Departmer	it	Prov	Provider Number: 0279595-00 Date: 07/01/2023 Fiscal Year End: 06/30/2022			
P. O. Box 4503091875 Boggy Cree	ek Road					
Kissimmee, FL 34745-0309		 Fis				
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		134.81	163.27	07/01/2023		
Rate Type						
<u>Interim</u>		X Prospec	<u>tive</u>			
Total Inte	rim	X	Total Prospective			
Settlemer	nt Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	d Cost				
	Desk Rev	riewed Cost				
	Desk Aud	lited Cost				
	Field Aud	ited Cost				
DISTRIBUTION						
DISTRIBUTION:			(10)			
Fiscal Agent			CE laskson Financial	Charialist		
Contract Management Program Finance			CE Jackson, Financial Medicaid Program Fina	<u> </u>		
State Health Office			Medicald Frogram i ina	nce		
Glate Health Office						
			For Information O	nly		
			(No Change In Ra	ate)		



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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County F	Pasco County Health Department				Provider Number: 0279617-00			
10841 Little Roa	ad			Date: 07/01/2023				
New Port Riche	ey, FL 34654			Fiscal Year End: 06/30/2022				
				A	Audit Status: Unaudited	Cost		
Provider Typ	<u>pe</u>		Current F	<u>Rate</u>	New Rate	Effective Date		
<u>!</u>	<u>CHD</u>		163.9	6	163.27	07/01/2023		
Rate Type								
<u>l</u>	<u>nterim</u>		X_ <u>P</u>	rospectiv	<u>ve</u>			
_	Total Interin	ı	_	Х	Total Prospective			
_	Settlement	Based on Cost	_		Prospective Adjust	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	d Cost					
		Desk Rev	iewed Cost					
		Desk Aud	ited Cost					
		Field Audi	ited Cost					
DISTRIBUTION	<u>\:</u>				0 0			
Fiscal Ager	nt			(-84			
Contract M	anagement			(CE Jackson, Financial S	Specialist		
Program Fi	inance			N	Medicaid Program Finar	nce		
State Healt	th Office							
					For Information Or	nly		
					—— (No Change In Ra	te)		



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Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County Health Departmer	nt	Prov	Provider Number: 0279625-00			
500 7th Avenue South			Date: 07/01/2023			
St. Petersburg, FL 33701		Fis	cal Year End: 06/30/202	22		
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		163.96	163.27	07/01/2023		
Rate Type						
<u>Interim</u>		X Prospec	<u>tive</u>			
Total Inte	rim	X	Total Prospective			
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	d Cost				
	Desk Rev	iewed Cost				
	Desk Aud	ited Cost				
	Field Aud	ited Cost				
DISTRIBUTION:			0 0			
Fiscal Agent			CEL			
Contract Management			CE Jackson, Financial	Specialist		
Program Finance			Medicaid Program Fina	nce		
State Health Office						
			For Information O	nly		
			—— (No Change In Ra	ate)		



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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Provider Number: 0279633-00				
1290 Golfview Avenue, 4th Floor			Date: 07/01/2023			
Bartow, FL 33830-6740			Fiscal Year End: 06/30/2022			
			Д	udit Status: Un	audited Cos	t
Provider Type		Current Rate		New Ra	<u>te</u>	Effective Date
<u>CHD</u>		163.9	6	163.27	<u> </u>	07/01/2023
Rate Type						
<u>Interim</u>		X <u> </u>	Prospectiv	<u>re</u>		
Total Inte	erim		Χ	Total Prosp	ective	
Settleme	nt Based on Cost			Prospective	e Adjusted F	or New Costs
DISTRIBUTION: Fiscal Agent	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	lewed Cost	(2.EL		
Contract Management				E Jackson, Fin	ancial Speci	ialiet
Program Finance			_	/E Jackson, Fin Medicaid Progra		anst -
State Health Office			·			
				For Informa	ation Only	
			_	—— (No Chang	e In Rate)	



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Departmen	t	Prov	Provider Number: 0279641-00			
2801 Kennedy Street			Date: 07/01/2023			
Palatka, FL 32177		Fis	Fiscal Year End: 06/30/2022			
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		163.96	163.27	07/01/2023		
Rate Type						
<u>Interim</u>		X Prospec	<u>tive</u>			
Total Inte	rim	X	Total Prospective			
Settlemen	nt 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:						
Fiscal Agent			C 50			
Contract Management			CE Jackson, Financial	Specialist		
Program Finance			Medicaid Program Fina			
State Health Office						
			For Information O	nly		
			(No Change In Ra	ite)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County Health Departme	ent	Prov	Provider Number: 0279650-00			
1955 US 1 South			Date: 07/01/2023			
St. Augustine, FL 32086		Fis	Fiscal Year End: 06/30/2022			
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		163.96	163.27	07/01/2023		
Rate Type						
<u>Interim</u>		X Prospect	<u>tive</u>			
Total Inte	rim	X	Total Prospective			
Settlemen	nt 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:			$\Omega \Omega$			
Fiscal Agent			CEX			
Contract Management			CE Jackson, Financial S	<u> </u>		
Program Finance			Medicaid Program Fina	nce		
State Health Office						
			For Information O	nly		
		•	—— (No Change In Ra	ate)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department					Pr	ovide	r Number: (0279668-0	00		
5150 NW Miln	ner Drive							Date: 0	07/01/2023	3	
Port Saint Luc	cie, FL 34	963				Fiscal Year End: 06/30/2022					
							Au	dit Status: - -	Unaudited	Cost	
Provider T	ype				Current Rate		New Rate		Effective	Effective Date	
	<u>CHD</u>				163	3.96		163.	.27	07/01/2	2023
Rate Type											
	<u>Interim</u>				X	<u>Prospe</u>	ctive	<u>)</u>			
		Total Interim				X	(Total Pro	spective		
		Settlement Ba	ased o	on Cost				Prospec	tive Adjust	ed For New Co	sts
			D.A.C	NO-							
			BAS								
				Budget							
			X	Unaudited							
				_	iewed Cost						
				Desk Aud							
				Field Audi -	ted Cost						
DISTRIBUTIO	<u>ON:</u>										
Fiscal Ag	ent						C	-81			
Contract	Managem	ent					CE	E Jackson, F	Financial S	Specialist	
Program	Finance						Me	edicaid Prog	gram Finar	nce	
State Hea	alth Office										
								For Infor	mation On	nly	
								No Cha	nge In Rat	te)	



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Dep	partment	F	Provider Number: 0279676-00			
P.O. Box 929			Date: 0	7/01/2023		
Milton, FL 32572-0929			Fiscal Year End: 06/30/2022			
			Audit Status: U	naudited Cost		
Provider Type		Current Rate	New R	ate Effec	ctive Date	
<u>CHD</u>		163.96	163.2	27 07/	01/2023	
Rate Type Interim		X <u>Prosp</u>	ective			
	nterim		X Total Pros	spective		
Settle	ment Based on Cost		Prospecti	ve Adjusted For Nev	w Costs	
	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	iewed Cost ited Cost				
Fiscal Agent Contract Management				nancial Specialist		
Program Finance State Health Office			Medicaid Progi	am rinance		
State Floatin Office				nation Only ge In Rate)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Departme	nt	Pro	Provider Number: 0279684-00			
P. O. Box 2658			Date: 07/01/2023			
Sarasota, FL 34230-2658		 Fis	Fiscal Year End: 06/30/2022			
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		163.96	163.27	07/01/2023		
Rate Type						
<u>Interim</u>		X Prospec	<u>tive</u>			
Total Inte	rim	X	Total Prospective			
Settlemer	nt Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	d Cost				
		riewed Cost				
	Desk Aud					
	Field Aud					
DISTRIBUTION:			0 0			
Fiscal Agent			CEL			
Contract Management			CE Jackson, Financial	Specialist		
Program Finance			Medicaid Program Fina	nce		
State Health Office						
			For Information O	nly		
			(No Change In Ra	nte)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health D	epartment		Provid	er Number: 0279692-0	00		
400 West Airport Boulevar	d		Date: 07/01/2023				
Sanford, FL 32773			Fiscal Year End: 06/30/2022				
			А	udit Status: Unaudited	Cost		
Provider Type		Current R	<u>ate</u>	New Rate	Effective Date		
<u>CHD</u>		163.96	<u> </u>	163.27	07/01/2023		
Rate Type							
<u>Interim</u>		X_ <u>Pı</u>	rospectiv	<u>′e</u>			
Т	otal Interim		Χ	Total Prospective			
S	Settlement Based on Cost			Prospective Adjust	ted For New Costs		
	BASIS:						
	Budget X Unaudited	I Coot					
		iewed Cost					
	Desk Audi						
	Field Audi						
DISTRIBUTION:				0.0			
Fiscal Agent			(CEL			
Contract Management	t			CE Jackson, Financial S	Specialist		
Program Finance			N	ledicaid Program Finar	nce		
State Health Office							
				For Information Or	nly		
			_	—— (No Change In Rat	te)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter Count	umter County Health Department					Provider Number: 0279706-01				
P. O. Box 98						Date	: 07/01/2023			
Bushnell, FL	33513				Fi	scal Year End	: 06/30/2022			
						Audit Status	: Unaudited (Cost		
Provider T	уре			Curren	t Rate	<u>New</u>	<u>/ Rate</u>	Effective Date		
	<u>CHD</u>			163	.96	16	3.27	07/01/2023		
Rate Type				V	_					
	Interim -	Total Interim		X	_ Prospec X)roop ootivo			
		- Settlement Ba	and an Coat		^		Prospective	od For Now Coata		
		-	ased on Cost				ective Aujuste	ed For New Costs		
			BASIS:							
			Budget	10						
			X Unaudite							
				viewed Cost						
				dited Cost dited Cost						
DISTRIBUTIO	ON:									
Fiscal Ag	jent					CEL				
_	Manageme	ent				CE Jackson	, Financial Sp	pecialist		
Program	Finance					Medicaid Pr	ogram Finand	ce		
State Hea	alth Office									
						For Inf	ormation Onl	у		
						— (No Ch	nange In Rate	e)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County	/ Health De	epartment			Prov	vider Number:	0279722-0	01
1215 Peacock	k Street					Date	07/01/202	3
Perry, FL 323	347				Fis	cal Year End	06/30/202	22
						Audit Status:	Unaudited	l Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			163	.96	165	3.27	07/01/2023
Rate Type	<u>Interim</u>			X	<u>Prospec</u>	<u>tive</u>		
	_	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs
			Desk Au	ed Cost eviewed Cost dited Cost dited Cost				
DISTRIBUTION Fiscal Ag		ent				CEJ_ CE Jackson	. Financial :	Specialist
Program	-	511t				Medicaid Pro		<u> </u>
_	alth Office					Modicald I I	ogrami ma	1100
						For Info	ormation O	nly
						(No Ch	ange In Ra	ate)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Union County	Inion County Health Department					Pr	ovider	Number: 0279731-	00	
495 East Mair	n Street							Date: 07/01/202	3	
Lake Butler, F	L 32054					Fiscal Year End: 06/30/2022				
							Aud	lit Status: Unaudited	d Cost	
Provider T	ype				Curren	t Rate		New Rate	Effective Da	<u>te</u>
	CHD				163	.96		163.27	07/01/2023	3
Rate Type										
	<u>Interim</u>				X	<u>Prospe</u>	ctive			
		Total Interim				X		Total Prospective		
		Settlement Ba	ased o	on Cost				Prospective Adjus	ted For New Costs	
			BAS							
				Budget -						
			X	Unaudited -						
				_	iewed Cost					
				Desk Aud						
				Field Audi -	ted Cost					
DISTRIBUTIO	ON:									
Fiscal Ag	ent							8		
Contract	Managem	ent					CE	Jackson, Financial	Specialist	
Program	Finance							dicaid Program Fina		
State Hea	alth Office									
								For Information O	nly	
								_ (No Change In Ra	ate)	



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County	Health Department			Provider Number: 0279749-00				
P. O. Box 9190)			Date: 07/01/2023				
Daytona Beach	n, FL 32120			Fiscal Year End: 06/30/2022				
				A	audit Status: Unaudited	Cost		
Provider Ty	<u>pe</u>		Current F	<u>Rate</u>	New Rate	Effective Date		
	<u>CHD</u>		163.9	6	163.27	07/01/2023		
Rate Type								
	<u>Interim</u>		X_ <u>P</u>	rospectiv	<u>/e</u>			
	Total Interim			Χ	Total Prospective			
_	Settlement E	Based on Cost	_		Prospective Adjust	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		Desk Rev	iewed Cost					
		Desk Aud	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION	N <u>:</u>				2 0			
Fiscal Age				(-84			
_	lanagement			C	E Jackson, Financial S	Specialist		
Program F	ïnance			<u> </u>	Medicaid Program Finar	nce		
State Heal	th Office							
					For Information Or	nly		
				_	—— (No Change In Ra	te)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department	Wakulla County Health Department				00		
48 Oak Street			Date: 07/01/2023				
Crawfordville, FL 32327			Fiscal Year End: 06/30/2022				
			A	Audit Status: Unaudited	l Cost		
Provider Type		Current	Rate	New Rate	Effective Date		
<u>CHD</u>		163.9	6	163.27	07/01/2023		
Rate Type							
<u>Interim</u>		Х <u>і</u>	Prospecti	<u>ve</u>			
Total Interin	า		X	Total Prospective			
Settlement	Based on Cost			Prospective Adjus	ted For New Costs		
DISTRIBUTION:	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	iewed Cost					
Fiscal Agent			(-27			
Contract Management			(CE Jackson, Financial	Specialist		
Program Finance			7	Medicaid Program Fina	nce		
State Health Office							
				For Information O	nly		
			_	—— (No Change In Ra	ite)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Washington C	County Hea	alth Departmen	t		Provi	ider Number:	0279773-0	00
1338 South B	oulevard					Date	07/01/202	3
Chipley, FL 3	32428				Fisc	al Year End:	06/30/2022	2
						Audit Status:	Unaudited	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			163	.96	163	3.27	07/01/2023
Rate Type	Interim			X	Prospect	<u>ive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs
			Desk Aud	d Cost viewed Cost dited Cost dited Cost				
DISTRIBUTION Fiscal Ag					(00		
_	Manageme	ent				CE Jackson,	Financial S	specialist
Program	_					Medicaid Pro		<u></u>
State Hea	alth Office							
						For Info	ormation Or	nly
					_	—— (No Ch	ange In Ra	te)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Departn	nent	Pro	vider Number: 0290068	-00			
597 West 11th Street			Date: 07/01/20	23			
Panama City, FL 32401-23	330	Fis	Fiscal Year End: 06/30/2022				
			Audit Status: Unaudite	ed Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	146.32	163.27	07/01/2023			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
To	otal Interim	x	Total Prospective	9			
Se	ettlement Based on Cost		Prospective Adju	sted For New Costs			
	BASIS: Budget X Unaudited Desk Revie Desk Audit Field Audit	ewed Cost red Cost					
DISTRIBUTION: Fiscal Agent			CEL				
Contract Management			CE Jackson, Financial	Specialist			
Program Finance			Medicaid Program Fina	ance			
State Health Office							
			For Information C	Only			
			(No Change In R	tate)			



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Medicaid Reimbursement Rate Change Form for CHDs

Lafayette Cou	afayette County Health Department					Provider Number: 0290343-00				
P.O. Box 180	6					Date	: 07/01/2023	}		
Mayo, FL 320	066				Fis	scal Year End	: 06/30/2022	2		
						Audit Status	: Unaudited	Cost		
Provider T	уре			Curren	t Rate	New	/ Rate	Effective Date		
	CHD			163	.96	16	3.27	07/01/2023		
Rate Type										
	<u>Interim</u>			X	Prospec	<u>tive</u>				
	_	Total Interim			_ X	Total F	Prospective			
		Settlement Ba	ased on Cost			Prospe	ective Adjuste	ed For New Costs		
DISTRIBUTIO			Desk Au	ed Cost eviewed Cost dited Cost dited Cost		Ca				
Fiscal Ag	jent					CEX				
	Manageme	ent					, Financial S	<u>-</u>		
Program State Hea	Finance alth Office					Medicaid Pr	ogram Finan	ce		
						For Inf	ormation On	ly		
						(No Cł	nange In Rat	e)		



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Madison Cou	ladison County Health Department					Provider Number: 0290408-00				
801 S.W. Smi	ith Street							Date: 07/01/2023	3	
Madison, FL	32340					Fiscal Year End: 06/30/2022				
							Auc	it Status: Unaudited	Cost	
Provider T	уре				Curren	t Rate	!	New Rate	Effective Date	
	CHD			_	163	.96		163.27	07/01/2023	
Rate Type										
	<u>Interim</u>				X	<u>Pros</u>	<u>pective</u>			
		Total Interim					Х	Total Prospective		
		Settlement Ba	ased on Co	st				Prospective Adjust –	ted For New Costs	
			Des Des	audited sk Revi	Cost ewed Cost ted Cost ted Cost					
DISTRIBUTIO Fiscal Ag							C	-EJ_		
Contract	Manageme	ent					CE	Jackson, Financial S	Specialist	
Program	Finance						Ме	dicaid Program Finar	nce	
State Hea	alth Office									
								For Information Or	nly	
								– (No Change In Rat	te)	



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Suwannee Co	uwannee County Health Department					ider Number:	0518328-0	00
P. O. Box 603	30					Date	07/01/202	3
Live Oak, FL	32060				Fisc	cal Year End:	06/30/202	2
						Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			163	.96	13	5.66	07/01/2023
Rate Type	<u>Interim</u>			X	Prospect	<u>ive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs
			Desk Au	ed Cost viewed Cost dited Cost dited Cost				
	ent Manageme	ent				CE Jackson		<u> </u>
Program						Medicaid Pro	ogram Finai	nce
State Hea	alth Office							
						For Info	ormation Or	nly
					•	(No Ch	ange In Ra	te)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Holmes County Health Department		Prov	Provider Number: 0519022-00					
P. O. Box 337603 Scenic Circle			Date: 07/01/202	3				
Bonifay, FL 32425		 Fis	Fiscal Year End: 06/30/2022					
			Audit Status: Unaudited	d Cost				
Provider Type		Current Rate	New Rate	Effective Date				
<u>CHD</u>		142.84	142.28	07/01/2023				
Rate Type								
<u>Interim</u>		X Prospec	<u>tive</u>					
Total Inter	rim	X	Total Prospective					
Settlemen	t Based on Cost		Prospective Adjus	ted For New Costs				
	BASIS:							
	Budget							
	X Unaudited	d Cost						
	——— Desk Rev	riewed Cost						
	——— Desk Aud	lited Cost						
	Field Aud							
DISTRIBUTION:			0 0					
Fiscal Agent			CEL					
Contract Management			CE Jackson, Financial S	Specialist				
Program Finance			Medicaid Program Fina	nce				
State Health Office								
			For Information O	nly				
			(No Change In Ra	nte)				



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Departi	ment	Pro	vider Number: 0519251-0	00	
2572 N. Courtenay Parkway			Date: 07/01/202	ate: 07/01/2023	
Merritt Island, FL 32953-4147		 Fis	scal Year End: 06/30/202	2	
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		163.96	163.27	07/01/2023	
Rate Type					
<u>Interim</u>		X <u>Prospec</u>	<u>tive</u>		
 Total	Interim	x	Total Prospective		
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	ewed Cost ted Cost			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office			CE Jackson, Financial S Medicaid Program Fina	<u> </u>	
			For Information O		
			(INO Change in Ra	uc)	



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Hea	Ith Department			Pro	ovider Number	: 0520331-0	00
P. O. Box 29					Date	e: 07/01/2023	
West Palm Beach, FL 3	3402			Fi	scal Year End	: 06/30/202	2
					Audit Status	: Unaudited	Cost
Provider Type		!	Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
<u>CHD</u>			163.	.96	16	3.27	07/01/2023
Rate Type							
<u>Interim</u>			X	Prospec	<u>ctive</u>		
	Total Interim			X	Total F	rospective	
	Settlement Based on 0	Cost		Prospective Adjusted For New			
	BASIS	2.					
		<u>. </u>					
		naudited Co	net				
		esk Review					
		esk Audited					
		ield Audited					
		ieia Addited	Cost				
DISTRIBUTION:							
Fiscal Agent					CEL	_	
Contract Manageme	ent				CE Jackson	, Financial S	Specialist
Program Finance					Medicaid Pr	ogram Finar	nce
State Health Office							
					For Inf	ormation Or	nly
					(No Ch	nange In Ra	te)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department					Provider Number: 0520446-00				
514 East Grace Street					Date: 07/01/2023				
Punta Gorda,	FL 33950)				F	iscal Y	ear End: 06/30/2022	2
							Aud	it Status: Unaudited	Cost
Provider T	ype				Curren	t Rate		New Rate	Effective Date
	<u>CHD</u>				163	.96		162.37	07/01/2023
Rate Type									
	Interim -				X	Prospe			
		Total Interim				X		Total Prospective	
		Settlement Ba	ased c	on Cost				Prospective Adjust -	ted For New Costs
			BAS	SIS:					
				Budget					
			X	_ Unaudited	d Cost				
				Desk Rev	iewed Cost				
				Desk Aud	ited Cost				
				Field Audi	ited Cost				
DISTRIBUTIO	ON:						0		
Fiscal Ag	ent						C	EL_	
Contract	Managem	ent					CE	Jackson, Financial S	Specialist
Program	Finance						Med	dicaid Program Finar	nce
State Hea	alth Office								
								For Information Or	nly
								_ (No Change In Ra	te)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Hillsborough (County He	alth Departmei	nt		Prov	ider Number:	0557269-0	00
1105 E. Kenn	edy Boule	vard				Date	07/01/202	3
Tampa, FL 33	3602				Fisc	cal Year End:	06/30/2022	2
						Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			163	.96	163	3.27	07/01/2023
Rate Type	Interim			X	Prospect	<u>ive</u>		
	_	Total Interim			- x		rospective	
		- Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs
			Desk Au	ed Cost eviewed Cost dited Cost dited Cost				
Program	ent Manageme	ent				CE Jackson Medicaid Pro		
					-		ormation Or	-



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Depart	ment	I	Provider Number: 0563234-00 Date: 07/01/2023				
P. O. Box 1305421 West M	ain Street						
Tavares, FL 32778-1305			Fiscal Year End: 06/30	/2022			
			Audit Status: Unau	dited Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		163.96	163.27	07/01/2023			
Rate Type							
<u>Interim</u>		X Pros	<u>oective</u>				
To	otal Interim		X Total Prospec	tive			
Se	ettlement Based on Cost		Prospective A	Adjusted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	l Cost					
	Desk Revi	iewed Cost					
	Desk Audi	ited Cost					
	Field Audi	ted Cost					
DISTRIBUTION:							
Fiscal Agent			(19)				
Contract Management			CE Jackson, Finar	icial Specialist			
Program Finance			Medicaid Program	Finance			
State Health Office							
			For Information	on Only			
			(No Change I	n Rate)			



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Depa	rtment	Pro	ovider Number: 0600181-	00			
1295 West Fairfield Drive			Date: 07/01/2023 Fiscal Year End: 06/30/2022				
Pensacola, FL 32501							
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		163.96	163.27	07/01/2023			
Rate Type							
<u>Interim</u>		X Prospe	<u>ctive</u>				
Total I	Interim	x	Total Prospective				
Settle	ment 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:			00				
Fiscal Agent			CEL				
Contract Management			CE Jackson, Financial	Specialist			
Program Finance			Medicaid Program Fina	nce			
State Health Office							
			For Information O	nly			
			(No Change In Ra	ite)			