Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### Medicaid Reimbursement Rate Change Form for CHDs

Alachua County	Health D	Department			Provid	der Number:	0279111-0	0
224 SE 24th Street730 N.E. Waldo Road, Suite 500				Date: 07/01/2021				
Gainesville, FL 32641				Fisca	al Year End:	06/30/2020	)	
					A	Audit Status:	Unaudited	Cost
Provider Typ	<u>e</u>			<u>Current F</u>	Rate	New	Rate	Effective Date
<u>C</u>	<u>CHD</u>			166.59	9	164	.28	07/01/2021
<u>Rate Type</u>	<u>nterim</u>			х <u>р</u>	rospectiv	ve		
		Total Interim			Х	Total Pr	ospective	
_		Settlement Base	ed on Cost	_		Prospec	ctive Adjuste	ed For New Costs
		<u>B</u>	ASIS:					
			Budget					
			X Unaudited	Cost				
			Desk Revi	iewed Cost				
			Desk Audi	ited Cost				
		_	Field Audit	ted Cost				
DISTRIBUTION: Fiscal Agent	_					FF		
Contract Ma		nt			F	Rydell Samue	el. Administ	rator

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 Health Dep	Prov	ider Number: 0279111-	91	
224 SE 24th Street730 N.E.		Date: 07/01/202	: 07/01/2021	
Gainesville, FL 32641	Fise	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		166.59	164.28	07/01/2021
Rate Type				
Interim		X Prospect	ive	
To	tal Interim	X	Total Prospective	
Se	ettlement 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			1	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Alachua County Health Depa	Prov	ider Number: 0279111-9	93	
224 SE 24th Street730 N.E. V		Date: 07/01/202	07/01/2021	
Gainesville, FL 32641	Fise	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		166.59	164.28	07/01/2021
Rate Type				
Interim		X Prospect	ive	
Tota	I Interim	X	Total Prospective	
Settl	lement 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:			TR	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Baker County Health Departm	nent	Provi	ider Number: 0279129-0	00	
480 West Lowder Street			Date: 07/01/202	: 07/01/2021	
Macclenny, FL 32063	Fisc	cal Year End: 06/30/202	0		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	163.76	165.26	07/01/2021	
Rate Type					
<u>Interim</u>		X <u>Prospect</u>	ive		
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	ed Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			[N		
Contract Management			Rydell Samuel, Adminis		
Program Finance			Medicaid Program Final	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Baker County Health Departme	ent	Prov	ider Number: 0279129-0	01	
480 West Lowder Street			Date: 07/01/202	07/01/2021	
Macclenny, FL 32063	Fis	cal Year End: 06/30/202	0		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	163.76	165.26	07/01/2021	
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	Cost			
	Desk Revi	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

Baker County Health Department		Provi	der Number: 0279129-1	1
480 West Lowder Street			Date: 07/01/202	1
Macclenny, FL 32063	Fisc	al Year End: 06/30/2020	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	163.76	165.26	07/01/2021
Rate Type				
Interim		X Prospect	<u>ve</u>	
Total Inte	rim	X	Total Prospective	
Settleme	nt Based on Cost		Prospective Adjust	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			[N	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Finar	nce

State Health Office

Medicaid Program Finance



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Departme	Prov	ider Number: 0279145-0	00		
1801 North Temple Avenue			Date: 07/01/202	: 07/01/2021	
Starke, FL 32091	Fise	cal Year End: 06/30/202	0		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		166.59	165.26	07/01/2021	
Rate Type					
Interim		X Prospect	<u>ive</u>		
Total Inte	rim	X	Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs	
	<u>BASIS:</u> Budget				
	X Unaudited	l Cost			
		iewed Cost			
	 Desk Audi				
	 Field Audi	ted Cost			
DISTRIBUTION: Fiscal Agent			TA		
Contract Management			I Dydoll Somuol Adminia	trator	
Program Finance			Rydell Samuel, Adminis Medicaid Program Fina		

State Health Office

Medicaid Program Finance



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Department		Provider Numb	er: 0279145-0	04	
1801 North Temple Avenue		Da	ate: 07/01/202	: 07/01/2021	
Starke, FL 32091		Fiscal Year E	nd: 06/30/202	0	
		Audit Stat	us: Unaudited	l Cost	
Provider Type	Current	Rate No	ew Rate	Effective Date	
CHD	166.5	591	65.26	07/01/2021	
Rate Type					
Interim	X	Prospective			
Total Interim	_	X Tota	I Prospective		
Settlement Based on C	Cost	Pros	spective Adjus	ted For New Costs	
BASIS	<u>):</u>				
В	udget				
	naudited Cost				
D	esk Reviewed Cost				
D	esk Audited Cost				
Fi	eld Audited Cost				
DISTRIBUTION:		TR			
Fiscal Agent		p()			
Contract Management		, Rydell Sa	muel, Adminis	strator	
Program Finance			Program Fina		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Departm	Prov	ider Number: 0279145-3	30	
1801 North Temple Avenue			Date: 07/01/202	1
Starke, FL 32091	Fise	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Int	terim	X	Total Prospective	
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited			
		iewed Cost		
	Desk Aud			
	Field Audi	ited Cost		
			TR	
DISTRIBUTION:			a	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Departm	Prov	ider Number: 0279145-9	91	
1801 North Temple Avenue			Date: 07/01/202	1
Starke, FL 32091	Fise	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Int	terim	X	Total Prospective	
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited			
		iewed Cost		
	Desk Audi			
	Field Audi	ted Cost		
			TR	
DISTRIBUTION:			R	
Fiscal Agent			1.	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Broward Coun	nty Health	Department					Provi	der Nun	nber: 0279	161-00	
780 SW 24th Street				Date:		Date: 07/01	: 07/01/2021				
Fort Lauderdale, FL 33315					Fisc	al Year	End: 06/30	0/2020			
							1	Audit St	atus: Unau	udited Cos	st
Provider Ty	<u>/pe</u>				<u>Curre</u>	nt Rat	: <u>e</u>	ļ	New Rate	<u>1</u>	Effective Date
	<u>CHD</u>			-	96	.69			125.03	·	07/01/2021
Rate Type	Interim				Х	Pro	specti	Ve			
	- -	Total Interim					<u>эрсси</u> Х		tal Prospec	ctive	
		- Settlement Bas	sed on	n Cost					•		For New Costs
		-		_						-	
		<u>I</u>	BASI								
		-		Budget	_						
		_		Unaudited							
		-		Desk Revi		t					
		-		Desk Audi							
		-	I	Field Audi	ted Cost						
	<b>N</b> I.							THE			
DISTRIBUTIO								R			
Fiscal Age								1.			
	Managem 	ent					-	-	Samuel, Ad		<u>or</u>
Program I	Finance							Medicai	d Program	Finance	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health De	epartment	Provider Number: 0279161-01 Date: 07/01/2021			
780 SW 24th Street					
Fort Lauderdale, FL 3331	5	Fiscal Y	/ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost
Provider Type		Curren	t Rate	New Rate	Effective Date
<u>CHD</u>		96.	69	125.03	07/01/2021
Rate Type					
<u>Interim</u>		Х	Prospective		
т	otal Interim		- x	Total Prospective	
S	Settlement Based on Cos	st		Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Bud	get			
	X Una	udited Cost			
	Desl	k Reviewed Cost			
	Desl	k Audited Cost			
	Field	d Audited Cost			
DISTRIBUTION:				R	
Fiscal Agent			1	N N	
Contract Managemen	t		Ryc	lell Samuel, Adminis	trator
Program Finance				dicaid Program Finar	
State Health Office					



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#### Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Departm	nent		Provider Number: 0279161-04 Date: 07/01/2021			
780 SW 24th Street						
Fort Lauderdale, FL 33315			Fiscal Y	/ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current Ra	ite	New Rate	Effective Date	
CHD	-	96.69		125.03	07/01/2021	
Rate Type						
Interim		X <u>Pr</u>	<u>ospective</u>			
Total Ir	nterim		Х	Total Prospective		
Settlen	nent Based on Cost			Prospective Adjust	ted For New Costs	
				-		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			~	R		
Fiscal Agent			1			
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

Broward County Health Departm	nent		Provider Number: 0279161-93 Date: 07/01/2021			
780 SW 24th Street						
Fort Lauderdale, FL 33315			Fiscal Y	ear End: 06/30/2020	0	
			Audi	t Status: Unaudited	Cost	
Provider Type		Current Rat	<u>e</u>	New Rate	Effective Date	
CHD	-	96.69		125.03	07/01/2021	
Rate Type						
<u>Interim</u>		X <u>Pro</u>	<u>spective</u>			
Total Ir	iterim		Х	Total Prospective		
Settlem	nent Based on Cost			Prospective Adjust	ted For New Costs	
	BASIS:					
	Budget					
	X Unaudited	Cost				
	 Desk Revie					
	 Desk Audit					
	Field Audit	ed Cost				
DISTRIBUTION:			_	R		
Fiscal Agent			۴	V		
Contract Management			Ryd	ell Samuel, Adminis	trator	
Program Finance			Med	licaid Program Finar	nce	
State Health Office						



Office of Medicaid Program Finance

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### Medicaid Reimbursement Rate Change Form for CHDs

Calhoun Cour	nty Health	Department				Provid	der Number:	0279170-00	0	
19611 S.R. 20	) West						Date	07/01/2021		
Blountstown,	FL 32424					Fiscal Year End: 06/30/2020				
						ŀ	Audit Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospective Street Prospective ProspectiProspective Prospective Prospective Prospective Pr	ve			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs	
			BAS	SIS:						
				Budget						
			X	_ Unaudited	Cost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						T			
Fiscal Ag	ent						$(\mathbb{N})$			
Contract	Managem	ent				<u> </u>	Rydell Samu	iel, Administ	rator	
Program	Finance					ſ	Medicaid Pro	ogram Finan	се	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Calhoun County Health I	Department			Provide	r Number: 0279170-3	0
19611 S.R. 20 West					Date: 07/01/202	1
Blountstown, FL 32424				Fiscal	Year End: 06/30/2020	)
				Au	dit Status: Unaudited	Cost
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>		-	166	.59	165.26	07/01/2021
Rate Type						
<u>Interim</u>			Х	<b>Prospective</b>	2	
	Total Interim			- x	Total Prospective	
	Settlement Base	ed on Cost			Prospective Adjust	ed For New Costs
	<u>E</u>	<u>BASIS:</u>				
	_	Budget				
		X Unaudited	Cost			
	_	Desk Revi	ewed Cost			
	_	Desk Audi	ted Cost			
	_	Field Audit	ted Cost			
DISTRIBUTION:				-	K	
Fiscal Agent					pl)	
Contract Manageme	ent			Ry	dell Samuel, Administ	trator
Program Finance				Me	edicaid Program Finar	nce
State Health Office						



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#### Medicaid Reimbursement Rate Change Form for CHDs

Calhoun County Health Department		Provider Nu	mber: 0279170-9	91	
19611 S.R. 20 West			Date: 07/01/202	1	
Blountstown, FL 32424		Fiscal Year End: 06/30/2020			
		Audit S	tatus: Unaudited	Cost	
Provider Type	Curre	nt Rate	New Rate	Effective Date	
CHD	160	6.59	165.26	07/01/2021	
Rate Type	х	Processiva			
Interim Total Interi		_	otal Prospective		
	Based on Cost			ted For New Costs	
	BASIS:         Budget         X       Unaudited Cost         Desk Reviewed Cost         Desk Audited Cost         Field Audited Cost	st			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance			Samuel, Adminis		

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### Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Depa	artment	Prov	ider Number: 0279196-	00		
3700 Sovereign Path			Date: 07/01/202	21		
Lecanto, FL 34461-8071		Fise	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudite	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		166.59	165.27	07/01/2021		
Rate Type		Y Decomposit				
<u>Interim</u>	otal Interim	X Prospect	Total Prospective			
	Settlement Based on Cost	X		sted For New Costs		
3	elliement based on Cost			sied for new Cosis		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audi	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			M			
Contract Management	t		Rydell Samuel, Admini	strator		
Program Finance			Medicaid Program Fina	ance		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department		Prov	ider Number: 0279196-0	01			
3700 Sovereign Path			Date: 07/01/202	1			
Lecanto, FL 34461-8071		Fiso	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	_	166.59	165.27	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	<u>ive</u>				
Total Inte	erim	X	Total Prospective				
Settleme	ent 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			<u> </u>				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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#### Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department		Prov	ider Number: 0279196-0	)2
3700 Sovereign Path			Date: 07/01/202	1
Lecanto, FL 34461-8071		Fiso	cal Year End: 06/30/2020	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.27	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect		
Total Inte		X	Total Prospective	
Settlemer	nt Based on Cost		Prospective Adjust	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			[N]	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Finar	nce

State Health Office



Office of Medicaid Program Finance

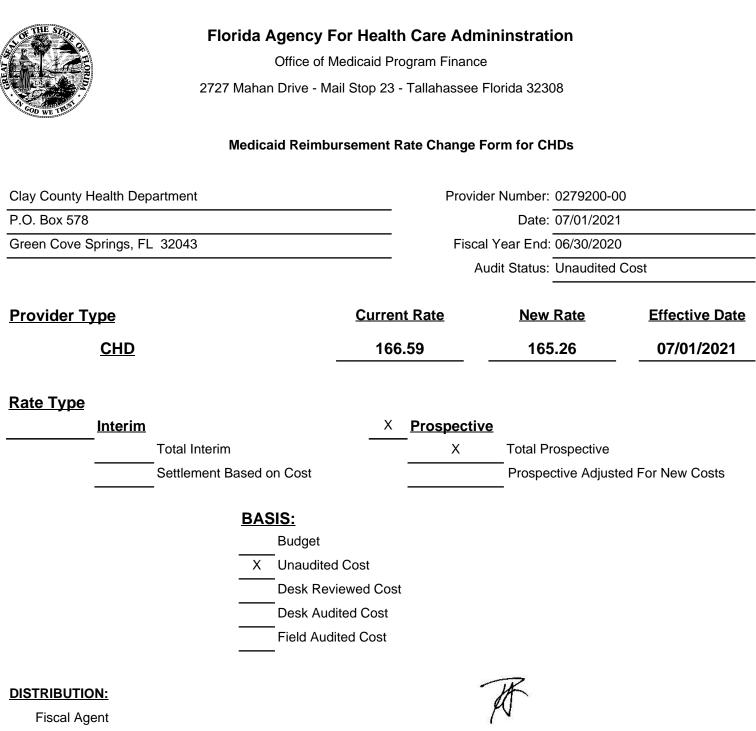
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#### Medicaid Reimbursement Rate Change Form for CHDs

Citrus County H	-lealth De	partment			Prov	vider Number	: 0279196-9	€
3700 Sovereigr	n Path					Date	: 07/01/202	1
Lecanto, FL 34	4461-807	1			Fis	scal Year End	: 06/30/202	0
						Audit Status	: Unaudited	Cost
Provider Ty	<u>pe</u>			<u>Curren</u>	t Rate	New	<u> Rate</u>	Effective Date
	<u>CHD</u>			166	.59	16	5.27	07/01/2021
Rate Type								
<u> </u>	<u>Interim</u>			X	Prospec	<u>tive</u>		
_		Total Interim			X	Total F	rospective	
_		Settlement Based	on Cost			Prospe	ective Adjus	ted For New Costs
		BA	<u>SIS:</u>					
			Budget					
		X	Unaudited	l Cost				
			 Desk Revi	iewed Cost				
			 Desk Audi	ited Cost				
			Field Audi	ted Cost				
						R		
DISTRIBUTION						ar		
Fiscal Age						/ *		
Contract M	-	ent				Rydell Sam		
Program F	inance					Medicaid Pr	ogram Finai	nce

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State Health Office



**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

Clay County Health Department			Provider Number: 0279200-01				
P.O. Box 578			Date: 07/01/2021				
Green Cove Springs, FL 32043			Fiscal Y	/ear End: 06/30/202	0		
			Aud	lit Status: Unaudited	Cost		
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date		
<u>CHD</u>	-	166	.59	165.26	07/01/2021		
Rate Type							
<u>Interim</u>		Х	<b>Prospective</b>				
Total Interin	m		×	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 Audite	ed Cost					
DISTRIBUTION:			/	R			
Fiscal Agent			1	20			
Contract Management			Ryc	lell Samuel, Adminis	trator		
Program Finance				dicaid Program Fina			
State Health Office							



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-02				
P.O. Box 578			Date: 07/01/2021				
Green Cove Springs, FL 32043			Fiscal Y	/ear End: 06/30/202	0		
			Aud	lit Status: Unaudited	Cost		
Provider Type		Curren	t Rate	New Rate	Effective Date		
<u>CHD</u>	-	166.	.59	165.26	07/01/2021		
Rate Type							
<u>Interim</u>		Х	<b>Prospective</b>				
Total Interi	m		×	Total Prospective			
Settlement	Based on Cost			Prospective Adjus	ted For New Costs		
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	BASIS:						
	Budget						
	X Unaudited	Cost					
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DISTRIBUTION:			~	R			
Fiscal Agent			1	e(j			
Contract Management			Ryc	lell Samuel, Adminis	strator		
Program Finance			Med	dicaid Program Finar	nce		
State Health Office							



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-03			
P.O. Box 578				Date: 07/01/202	1	
Green Cove Springs, FL 32043			Fiscal Y	/ear End: 06/30/202	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>	-	166.	59	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	<b>Prospective</b>			
Total Interi	m		x	Total Prospective		
Settlement	Based on Cost			Prospective Adjus	ted For New Costs	
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	BASIS:					
	Budget					
	X Unaudited	Cost				
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	Field Audite	ed Cost				
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Fiscal Agent			1	u)		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Fina	nce	
State Health Office						



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### Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-04			
P.O. Box 578			Date: 07/01/2021			
Green Cove Springs, FL 32043		Fiscal Y	/ear End: 06/30/202	0		
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD	-	166.	59	165.26	07/01/2021	
Rate Type						
Interim		Х	Prospective			
Total In	terim		Х	Total Prospective		
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	Field Audit	ted Cost				
DISTRIBUTION:			-	IR		
Fiscal Agent			ť	K) `		
Contract Management			Ryd	lell Samuel, Adminis	strator	
Program Finance			Med	dicaid Program Finar	nce	
State Health Office						



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### Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider	Number: 0279200-0	)5	
P.O. Box 578			Date: 07/01/2021			
Green Cove Springs, FL 32043			Fiscal Y	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD	_	166.5	9	165.26	07/01/2021	
Rate Type						
Interim		Х <u>і</u>	Prospective			
Total Inte	rim		Х	Total Prospective		
Settlemer	nt Based on Cost	-		Prospective Adjus	ted For New Costs	
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	Budget					
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DISTRIBUTION: Fiscal Agent			1	AT I		
Contract Management			Rvo	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office				-		



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#### Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider	Number: 0279200-9	91
P.O. Box 578		Date: 07/01/2021			
Green Cove Springs, FL 32043		Fiscal Y	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost
Provider Type		Curren	t Rate	New Rate	Effective Date
<u>CHD</u>	-	166	.59	165.26	07/01/2021
Rate Type					
<u>Interim</u>		Х	<b>Prospective</b>		
Total Interi	m		×	Total Prospective	
Settlement	Based on Cost			Prospective Adjus	ted For New Costs
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	Desk Revie	ewed Cost			
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	Field Audit	ed Cost			
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Fiscal Agent			1		
Contract Management			Ryc	lell Samuel, Adminis	strator
Program Finance			Med	dicaid Program Finar	nce
State Health Office					



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#### Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider	Number: 0279200-9	92
P.O. Box 578		Date: 07/01/2021			
Green Cove Springs, FL 32043		Fiscal \	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date
CHD		166	.59	165.26	07/01/2021
Rate Type					
Interim		Х	Prospective		
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	Desk Audi	ted Cost			
	Field Audit	ted Cost			
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Fiscal Agent Contract Management			1		4
Program Finance				lell Samuel, Adminis dicaid Program Finar	
State Health Office			Med	aloaid i Tograffi i Indi	



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### Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department		Provider	Number: 0279218-	00
P.O. Box 429			Date: 07/01/202	21
Naples, FL 34106-0429		Fiscal `	Year End: 06/30/202	20
		Auc	lit Status: Unaudited	d Cost
Provider Type	Current	Rate	New Rate	Effective Date
<u>CHD</u>	166.5	9	165.26	07/01/2021
Rate Type				
<u>Interim</u>	<u> </u>	Prospective		
Total Interim	_	Х	Total Prospective	
Settlement Based on C	ost –		Prospective Adjus	sted For New Costs
BASIS:	<u>.</u>			
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De	esk Reviewed Cost			
De	esk Audited Cost			
Fie	eld Audited Cost			
		/	TR	
DISTRIBUTION:		j	a	
Fiscal Agent		1	2	
Contract Management			dell Samuel, Adminis	
Program Finance		Me	dicaid Program Fina	nce

For Information Only
(No Change In Rate)

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#### Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Depa	artment		Provider	Number: 0279218-0	)1	
P.O. Box 429			Date: 07/01/2021 Fiscal Year End: 06/30/2020			
Naples, FL 34106-0429						
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		166	.59	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	Prospective			
т	otal Interim		- x	Total Prospective		
S	ettlement Based on C	ost		Prospective Adjust	ted For New Costs	
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	BASIS:	_				
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	XUn	audited Cost				
	De	sk Reviewed Cost				
	De	sk Audited Cost				
	Fie	eld Audited Cost				
DISTRIBUTION:			~	R		
Fiscal Agent			1	W		
Contract Management	t		Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office						



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### Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Departm	nent		Provider	Number: 0279218-1	1	
P.O. Box 429			Date: 07/01/2021			
Naples, FL 34106-0429			Fiscal Y	'ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current I	Rate	New Rate	Effective Date	
CHD	-	166.5	9	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х <u></u>	Prospective			
Total	Interim		Х	Total Prospective		
Settle	ement Based on Cost	_		Prospective Adjust	ted For New Costs	
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	BASIS:					
	Budget					
	X Unaudited	Cost				
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DISTRIBUTION:			ý	at the second se		
Fiscal Agent			1	<b>A</b> .		
Contract Management				lell Samuel, Adminis		
Program Finance			Med	dicaid Program Finar	nce	
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### Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Departmen	t		Provider	Number: 0279218-1	15	
P.O. Box 429			Date: 07/01/2021 Fiscal Year End: 06/30/2020			
Naples, FL 34106-0429						
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	-	166.	59	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Int	erim		Х	Total Prospective		
Settleme	ent Based on Cost			Prospective Adjust	ted For New Costs	
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	<b>BASIS:</b>					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audito	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	V		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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### Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Depart	ment		Provider	Number: 0279218-3	0	
P.O. Box 429			Date: 07/01/2021			
Naples, FL 34106-0429			Fiscal Y	'ear End: 06/30/2020	)	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current F	late	New Rate	Effective Date	
<u>CHD</u>	-	166.59	)	165.26	07/01/2021	
Rate Type						
Interim		х <u>р</u>	<u>rospective</u>			
Tota	al Interim		Х	Total Prospective		
Sett	tlement Based on Cost			Prospective Adjust	ed For New Costs	
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	<b>BASIS:</b>					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
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DISTRIBUTION:			ý	at the second se		
Fiscal Agent			1	<b>A</b> .		
Contract Management				lell Samuel, Administ		
Program Finance			Med	dicaid Program Finar	nce	
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#### Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Departme	ent		Provider	Number: 0279218-9	91	
P.O. Box 429			Date: 07/01/2021			
Naples, FL 34106-0429			Fiscal Y	/ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current R	ate	New Rate	Effective Date	
<u>CHD</u>	-	166.59		165.26	07/01/2021	
Rate Type						
<u>Interim</u>		X <u>Pr</u>	ospective			
Total	Interim		Х	Total Prospective		
Settle	ment Based on Cost			Prospective Adjust	ted For New Costs	
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	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
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DISTRIBUTION:				IK		
Fiscal Agent			(			
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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### Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Departm	ent	Prov	ider Number: 0279226-0	00
217 North East Franklin Street		Date: 07/01/202	e: 07/01/2021	
Lake City, FL 32055		Fise	cal Year End: 06/30/202	20
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.27	07/01/2021
Rate Type				
Interim		X <u>Prospect</u>	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			[N]	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Columbia County He	ealth Department			Provider	Number: 0279	226-09		
217 North East Fran	klin Street				Date: 07/0	1/2021		
Lake City, FL 3205	5			Fiscal Year End: 06/30/2020				
				Aud	it Status: Una	udited Cost		
Provider Type			<u>Current R</u>	<u>ate</u>	New Rate	<u>e</u> <u>E</u>	ffective Date	
<u>CHI</u>	<u>)</u>		166.59		165.27		07/01/2021	
Rate Type								
Inter	<u>im</u>		X <u>P</u>	<u>rospective</u>				
	Total Interim			Х	Total Prospe	ctive		
	Settlement Ba	ased on Cost			Prospective	Adjusted For	New Costs	
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		Desk Revi	iewed Cost					
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DISTRIBUTION:				-	R			
Fiscal Agent				1	Ń			
Contract Manag		Ryd	ell Samuel, Ac	Iministrator				
Program Financ	e			Med	licaid Program	Finance		

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### Medicaid Reimbursement Rate Change Form for CHDs

Columbia Count	columbia County Health Department						vider Numbei	: 0279226	-91	
217 North East	Franklin	Street					Date	: 07/01/202	21	
Lake City, FL 3	2055					Fiscal Year End: 06/30/2020				
							Audit Status	: Unaudite	d Cost	
Provider Typ	<u>be</u>				<u>Curren</u>	t Rate	Nev	v Rate	Effective Date	
<u>(</u>	<u>CHD</u>				166.59		16	5.27	07/01/2021	
Rate Type										
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DISTRIBUTION	<u>l:</u>						TR			
Fiscal Agen	nt						7V			
Contract Management							Rydell Sam	uel, Admini	istrator	
Program Fi	nance						Medicaid Pr	ogram Fina	ance	

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### Medicaid Reimbursement Rate Change Form for CHDs

Columbia Cou	Columbia County Health Department						vider Nu	mber: 0279220	6-92	
217 North East	st Franklin	Street						Date: 07/01/20	021	
Lake City, FL	32055					Fiscal Year End: 06/30/2020				
							Audit S	Status: Unaudit	ed Cost	
Provider Type Curre				Curren	nt Rate		New Rate	Effective Date		
	<u>CHD</u>				166	.59		165.27	07/01/2021	
Rate Type	Intorim				х	Droopoo				
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			BAS	<u> 815:</u>						
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DISTRIBUTIC	<u>DN:</u>						U	Z		
Fiscal Ag	ent						74			
Contract	Managem	ent					Rydell	Samuel, Admir	nistrator	
Program	Finance						Medic	aid Program Fir	nance	

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### Medicaid Reimbursement Rate Change Form for CHDs

Dade County	Dade County Health Department					Prov	vider Number:	0279234-0	00	
1350 N.W. 14	th Street						Date	07/01/202	1	
Miami, FL 33	125					Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited	l Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			166.59		16	5.26	07/01/2021		
Rate Type										
	Interim				X	Prospect	<u>tive</u>			
		Total Interim				Х	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ective Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	Unaudited	Cost					
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				– Field Audi	ted Cost					
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DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						γv			
Contract I	Managem	ent					Rydell Samu	uel, Adminis	strator	
Program	Program Finance						Medicaid Pro	ogram Fina	nce	

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### Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Departmer	t	Prov	vider Number: 0279234-3	30			
1350 N.W. 14th Street			Date: 07/01/202	1			
Miami, FL 33125		Fis					
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		166.59		07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	tive				
Total Ir	nterim	X	Total Prospective				
Settlen	nent Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
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	X Unaudited	d Cost					
	Desk Rev	iewed Cost					
	Desk Aud	ited Cost					
	Field Audi	ited Cost					
DISTRIBUTION:			TR				
Fiscal Agent			r v				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Department	t	Prov	ider Number: 0279234-9	91			
1350 N.W. 14th Street			Date: 07/01/2021				
Miami, FL 33125		Fis					
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		166.59		07/01/2021			
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	Cost					
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	Desk Audi	ted Cost					
	Field Audit	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			74				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Dep	partment	Prov	Provider Number: 0279242-00 Date: 07/01/2021 Fiscal Year End: 06/30/2020				
34 South Baldwin Avenue							
Arcadia, FL 33821		Fiso					
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		122.60		07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
To	otal Interim	X	Total Prospective				
S6	ettlement 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			/ `				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

DeSoto Count	DeSoto County Health Department						vider Number:	0279242-0	02		
34 South Balo	dwin Avenu	le				Date: 07/01/2021			1		
Arcadia, FL 3	33821					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Unaudited Cost		
<u>Provider Ty</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				122.60		12^	1.40	07/01/2021		
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		
			BAS	SIS:							
				Budget							
			X	– Unaudited	d Cost						
				– Desk Rev	iewed Cost						
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DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						PV.				
Contract	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

DeSoto County Heal	h Department			Provider N	Number: 0279242-0	03		
34 South Baldwin Av	enue				Date: 07/01/202	1		
Arcadia, FL 33821				Fiscal Year End: 06/30/2020				
				Audi	Status: Unaudited	l Cost		
Provider Type			<u>Current R</u>	ate	New Rate	Effective Date		
CHD	<u>)</u>		122.60		121.40	07/01/2021		
Rate Type								
<u>Interi</u>	<u>m</u>		X <u>P</u>	ospective				
	Total Interim			Х	Total Prospective			
	Settlement Base	ed on Cost			Prospective Adjus	ted For New Costs		
	Е	BASIS:						
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DISTRIBUTION:				Ĩ	R			
Fiscal Agent				[	N			
Contract Manage	ement			Ryde	ell Samuel, Adminis	strator		
Program Finance	e			Med	caid Program Fina	nce		

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Office of Medicaid Program Finance

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### Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Departme	nt	Prov	Provider Number: 0279242-04				
34 South Baldwin Avenue			Date: 07/01/2021				
Arcadia, FL 33821		Fise	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	122.60		07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total Int	erim	X	Total Prospective				
Settleme	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:			TR				
Fiscal Agent			[N				
Contract Management			Rydell Samuel, Adminis	trator			
Program Finance			Medicaid Program Final	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

DeSoto Count	DeSoto County Health Department						vider Number:	0279242-1	11		
34 South Balo	dwin Avenu	le				Date: 07/01/2021			1		
Arcadia, FL 3	33821					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Unaudited Cost		
Provider Ty	ype				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				122.60		12 <sup>,</sup>	1.40	07/01/2021		
Rate Type											
	<u>Interim</u>				Х	Prospec	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
Settlement Based on			on Cost			Prospe	ctive Adjust	ted For New Costs			
			BAS	SIS:							
			<u></u>	Budget							
			<u> </u>	 Unaudited	d Cost						
				_ Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						M				
Contract Management							Rydell Samu	iel, Adminis	trator		
Program	Finance						Medicaid Pro	ogram Finar	nce		

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### Medicaid Reimbursement Rate Change Form for CHDs

DeSoto Count	DeSoto County Health Department						/ider Number:	0279242-3	30		
34 South Balo	dwin Avenu	le					Date	07/01/202	1		
Arcadia, FL 3	33821					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Unaudited Cost		
Provider Ty	ype				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				122.60		12 <sup>·</sup>	1.40	07/01/2021		
Rate Type											
	<u>Interim</u>				Х	Prospect	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
Settlement Based on			on Cost			Prospe	ctive Adjus	ted For New Costs			
		_	BAS	sis							
			<u></u>	Budget							
			X	 Unaudited	dCost						
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				_ Desk Aud	ited Cost						
				– Field Audi							
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						M				
Contract	Contract Management						Rydell Samu	iel, Adminis	trator		
Program	Finance						Medicaid Pro	ogram Finai	nce		

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### Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Departme	Prov	ider Number: 0279242-9	91	
34 South Baldwin Avenue			Date: 07/01/2021	
Arcadia, FL 33821		Fise	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	122.60	121.40	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Int	erim	X	Total Prospective	
Settleme	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:			R	
Fiscal Agent			( N	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Dixie County Health Department		Prov	ider Number: 0279251-0	00
149 NE 241ST			Date: 07/01/2021	
Cross City, FL 32628		Fise	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
Interim		X Prospect	ive	
Total In	iterim	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:			TR	
Fiscal Agent			[N]	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Dixie County Health Departmer	nt	Prov	ider Number: 0279251-9	<b></b> 91
149 NE 241ST		Date: 07/01/2021		
Cross City, FL 32628		Fiso	cal Year End: 06/30/202	0
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	166.59	165.26	07/01/2021
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	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ed Cost		
	Field Audit	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

Duval County Health Department 515 West Sixth Street Jacksonville, FL 32206			Provide	er Number:	0279269-00	)			
			Date: 07/01/2021						
			Fisca	I Year End	06/30/2020				
						A	udit Status:	Unaudited C	Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166	.59	16	5.26	07/01/2021
Rate Type									
	Interim				Х	<b>Prospectiv</b>	<u>e</u>		
	-	Total Interim				X	Total P	rospective	
		_ Settlement B	ased o	on Cost			Prospe	ctive Adjuste	d For New Costs
			BAS	SIS:					
				Budget					
			X	– Unaudited	l Cost				
				– Desk Rev	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ted Cost				
				_					
DISTRIBUTIO							F		
Fiscal Age							1 *		
Contract N	•	ent					•	el, Administr	
Program I	-inance					Μ	edicaid Pro	ogram Financ	ce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health	Department	Provi	der Number: 0279269-	01	
515 West Sixth Street			Date: 07/01/202	07/01/2021	
Jacksonville, FL 32206		Fisc	al Year End: 06/30/202	20	
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		166.59	165.26	07/01/2021	
Rate Type	n	X <u>Prospect</u>	ve		
<u></u>	Total Interim	X	Total Prospective		
	 Settlement Based on Cost			sted For New Costs	
	Desk Auc	d Cost viewed Cost dited Cost lited Cost			
DISTRIBUTION: Fiscal Agent Contract Manage		•	Rydell Samuel, Adminis		
Program Finance			Medicaid Program Fina		

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departmer	nt	Prov	ider Number: 0279269-	02	
515 West Sixth Street Jacksonville, FL 32206			Date: 07/01/202	21	
		Fise	cal Year End: 06/30/202	20	
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		166.59	165.26	07/01/2021	
Rate Type					
Interim		X Prospect			
Total Ir		X	Total Prospective		
Settlen	nent Based on Cost		Prospective Adjus	sted 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			rv.		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department	Prov	vider Number: 027926	9-03	
515 West Sixth Street		Date: 07/01/20	07/01/2021	
Jacksonville, FL 32206	Fis	scal Year End: 06/30/20	020	
		Audit Status: Unaudit	ed Cost	
Provider Type	Current Rate	New Rate	Effective Date	
<u>CHD</u>	166.59	165.26	07/01/2021	
Rate Type	X <u>Prospec</u>	tive		
Total Interim	X	Total Prospectiv	е	
Settlement Based on Cost			usted For New Costs	
BASIS: Budget X Unaudited Co Desk Review Desk Audited Field Audited	ed Cost I Cost			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance		Rydell Samuel, Admir Medicaid Program Fir		

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departmer	ıt	Prov	ider Number: 0279269-	04	
515 West Sixth Street Jacksonville, FL 32206			Date: 07/01/202		
		Fise	cal Year End: 06/30/202	20	
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		166.59	165.26	07/01/2021	
Rate Type					
Interim		X Prospect	ive		
Total Ir	iterim	X	Total Prospective		
Settlem	nent Based on Cost		Prospective Adjus	sted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audi	ted 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

Duval County Health Departme	ent	Prov	ider Number: 0279269-0	05
515 West Sixth Street Jacksonville, FL 32206			Date: 07/01/2021	
		Fiso	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
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	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			<u> </u>	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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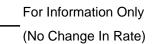
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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department	Prov	ider Number: 0279269-	11	
515 West Sixth Street		Date: 07/01/202	7/01/2021	
Jacksonville, FL 32206	Fis	cal Year End: 06/30/202	20	
		Audit Status: Unaudited	Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	166.59	165.26	07/01/2021	
Rate Type Interim	X Prospect	ive		
Total Interim	X	Total Prospective		
Settlement Based on Cost			ted For New Costs	
Desk Aud	ed Cost viewed Cost dited Cost dited Cost			
DISTRIBUTION: Fiscal Agent Contract Management		The Pudall Samuel Adminic	strator	
Program Finance		Rydell Samuel, Adminis Medicaid Program Fina		

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department		Prov	ider Number: 0279269-4	43
515 West Sixth Street		Date: 07/01/2021		
Jacksonville, FL 32206		Fise	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	166.59	165.26	07/01/2021
Rate Type				
Interim		X <u>Prospect</u>	ive	
Total	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 Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Finar	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department 515 West Sixth Street Jacksonville, FL 32206		Prov	ider Number: 0279269-4	45
			Date: 07/01/2021	
		Fise	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X <u>Prospect</u>	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 Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			<u> </u>	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	ent	Prov	ider Number: 0279269-4	46
515 West Sixth Street			Date: 07/01/202	1
Jacksonville, FL 32206		Fiso	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
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	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ted Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			<u> </u>	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Finar	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department	Prov	ider Number: 0279269-	52
515 West Sixth Street		Date: 07/01/202	:1
Jacksonville, FL 32206	Fise	cal Year End: 06/30/202	0
		Audit Status: Unaudited	l Cost
Provider Type	Current Rate	New Rate	Effective Date
CHD	166.59	165.26	07/01/2021
Rate Type Interim	X <u>Prospect</u>	ive	
Total Interim	X	Total Prospective	
Settlement Based on Cost		Prospective Adjus	ted For New Costs
BASIS: Budget X Unaudited C Desk Review Desk Audited Field Audited	ved Cost d Cost		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance		Rydell Samuel, Adminis Medicaid Program Fina	

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departmen	t	Prov	ider Number: 0279269-5	53
515 West Sixth Street			Date: 07/01/202	1
Jacksonville, FL 32206		Fiso	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>	torim	X Prospect		
Total In		X	Total Prospective	
Settler	ent 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			۲N	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departm	ent	Prov	ider Number: 0279269-8	39
515 West Sixth Street Jacksonville, FL 32206			Date: 07/01/2021	
		Fiso	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		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 Audit	ed Cost		
	Field Audite	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department	Prov	ider Number: 0279269-	91
515 West Sixth Street		Date: 07/01/202	21
Jacksonville, FL 32206	Fise	cal Year End: 06/30/202	20
		Audit Status: Unaudited	d Cost
Provider Type	Current Rate	New Rate	Effective Date
<u>CHD</u>	166.59	165.26	07/01/2021
Rate Type Interim	X <u>Prospect</u>	ive	
Total Interim	X	Total Prospective	
Settlement Based on Cost			sted For New Costs
BASIS: Budget X Unaudited C Desk Revie Desk Audite Field Audite	wed Cost ed Cost		
DISTRIBUTION: Fiscal Agent		R	
Contract Management Program Finance		Rydell Samuel, Adminis Medicaid Program Fina	

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departmen	t	Provi	der Number: 0279269-9	03
515 West Sixth Street			Date: 07/01/202	1
Jacksonville, FL 32206		Fisc	al Year End: 06/30/2020	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type		× -		
<u>Interim</u> Total In	torim	X Prospecti		
			Total Prospective	
	ent Based on Cost		Prospective Adjust	ted For New Costs
	<b>BASIS:</b>			
	Budget			
	X Unaudited	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ted Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			(N	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Finar	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	ent	Prov	ider Number: 0279269-9	95
515 West Sixth Street Jacksonville, FL 32206			Date: 07/01/2021	
		Fise	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
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 Audit	ed Cost		
	Field Audite	ed Cost		
DISTRIBUTION:			R	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	ent	Prov	ider Number: 0279269-9	96
515 West Sixth Street Jacksonville, FL 32206			Date: 07/01/2021	
		Fiso	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
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	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N]	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	ent	Prov	ider Number: 0279269-9	97
515 West Sixth Street			Date: 07/01/202	1
Jacksonville, FL 32206		Fise	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
Interim		X <u>Prospect</u>	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 Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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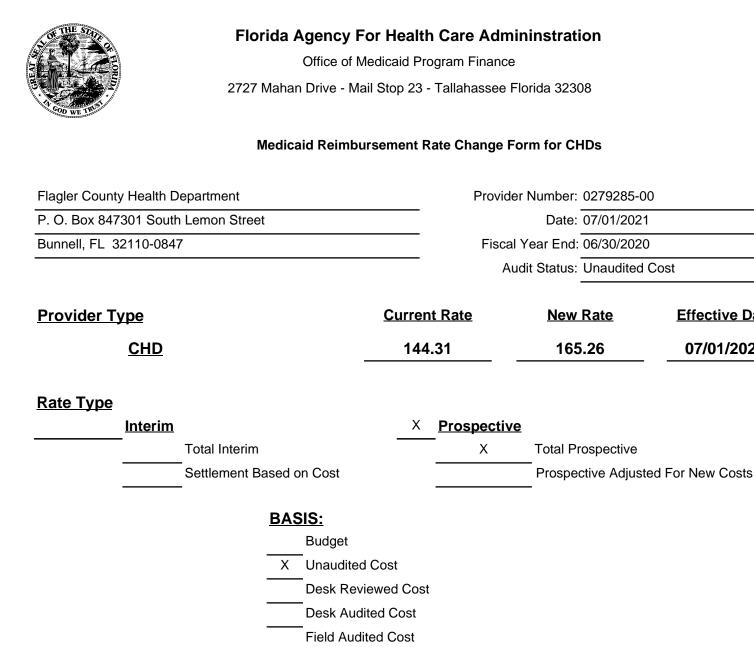
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### Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	ent	Prov	ider Number: 0279269-9	98
515 West Sixth Street Jacksonville, FL 32206			Date: 07/01/2021	
		Fiso	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	166.59	165.26	07/01/2021
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 (	Cost		
	Desk Revie	wed Cost		
	Desk Audite	ed Cost		
	Field Audite	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N]	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Final	nce

State Health Office



#### **DISTRIBUTION:**

**Fiscal Agent Contract Management Program Finance** 

State Health Office

Rydell Samuel, Administrator Medicaid Program Finance

> For Information Only (No Change In Rate)

**Effective Date** 

07/01/2021



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### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department	:	Provi	ider Number: 0279285-0	01
P. O. Box 847301 South Lemon Street			Date: 07/01/2021	
Bunnell, FL 32110-0847		Fiso	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	144.31	165.26	07/01/2021
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 Revie	ewed Cost		
	Desk Audit	ted Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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Medicaid Program Finance



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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department		Provi	ider Number: 0279285-0	)2	
P. O. Box 847301 South Lemon Str	reet		Date: 07/01/2021		
Bunnell, FL 32110-0847	Fiso	cal Year End: 06/30/2020	0		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	144.31	165.26	07/01/2021	
Rate Type					
Interim		X Prospect	ive		
Total Inter	im	X	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjust	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			/ *		
Contract Management			Rydell Samuel, Adminis		
Program Finance			Medicaid Program Finar	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County He	ealth Department			Provide	er Number: 0279285-	03
P. O. Box 847301	South Lemon Stree	t			Date: 07/01/202	21
Bunnell, FL 3211	0-0847			Fisca	Year End: 06/30/202	20
				Au	udit Status: Unaudited	d Cost
Provider Type	2		<u>Curren</u>	t Rate	New Rate	Effective Date
<u>C</u>	HD		144.	.31	165.26	07/01/2021
Rate Type						
Int	<u>erim</u>		Х	<b>Prospectiv</b>	<u>e</u>	
	Total Interim			- X	Total Prospective	
	Settlement B	ased on Cost			Prospective Adjus	sted For New Costs
		BASIS:				
		Budget				
		X Unaudited	Cost			
			iewed Cost			
		 Desk Aud				
		 Field Audi				
DISTRIBUTION:					TR	
Fiscal Agent					M	
Contract Man	agement			R	ydell Samuel, Adminis	strator
Program Fina	ance			M	edicaid Program Fina	ince

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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department		Provi	der Number: 0279285-0	)4
P. O. Box 847301 South Lemon Stre	eet		Date: 07/01/202	1
Bunnell, FL 32110-0847	Fisc	al Year End: 06/30/2020	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	144.31	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ve	
Total Interi	m	X	Total Prospective	
Settlement	Based on Cost		Prospective Adjust	ted For New Costs
	BASIS: Budget			
	X Unaudited	Cost		
	 Desk Revie	ewed Cost		
	 Desk Audite			
	Field Audite			
DISTRIBUTION: Fiscal Agent			T	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance		-	Medicaid Program Finar	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County H	ealth Department			Provide	er Number: 0279285-0	05
P. O. Box 847307	South Lemon Stree	et			Date: 07/01/202	1
Bunnell, FL 3211	0-0847			Fisca	Year End: 06/30/202	0
				Au	udit Status: Unaudited	l Cost
Provider Type	2		Current	t Rate	New Rate	Effective Date
<u>C</u>	HD		144.	.31	165.26	07/01/2021
Rate Type						
In	<u>terim</u>		Х	<b>Prospectiv</b>	<u>e</u>	
	Total Interim	I		- X	Total Prospective	
	Settlement E	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:				2	TR	
Fiscal Agent					rv .	
Contract Mar	nagement			R	ydell Samuel, Adminis	strator
Program Fina	ance			M	edicaid Program Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County He	ealth Department			Provide	er Number: 0279285	-06
P. O. Box 847301	South Lemon Stree	t			Date: 07/01/20	21
Bunnell, FL 3211	0-0847			Fisca	l Year End: 06/30/20	20
				A	udit Status: Unaudite	d Cost
Provider Type			<u>Curren</u>	t Rate	<u>New Rate</u>	Effective Date
<u>C</u>	HD		144	.31	165.26	07/01/2021
Rate Type						
Int	<u>erim</u>		Х	Prospectiv	<u>e</u>	
	Total Interim			- x	Total Prospective	)
	Settlement B	ased on Cost			Prospective Adju	sted For New Costs
		BASIS:				
		Budget				
		X Unaudited	Cost			
		 Desk Rev	iewed Cost			
		 Desk Aud	ited Cost			
		Field Audi	ted Cost			
DISTRIBUTION:				J.	TR	
Fiscal Agent					PN .	
Contract Man	agement			R	ydell Samuel, Admini	istrator
Program Fina	ance			M	edicaid Program Fina	ance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department	:	Prov	ider Number: 0279285-0	)7			
P. O. Box 847301 South Lemon S	treet		Date: 07/01/202	1			
Bunnell, FL 32110-0847		Fiso	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	144.31	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		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 Revi	ewed Cost					
	Desk Audit	ted Cost					
	Field Audit	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			/ *				
Contract Management			Rydell Samuel, Adminis				
Program Finance			Medicaid Program Final	nce			

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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County He	ealth Department			Provide	er Number: 0279285-	08
P. O. Box 847301	South Lemon Stree	t			Date: 07/01/202	21
Bunnell, FL 3211	0-0847			Fisca	Year End: 06/30/202	20
				Au	udit Status: Unaudited	d Cost
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date
<u>C</u>	HD		144.	.31	165.26	07/01/2021
Rate Type						
Int	erim		Х	Prospectiv	<u>e</u>	
	Total Interim			- X	Total Prospective	
	Settlement B	ased on Cost			Prospective Adjus	sted For New Costs
		BASIS:				
		Budget				
		X Unaudited	l Cost			
		 Desk Revi	iewed Cost			
		 Desk Aud	ited Cost			
		 Field Audi	ted Cost			
DISTRIBUTION:				2	TR	
Fiscal Agent					rv .	
Contract Mar	agement			R	ydell Samuel, Adminis	strator
Program Fina	ance			M	edicaid Program Fina	ince

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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County He	ealth Department			Provide	er Number: 0279285-	09
P. O. Box 847301	South Lemon Stree	et			Date: 07/01/202	21
Bunnell, FL 3211	0-0847			Fisca	Year End: 06/30/202	20
				Au	udit Status: Unaudited	d Cost
Provider Type	2		Current	t Rate	New Rate	Effective Date
<u>C</u>	HD		144.	.31	165.26	07/01/2021
Rate Type						
In	<u>terim</u>		Х	<b>Prospectiv</b>	<u>e</u>	
	Total Interim			X	Total Prospective	
	Settlement E	Based on Cost			Prospective Adjus	sted For New Costs
		BASIS:				
		Budget				
		X Unaudited	d Cost			
		 Desk Rev	iewed Cost			
		 Desk Aud	ited Cost			
		Field Audi	ited Cost			
DISTRIBUTION:				2	TR	
Fiscal Agent					PV .	
Contract Mar	nagement			R	ydell Samuel, Adminis	strator
Program Fina	ance			M	edicaid Program Fina	ince

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#### Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department	t	Provi	ider Number: 0279285-3	30			
P. O. Box 847301 South Lemon S	treet		Date: 07/01/202	1			
Bunnell, FL 32110-0847		Fiso	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	144.31	165.26	07/01/2021			
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 Revie	ewed Cost					
	Desk Audit	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			/ N				
Contract Management			Rydell Samuel, Adminis	trator			
Program Finance			Medicaid Program Final	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health	Department			Provid	er Number:	0279293-00		
139 12th Street				Date: 07/01/2021		07/01/2021		
Apalachicola, FL 32320	)			Fiscal Year End: 06/30/2020				
				A	udit Status:	Unaudited Co	st	
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date	
<u>CHD</u>			166.	59	165	5.27	07/01/2021	
Rate Type								
<u>Interim</u>			Х	Prospectiv	<u>e</u>			
	Total Interim			Х	Total P	rospective		
	Settlement Based o	on Cost			Prospe	ctive Adjusted	For New Costs	
	BA	SIS:						
		Budget						
	X	Unaudited C	Cost					
		_ Desk Review	wed Cost					
		_ Desk Audite	d Cost					
		Field Audite	d Cost					
		_						
DISTRIBUTION:					TR			
Fiscal Agent					۲N N			
Contract Managem	ent			R	ydell Samu	el, Administrat	or	
Program Finance				Ν	ledicaid Pro	gram Finance		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health De	partment		Provider Number: 0279293-01			
139 12th Street				Date: 07/01/202	1	
Apalachicola, FL 32320			Fiscal Y	/ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>		166	.59	165.27	07/01/2021	
Rate Type						
<u>Interim</u>		Х	<b>Prospective</b>			
T	otal Interim		- x	Total Prospective		
S	ettlement Based on Cos	st		Prospective Adjust	ted For New Costs	
	BASIS:					
	Budg	aet				
		udited Cost				
	 Desl	k Reviewed Cost				
	 Desl	k Audited Cost				
	Field	d Audited Cost				
DISTRIBUTION:				R		
Fiscal Agent			1	N		
Contract Management	t		Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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#### Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Departm	nent		Provider Number: 0279293-30		
139 12th Street				Date: 07/01/202	1
Apalachicola, FL 32320			Fiscal Y	/ear End: 06/30/2020	0
			Aud	it Status: Unaudited	Cost
<u>Provider Type</u>		Current	Rate	New Rate	Effective Date
<u>CHD</u>	-	166.	59	165.27	07/01/2021
Rate Type					
<u>Interim</u>		Х	Prospective		
Total Ir	nterim		Х	Total Prospective	
Settlen	nent Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ted Cost			
DISTRIBUTION:			~	R	
Fiscal Agent			1		
Contract Management			Ryd	lell Samuel, Adminis	trator
Program Finance			Med	dicaid Program Finar	nce
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#### Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Departr	ment		Provider	Number: 0279293-9	02	
139 12th Street			Date: 07/01/2021			
Apalachicola, FL 32320			Fiscal Y	'ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current	Rate	New Rate	Effective Date	
<u>CHD</u>	-	166.	59	165.27	07/01/2021	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total I	Interim		Х	Total Prospective		
Settle	ment Based on Cost			Prospective Adjust	ed For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			~	R		
Fiscal Agent			1	e()		
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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#### Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Departn	nent		Provider	Number: 0279293-9	93	
139 12th Street			Date: 07/01/2021			
Apalachicola, FL 32320			Fiscal Y	'ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
<u>Provider Type</u>		Current	Rate	New Rate	Effective Date	
<u>CHD</u>	-	166.	59	165.27	07/01/2021	
Rate Type						
<u>Interim</u>		Х	<b>Prospective</b>			
Total I	nterim		Х	Total Prospective		
Settler	ment Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			~	R		
Fiscal Agent			1	e()		
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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### Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Depar	tment	Prov	rider Number: 0279307-0	00
P. O. Box 1000		Date: 07/01/2021		
Quincy, FL 32353-1000		Fis	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		105.88	146.96	07/01/2021
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	Cost		
	Desk Rev	iewed Cost		
	 Desk Aud	ited Cost		
	 Field Audi	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			r v	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department	Prov	ider Number: 0279307-	01	
P. O. Box 1000		Date: 07/01/2021		
Quincy, FL 32353-1000	Fise	cal Year End: 06/30/202	20	
		Audit Status: Unaudited	d Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	105.88	146.96	07/01/2021	
Rate Type				
<u>Interim</u>	X Prospect	ive		
Total Interim	X	Total Prospective		
Settlement Based on Cost	t	Prospective Adjus	sted For New Costs	
BASIS:				
Budg	et			
X Unau	dited Cost			
Desk	Reviewed Cost			
Desk	Audited Cost			
Field	Audited Cost			
DISTRIBUTION:		TR		
Fiscal Agent		PU		
Contract Management		' Rydell Samuel, Adminis	strator	
Program Finance		Medicaid Program Fina		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department		Provider	Number: 0279307-	-02
P. O. Box 1000			Date: 07/01/202	21
Quincy, FL 32353-1000		Fiscal Y	ear End: 06/30/202	20
		Aud	it Status: Unaudite	d Cost
Provider Type	Curren	t Rate	New Rate	Effective Date
CHD	105	.88	146.96	07/01/2021
Rate Type	X			
<u>Interim</u>	<u></u>	Prospective	Tatal Draam a stirra	
Total Interim		X	Total Prospective	
Settlement Based	I on Cost		Prospective Adjus	sted For New Costs
<u>B/</u>	ASIS:			
	Budget			
	Unaudited Cost			
	Desk Reviewed Cost			
	Desk Audited Cost			
	Field Audited Cost			
		9983		
DISTRIBUTION:			KK .	
Fiscal Agent		ľ	Ń	
Contract Management		Ryd	ell Samuel, Admini	strator
Program Finance		Mec	licaid Program Fina	ance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Departme	ent		Provider Number: 0279307-04		
P. O. Box 1000				1	
Quincy, FL 32353-1000			Fiscal Y	/ear End: 06/30/2020	0
			Aud	lit Status: Unaudited	Cost
Provider Type		Curren	t Rate	New Rate	Effective Date
<u>CHD</u>		105	.88	146.96	07/01/2021
Rate Type					
Interim		Х	Prospective		
Total Inte	erim		- x	Total Prospective	
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs
				_	
	<b>BASIS:</b>				
	Budget				
	X Unaudited Co	ost			
	Desk Review	ved Cost			
	Desk Audited	d Cost			
	Field Audited	l Cost			
DISTRIBUTION:			-	IR	
Fiscal Agent			1	N	
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

Gadsden Coun	ty Health	Department			Provi	der Number:	0279307-1	12
P. O. Box 1000	)					Date	07/01/202	1
Quincy, FL 323	353-1000				Fisc	al Year End	06/30/202	0
						Audit Status:	Unaudited	Cost
Provider Ty	<u>pe</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			105	.88	140	6.96	07/01/2021
Rate Type				х	Dreeneet			
	<u>Interim</u>	Total Interim			- Prospecti X		rospective	
-		Settlement Based	on Cost		Λ			ted For New Costs
-			On Cost			P105pe	clive Aujus	led for new Cosis
		BA	<u>SIS:</u>					
			Budget					
		X	Unaudited	d Cost				
			 Desk Rev	iewed Cost				
			Desk Aud	ited Cost				
			Field Audi	ited Cost				
						TP		
DISTRIBUTION						at		
Fiscal Age						/ N		
Contract M	-	ent			-	Rydell Samu		
Program F	inance					Medicaid Pro	ogram Finai	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department		Provider N	Number: 0279307-3	30
P. O. Box 1000			1	
Quincy, FL 32353-1000		Fiscal Ye	ear End: 06/30/202	0
		Audit	Status: Unaudited	Cost
Provider Type	Curren	t Rate	New Rate	Effective Date
CHD	105	.88	146.96	07/01/2021
Rate Type				
<u>Interim</u>	X	Prospective		
Total Interim		X	Total Prospective	
Settlement Based	on Cost		Prospective Adjus	ted For New Costs
BA	<u>SIS:</u>			
	Budget			
X	Unaudited Cost			
	 Desk Reviewed Cost			
	Desk Audited Cost			
	Field Audited Cost			
DISTRIBUTION:			R	
Fiscal Agent		Į.	U T	
Contract Management		l Duda		4.040.0
Program Finance			ell Samuel, Adminis	
		Meu		

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### Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Departm	nent	Prov	ider Number: 0279315-0	00
119 N.E. First Street		Date: 07/01/202	1	
Trenton, FL 32693-3459	Fiso	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total Ir	nterim	X	Total Prospective	
Settlen	nent 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:			TR	
Fiscal Agent			۲۷.	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Depar	tment		Provider	Number: 0279315-9	)1	
119 N.E. First Street			Date: 07/01/2021			
Trenton, FL 32693-3459			Fiscal Y	'ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	-	166.5	59	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		X	Prospective			
Total	l Interim		Х	Total Prospective		
Settle	ement Based on Cost	-		Prospective Adjust	ed For New Costs	
		-		-		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:				R		
Fiscal Agent			ť	V		
Contract Management			Ryd	ell Samuel, Adminis	trator	
Program Finance				licaid Program Finar		
State Health Office						



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### Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Departm	nent	F	Provider Number: 0279323-	00		
P. O. Box 489			Date: 07/01/2021			
Moore Haven, FL 33471			Fiscal Year End: 06/30/202	0		
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	166.59	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X <u>Pros</u> p	<u>ective</u>			
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 Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TK			
Fiscal Agent			PU			
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

Glades County Health Dep	partment		Provider	Number: 0279323-3	30	
P. O. Box 489			Date: 07/01/2021			
Moore Haven, FL 33471			Fiscal \	/ear End: 06/30/2020	0	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>		166	.59	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		X	Prospective			
Т	otal Interim		X	Total Prospective		
s	Settlement Based on C	Cost		Prospective Adjust	ted For New Costs	
	D A O I O	_		-		
	BASIS	_				
		idget naudited Cost				
		esk Reviewed Cost				
		esk Audited Cost				
	Fie	eld Audited Cost				
DISTRIBUTION: Fiscal Agent			-	R		
Contract Managemen	t		I Duc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office						



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#### Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Department			Provide	r Number: 0	279323-91	
P. O. Box 489				Date: 0	7/01/2021	
Moore Haven, FL 33471			Fiscal	Year End: 0	6/30/2020	
			Au	dit Status: L	Inaudited Cos	st
<u>Provider Type</u>		<u>Current</u>	t Rate	<u>New R</u>	late	Effective Date
CHD		166.	59	165.2	26	07/01/2021
Rate Type						
<u>Interim</u>		X	Prospective			
Total Interir	n		Χ	Total Pro	spective	
Settlement	Based on Cost			Prospect	ive Adjusted I	For New Costs
	BASIS:					
	Budget					
	X Unaudited Co	ost				
	Desk Review	ed Cost				
	Desk Audited	d Cost				
	Field Audited	l Cost				
DISTRIBUTION:			/	TR		
Fiscal Agent				M		
Contract Management			Rv	dell Samuel	, Administrato	or
Program Finance					ram Finance	_

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### Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department         2475 Garrison Avenue         Port St. Joe, FL 32456-5265				Provid	der N	umber:	0279331-00				
			Date:		: 07/01/2021						
				Fisca	al Ye	ar End:	06/30/2020				
							Ą	Audit	Status:	Unaudited C	ost
Provider Ty	<u>/pe</u>				<u>Curre</u>	nt	t Rate		<u>New</u>	Rate	Effective Date
	<u>CHD</u>				16	6.	59		165	5.26	07/01/2021
Rate Type											
	Interim				X		Prospectiv	<u>ve</u>			
		Total Interim					Х		Total P	rospective	
		Settlement Bas	sed o	n Cost					Prospe	ctive Adjustee	d For New Costs
		<u> </u>	BAS	<u>SIS:</u>							
				Budget							
		-	Х	- Unaudited	l Cost						
		-		- Desk Revi	iewed Cos	st					
		-		- Desk Audi	ited Cost						
		-		- Field Audi	ted Cost						
		-		-							
DISTRIBUTIO	<u>N:</u>							K	R		
Fiscal Age	ent							M	l		
Contract N	Manageme	ent					F	Ryde	II Samu	el, Administra	ator
Program I	Finance									gram Financ	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Prov	ider Number: 0279331-0	01	
2475 Garrison Avenue		Date: 07/01/202	07/01/2021	
Port St. Joe, FL 32456-5265	Fiso	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total In	terim	X	Total Prospective	
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revi	ewed Cost		
	Desk Audit	ted Cost		
	Field Audit	ted Cost		
DISTRIBUTION:			R	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	strator
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#### Medicaid Reimbursement Rate Change Form for CHDs

2475 Garrison Avenue       Date: 07/01/2021         Port St. Joe, FL 32456-5265       Fiscal Year End: 06/30/2020         Audit Status:       Unaudited Cost         Provider Type       Current Rate       New Rate       Effective Date         CHD       166.59       165.26       07/01/2021         Rate Type       X       Prospective       07/01/2021         Interim       X       Prospective       Prospective         Settlement Based on Cost       X       Prospective Adjusted For New Costs         BASIS:       BASIS:       Ender State       Prospective Adjusted For New Costs				Provider	Number: 0279331-0	)3	
Provider Type       Current Rate       New Rate       Effective Date         CHD       166.59       165.26       07/01/2021         Rate Type					Date: 07/01/202	07/01/2021	
Provider Type       Current Rate       New Rate       Effective Date         CHD       166.59       165.26       07/01/2021         Rate Type       X       Prospective       X       Total Prospective				Fiscal Y	'ear End: 06/30/2020	0	
CHD       166.59       165.26       07/01/2021         Rate Type       X       Prospective       Vertical Prospective         Interim       X       Prospective       Vertical Prospective         Settlement Based on Cost       X       Total Prospective Adjusted For New Costs				Aud	it Status: Unaudited	Cost	
Kate Type       X       Prospective         Interim       X       Prospective         Total Interim       X       Total Prospective         Settlement Based on Cost       Prospective Adjusted For New Costs	Provider Type	<u>Cı</u>	urrent F	Rate	New Rate	Effective Date	
Interim       X       Prospective         Total Interim       X       Total Prospective         Settlement Based on Cost       X       Prospective Adjusted For New Costs	<u>CHD</u>		166.5	9	165.26	07/01/2021	
Total Interim     X     Total Prospective       Settlement Based on Cost     Prospective Adjusted For New Costs	Rate Type						
Settlement Based on Cost Prospective Adjusted For New Costs			Х <u></u>	<u>rospective</u>			
	Total I	nterim		Х	Total Prospective		
BASIS:	Settler	nent Based on Cost			Prospective Adjust	ted For New Costs	
		BASIS:					
Budget							
X Unaudited Cost							
Desk Reviewed Cost		Desk Reviewed	Cost				
Desk Audited Cost							
Field Audited Cost		Field Audited Co	ost				
DISTRIBUTION:				, F	F		
Fiscal Agent / N	-			1			
Contract Management       Rydell Samuel, Administrator         Program Finance       Medicaid Program Finance	-						

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Prov	ider Number: 0279331-0	05	
2475 Garrison Avenue		Date: 07/01/202	07/01/2021	
Port St. Joe, FL 32456-5265	Fise	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total In	terim	X	Total Prospective	
Settlem	ent 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:			R	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	strator
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#### Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Prov	vider Number: 0279331-0	07	
2475 Garrison Avenue		Date: 07/01/202	07/01/2021	
Port St. Joe, FL 32456-5265	Fis	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	tive	
Total I	nterim	X	Total Prospective	
Settler	ment 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			1	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Provi	der Number: 0279331-1	1	
2475 Garrison Avenue		Date: 07/01/202	1	
Port St. Joe, FL 32456-5265	Fisc	cal Year End: 06/30/2020	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	166.59	165.26	07/01/2021
Rate Type				
Interim		X Prospect	ive	
Total Inte	erim	X	Total Prospective	
Settleme	nt Based on Cost		Prospective Adjust	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ted Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			- UT	
Fiscal Agent			/ N	
Contract Management		_	Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Finar	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Prov	ider Number: 0279331-	19	
2475 Garrison Avenue		Date: 07/01/202	07/01/2021	
Port St. Joe, FL 32456-5265	Fise	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total Ir	iterim	X	Total Prospective	
Settlement 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
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#### Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Prov	vider Number: 0279331-2	21	
2475 Garrison Avenue		Date: 07/01/202	)7/01/2021	
Port St. Joe, FL 32456-5265	Fis	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	tive	
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 Audit	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			/ *	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Prov	ider Number: 0279331-3	30				
2475 Garrison Avenue		Date: 07/01/202	07/01/2021				
Port St. Joe, FL 32456-5265	Fiso	cal Year End: 06/30/202	0				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		166.59	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total I	nterim	X	Total Prospective				
Settlement Based on Cost			Prospective Adjusted For New C				
	BASIS:						
	Budget						
	X Unaudited	l Cost					
	Desk Revi	iewed Cost					
	 Desk Audi	ited Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			/ N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance Medicaid Program Finance							

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### Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department P. O. Box 267				Provider N	Number: 0279340-0	00
					Date: 07/01/202	07/01/2021
Jasper, FL 32052			Fiscal Year End: 06/30/2			0
				Audit	Status: Unaudited	Cost
Provider Type			Current I	Rate	New Rate	Effective Date
CHD	<u>!</u>		166.5	9	165.26	07/01/2021
Rate Type						
Interi	<u>m</u>		Х <u></u>	Prospective		
	Total Interim			Х	Total Prospective	
	Settlement Ba	sed on Cost	_		Prospective Adjus	ted For New Costs
		BASIS:				
		Budget				
		X Unaudited	d Cost			
		 Desk Rev	viewed Cost			
		Desk Aud	lited Cost			
		Field Aud	lited Cost			
DISTRIBUTION:					R	
Fiscal Agent				1	V	
Contract Manage	ement			Ryde	ell Samuel, Adminis	strator
Program Finance				Medi	caid Program Final	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department		Provider N	umber: 0279340-2	25
P. O. Box 267			1	
Jasper, FL 32052		Fiscal Ye	ar End: 06/30/202	0
		Audit	Status: Unaudited	Cost
Provider Type	Curren	t Rate	New Rate	Effective Date
CHD	166	.59	165.26	07/01/2021
Rate Type Interim	х	Prospective		
Total Interim			Total Prospective	
Settlement Based on C	Cost		Prospective Adjus	ted For New Costs
X Ur De De	idget naudited Cost esk Reviewed Cost esk Audited Cost eld Audited Cost			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance			R Il Samuel, Adminis caid Program Finar	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Hamilton Cou	milton County Health Department				Provider Number: 0279340-30			
P. O. Box 267						Date:	07/01/2021	
Jasper, FL 32	2052				Fisca	I Year End:	06/30/2020	
					A	udit Status:	Unaudited C	ost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166	.59	165	5.26	07/01/2021
Rate Type	Interim			Х	Prospectiv	e		
		Total Interim			- <u></u> X		rospective	
		Settlement Base	ed on Cost			Prospe	ctive Adjusted	For New Costs
		_	Desk Auc	viewed Cost lited Cost				
		_	Field Aud	lited Cost				
DISTRIBUTIC	<u>N:</u>				2	TR		
Fiscal Ag	ent					M		
Contract I	Manageme	ent			R	ydell Samu	el, Administra	itor
Program	Finance				N	ledicaid Pro	ogram Finance	9

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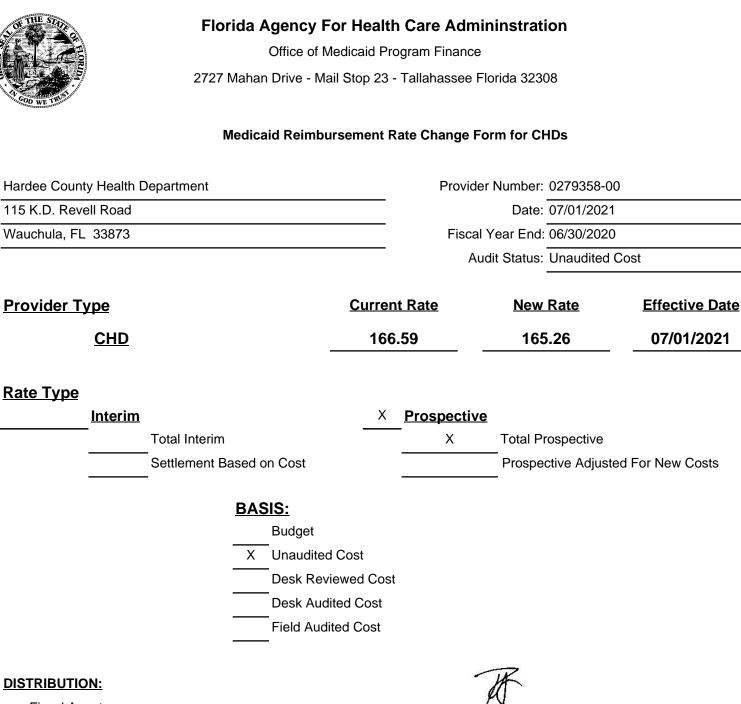
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#### Medicaid Reimbursement Rate Change Form for CHDs

Hamilton Cou	amilton County Health Department				Provider Number: 0279340-91			
P. O. Box 267	,					Date:	07/01/2021	
Jasper, FL 32	2052				Fisca	al Year End:	06/30/2020	
					A	udit Status:	Unaudited Co	ost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166	.59	165	5.26	07/01/2021
Rate Type	Interim			Х	Prospectiv	/e		
	-	Total Interim			- X		rospective	
		Settlement Base	ed on Cost				-	For New Costs
			ASIS: Budget X Unaudited Desk Rev Desk Aud Field Aud	viewed Cost lited Cost				
	ent Manageme	ent				-	el, Administra	
Program	rinance				N	legicald Pro	ogram Finance	;

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**Fiscal Agent 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

Hardee County Health Department	Prov	ider Number: 0279358-	01			
115 K.D. Revell Road		Date: 07/01/202	21			
Wauchula, FL 33873	Fise	Fiscal Year End: 06/30/2020				
		Audit Status: Unaudited	d Cost			
Provider Type	Current Rate	New Rate	Effective Date			
<u>CHD</u>	166.59	165.26	07/01/2021			
Rate Type						
Interim	X Prospect	ive				
Total Interim	X	Total Prospective				
Settlement Based on Cost		Prospective Adjus	sted For New Costs			
BASIS:						
Budget						
X Unaudited	Cost					
Desk Revie	ewed Cost					
Desk Audit	ed Cost					
Field Audite	ed Cost					
DISTRIBUTION:		TR				
Fiscal Agent		PU				
Contract Management		Rydell Samuel, Adminis	strator			
Program Finance		Medicaid Program Fina				

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#### Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Department	Prov	ider Number: 0279358-	09		
115 K.D. Revell Road		Date: 07/01/202	21		
Wauchula, FL 33873	Fise	Fiscal Year End: 06/30/2020			
		Audit Status: Unaudited	d Cost		
Provider Type	Current Rate	New Rate	Effective Date		
<u>CHD</u>	166.59	165.26	07/01/2021		
Rate Type					
<u>Interim</u>	X Prospect	ive			
Total Interim	Х	Total Prospective			
Settlement Based on Cost		Prospective Adjus	sted For New Costs		
BASIS:					
Budget					
X Unaudited	Cost				
Desk Revie	ewed Cost				
Desk Audit	ted Cost				
Field Audit	ed Cost				
DISTRIBUTION:		TR			
Fiscal Agent		PU			
Contract Management		Rydell Samuel, Adminis	strator		
Program Finance		Medicaid Program Fina			

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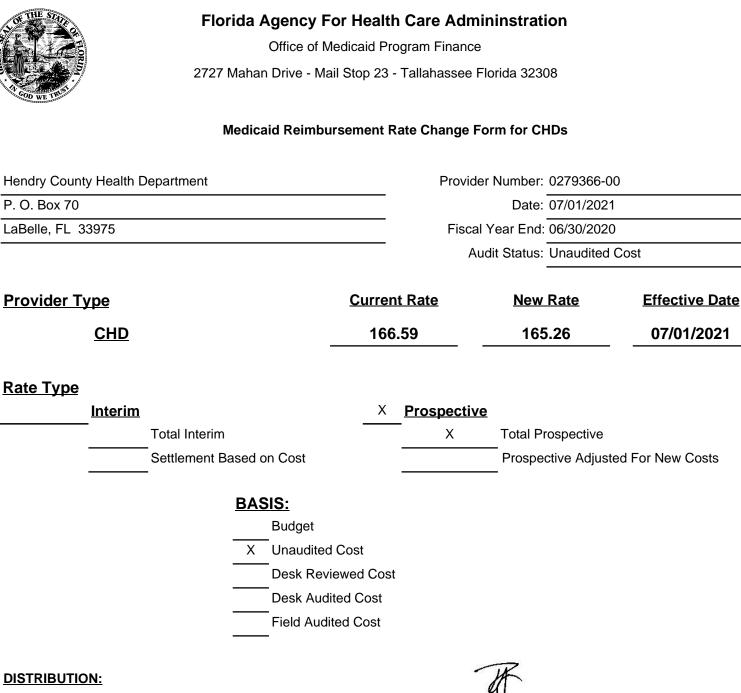
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#### Medicaid Reimbursement Rate Change Form for CHDs

Hardee Count	ardee County Health Department					Provider Number: 0279358-30			
115 K.D. Rev	ell Road						Date:	07/01/202	1
Wauchula, FL	. 33873					Fis	scal Year End	06/30/2020	0
							Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166	.59	16	5.26	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospec	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased	on Cost			Prospe	ctive Adjust	ted For New Costs
			BAS	SIS:					
				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						M		
Contract	Managem	ent					Rydell Samu	iel, Adminis	trator
Program	Finance						Medicaid Pro	ogram Finar	nce

State Health Office



- **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

Hendry County Health Department		Provider Number: 0279366-30			
P. O. Box 70			Date: 07/01/202	1	
LaBelle, FL 33975		Fiscal `	Year End: 06/30/2020	0	
		Audit Status: Unaudited Cost			
Provider Type	Curre	nt Rate <u>New Rate E</u>		Effective Date	
CHD	16	6.59	165.26	07/01/2021	
Rate Type					
Interim	Х	<b>Prospective</b>			
Total Inte	rim	— x	Total Prospective		
Settlemer	it Based on Cost		Prospective Adjust	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed Cos	st			
	Desk Audited Cost				
	Field Audited Cost				
DISTRIBUTION:		-	TR		
Fiscal Agent		1	N		
Contract Management		Ryc	dell Samuel, Adminis	strator	
Program Finance		Me	dicaid Program Finar	nce	
State Health Office					



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### Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Hea	endry County Health Department				Provider Number: 0279366-92				
P. O. Box 70					Date:	07/01/2021			
LaBelle, FL 33975				Fiscal	Year End:	06/30/2020			
				Au	dit Status:	Unaudited Co	st		
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date		
<u>CH</u>	<u>ID</u>		166.	59	165	.26	07/01/2021		
Rate Type	rim		Х	Prospective					
<u>inte</u>	Total Interim			X		ospective			
	Settlement Bas	sed on Cost		~		•	For New Costs		
						are rajuotoa			
	<u> </u>	BASIS:							
		Budget							
	-	X Unaudited	l Cost						
	-	Desk Revi	iewed Cost						
	-	Desk Audi	ited Cost						
	-	Field Audi	ted Cost						
	-								
DISTRIBUTION:				-	TR				
Fiscal Agent					M				
Contract Mana	igement			Ry	vdell Samue	el, Administrat	or		
Program Finar	ice					gram Finance	_		

State Health Office



Office of Medicaid Program Finance

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### Medicaid Reimbursement Rate Change Form for CHDs

Hernando Co	ernando County Health Department				Provider Number: 0279374-00				
300 S. Main S	St.					Date	: 07/01/2021		
Brooksville, F	L 34601				Fis	cal Year End	: 06/30/2020		
						Audit Status	Unaudited	Cost	
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	New	<u>v Rate</u>	Effective Date	
	<u>CHD</u>			166	.59	16	5.26	07/01/2021	
Rate Type									
	Interim			X	Prospect	ive			
		Total Interim			Χ	Total P	rospective		
		Settlement Base	d on Cost			Prospe	ective Adjuste	ed For New Costs	
		<u>B</u>	ASIS:						
			Budget						
			X Unaudited	l Cost					
			Desk Rev	iewed Cost					
			Desk Aud	ited Cost					
			Field Audi	ted Cost					
DISTRIBUTIC	<u>DN:</u>					T			
Fiscal Ag						/ `			
	Manageme	ent				-	uel, Administ		
Program	Finance					Medicaid Pro	ogram Finan	се	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Hernando Co	rnando County Health Department				Provi	der Number	: 0279374-	91
300 S. Main S	St.					Date	: 07/01/202	21
Brooksville, F	L 34601				Fisc	al Year End	: 06/30/202	20
						Audit Status	: Unaudited	d Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	<u>r Rate</u>	Effective Date
	<u>CHD</u>			166	.59	16	5.26	07/01/2021
Rate Type								
	Interim			X	Prospecti			
		Total Interim			X	Total P	rospective	
		Settlement Base	d on Cost			Prospe	ective Adjus	sted For New Costs
		<u>B</u>	ASIS:					
			Budget					
		>	C Unaudited	d Cost				
			Desk Rev	viewed Cost				
			 Desk Aud	lited Cost				
			Field Aud	ited Cost				
DISTRIBUTIO	<u>DN:</u>					IK		
Fiscal Ag	ent					M		
Contract	Manageme	ent				Rydell Samı	uel, Adminis	strator
Program	Finance				-	Medicaid Pr	ogram Fina	nce

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Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

Hernando County	Health Department		Provider Number: 0279374-92				
300 S. Main St.				Date: 0	)7/01/2021		
Brooksville, FL 34	601		Fiscal	Year End: (	06/30/2020		
			Au	dit Status: L	Jnaudited Cos	t	
Provider Type		Currer	nt Rate	<u>New F</u>	Rate	Effective Date	
<u>CH</u>	ID	166	5.59	165.	26	07/01/2021	
Rate Type							
Inte	erim (	X	_Prospective	<u>!</u>			
	Total Interim		X	Total Pro	spective		
	Settlement Based	on Cost		Prospect	ive Adjusted F	or New Costs	
	BA	<u>SIS:</u>					
		Budget					
	X	Unaudited Cost					
		Desk Reviewed Cost	t				
		Desk Audited Cost					
		Field Audited Cost					
		_					
DISTRIBUTION:			/	TR			
Fiscal Agent				M			
Contract Mana	agement		Ry	dell Samuel	l, Administrato	r	
Program Finar	nce				ram Finance	_	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Highlands County	Health Department			Provider Number: 0279382-00				
7205 South Georg	e Boulevard				Date: 07/01/20	21		
Sebring, FL 33872	2			Fiscal Year End: 06/30/2020		20		
				Aud	t Status: Unaudite	ed Cost		
Provider Type			Current Ra	ate	New Rate	Effective Date		
<u>C</u> +	<u>ID</u>		135.85		162.89	07/01/2021		
Rate Type								
<u>Inte</u>	<u>erim</u>		X <u>Pr</u>	<u>ospective</u>				
	Total Interim			Х	Total Prospective	9		
	Settlement E	Based on Cost			Prospective Adju	sted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	d Cost					
		 Desk Rev	viewed Cost					
		Desk Aud	lited Cost					
		Field Aud	ited Cost					
DISTRIBUTION:				_	R			
Fiscal Agent				ľ	V			
Contract Mana	agement			Ryd	ell Samuel, Admin	istrator		
Program Fina	nce			Mec	licaid Program Fin	ance		

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Office of Medicaid Program Finance

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### Medicaid Reimbursement Rate Change Form for CHDs

Highlands County Health De	epartment	Provi	Provider Number: 0279382-91				
7205 South George Bouleva	ard		Date: 07/01/202	1			
Sebring, FL 33872		Fisc	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	135.85	162.89	07/01/2021			
Rate Type							
Interim		X Prospecti	ve				
Tot	tal Interim	X	Total Prospective				
Se	ettlement 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 County Health	Department	Provi	Provider Number: 0279412-00			
1900 27th Street			Date: 07/01/2021			
Vero Beach, FL 32960		Fiso	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost		
Provider Type	Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	147.15	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Tot	al Interim	X	Total Prospective			
Set	ttlement 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

Indian River C	ndian River County Health Department				Provider Number: 0279412-01				
1900 27th Stre	eet					Date: 07/01/2021			21
Vero Beach, F	L 32960					Fiscal Year End: 06/30/2020			
							Audit Status	Unaudited	d Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				147	.15	16	5.26	07/01/2021
Rate Type									
	Interim				X	Prospect	<u>tive</u>		
	-	Total Interim				X	Total P	rospective	
		Settlement Ba	ised c	on Cost			Prospe	ective Adjus	sted For New Costs
			BAS	SIS:					
				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						M		
Contract N	Managem	ent					Rydell Samu	iel, Admini	strator
Program F	Finance						Medicaid Pr	ogram Fina	ance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Indian River Cou	ndian River County Health Department				Provider Number: 0279412-02				
1900 27th Street	t					Date: 07/01/2021 Fiscal Year End: 06/30/2020			
Vero Beach, FL	32960								
							Audit Status:	Unaudited	d Cost
Provider Typ	e				<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>C</u>	<u>CHD</u>			-	147	.15	16	5.26	07/01/2021
Rate Type									
<u>In</u>	<u>nterim</u>				Х	Prospect	<u>tive</u>		
		Total Interim				- X	Total P	rospective	
		Settlement Ba	sed c	on Cost			Prospe	ctive Adjus	sted 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>.</u>						TR		
Fiscal Agent	t						γv		
Contract Ma	inageme	ent					Rydell Samu	iel, Admini	strator
Program Fin	nance						Medicaid Pro	ogram Fina	ance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Indian River County	ndian River County Health Department				Provider Number: 0279412-03			
1900 27th Street				Date: 07/01/2021 Fiscal Year End: 06/30/2020				
Vero Beach, FL 329	60							
				Au	dit Status: Unau	udited Cost		
Provider Type			<u>Current F</u>	late	New Rate	Effective Date		
CHD	<u>)</u>		147.1	5	165.26	07/01/2021		
Rate Type								
Interi	<u>m</u>		х <u>р</u>	rospective	<u>}</u>			
	Total Interim			Х	Total Prospec	ctive		
	Settlement Ba	sed on Cost	_		Prospective A	Adjusted 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					r v			
Contract Manage	ement			Ry	dell Samuel, Ad	Iministrator		
Program Finance	9			Me	edicaid Program	Finance		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Dep	ndian River County Health Department			04	
1900 27th Street			Date: 07/01/202	21	
Vero Beach, FL 32960		Fis	Fiscal Year End: 06/30/2020		
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		147.15	165.26	07/01/2021	
Rate Type					
Interim		X Prospect	ive		
Total Ir	nterim	X	Total Prospective		
Settlen	nent 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:			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 County Health Dep	ndian River County Health Department			Provider Number: 0279412-05			
1900 27th Street			Date: 07/01/202	7/01/2021			
Vero Beach, FL 32960		Fis	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		147.15	165.26	07/01/2021			
Rate Type							
Interim		X Prospect	ive				
Total Ir	nterim	X	Total Prospective				
Settlen	nent 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			

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#### Medicaid Reimbursement Rate Change Form for CHDs

Indian River Count	ndian River County Health Department			Provider Number: 0279412-30			
1900 27th Street				Date: 07/01/2021 Fiscal Year End: 06/30/2020			
Vero Beach, FL 32	960						
				Au	dit Status: Unaudited	l Cost	
Provider Type			<u>Current R</u>	ate	New Rate	Effective Date	
<u>CH</u>	D		147.15		165.26	07/01/2021	
Rate Type							
Inte	<u>rim</u>		X <u>P</u>	ospective	<u>!</u>		
	Total Interim			Х	Total Prospective		
	Settlement E	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				5	rv .		
Contract Mana	gement			Ry	dell Samuel, Adminis	strator	
Program Finan	ce			Me	edicaid Program Fina	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Indian River Count	y Health Departm	ent	Pro	Provider Number: 0279412-91			
1900 27th Street				Date: 07/01/2021			
Vero Beach, FL 32	2960		 Fi	Fiscal Year End: 06/30/2020			
				Audit Status: Unaudited	d Cost		
Provider Type			Current Rate	New Rate	Effective Date		
<u>CH</u>	<u>ID</u>		147.15	165.26	07/01/2021		
Rate Type							
Inte	erim		X <u>Prospec</u>	tive			
	Total Interir	n	X	Total Prospective			
	Settlement	Based on Cost		Prospective Adjus	sted 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 Mana	gement			Rydell Samuel, Adminis	strator		
Program Finar	ice			Medicaid Program Fina	ince		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Indian River Count	y Health Departme	ent	Pro	Provider Number: 0279412-92 Date: 07/01/2021 Fiscal Year End: 06/30/2020			
1900 27th Street							
Vero Beach, FL 32	2960		Fi				
				Audit Status: Unaudited	d Cost		
Provider Type			Current Rate	New Rate	Effective Date		
<u>CH</u>	D		147.15	165.26	07/01/2021		
Rate Type							
Inte	e <u>rim</u>		X <u>Prospec</u>	<u>ctive</u>			
	Total Interim	ı	x	Total Prospective			
	Settlement I	Based on Cost		Prospective Adjus	sted For New Costs		
		BASIS:					
		Budget					
		X Unaudited	d Cost				
		Desk Rev	iewed Cost				
		Desk Aud	ited Cost				
		Field Aud	ited Cost				
DISTRIBUTION:				TR			
Fiscal Agent				rv,			
Contract Mana	gement			Rydell Samuel, Adminis	strator		
Program Finan	се			Medicaid Program Fina	ince		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Indian River C	Indian River County Health Department				Provider Number: 0279412-96				
1900 27th Str	eet					Date: 07/01/2021 Fiscal Year End: 06/30/2020			21
Vero Beach, F	FL 32960								20
							Audit Status:	Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				147	.15	16	5.26	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	_	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ective Adjus	sted 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	uel, Adminis	strator
Program	Finance						Medicaid Pro	ogram Fina	ince

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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Departme	ent	Prov	Provider Number: 0279421-00			
P. O. Box 310			Date: 07/01/2021 Fiscal Year End: 06/30/2020			
Marianna, FL 32447		Fis				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	159.23	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total Int	erim	X	Total Prospective			
Settleme	ent 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			ſN			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health I	Department			Provider Number: 0279421-01 Date: 07/01/2021 Fiscal Year End: 06/30/2020			
P. O. Box 310							
Marianna, FL 32447							
				Au	dit Status: Unaudited	Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		-	159	.23	165.26	07/01/2021	
Rate Type							
<u>Interim</u>			Х	<b>Prospective</b>	<u>)</u>		
	Total Interim			- X	Total Prospective		
	Settlement Base	ed on Cost			Prospective Adjust	ted For New Costs	
	<u> </u>	BASIS:					
	_	Budget	Qual				
	_	X Unaudited					
	_		ewed Cost				
	_	Desk Audi					
	_	Field Audit	ted Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent					[ N		
Contract Manageme	ent			Ry	dell Samuel, Adminis	trator	
Program Finance				Me	edicaid Program Finar	nce	
State Health Office							



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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Departme	Prov	Provider Number: 0279421-02				
P. O. Box 310			Date: 07/01/2021			
Marianna, FL 32447		Fise	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	159.23	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
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	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			7 N			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Finar	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Departme	Prov	Provider Number: 0279421-03				
P. O. Box 310			Date: 07/01/2021			
Marianna, FL 32447		Fise	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	159.23	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
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	trator		
Program Finance			Medicaid Program Finar	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Departm	Prov	ider Number: 0279421-0	)4			
P. O. Box 310			Date: 07/01/202	07/01/2021		
Marianna, FL 32447		Fis	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		159.23	165.26	07/01/2021		
Rate Type						
Interim		X Prospect	ive			
Total In	iterim	X	Total Prospective			
Settlem	ent 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			[N			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department				Prov	ider Number:	0279421-	13		
P. O. Box 310	)					Date: 07/01/2021		21	
Marianna, FL	32447					Fise	cal Year End	: 06/30/202	20
							Audit Status:	Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				159	.23	16	5.26	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ective Adjus	sted For New Costs
			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						/ N		
Contract	Managem	ent					Rydell Samu	uel, Adminis	strator
Program	Finance						Medicaid Pro	ogram Fina	nce

State Health Office



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health	Department			Provider Number: 0279421-14 Date: 07/01/2021			
P. O. Box 310							
Marianna, FL 32447				Fiscal Year End: 06/30/2020			
				A	udit Status:	Unaudited Co	ost
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>		-	159	.23	165	.26	07/01/2021
Rate Type							
<u>Interim</u>			Х	<b>Prospectiv</b>	<u>e</u>		
	Total Interim			- X	Total Pro	ospective	
	Settlement Base	d on Cost			Prospec	tive Adjusted	For New Costs
	<u>B</u>	<u>ASIS:</u>					
		Budget					
		X Unaudited	Cost				
		Desk Revi	ewed Cost				
		Desk Audi	ted Cost				
	_	Field Audit	ted Cost				
DISTRIBUTION:					TR		
Fiscal Agent					M		
Contract Manageme	ent			R	ydell Samue	el, Administrat	or
Program Finance					-	gram Finance	
State Health Office							



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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Departme	Prov	Provider Number: 0279421-30				
P. O. Box 310			Date: 07/01/2021			
Marianna, FL 32447		Fise	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	159.23	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
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	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			<u> </u>			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Finan	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Departme	Prov	ider Number: 0279421-9	91			
P. O. Box 310			Date: 07/01/2021			
Marianna, FL 32447		Fise				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		159.23	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	<u>ive</u>			
Total Int	terim	X	Total Prospective			
Settlement 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:			R			
Fiscal Agent			[N			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Final	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Departm	Prov	ider Number: 0279439-0	00		
1255 W. Washington Street			Date: 07/01/202	: 07/01/2021	
Monticello, FL 32344		Fise	Fiscal Year End: 06/30/2020		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	160.57	165.26	07/01/2021	
Rate Type					
<u>Interim</u>		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 Audite	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			( N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance		Medicaid Program Final	nce		

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### Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Department				Prov	vider Number:	0279439-	04		
1255 W. Wash	ington St	reet				Date: 07/01/2021			21
Monticello, FL	32344					Fis	cal Year End	06/30/202	20
							Audit Status:	Unaudited	d Cost
<u>Provider Ty</u>	v <u>pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				160	.57	16	5.26	07/01/2021
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	sted 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						74		
Contract N	lanagem	ent					Rydell Samu	iel, Adminis	strator
Program Finance					Medicaid Pro	ogram Fina	ince		

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### Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Departme	Prov	ider Number: 0279439-3	30			
1255 W. Washington Street			Date: 07/01/202	e: 07/01/2021		
Monticello, FL 32344		Fiso	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	160.57	165.26	07/01/2021		
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 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		

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### Medicaid Reimbursement Rate Change Form for CHDs

Lee County Health Departm	ent	Prov	ider Number: 0279463-	00
3920 Michigan Avenue		Date: 07/01/2021		
Fort Myers, FL 33916	Fise	cal Year End: 06/30/202	20	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.27	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Tot	tal Interim	X	Total Prospective	
Set	ttlement 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			74	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Lee County Health Depa	rtment			Provi	der Number:	0279463-01	
3920 Michigan Avenue				Date: 07/01/2021			
Fort Myers, FL 33916				Fisc	al Year End:	06/30/2020	
				/	Audit Status:	Unaudited Co	st
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date
<u>CHD</u>			166.	59	165	5.27	07/01/2021
Rate Type							
Interim			Х	Prospecti	<u>ve</u>		
	Total Interim			Х	Total P	rospective	
	Settlement Based of	on Cost			Prospe	ctive Adjusted	For New Costs
	BAS	SIS:					
		Budget					
	X	- Unaudited Co	ost				
		- Desk Review	ed Cost				
		- Desk Audited	d Cost				
		- Field Audited	l Cost				
		-					
DISTRIBUTION:					TR		
Fiscal Agent					PV.		
Contract Manageme	ent				Rydell Samu	el, Administrat	or
Program Finance				Ī	Medicaid Pro	gram Finance	

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### Medicaid Reimbursement Rate Change Form for CHDs

Lee County H	ealth Depa	artment				Prov	vider Number:	0279463-	04
3920 Michigan Avenue				Date: 07/01/2021			21		
Fort Myers, F	L 33916					Fis	cal Year End	: 06/30/202	20
							Audit Status	Unaudited	d Cost
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166	.59	16	5.27	07/01/2021
Rate Type									
	Interim				Х	Prospect	<u>tive</u>		
	-	Total Interim				X	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs
			BAS	<u>SIS:</u>					
				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						γv		
Contract	Managem	ent					Rydell Samu	uel, Adminis	strator
Program	Finance						Medicaid Pre	ogram Fina	ince

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#### Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Department				Prov	vider Number:	0279471-0	0		
2965 Municipa	al Way					Date: 07/01/2021			l
Tallahassee, FL 32304				Fis	cal Year End	06/30/2020	)		
							Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				118	.82	150	6.94	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospect	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs
			BAS	SIS:					
				Budget					
			Х	_ Unaudited	d Cost				
				_ Desk Rev	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ited Cost				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						74		
Contract	Managem	ent					Rydell Samu	iel, Administ	trator
Program	Finance						Medicaid Pro	ogram Finan	ice

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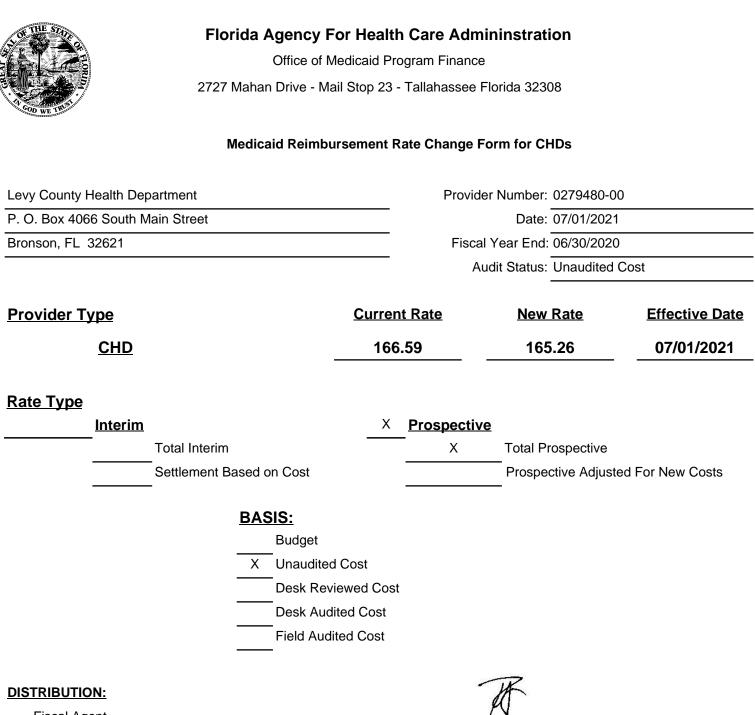
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### Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Depart	tment	Prov	vider Number: 0279471-	91
2965 Municipal Way		Date: 07/01/202	2021	
Tallahassee, FL 32304	Fis	cal Year End: 06/30/202	20	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		118.82	156.94	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	tive	
To	otal Interim	X	Total Prospective	
S6	ettlement Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudite	d Cost		
	Desk Rev	viewed Cost		
	Desk Aud	dited Cost		
	Field Auc	dited Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[ 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

Levy County Health Department		Provide	· Number:	0279480-91	
P. O. Box 4066 South Main Street		- Date:		: 07/01/2021	
Bronson, FL 32621		Fiscal	Year End:	06/30/2020	
		Au	dit Status:	Unaudited Cos	st
Provider Type	Curren	t Rate	New	Rate	Effective Date
<u>CHD</u>	166.	.59	165	.26	07/01/2021
Rate Type					
<u>Interim</u>	X	Prospective			
Total Interim		Х	Total Pro	ospective	
Settlement Bas	sed on Cost		Prospec	tive Adjusted	For New Costs
<u> </u>	BASIS:				
	Budget				
-	X Unaudited Cost				
-	Desk Reviewed Cost				
-	Desk Audited Cost				
-	Field Audited Cost				
-					
DISTRIBUTION:		-	TR		
Fiscal Agent		1	rv		
Contract Management		Ry	dell Samue	el, Administrato	or
Program Finance		Me	dicaid Pro	gram Finance	

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### Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Departmen	Prov	ider Number: 0279498-0	00	
P. O. Box 489247 N. Central Stre		Date: 07/01/202	: 07/01/2021	
Bristol, FL 32321	Fiso	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Inte	erim	X	Total Prospective	
Settleme	ent Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited 0	Cost		
	Desk Revie	wed Cost		
	Desk Audite	ed Cost		
	Field Audite	d Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N]	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department	Prov	rider Number: 0279498-0	08	
P. O. Box 489247 N. Central Stree		Date: 07/01/202	)1/2021	
Bristol, FL 32321	Fis	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Inte	rim	X	Total Prospective	
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited C	Cost		
	Desk Review	wed Cost		
	Desk Audite	ed Cost		
	Field Audite	d Cost		
DISTRIBUTION:			TR	
Fiscal Agent			ſN	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department	Prov	vider Number: 0279498-	10	
P. O. Box 489247 N. Central Stree		Date: 07/01/202	21	
Bristol, FL 32321	Fis	cal Year End: 06/30/202	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	tive	
Total Inte	rim	X	Total Prospective	
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited C	Cost		
	Desk Review	wed Cost		
	Desk Audite	ed Cost		
	Field Audite	d Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[ N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department	Р	rovider Number: 0279498-1	14
P. O. Box 489247 N. Central Street		Date: 07/01/2021	
Bristol, FL 32321		Fiscal Year End: 06/30/202	0
		Audit Status: Unaudited	Cost
Provider Type	Current Rate	New Rate	Effective Date
CHD	166.59	165.26	07/01/2021
Rate Type Interim	X <u>Prosp</u>	ective	
Total Interim		C Total Prospective	
Settlement Based on Cost			ted For New Costs
Desk A			
DISTRIBUTION: Fiscal Agent		R	
Contract Management		Rydell Samuel, Adminis	trator

**Program Finance** 

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### Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department	F	Provider Number: 0	279498-30
P. O. Box 489247 N. Central Street		Date: 0	7/01/2021
Bristol, FL 32321		Fiscal Year End: 0	6/30/2020
		Audit Status: L	naudited Cost
Provider Type	Current Rate	<u>New R</u>	ate Effective Date
CHD	166.59	165.2	26 07/01/2021
Rate Type Interim	X Prosp	<u>ective</u>	
Total Interim		X Total Pros	spective
Settlement Based on Cost			ve Adjusted For New Costs
BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	ewed Cost ited Cost		
DISTRIBUTION: Fiscal Agent		T	
Contract Management		r Rydell Samuel	, Administrator

**Program Finance** 

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Medicaid Program Finance



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### Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department	P	rovider Number: 02794	98-91	
P. O. Box 489247 N. Central Street		Date: 07/01/	2021	
Bristol, FL 32321		Fiscal Year End: 06/30/	2020	
		Audit Status: Unaud	lited Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	166.59	165.26	07/01/2021	
Rate Type Interim	X <u>Prosp</u>	ective		
Total Interim		X Total Prospect	ive	
Settlement Based on Cost			djusted For New Costs	
BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	ewed Cost ited Cost			
DISTRIBUTION: Fiscal Agent		TH		
Contract Management		r Rydell Samuel, Adm	ninistrator	

**Program Finance** 

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Medicaid Program Finance



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#### Medicaid Reimbursement Rate Change Form for CHDs

Manatee Cou	nty Health	Department	Ianatee County Health Department						00	
410 Six Avenu	ue East						Date	07/01/202	1	
Bradenton, FL	34208					Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited	Cost	
Provider Type Curre				<u>Currer</u>	nt Rate	New	Rate	Effective Date		
	<u>CHD</u>				95.	.90	120	6.36	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ective Adjus	ted For New Costs	
		_	BAS	SIS:						
				Budget						
			X	- Unaudited	l Cost					
				- Desk Revi	iewed Cost	t				
				- Desk Aud	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						/ N			
Contract	Managem	ent					Rydell Samu	iel, Adminis	trator	
Program	Finance					Medicaid Program Finance				

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### Medicaid Reimbursement Rate Change Form for CHDs

Manatee Cou	nty Health	Department			Provid	ler Number:	0279510-0	1	
410 Six Avenu	ue East					Date:	07/01/2021	1	
Bradenton, FL	34208				Fiscal Year End: 06/30/2020				
					Ą	udit Status:	Unaudited	Cost	
Provider Type Curr				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			95.	90	120	6.36	07/01/2021	
Rate Type									
	Interim			X	Prospectiv	<u>/e</u>			
		Total Interim			X	Total P	rospective		
		Settlement Bas	ed on Cost			Prospe	ctive Adjust	ed For New Costs	
		<u> </u>	BASIS:						
			Budget						
		_	X Unaudite	d Cost					
		_	Desk Rev	viewed Cost					
		-	Desk Aud	dited Cost					
		-	Field Aud	lited Cost					
		_							
DISTRIBUTIC	<u>)N:</u>					TR			
Fiscal Ag	ent					M			
Contract	Managem	ent			F	Rydell Samu	iel, Administ	trator	
Program	Finance				Ν	Aedicaid Pro	ogram Finar	nce	

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### Medicaid Reimbursement Rate Change Form for CHDs

Manatee County Health De	epartment	Provi	ider Number: 0279510-3	80			
410 Six Avenue East			Date: 07/01/202	1			
Bradenton, FL 34208		Fiso	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		95.90	126.36	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
т	otal Interim	X	Total Prospective				
s	Settlement Based on Cost		Prospective Adjust	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			/ N				
Contract Managemen	.t		Rydell Samuel, Administrator				
Program Finance			Medicaid Program Finar	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

Manatee County Health Depart	ment	Prov	Provider Number: 0279510-91				
410 Six Avenue East			Date: 07/01/2021				
Bradenton, FL 34208		Fis	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	95.90	126.36	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total I	nterim	X	Total Prospective				
Settler	ment 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			[N				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Finance				

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### Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department	Pr	Provider Number: 0279528-00					
1801 S.E. 32nd AvenueP. O. Box 2408		Date: 07/01/2021					
Ocala, FL 34478-2408	F	Fiscal Year End: 06/30/2020					
		Audit Status: Unaudited	Cost				
Provider Type	Current Rate	New Rate	Effective Date				
CHD	166.59	165.26	07/01/2021				
Rate Type Interim	X <u>Prospe</u>	ective					
Total Interim	x	Total Prospective					
Settlement Based on Cost		Prospective Adjus	ted For New Costs				
Desk Aud	d Cost viewed Cost dited Cost dited Cost						
DISTRIBUTION: Fiscal Agent		T					
Contract Management		Rydell Samuel, Adminis	strator				

**Program Finance** 

State Health Office

Medicaid Program Finance



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department		Prov	Provider Number: 0279528-01				
1801 S.E. 32nd AvenueP. O. Box 2	2408		Date: 07/01/202	7/01/2021			
Ocala, FL 34478-2408		Fise	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	166.59	165.26	07/01/2021			
Rate Type							
Interim		X Prospect	<u>ive</u>				
Total Inte	rim	X	Total Prospective				
Settlemer	t Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited C	Cost					
	Desk Review	wed Cost					
	Desk Audite	d Cost					
	Field Audited	d Cost					
DISTRIBUTION:			TR				
Fiscal Agent			rv.				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Finance				

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### Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Marion County Health Department						Provider Number: 0279528-02				
1801 S.E. 32r	nd Avenue	P. O. Box 2408	В				Date	07/01/202	1		
Ocala, FL 344	478-2408					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Cost		
<u>Provider Ty</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
CHD				166.59		16	5.26	07/01/2021			
Rate Type											
	<u>Interim</u>				Х	Prospect	<u>tive</u>				
	-	Total Interim				X	Total P	rospective			
		Settlement Ba	ased	on Cost			Prospe	ctive Adjust	ted For New Costs		
			BAS	SIS:							
				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						M				
Contract I	Contract Management						Rydell Samuel, Administrator				
Program	Finance						Medicaid Pro	ogram Finar	nce		

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### Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Narion County Health Department						Provider Number: 0279528-04				
1801 S.E. 32r	nd Avenue	P. O. Box 2408	В				Date:	07/01/202	1		
Ocala, FL 344	478-2408					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Cost		
Provider Type <u>Cu</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date				
CHD				166.59		16	5.26	07/01/2021			
Rate Type											
	<u>Interim</u>				Х	Prospect	tive				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs		
			BAS	SIS:							
				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						M				
Contract I	Managem	ent				Rydell Samuel, Administrator					
Program	Finance						Medicaid Pro	ogram Finar	nce		

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### Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department		Prov	ider Number: 0279528-0	05			
1801 S.E. 32nd AvenueP. O. Box	2408		Date: 07/01/202	7/01/2021			
Ocala, FL 34478-2408		Fise	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	166.59	165.26	07/01/2021			
Rate Type							
Interim		X Prospect	ive				
Total Inte	rim	X	Total Prospective				
Settlemer	nt Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited C	Cost					
	Desk Review	wed Cost					
	Desk Audite	ed Cost					
	Field Audite	d Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Finance				

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### Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Narion County Health Department						Provider Number: 0279528-12				
1801 S.E. 32n	nd Avenue	P. O. Box 2408	3				Date	07/01/2022	1		
Ocala, FL 344	478-2408					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Cost		
Provider Type Cur			<u>Curren</u>	ent Rate New		Rate	Effective Date				
CHD				166.59		16	5.26	07/01/2021			
Rate Type											
	<u>Interim</u>				Х	Prospect	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs		
			BAS	SIS:							
				Budget							
			X	_ Unaudited	d Cost						
				– Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
DISTRIBUTIO	<u>DN:</u>						TR				
Fiscal Age	Fiscal Agent						γv				
Contract I	Contract Management						Rydell Samuel, Administrator				
Program	Finance						Medicaid Pro	ogram Finar	nce		

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### Medicaid Reimbursement Rate Change Form for CHDs

Marion Count	Iarion County Health Department						Provider Number: 0279528-30				
1801 S.E. 32r	nd Avenue	P. O. Box 240	8				Date	07/01/2022	1		
Ocala, FL 34	478-2408					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Cost		
<u>Provider Ty</u>	<u>ype</u>				Curren	t Rate	New	Rate	Effective Date		
<u>CHD</u>				166.59		16	5.26	07/01/2021			
Rate Type											
	<u>Interim</u>				Х	Prospect	tive				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	ased	on Cost			Prospe	ctive Adjust	ed For New Costs		
		_	BAS	sis							
				Budget							
			X	– Unaudited	l Cost						
				_	iewed Cost						
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				– Field Audi							
							-IP				
DISTRIBUTIC	<u>DN:</u>						at				
Fiscal Ag	Fiscal Agent						/ N				
Contract	Managem	ent				Rydell Samuel, Administrator					
Program	Program Finance						Medicaid Pro	ogram Finar	nce		

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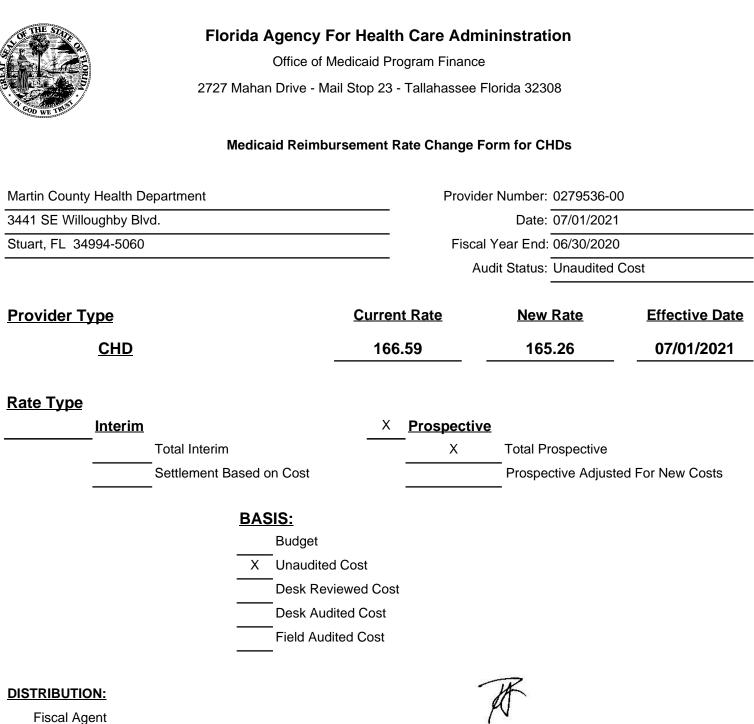
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### Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Marion County Health Department						Provider Number: 0279528-91				
1801 S.E. 32n	nd Avenue	P. O. Box 240	В				Date:	07/01/202	1		
Ocala, FL 344	478-2408					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Cost		
Provider Type <u>Cu</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date				
CHD				166.59		16	5.26	07/01/2021			
Rate Type											
	<u>Interim</u>				Х	Prospect	tive				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	ased	on Cost			Prospe	ctive Adjust	ted For New Costs		
			BAS	SIS:							
				Budget							
			Х	_ Unaudited	d Cost						
				– Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
DISTRIBUTIO	<u>DN:</u>						TR				
Fiscal Age	ent						μų				
Contract I	Contract Management						Rydell Samuel, Administrator				
Program	Finance						Medicaid Pro	ogram Finar	nce		

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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

Martin County Health Department		Provi	ider Number: 0279536-	11		
3441 SE Willoughby Blvd.			Date: 07/01/202	1		
Stuart, FL 34994-5060		Fiso	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost		
Provider Type	Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	166.59	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total Inte	erim	Х	Total Prospective			
Settleme	ent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			<sup>rv</sup>			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Finance			

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### Medicaid Reimbursement Rate Change Form for CHDs

Martin County	Martin County Health Department					Prov	vider Number:	0279536-9	<b></b> 91	
3441 SE Willo	oughby Blv	rd.					Date:	07/01/202	1	
Stuart, FL 34	994-5060					- Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited	l Cost	
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospec	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	dCost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
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DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						M			
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

Monroe County Health Department						Prov	ider Number:	0279544-00	)	
5100 College	Road						Date:	: 07/01/2021		
Key West, FL	33040					Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited (	Cost	
Provider Type Curre			Current	t Rate	New	Rate	Effective Date			
	<u>CHD</u>				166.	59	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				X	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs	
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			Х	_ Unaudited	d Cost					
				_ Desk Revi	iewed Cost					
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DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						ſN			
Contract I	Managem	ent					Rydell Samu	el, Administr	rator	
Program Finance							Medicaid Pro	ogram Finan	се	

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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department						Prov	ider Number:	0279544-01	1	
5100 College	Road						Date:	07/01/2021		
Key West, FL	33040					Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited (	Cost	
Provider Type Curre				<u>Current</u>	<u>Rate</u>	New	Rate	Effective Date		
	<u>CHD</u>				166.	59	16	5.26	07/01/2021	
Rate Type										
	Interim				Х	Prospect	ive			
	-	Total Interim				x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			X	- Unaudited	Cost					
				- Desk Revi	iewed Cost					
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				- Field Audi	ted Cost					
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<u>DISTRIBUTIO</u>	<u>N:</u>						TR			
Fiscal Age	ent						74			
Contract N	Manageme	ent					Rydell Samu	el, Administr	rator	
Program Finance							Medicaid Pro	ogram Finano	се	

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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health D	epartment		Provider Number: 0279544-03				
5100 College Road			_	Date:	07/01/2021		
Key West, FL 33040			Fiscal Year End: 06/30/2020				
			-	Audit Status:	Unaudited Co	st	
Provider Type Curre			ent Rate	New	Rate	Effective Date	
<u>CHD</u>		1	66.59	165	5.26	07/01/2021	
Rate Type							
<u>Interim</u>		2	X Prospect	ive			
	Total Interim		X	Total Pr	ospective		
	Settlement Based o	n Cost		Prospec	ctive Adjusted	For New Costs	
	BAS	SIS:					
		Budget					
	X	- Unaudited Cost					
		- Desk Reviewed Co	ost				
		- Desk Audited Cost	t				
		- Field Audited Cost					
		-					
DISTRIBUTION:				TR			
Fiscal Agent				[ N			
Contract Manageme	nt			Rydell Samu	el, Administrat	or	
Program Finance				Medicaid Pro	gram Finance		

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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health D		Provid	der Number:	0279544-04				
5100 College Road					Date:	07/01/2021		
Key West, FL 33040				Fiscal Year End: 06/30/2020				
				ŀ	Audit Status:	Unaudited Co	ost	
Provider Type Curre			Current	t Rate	New	Rate	Effective Date	
<u>CHD</u>			166.	59	165	5.26	07/01/2021	
Rate Type								
<u>Interim</u>			Х	<u>Prospecti</u>	<u>ve</u>			
	Total Interim			X	Total P	rospective		
	Settlement Based o	on Cost			Prospe	ctive Adjusted	For New Costs	
	BAS	SIS:						
		Budget						
	X	- Unaudited Cos	st					
		_ Desk Reviewe	d Cost					
		- Desk Audited (	Cost					
		- Field Audited (	Cost					
		-						
DISTRIBUTION:					TR			
Fiscal Agent					(N			
Contract Manageme	ent			<u> </u>	Rydell Samu	el, Administrat	tor	
Program Finance		I	Medicaid Pro	ogram Finance				

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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health D		Provid	der Number:	0279544-08				
5100 College Road					Date:	07/01/2021		
Key West, FL 33040				Fiscal Year End: 06/30/2020				
				P	Audit Status:	Unaudited Co	ost	
Provider Type Curre			urrent	Rate	New	Rate	Effective Date	
<u>CHD</u>			166.	59	16	5.26	07/01/2021	
Rate Type								
<u>Interim</u>			Х	Prospectiv	ve			
	Total Interim	-		Х	Total P	rospective		
	Settlement Based of	on Cost	-		Prospe	ctive Adjusted	For New Costs	
	BAS	SIS:						
		Budget						
	X	- Unaudited Cost						
		_ Desk Reviewed	Cost					
		Desk Audited Co	ost					
		- Field Audited Co	ost					
		-						
DISTRIBUTION:					TR			
Fiscal Agent					(N			
Contract Manageme	ent			<u>F</u>	Rydell Samu	el, Administrat	tor	
Program Finance		ſ	Medicaid Pro	ogram Finance				

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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Departr	nent	Prov	ider Number: 0279544-	13			
5100 College Road			Date: 07/01/202	1			
Key West, FL 33040		Fise					
			Audit Status: Unaudited	Cost			
Provider Type	Current Rate	New Rate	Effective Date				
<u>CHD</u>	-	166.59	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X <u>Prospect</u>	ive				
Total	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 Audit	ed Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			R				
Fiscal Agent			/ N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department						Prov	ider Number:	0279544-30	
5100 College I	Road						Date:	07/01/2021	
Key West, FL	33040					Fis	cal Year End	06/30/2020	
							Audit Status:	Unaudited C	Cost
Provider Ty	v <u>pe</u>				Current	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166.	59	16	5.26	07/01/2021
Rate Type									
	Interim				X	Prospect			
		Total Interim				Χ	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	d 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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DISTRIBUTIO	<u>N:</u>						TR		
Fiscal Age	ent						[ ]		
Contract N	lanageme	ent					Rydell Samu	iel, Administra	ator
Program F	inance						Medicaid Pro	ogram Financ	e

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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health D	epartment		Provider Number: 0279544-91				
5100 College Road			-	Date:	07/01/2021		
Key West, FL 33040			Fiscal Year End: 06/30/2020				
			-	Audit Status:	Unaudited Co	st	
Provider Type Curre			ent Rate	New	<u>Rate</u>	Effective Date	
<u>CHD</u>		10	66.59	165	5.26	07/01/2021	
Rate Type							
<u>Interim</u>		>	× Prospect	ive			
	Total Interim		X	Total Pr	ospective		
	Settlement Based o	n Cost		Prospe	ctive Adjusted	For New Costs	
	BAS	SIS:					
		Budget					
	X	Unaudited Cost					
		- Desk Reviewed Co	ost				
		- Desk Audited Cost	t				
		- Field Audited Cost					
		-					
DISTRIBUTION:				TR			
Fiscal Agent				/ N			
Contract Manageme	nt			Rydell Samu	el, Administrat	or	
Program Finance				Medicaid Pro	gram Finance		

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Medicaid Program Finance



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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe Coun	onroe County Health Department					Provider Number: 0279544-92				
5100 College	Road						Date:	07/01/202	1	
Key West, FL	33040					Fis	cal Year End	06/30/202	0	
							Audit Status:	Unaudited	Cost	
Provider Type			Current Rate New		New	<u>/ Rate Effective Date</u>				
CHD				166.59		16	5.26	07/01/2021		
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based		on Cost		Prospe	ctive Adjus	ted For New Costs				
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DISTRIBUTIO							ar			
Fiscal Ag							1			
	Contract Management						Rydell Samu			
Program Finance							Medicaid Pro	ogram Finai	nce	

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Medicaid Program Finance



Office of Medicaid Program Finance

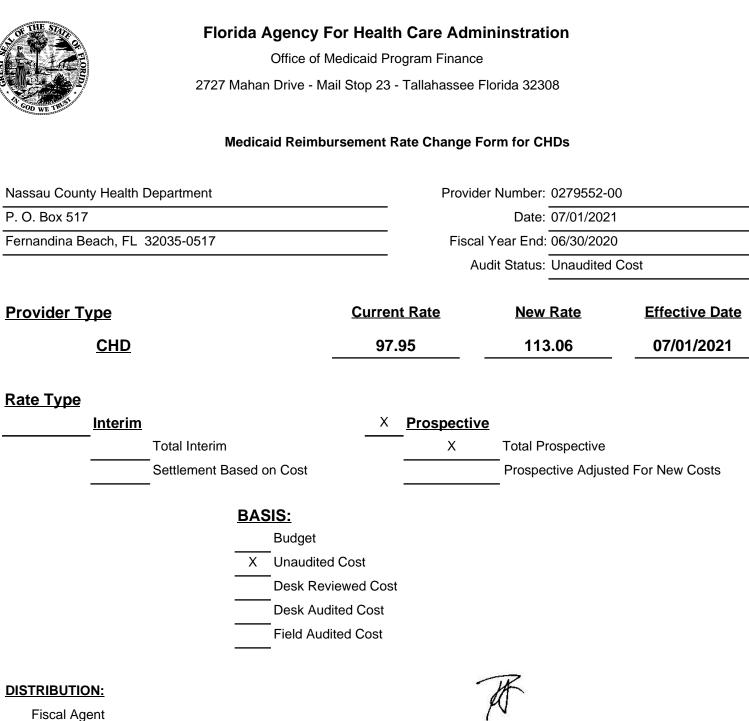
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### Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health D	onroe County Health Department					Provider Number: 0279544-93				
5100 College Road					Date:	07/01/2021				
Key West, FL 33040				Fisca	al Year End:	06/30/2020				
				A	udit Status:	Unaudited Co	ost			
Provider Type Cur			urrent	<u>Rate</u>	New	Rate	Effective Date			
<u>CHD</u>		166.59		165.26		07/01/2021				
Rate Type										
Interim			х <u>г</u>	Prospectiv	<u>/e</u>					
	Total Interim	-		Х	Total P	rospective				
Settlement Base		on Cost		Prospe	ctive Adjusted	For New Costs				
	BAS	SIS:								
		Budget								
	X	- Unaudited Cost								
		_ Desk Reviewed	Cost							
		Desk Audited C	ost							
		- Field Audited Co	ost							
		-								
DISTRIBUTION:					TR					
Fiscal Agent					[N					
Contract Management				Rydell Samuel, Administrator						
Program Finance		Ν	ledicaid Pro	gram Finance						

State Health Office

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

Nassau County Health Department		Provider Number: 0279552-01				
P. O. Box 517				Date: 07/01/202	1	
Fernandina Beach, FL 32035-0517			Fiscal \	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost	
Provider Type	<u>Curren</u>	t Rate	New Rate	Effective Date		
CHD		97.9	95	113.06	07/01/2021	
Rate Type						
Interim		Х	Prospective			
Total Interim	ı		- x	Total Prospective		
Settlement E			Prospective Adjus	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	<sup>N</sup>		
Contract Management			Rydell Samuel, Administrator			
Program Finance			Mee	dicaid Program Finar	nce	
State Health Office						



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### Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department		Provider Number: 0279552-04					
P. O. Box 517				Date:	07/01/2021		
Fernandina Beach, FL 32035-0517			Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited Cost				
Provider Type <u>C</u>			Rate	New	<u>Rate</u>	Effective Date	
CHD		97.95		113.06		07/01/2021	
Rate Type							
Interim		X	<b>Prospective</b>				
Total Interim			Х	Total Pro	ospective		
Settlement Bas	sed on Cost			Prospec	tive Adjusted I	For New Costs	
	BASIS:						
	Budget						
-	X Unaudited	Cost					
-	Desk Revi	ewed Cost					
-	Desk Audi	ted Cost					
-	Field Audit	ed Cost					
DISTRIBUTION: Fiscal Agent			-	R			
Contract Management			Rydell Samuel, Administrator				
Program Finance				gram Finance	<u> </u>		

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### Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department	t		Provider Number: 0279552-05				
P. O. Box 517				Date: 07/01/202	1		
Fernandina Beach, FL 32035-051	7		Fiscal Y	/ear End: 06/30/202	0		
			Audit Status: Unaudited Cost				
Provider Type			t Rate	Effective Date			
CHD		97.	95	113.06	07/01/2021		
Rate Type							
Interim		Х	Prospective				
Total Inte	rim		- X	Total Prospective			
Settlemer			Prospective Adjus	ted For New Costs			
				_			
	<b>BASIS:</b>						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			-	R			
Fiscal Agent			1	el)			
Contract Management			Ryc	lell Samuel, Adminis	trator		
Program Finance			Med	dicaid Program Finai	nce		
State Health Office							



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### Medicaid Reimbursement Rate Change Form for CHDs

Nassau County	assau County Health Department					Provider Number: 0279552-95			
P. O. Box 517						Date:	07/01/202	21	
Fernandina Bea	ach, FL 🕄	32035-0517			Fiscal Year End: 06/30/2020				
					Audit Status: Unaudited Cost				
Provider Type Cu			<u>Curren</u>	t Rate	New	Rate	Effective Date		
CHD			97.95		11:	3.06	07/01/2021		
Rate Type									
<u> </u>	<u>Interim</u>			X	Prospecti	ve			
		Total Interim			X	Total P	rospective		
_		Settlement Based	on Cost			Prospe	ctive Adju	sted For New Costs	
		BA	<u>SIS:</u>						
			Budget						
		X	Unaudited	d Cost					
			 Desk Rev	iewed Cost					
			 Desk Aud	ited Cost					
			Field Audi	ited Cost					
						TR			
DISTRIBUTION						at			
Fiscal Age						1			
	Contract Management				Rydell Samuel, Administrator				
Program Finance						Medicaid Pro	ogram Fina	ance	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health Depar	rtment	Provi	Provider Number: 0279561-00				
221 Hospital Drive, N.E.			Date: 07/01/202	1			
Ft. Walton Beach, FL 32548		Fisc	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited Cost				
Provider Type		Current Rate	New Rate	Effective Date			
CHD		165.33	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X <u>Prospecti</u>	ve				
Total	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 Audit	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			/ N				
Contract Management		-	Rydell Samuel, Adminis	trator			
Program Finance			Medicaid Program Finai	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health De	epartment	Prov	Provider Number: 0279561-91				
221 Hospital Drive, N.E.			Date: 07/01/2021				
Ft. Walton Beach, FL 3254	.8	Fis	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		165.33	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
То	otal Interim	X	Total Prospective				
Se	ettlement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	d Cost					
	Desk Rev	viewed Cost					
	Desk Aud	lited Cost					
	Field Aud	lited Cost					
DISTRIBUTION:			TR				
Fiscal Agent			7N				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Finance				

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### Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Depar	rtment	Pro	Provider Number: 0279579-00				
P.O. Box 18791728 N.W. 9th Aver	nue		Date: 07/01/2021				
Okeechobee , FL 34973-1879		Fis	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited Cost				
Provider Type	Current Rate	New Rate	Effective Date				
CHD	_	154.03	104.70	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospec	tive				
Total Inte	rim	X	Total Prospective				
Settleme	nt Based on Cost		Prospective Adjusted For N				
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			R				
Fiscal Agent		1					
Contract Management			Rydell Samuel, Adminis				
Program Finance			Medicaid Program Fina	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department		Provider Number: 0279579-01				
P.O. Box 18791728 N.W. 9th Avenue		Date: 07/01/2021				
Okeechobee, FL 34973-1879		Fiscal Year End: 06/30/2020				
		Audit Status: Unaudited Cost				
Provider Type	<u>Current</u>	Rate	New Rate	Effective Date		
CHD	154.0	03	104.70	07/01/2021		
Rate Type						
<u>Interim</u>	<u> </u>	Prospective				
Total Interim		Х	Total Prospective			
Settlement Based on Co	ost .		Prospective Adjust	ted For New Costs		
BASIS:						
Buc	dget					
X Una	audited Cost					
Des	sk Reviewed Cost					
Des	sk Audited Cost					
Fiel	ld Audited Cost					
DISTRIBUTION:			R			
Fiscal Agent		p	V			
Contract Management		Rydell Samuel, Administrator				
Program Finance		Med	caid Program Finar	nce		

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### Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee (	Dkeechobee County Health Department					Provider Number: 0279579-02				
P.O. Box 1879	91728 N.W	/. 9th Avenue					Date:	07/01/202	21	
Okeechobee,	, FL 3497	3-1879				Fiscal Year End: 06/30/2020				
						Audit Status: Unaudited Cost				
Provider Type		<u>Curren</u>	t Rate	New	Rate	Effective Date				
CHD			154.03		104	4.70	07/01/2021			
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost				Prospective Adjusted For			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					
				-						
DISTRIBUTIC							TR			
-	Fiscal Agent						1			
	Contract Management						Rydell Samu			
Program Finance							Medicaid Pro	ogram Fina	nce	

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### Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee (	Dkeechobee County Health Department					Provider Number: 0279579-03				
P.O. Box 1879	91728 N.W	/. 9th Avenue					Date:	07/01/202	21	
Okeechobee,	, FL 3497	3-1879				Fiscal Year End: 06/30/2020				
						Audit Status: Unaudited Cost				
Provider Type		<u>Curren</u>	Irrent Rate		Rate	Effective Date				
CHD			154.03		104	4.70	07/01/2021			
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost				Prospective Adjusted For N			sted For New Costs			
			BAS	SIS:						
				Budget						
			X	- Unaudited	Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	Fiscal Agent						/ N			
	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

Okeechobee C	ounty He	alth Department			Provider Number: 0279579-04				
P.O. Box 1879	1728 N.W	/. 9th Avenue				Date	07/01/202	1	
Okeechobee,	FL 34973	3-1879			Fiscal Year End: 06/30/2020				
						Audit Status:	Unaudited	Cost	
Provider Ty	pe			<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			154	.03	104	4.70	07/01/2021	
Rate Type				V					
	<u>Interim</u>	Total Interim		X	-Prospect X		roopootivo		
-		- Settlement Based	Lon Cost				rospective	tod For Now Cooto	
-		-	I ON COSI			PT0spe	clive Adjus	ted For New Costs	
		<u>B</u>	<u>ASIS:</u>						
			Budget						
		×	Unaudited	d Cost					
			Desk Rev	viewed Cost					
			Desk Aud	lited Cost					
			Field Aud	ited Cost					
<u>DISTRIBUTIO</u>	<u>N:</u>					TR			
Fiscal Age	ent					M			
Contract M	lanageme	ent				Rydell Samu	iel, Adminis	trator	
Program F	inance					Medicaid Pro	ogram Finar	nce	

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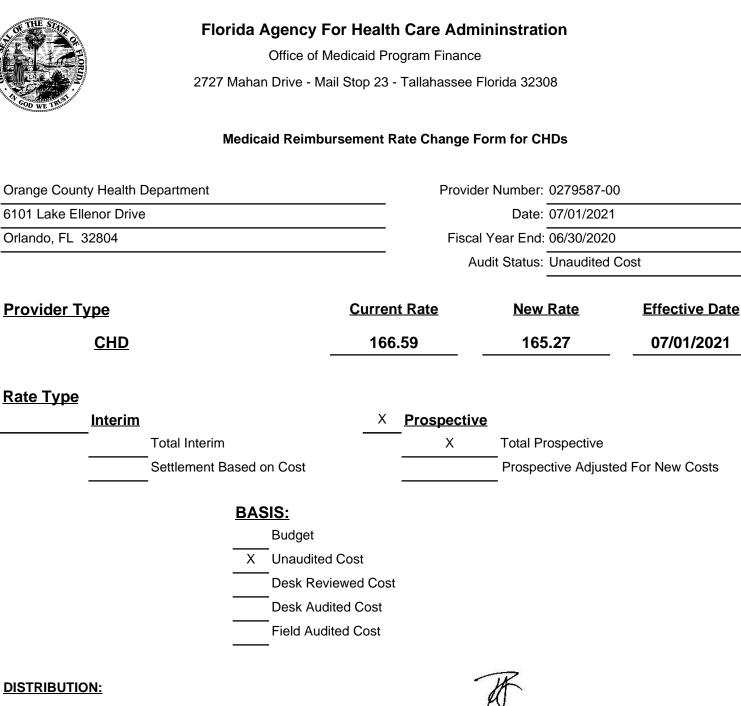
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### Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health De	partment		Provider	Number: 0279579-3	30		
P.O. Box 18791728 N.W. 9th Av	venue			Date: 07/01/202	1		
Okeechobee , FL 34973-1879			Fiscal Year End: 06/30/2020				
			Aud	it Status: Unaudited	Cost		
Provider Type Curr				New Rate	Effective Date		
CHD		154.03		104.70	07/01/2021		
Rate Type							
<u>Interim</u>		X Pros	pective	<b>T</b> ( <b>ID</b> ) (			
Total I			Х	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:			_	R			
Fiscal Agent			ľ	N V			
Contract Management			Ryd	ell Samuel, Adminis	trator		
Program Finance			Med	licaid 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

Orange Count	ty Health [	Department				Provider Number: 0279587-01				
6101 Lake Ell	enor Drive	!				Date: 07/01/2021			:1	
Orlando, FL 3	32804					Fiscal Year End: 06/30/2020				
							Audit Status	Unaudited	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	ent Rate New Rate		Effective Date		
	<u>CHD</u>				166	.59	16	5.27	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- X	Total P	rospective		
		Settlement B	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs	
			BAS	SIS:						
				Budget						
			X	_ Unaudited	Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						7N			
Contract	Managem	ent				_	Rydell Samu	uel, Adminis	strator	
Program	Finance					-	Medicaid Pr	ogram Fina	nce	

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### Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health D	epartment		Provider	Number: 0279595-0	00		
P. O. Box 4503091875 Bo	oggy Creek Road			1			
Kissimmee, FL 34745-03	309		Fiscal Year End: 06/30/2020				
			Aud	it Status: Unaudited	Cost		
Provider Type		<u>Curren</u>	<u>t Rate</u>	New Rate	Effective Date		
CHD		166	.59	165.26	07/01/2021		
Rate Type Interim		х	Prospective				
	Total Interim		- X	Total Prospective			
	Settlement Based on Cost			Prospective Adjus	ted For New Costs		
	BASIS:						
	Budget						
	X Unaudited						
		iewed Cost					
	Desk Aud						
	Field Audi	ited Cost					
DISTRIBUTION: Fiscal Agent				R			
Contract Managemer	nt		Ryd	lell Samuel, Adminis	trator		

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**Program Finance** 



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### Medicaid Reimbursement Rate Change Form for CHDs

Osceola Coun	ty Health	Department				Provider Number: 0279595-30				
P. O. Box 450	3091875 E	Boggy Creek R	load				Date:	07/01/2021		
Kissimmee, Fl	L 34745-0	309				Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited (	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	Interim				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	ed 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						1 N			
Contract I	Manageme	ent					Rydell Samu	el, Administr	ator	
Program	Finance						Medicaid Pro	ogram Finano	ce	

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### Medicaid Reimbursement Rate Change Form for CHDs

Osceola County He	alth Department			Provider Number: 0279595-92				
P. O. Box 45030918	375 Boggy Creek Road	d			Date:	07/01/2021		
Kissimmee, FL 347	45-0309			Fiscal Year End: 06/30/2020				
				A	udit Status:	Unaudited (	Cost	
Provider Type			<u>Current</u>	<u>Rate</u>	New	Rate	Effective Date	
<u>CH</u>	D	-	166.	59	165	5.26	07/01/2021	
Rate Type	<u>rim</u>		х	Prospectiv	<u>e</u>			
	Total Interim			X	Total Pr	ospective		
	Settlement Base	d on Cost	-		Prospec	ctive Adjuste	ed For New Costs	
	B	ASIS:						
		Budget						
		X Unaudited	Cost					
		Desk Revi	ewed Cost					
		Desk Audi	ted Cost					
		Field Audit	ted Cost					
DISTRIBUTION:					R			
Fiscal Agent	romont			_	1			
Contract Manag	yemeni			Rydell Samuel, Administrator				

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### Medicaid Reimbursement Rate Change Form for CHDs

Osceola Cour	nty Health	Department				Prov	vider Number:	0279595-	-93
P. O. Box 450	3091875	Boggy Creek Ro	bad			Date:		07/01/2021	
Kissimmee, F	L 34745-0	0309				Fiscal Year End: 06/30/2020			
							d Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			_	166	.59	16	5.26	07/01/2021
Rate Type	Intorim				x	Dreenee	tivo		
	<u>Interim</u>	Total Interim				- Prospec X		rospective	
		Settlement Bas	sed or	n Cost				•	sted For New Costs
		_	BAS	IS:					
				Budget					
		-	Х	Unaudited	Cost				
		-		Desk Revie	ewed Cost				
		-		Desk Audit	ted Cost				
		-		Field Audit	ted Cost				
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						M		
Contract Management							Rydell Samu	el, Admini	strator

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#### Medicaid Reimbursement Rate Change Form for CHDs

Pasco County	/ Health De	epartment				Provider Number: 0279617-00				
10841 Little R	load									
New Port Rick	hey, FL 34	654				Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	ent Rate <u>New Rat</u>		Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospect	tive			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs	
			BAS	SIS:						
			<u></u>	Budget						
			X	_	Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Aud	ited Cost					
				_ Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						M			
Contract	Manageme	ent					Rydell Samu	iel, Administ	rator	
Program	Finance						Medicaid Pro	ogram Finan	ce	

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### Medicaid Reimbursement Rate Change Form for CHDs

Pasco County	Health Dep	partment				Prov	ider Number:	0279617-0	)1	
10841 Little R	oad					Date: 07/01/2021			1	
New Port Rich	ney, FL 346	654				Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	ent Rate New		Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
		Total Interim				- x	Total P	rospective		
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjust	ted For New Costs	
			BAS	219.						
				Budget						
			X	- Unaudited	l Cost					
				_	iewed Cost					
				_  Desk Audi						
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				-						
	NNI.						TIK			
							RI È			
Fiscal Age		~4								
	Managemei	nt					Rydell Samu			
Program	rinance					Medicaid Program Finance				

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### Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department		Prov	ider Number: 0279617-	91			
10841 Little Road			Date: 07/01/2021				
New Port Richey, FL 34654		Fise	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	166.59	165.26	07/01/2021			
Rate Type							
Interim		X Prospect	ive				
Total Inte	erim	x	Total Prospective				
Settleme	ent 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

Pasco County	Health Departm	ent	Pi	ovider Number: 0279617-	92			
10841 Little Ro	oad			Date: 07/01/2021				
New Port Rich	ey, FL 34654		F	Fiscal Year End: 06/30/2020				
				Audit Status: Unaudited	d Cost			
Provider Ty	<u>/pe</u>		Current Rate	New Rate	Effective Date			
	<u>CHD</u>		166.59	165.26	07/01/2021			
Rate Type								
	<u>Interim</u>		X <u>Prospe</u>	ective				
	- Total	Interim	>	C Total Prospective				
	Settle	ment Based on Cost		Prospective Adjus	sted For New Costs			
		BASIS:						
		Budget						
		X Unaudite	ed Cost					
		Desk Re	viewed Cost					
		Desk Au	dited Cost					
		Field Au	dited Cost					
DISTRIBUTIO	<u>N:</u>			TR				
Fiscal Age	ent			1 N				
Contract N	Vanagement			Rydell Samuel, Adminis	strator			
Program I	Finance			Medicaid Program Fina	ance			

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### Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County Health Departme	nt	Prov	Provider Number: 0279625-00				
500 7th Avenue South			Date: 07/01/2021				
St. Petersburg, FL 33701		Fis	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	166.59	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	tive				
Total Int	erim	X	Total Prospective				
Settleme	ent 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			( •				
Contract Management			Rydell Samuel, Adminis				
Program Finance			Medicaid Program Fina	nce			

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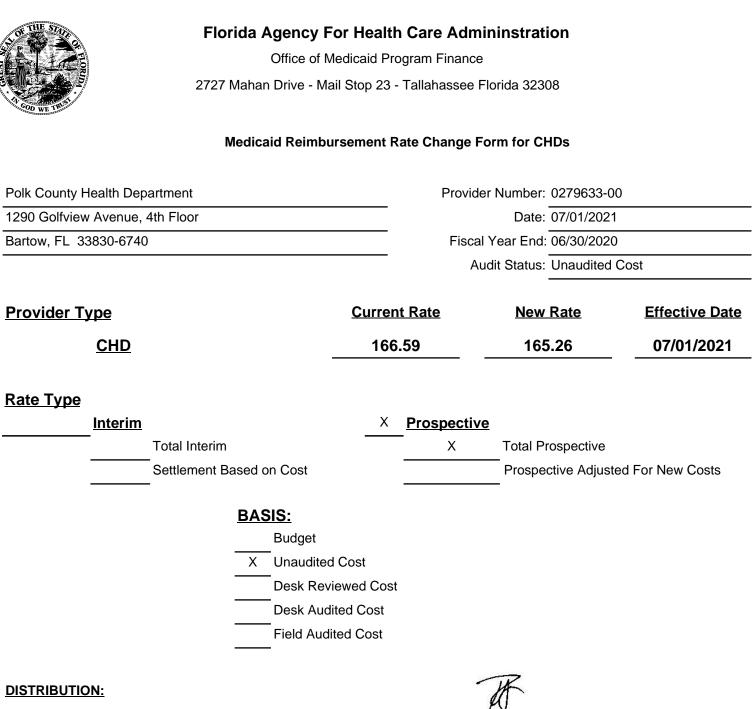
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### Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County Health Department         500 7th Avenue South         St. Petersburg, FL 33701			Provider	Number: 0279625-	91	
				Date: 07/01/202	: 07/01/2021	
			Fiscal	/ear End: 06/30/202	20	
			Auc	it Status: Unaudited	d Cost	
Provider Type		Curren	it Rate	New Rate	Effective Date	
CHD	<u> </u>	166	.59	165.26	07/01/2021	
Rate Type	m	х	Prospective			
	Total Interim		- <u></u> X	Total Prospective		
	Settlement Based on (	Cost		Prospective Adjus	sted For New Costs	
		:: udget naudited Cost esk Reviewed Cost esk Audited Cost eld Audited Cost		_		
DISTRIBUTION: Fiscal Agent Contract Manage Program Finance				lell Samuel, Adminis dicaid Program Fina		

State Health Office



- **Fiscal Agent 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

Polk County Health Department		Provider	Number:	0279633-01	
1290 Golfview Avenue, 4th Floor	- Date:		: 07/01/2021		
Bartow, FL 33830-6740		Fiscal Y	ear End:	06/30/2020	
		Aud	it Status:	Unaudited Cos	st
Provider Type	Curren	t Rate	New	Rate	Effective Date
CHD	166	.59	165	.26	07/01/2021
Rate Type					
<u>Interim</u>	X	Prospective			
Total Interim		Х	Total Pr	ospective	
Settlement Based	on Cost		Prospec	tive Adjusted I	For New Costs
BA	<u>SIS:</u>				
	Budget				
X	Unaudited Cost				
	_ Desk Reviewed Cost				
	Desk Audited Cost				
	Field Audited Cost				
	_				
DISTRIBUTION:		_	IR		
Fiscal Agent		1	N		
Contract Management		Ryc	lell Samue	el, Administrato	or
Program Finance				gram Finance	_

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### Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department	Prov	ider Number: 0279633-0	02	
1290 Golfview Avenue, 4th Floor		Date: 07/01/202	: 07/01/2021	
Bartow, FL 33830-6740	Fiso	Fiscal Year End: 06/30/2020		
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Inter	im	X	Total Prospective	
Settlement 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			[N]	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department	Prov	ider Number: 0279633-0	03	
1290 Golfview Avenue, 4th Floor		Date: 07/01/202	: 07/01/2021	
Bartow, FL 33830-6740	Fise	Fiscal Year End: 06/30/2020		
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Interi	m	X	Total Prospective	
Settlement 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			[N]	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department	Prov	ider Number: 0279633-0	)4	
1290 Golfview Avenue, 4th Floor		Date: 07/01/202	: 07/01/2021	
Bartow, FL 33830-6740	Fis	- Fiscal Year End: 06/30/2020		
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	_	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Inte	rim	X	Total Prospective	
Settlement Based on Cos			Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
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	Field Audite	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department	Prov	ider Number: 0279633-0	05	
1290 Golfview Avenue, 4th Floor		Date: 07/01/202	: 07/01/2021	
Bartow, FL 33830-6740	Fis			
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	_	166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Inte	rim	X	Total Prospective	
Settlement Based on Cos			Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	wed 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

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### Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department	Provi	der Number: 0279633-3	30	
1290 Golfview Avenue, 4th Floor		Date: 07/01/202	: 07/01/2021	
Bartow, FL 33830-6740	Fiso	al Year End: 06/30/202	0	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	166.59	165.26	07/01/2021
Rate Type				
Interim		X Prospect	ive	
Total Inte	rim	X	Total Prospective	
Settlement Based on Co		Prospective Adju		usted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revi	ewed Cost		
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	Field Audit	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department	Prov	ider Number: 0279633-9	90		
1290 Golfview Avenue, 4th Floor		Date: 07/01/202	: 07/01/2021		
Bartow, FL 33830-6740	Fise	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	_	166.59	165.26	07/01/2021	
Rate Type					
<u>Interim</u>		X Prospect	<u>ive</u>		
Total Inte	rim	X	Total Prospective		
Settlement Based on Cos			Prospective Adjus	ective Adjusted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
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Program Finance			Medicaid Program Final	nce	

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### Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department	Prov	ider Number: 0279633-9	95	
1290 Golfview Avenue, 4th Floor		Date: 07/01/202	: 07/01/2021	
Bartow, FL 33830-6740	Fise	Fiscal Year End: 06/30/2020		
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	166.59	165.26	07/01/2021
Rate Type				
Interim		X Prospect	<u>ive</u>	
Total Inte	rim	X	Total Prospective	
Settlement Based on Cos			Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	wed Cost		
	Desk Audite	ed Cost		
	Field Audite	ed Cost		
DISTRIBUTION:			TR	
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Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Departme	nt	Prov	vider Number: 0279641-0	00
2801 Kennedy Street			Date: 07/01/202	1
Palatka, FL 32177		Fis	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	166.59	165.27	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Int	erim	X	Total Prospective	
Settleme	ent Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	ewed Cost		
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	Field Audite	ed Cost		
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Program Finance			Medicaid Program Final	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Putnam Coun	nam County Health Department					Prov	ider Number:	0279641-0	01
2801 Kenned	y Street						Date	07/01/202	1
Palatka, FL 3	2177					Fis	cal Year End	06/30/202	0
						Audit Status: Unaudited Co			l Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166.59		16	165.27 07/01/		
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cost						Prospe	ctive Adjus	ted For New Costs	
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				Budget					
			X	– Unaudited	d Cost				
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Contract Management						Rydell Samu	iel, Adminis	strator	
Program	Program Finance						Medicaid Pro	ogram Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Putnam Coun	nam County Health Department					Prov	ider Number:	0279641-0	)3
2801 Kenned	y Street						Date	07/01/202	1
Palatka, FL 3	2177					Fis	cal Year End	06/30/202	0
						Audit Status: Unaudited			Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166.59		16	5.27	07/01/2021	
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cost						Prospe	ctive Adjus	ted For New Costs	
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#### Medicaid Reimbursement Rate Change Form for CHDs

Putnam Coun	nam County Health Department					Prov	ider Number:	0279641-0	04	
2801 Kenned	y Street						Date	07/01/202	1	
Palatka, FL 3	2177					Fis	cal Year End	06/30/202	0	
						Audit Status: Una			audited Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			166.59		16	5.27	07/01/2021		
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost						Prospe	ctive Adjus	ted For New Costs		
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Contract Management						Rydell Samu	iel, Adminis	strator		
Program	Program Finance						Medicaid Pro	ogram Final	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Putnam Coun	nam County Health Department					Prov	vider Number:	0279641-9	91
2801 Kenned	y Street						Date	07/01/202	21
Palatka, FL 3	2177					Fis	cal Year End	06/30/202	20
						Audit Status: Unaudited Cost			l Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166.59		16	5.27	07/01/2021	
Rate Type									
	<u>Interim</u>				Х	Prospect	tive		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cost					Prospe	ctive Adjus	ted For New Costs		
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				Budget					
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Contract Management						Rydell Samu	iel, Adminis	strator	
Program	Program Finance						Medicaid Pro	ogram Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Johns Cou	Johns County Health Department					Prov	ider Number:	0279650-00	)
1955 US 1 So	uth						Date:	07/01/2021	
St. Augustine,	FL 3208	6				Fis	cal Year End	06/30/2020	
							Audit Status:	Unaudited (	Cost
Provider Ty	<u>vpe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166.59		16	165.26 07/01/		
Rate Type									
	Interim				Х	<b>Prospect</b>	ive		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cost						Prospe	ctive Adjuste	ed For New Costs	
			BAS	SIS:					
				Budget					
			X	 Unaudited	l Cost				
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				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
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DISTRIBUTIO	<u>)N:</u>						TR		
Fiscal Age	ent						M		
Contract Management					Rydell Samu	iel, Administi	rator		
Program I	Program Finance						Medicaid Pro	ogram Finan	се

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County Health Depar	tment	Prov	ider Number: 0279650-	91
1955 US 1 South			Date: 07/01/202	1
St. Augustine, FL 32086		Fis	cal Year End: 06/30/202	0
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	166.59		07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total I	nterim	X	Total Prospective	
Settler	ment Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revi	ewed Cost		
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	Field Audit	ted Cost		
DISTRIBUTION:			F	
Fiscal Agent			1	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Fina	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cou	Lucie County Health Department					Prov	ider Number:	0279668-0	00
5150 NW Miln	ner Drive						Date	07/01/202	1
Port Saint Luc	cie, FL 34	963				Fise	cal Year End	: 06/30/202	0
							Audit Status	Unaudited	l Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166.59		16	165.26 0		
Rate Type									
	<u>Interim</u>				X	_			
		Total Interim				X		rospective	
Settlement Based on Cost						Prospe	ective Adjus	ted For New Costs	
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				Budget					
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Fiscal Ag	ent						7V		
Contract Management					Rydell Samu	uel, Adminis	strator		
Program	Program Finance						Medicaid Pre	ogram Final	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Depa	artment	Provi	ider Number: 0279668-0	)1			
5150 NW Milner Drive			Date: 07/01/202	1			
Port Saint Lucie, FL 34963		Fisc	cal Year End: 06/30/202	0			
			Audit Status: Unaudited Cost				
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	166.59	165.26	07/01/2021			
Rate Type							
Interim		X <u>Prospect</u>	ive				
Tota	al Interim	X	Total Prospective				
Sett	tlement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
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	X Unaudited	Cost					
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	Desk Audit	ed Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			/ ``				
Contract Management		-	Rydell Samuel, Adminis				
Program Finance			Medicaid Program Final	nce			

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cour	Lucie County Health Department					Provid	ler Number:	0279668-0	2	
5150 NW Miln	er Drive						Date:	07/01/202	1	
Port Saint Luc	ie, FL 349	963				Fisca	al Year End:	06/30/2020	)	
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			166.59		165.26 07		07/01/2021		
Rate Type										
	<u>Interim</u>				Х	Prospectiv	<u>/e</u>			
	-	Total Interim				X	Total P	rospective		
Settlement Based on Cost						Prospe	ctive Adjust	ed For New Costs		
			BAS	<u>SIS:</u>						
				Budget						
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Contract Management				F	Rydell Samu	el, Adminis	trator			
Program I	Program Finance						ledicaid Pro	ogram Finar	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cour	Lucie County Health Department					Provid	ler Number:	0279668-03	3	
5150 NW Miln	er Drive						Date:	07/01/2021		
Port Saint Luc	ie, FL 34	963				Fisca	al Year End:	06/30/2020	)	
						Audit Status: Unaudited Cost				
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			166.59		165	5.26	07/01/2021		
Rate Type										
	Interim				X	Prospectiv	<u>/e</u>			
		Total Interim				Х	Total P	rospective		
Settlement Based on Cost						Prospe	ctive Adjuste	ed For New Costs		
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				Budget						
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DISTRIBUTIO	<u>)N:</u>						TR			
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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cou	Lucie County Health Department					Provi	ider Number:	0279668-0	)4
5150 NW Milr	ner Drive						Date	07/01/202	1
Port Saint Luc	cie, FL 34	963				Fisc	cal Year End	: 06/30/202	0
							Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166.59		16	5.26	07/01/2021	
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cost						Prospe	ective Adjust	ted For New Costs	
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Fiscal Ag	ent						[ N		
Contract Management						Rydell Samuel, Administrator			
Program	Program Finance						Medicaid Pro	ogram Finar	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departm	nent		Provider Number: 0279668-05				
5150 NW Milner Drive				Date: 07/01/202	1		
Port Saint Lucie, FL 34963			Fiscal \	/ear End: 06/30/2020	0		
			Aud	lit Status: Unaudited	Cost		
Provider Type		Current R	<u>ate</u>	New Rate	Effective Date		
CHD	-	166.59	·	165.26	07/01/2021		
Rate Type							
<u>Interim</u>		X <u>P</u>	ospective				
Total In	iterim		Х	Total Prospective			
Settlem	ent Based on Cost			Prospective Adjust	ted For New Costs		
				_			
	<b>BASIS:</b>						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audit	ted Cost					
DISTRIBUTION:			-	R			
Fiscal Agent			1	V			
Contract Management			Ryc	lell Samuel, Adminis	trator		
Program Finance				dicaid Program Finar			
State Health Office							



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cou	St. Lucie County Health Department					der Number	: 0279668-1	1
5150 NW Miln	ner Drive					Date	: 07/01/202	1
Port Saint Luc	cie, FL 349	963			Fisc	al Year End	: 06/30/2020	0
						Audit Status	: Unaudited	Cost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	New	<u> Rate</u>	Effective Date
	<u>CHD</u>			166	.59	16	5.26	07/01/2021
Rate Type								
	Interim			X	Prospecti			
		Total Interim			Χ	Total P	rospective	
		Settlement Base	d on Cost			Prospe	ective Adjust	ed For New Costs
		<u>B</u>	ASIS:					
			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	Manageme	ent				Rydell Samu	uel, Adminis	trator
Program	Finance				-	Medicaid Pr	ogram Finar	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cour	nty Health	Department				Provic	ler Number:	0279668-	12
5150 NW Miln	er Drive						Date:	07/01/202	1
Port Saint Luc	ie, FL 349	963				Fisca	al Year End	06/30/202	0
						A	udit Status:	Unaudited	l Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166.59		165.26		07/01/2021	
Rate Type									
	Interim				Х	Prospectiv	<u>/e</u>		
	-	Total Interim				X	Total P	rospective	
		Settlement B	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 Aud	ited Cost				
				– Field Audi	ted Cost				
				_					
DISTRIBUTIO	<u>)N:</u>						TR		
Fiscal Age	ent						[N		
Contract N	Managem	ent				F	Rydell Samu	el, Adminis	strator
Program I	Finance					Ν	ledicaid Pro	ogram Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cour	nty Health	Department	St. Lucie County Health Department						80
5150 NW Miln	er Drive						Date:	07/01/202	1
Port Saint Luc	ie, FL 349	963				Fisca	al Year End:	06/30/202	0
						A	udit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
CHD			166.59		165.26		07/01/2021		
Rate Type									
	Interim				X	Prospectiv	<u>/e</u>		
		Total Interim				Х	Total P	rospective	
		Settlement B	ased o	on Cost			Prospe	ctive Adjust	ted For New Costs
			BAS	SIS:					
				Budget					
			Х	_ Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ted Cost				
				_					
DISTRIBUTIC	<u>)N:</u>						TR		
Fiscal Age	ent						1 N		
Contract I	Managem	ent				F	Rydell Samu	el, Adminis	trator
Program	Finance					N	ledicaid Pro	ogram Finar	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departm	nent	Prov	ider Number: 0279668-9	91
5150 NW Milner Drive			Date: 07/01/202	1
Port Saint Lucie, FL 34963		Fise	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		166.59	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total In	terim	X	Total Prospective	
Settlem	ent 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:			TR	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Final	nce

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### Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	ounty Hea	Ith Departmer	nt			Provid	er Number:	0279676-00	)
P.O. Box 929							Date:	07/01/2021	
Milton, FL 32	572-0929					Fisca	I Year End:	06/30/2020	
						А	udit Status:	Unaudited C	Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>				147.82		152.71		07/01/2021	
Rate Type									
	<u>Interim</u>				Х	Prospectiv	<u>e</u>		
	-	Total Interim				- x	Total P	rospective	
		Settlement B	ased o	on Cost			Prospe	ctive Adjuste	d For New Costs
			BAS	SIS:					
				Budget					
			X	- Unaudited	Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ted Cost				
				_					
						2	IF		
Fiscal Age							1 *		
	Manageme 	ent						el, Administr	
Program	Finance					N	ledicaid Pro	gram Financ	e

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#### Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County H	ealth Department			Provid	ler Number: 0279676-0	01
P.O. Box 929					Date: 07/01/202	1
Milton, FL 32572-092	9			Fisca	al Year End: 06/30/202	0
				Ą	udit Status: Unaudited	Cost
Provider Type			<u>Current</u>	Rate	New Rate	Effective Date
<u>CHD</u>		147.82		152.71	07/01/2021	
Rate Type						
Interin	<u>n</u>		Х	Prospectiv	<u>/e</u>	
	Total Interim			Х	Total Prospective	
	Settlement Bas	ed on Cost	-		Prospective Adjus	ted For New Costs
	Ī	BASIS:				
		Budget				
	-	X Unaudited	d Cost			
	-	Desk Rev	viewed Cost			
	-	Desk Aud	lited Cost			
	-	Field Aud	lited Cost			
	-					
DISTRIBUTION:					TR	
Fiscal Agent					74	
Contract Manage	ment			F	Rydell Samuel, Adminis	strator
Program Finance				Ν	ledicaid Program Final	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa Cou	nty Hea	Ith Department	I			Prov	vider Number:	0279676-0	2
P.O. Box 929							Date:	07/01/2021	
Milton, FL 32572	2-0929					Fis	cal Year End:	06/30/2020	)
							Audit Status:	Unaudited	Cost
Provider Typ	<u>e</u>				Current	t Rate	New	Rate	Effective Date
CHD				147.82		152.71		07/01/2021	
Rate Type									
In	nterim				Х	Prospect	tive		
		Total Interim				Х	Total P	rospective	
		Settlement Ba	sed c	on Cost			Prospe	ctive Adjust	ed For New Costs
			BAS	SIS:					
				Budget					
			Х	- Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				- Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTION:	<u>:</u>						TR		
Fiscal Agent	t						[N]		
Contract Ma	inageme	ent					Rydell Samu		
Program Fin	nance						Medicaid Pro	ogram Finan	ice

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#### Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa Count	y Health Departme	nt			Provi	ider Number: 0279676	-03
P.O. Box 929						Date: 07/01/202	21
Milton, FL 32572-0	)929				Fisc	cal Year End: 06/30/202	20
						Audit Status: Unaudite	d Cost
Provider Type				<u>Current</u>	t Rate	New Rate	Effective Date
<u>CHD</u>			_	147.82		152.71	07/01/2021
Rate Type							
Inte	erim_			Х	Prospect	ive	
	Total Interim				. х	Total Prospective	
	Settlement B	ased on	Cost			Prospective Adjus	sted For New Costs
		BASIS	S:				
		В	Budget				
		Χι	Jnaudited (	Cost			
		C	Desk Revie	wed Cost			
		C	Desk Audite	ed Cost			
		F	Field Audite	ed Cost			
DISTRIBUTION:						TR	
Fiscal Agent						(N	
Contract Mana	agement					Rydell Samuel, Admini	
Program Finar	nce					Medicaid Program Fina	ance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa Cour	nty Healtl	h Department				Prov	ider Number:	0279676-04	Ļ
P.O. Box 929							Date:	07/01/2021	
Milton, FL 32572	2-0929					Fis	cal Year End:	06/30/2020	
							Audit Status:	Unaudited C	Cost
Provider Type	<u>e</u>				<u>Current</u>	t Rate	New	<u>Rate</u>	Effective Date
CHD			-	147.82		152.71		07/01/2021	
Rate Type									
<u>In</u>	terim				Х	Prospect	ive		
	Г	Total Interim				x	Total P	rospective	
	5	Settlement Bas	ed o	n Cost			Prospe	ctive Adjuste	ed For New Costs
		E	BAS	SIS:					
				Budget					
		_	Х	- Unaudited	Cost				
		_		- Desk Revi	ewed Cost				
		_		- Desk Audi	ted Cost				
		_		- Field Audit	ted Cost				
		_		-					
DISTRIBUTION:							TR		
Fiscal Agent							[N		
Contract Mai	nagemen	nt					Rydell Samu		
Program Fina	ance						Medicaid Pro	ogram Financ	ce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County He	ealth Department			Provi	der Number: 0279676-0	05
P.O. Box 929					Date: 07/01/202	1
Milton, FL 32572-0929	)			Fisc	al Year End: 06/30/202	0
					Audit Status: Unaudited	l Cost
Provider Type			Current	Rate	New Rate	Effective Date
<u>CHD</u>		147.82		152.71	07/01/2021	
Rate Type						
Interim	<u>1</u>		Х	Prospect	ive	
	Total Interim			Х	Total Prospective	
	Settlement Base	d on Cost			Prospective Adjus	ted For New Costs
	B	ASIS:				
		Budget				
		Unaudited	d Cost			
		Desk Rev	viewed Cost			
		Desk Aud	lited Cost			
		Field Aud	ited Cost			
DISTRIBUTION:					TR	
Fiscal Agent					7N	
Contract Managen	nent			-	Rydell Samuel, Adminis	strator
Program Finance					Medicaid Program Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County He	ealth Department			Provider	Number: 0279676-3	30
P.O. Box 929					Date: 07/01/202	1
Milton, FL 32572-092	9			Fiscal `	Year End: 06/30/202	0
				Auc	lit Status: Unaudited	Cost
Provider Type			<u>Current R</u>	<u>ate</u>	New Rate	Effective Date
<u>CHD</u>		147.82		152.71	07/01/2021	
Rate Type						
Interin	<u>n</u>		X <u>Pr</u>	ospective		
	Total Interim			Х	Total Prospective	
	Settlement Bas	ed on Cost			Prospective Adjus	ted For New Costs
	<u>E</u>	BASIS:				
		Budget				
	_	X Unaudited	d Cost			
	_	Desk Rev	viewed Cost			
	_	Desk Aud	lited Cost			
	_	Field Aud	ited Cost			
	_					
DISTRIBUTION:				-	R	
Fiscal Agent				1	-V	
Contract Manager	ment			Ryo	dell Samuel, Adminis	strator
Program Finance				Me	dicaid Program Finai	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health	h Department	Provi	der Number: 0279676-9	91			
P.O. Box 929			Date: 07/01/202	1			
Milton, FL 32572-0929		Fisc	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		147.82	152.71	07/01/2021			
Rate Type Interim		X <u>Prospect</u>	ive				
	Fotal Interim		Total Prospective				
s	Settlement Based on Cost			ted For New Costs			
	BASIS: Budget X Unaudited Desk Revi Desk Audit	ewed Cost ted Cost					
DISTRIBUTION: Fiscal Agent Contract Managemen Program Finance	ıt	•	Rydell Samuel, Adminis Medicaid Program Fina				

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#### Medicaid Reimbursement Rate Change Form for CHDs

Sarasota Cou	nty Health	Department				Prov	ider Number:	0279684-0	0
P. O. Box 265	68						Date:	07/01/2021	
Sarasota, FL	34230-26	58				Fise	cal Year End	06/30/2020	
							Audit Status:	Unaudited	Cost
<u>Provider T</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				161	.01	16	5.26	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospect	<u>ive</u>		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	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						74		
Contract	Managem	ent					Rydell Samu	iel, Administ	rator
Program	Finance						Medicaid Pro	ogram Finan	се

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Medicaid Program Finance



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#### Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County H	arasota County Health Department			Provider Number: 0279684-91			
P. O. Box 2658					Date:	07/01/2021	
Sarasota, FL 3423	0-2658			Fiscal Year End: 06/30/2020			
				Aud	dit Status:	Unaudited Co	st
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CH</u>	D		161	.01	165	.26	07/01/2021
Rate Type							
<u>Inte</u>			X	Prospective			
	Total Interim			Χ	_	ospective	
	Settlement B	ased on Cost			Prospec	tive Adjusted	For New Costs
		BASIS:					
		Budget					
		X Unaudited	Cost				
		Desk Revi	ewed Cost				
		Desk Audi	ted Cost				
		Field Audi	ted Cost				
DISTRIBUTION:				~	TR		
Fiscal Agent				1	(N		
Contract Mana	gement			Ry	dell Samue	el, Administrat	or
Program Finan	се			Me	dicaid Pro	gram Finance	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Healt	arasota County Health Department			Provider Number: 0279684-92			
P. O. Box 2658					Date:	07/01/2021	
Sarasota, FL 34230-20	658			Fiscal Year End: 06/30/2020			
				Au	dit Status:	Unaudited Co	ost
Provider Type			Curren	it Rate	New	<u>Rate</u>	Effective Date
<u>CHD</u>			161	.01	165	.26	07/01/2021
Rate Type							
<u>Interim</u>			X	_ <u>Prospective</u> _			
	Total Interim			X	Total Pr	ospective	
	Settlement Ba	sed on Cost			Prospec	ctive Adjusted	For New Costs
		BASIS:					
		Budget					
	-	X Unaudi	ted Cost				
	-	Desk R	eviewed Cost				
	-	Desk A	udited Cost				
	-	Field A	udited Cost				
	-						
DISTRIBUTION:				-	TR		
Fiscal Agent				1			
Contract Managen	nent			Ry	dell Samue	el, Administrat	tor
Program Finance				Me	edicaid Pro	gram Finance	•

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#### Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County	arasota County Health Department					Prov	vider Number:	0279684-	-93	
P. O. Box 2658							Date	07/01/202	21	
Sarasota, FL 34	1230-265	58				Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudite	d Cost	
Provider Typ	<u>e</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
<u>(</u>	<u>CHD</u>				161	.01	16	5.26	07/01/2021	
Rate Type	_						_			
<u>lr</u>	nterim	<b>-</b>			X	- Prospec				
_		Total Interim				Χ		rospective		
_		Settlement Ba	ased o	on Cost			Prospe	ctive Adju	sted For New Costs	
			BAS	<u> 815:</u>						
				Budget						
			X	_ Unaudited	l Cost					
				- Desk Revi	iewed Cost					
				- Desk Aud	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTION	<u>:</u>						TR			
Fiscal Agen	t						74			
Contract Ma	anageme	ent					Rydell Samu	iel, Admini	strator	
Program Fir	nance						Medicaid Pro	ogram Fina	ance	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health I	Department		Provider Number: 0279692-00				
400 West Airport Bouleva	ırd			Date: 07/01/202	1		
Sanford, FL 32773			Fiscal Year End: 06/30/2020				
			Audit S	Status: Unaudited	Cost		
Provider Type		Currer	nt Rate	New Rate	Effective Date		
<u>CHD</u>		166	5.59	165.26	07/01/2021		
Rate Type							
<u>Interim</u>		Х	Prospective				
	Total Interim		— х т	otal Prospective			
	Settlement Based or	n Cost	F	Prospective Adjust	ted For New Costs		
	BAS	IS:					
		Budget					
	X	Unaudited Cost					
		Desk Reviewed Cost	:				
		Desk Audited Cost					
		Field Audited Cost					
DISTRIBUTION:			U	R			
Fiscal Agent			[N				
Contract Managemer	nt		Rydell	Samuel, Adminis	trator		
Program Finance			Medic	aid Program Finar	nce		

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Medicaid Program Finance



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#### Medicaid Reimbursement Rate Change Form for CHDs

Seminole Cou	eminole County Health Department					Prov	vider Number:	0279692-	30
400 West Airp	ort Boule	vard					Date	07/01/202	21
Sanford, FL 3	32773					Fis	cal Year End	: 06/30/202	20
							Audit Status	Unaudited	d Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166	.59	16	5.26	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospect	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ective Adjus	sted For New Costs
			BAS	SIS:					
				Budget					
			X	_ Unaudited	Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Aud	ited Cost				
				- Field Audi	ted Cost				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						[N		
Contract	Managem	ent					Rydell Samu	uel, Admini	strator
Program	Finance						Medicaid Pro	ogram Fina	ance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Departm	nent	Prov	Provider Number: 0279692-90				
400 West Airport Boulevard			Date: 07/01/202	1			
Sanford, FL 32773		Fis	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		166.59	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total Int	erim	X	Total Prospective				
Settlement 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:			TR				
Fiscal Agent			ſN				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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### Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health De	umter County Health Department				Provider Number: 0279706-01				
P. O. Box 98			_	Date:	07/01/2021				
Bushnell, FL 33513			Fiscal Year End: 06/30/2020						
			_	Audit Status:	Unaudited Co	st			
Provider Type		Cur	rent Rate	New	<u>Rate</u>	Effective Date			
<u>CHD</u>		1	43.23	165	.26	07/01/2021			
Rate Type									
Interim			X <u>Prospec</u>	<u>ctive</u>					
	Total Interim		X	Total Pr	ospective				
	Settlement Based	on Cost		Prospec	ctive Adjusted	For New Costs			
	BAS	SIS:							
		Budget							
	X	_ Unaudited Cost							
		_ Desk Reviewed C	ost						
		_ Desk Audited Cos	st						
		- Field Audited Cos	t						
		-							
DISTRIBUTION:				TR					
Fiscal Agent				1 N					
Contract Manageme	nt			Rydell Samue	el, Administrat	or			
Program Finance				Medicaid Pro	gram Finance				

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#### Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health De	mter County Health Department				Provider Number: 0279706-91				
P. O. Box 98					Date: 07/0	1/2021			
Bushnell, FL 33513				Fisca	Year End: 06/3	0/2020			
				Au	udit Status: Unau	udited Cost			
Provider Type			Curren	t Rate	New Rate	<u>1</u>	Effective Date		
<u>CHD</u>			143	.23	165.26		07/01/2021		
Rate Type									
<u>Interim</u>			Х	<b>Prospectiv</b>	<u>e</u>				
	Total Interim			- x	Total Prospe	ctive			
	Settlement Based	on Cost			Prospective .	Adjusted F	or New Costs		
	BA	<u>SIS:</u>							
		Budget							
	X	Unaudited	l Cost						
		Desk Revi	iewed Cost						
		Desk Audi	ited Cost						
		Field Audi	ted Cost						
DISTRIBUTION:					TR				
Fiscal Agent					PI				
Contract Manageme	nt			R	ydell Samuel, Ac	Iministrator			
Program Finance				M	edicaid Program	Finance	-		
State Health Office									



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#### Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health De	epartment			Provider Number: 0279706-92				
P. O. Box 98					Date: 07/01/2	021		
Bushnell, FL 33513				Fisca	I Year End: 06/30/2	020		
				Au	udit Status: Unaudit	ted Cost		
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date		
<u>CHD</u>			143	.23	165.26	07/01/2021		
Rate Type								
<u>Interim</u>			Х	<b>Prospectiv</b>	<u>e</u>			
	Total Interim			- x	Total Prospectiv	/e		
	Settlement Based	on Cost			Prospective Adj	usted For New Costs		
	BA	<u>SIS:</u>						
		Budget						
	X	Unaudited	l Cost					
		Desk Revi	iewed Cost					
		Desk Audi	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:					THE			
Fiscal Agent					P()			
Contract Manageme	nt			R	ydell Samuel, Admi	nistrator		
Program Finance				M	edicaid Program Fi	nance		
State Health Office								



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### Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Departmer	nt	Prov	Provider Number: 0279722-00				
1215 Peacock Street			Date: 07/01/202	1			
Perry, FL 32347		Fis	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	93.41	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total In	terim	X	Total Prospective				
Settlem	ent 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:			TR				
Fiscal Agent			[ <u>N</u>				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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#### Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department		Provi	ider Number: 0279722-0	01	
1215 Peacock Street			Date: 07/01/2021		
Perry, FL 32347	Fiso	cal Year End: 06/30/202	0		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	_	93.41	165.26	07/01/2021	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total Inte	erim	X	Total Prospective		
Settleme	ent 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			۲N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department		Prov	ider Number: 0279722-3	30	
1215 Peacock Street			Date: 07/01/2021		
Perry, FL 32347	Fise	cal Year End: 06/30/202	0		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	93.41	165.26	07/01/2021	
Rate Type					
Interim		X Prospect	ive		
Total Inte	rim	X	Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	wed Cost			
	Desk Audite	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

Union County Health Department	t	Prov	ider Number: 0279731-0	00		
495 East Main Street		Date: 07/01/2021				
Lake Butler, FL 32054	Fise	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	_	166.59	165.27	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total Int	erim	X	Total Prospective			
Settlem	ent 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		

Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Departn	nent	Prov	ider Number: 0279731-0	)1	
495 East Main Street			Date: 07/01/2021		
Lake Butler, FL 32054	Fiso	cal Year End: 06/30/202	0		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	166.59	165.27	07/01/2021	
Rate Type					
Interim		X Prospect	ive		
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	ed Cost			
	Field Audite	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			[N]		
Contract Management			Rydell Samuel, Adminis	trator	
Program Finance			Medicaid Program Final	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Union County Health D	Department			Provider Number: 0279731-03			
495 East Main Street Lake Butler, FL 32054				Date: 07/01/202	1		
			Fiscal	Year End: 06/30/202	0		
				Au	dit Status: Unaudited	Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>			166	.59	165.27	07/01/2021	
Rate Type							
Interim	<u>1</u>		Х	<b>Prospective</b>	<u>)</u>		
	Total Interim			x	Total Prospective		
	Settlement Ba	sed on Cost			Prospective Adjus	ted For New Costs	
	_	<b>D</b> 4 010					
		BASIS:					
	-	Budget					
	-	X Unaudited					
	-		ewed Cost				
		Desk Audi					
	-	Field Audit	ted Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent					M		
Contract Manager	nent			Ry	dell Samuel, Adminis	strator	
Program Finance					edicaid Program Fina		
State Health Office	Э						



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#### Medicaid Reimbursement Rate Change Form for CHDs

Union County	Health De	partment				Prov	ider Number:	0279731-0	04
495 East Mair	n Street					Date: 07/01/2021			
Lake Butler, FL 32054				Fis	cal Year End	: 06/30/202	20		
							Audit Status	Unaudited	Cost
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166	.59	16	5.27	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs
			BAS	SIS:					
				Budget					
			X	_ Unaudited	Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						74		
Contract	Manageme	ent					Rydell Samu	iel, Adminis	strator
Program	Finance						Medicaid Pro	ogram Fina	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Departm	nent	Provi	ider Number: 0279731-3	30	
495 East Main Street			Date: 07/01/2021		
Lake Butler, FL 32054	Fiso	cal Year End: 06/30/202	0		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	166.59	165.27	07/01/2021	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Tota	l Interim	X	Total Prospective		
Settl	ement Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ed Cost			
	Field Audito	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			[N]		
Contract Management			Rydell Samuel, Adminis	trator	
Program Finance			Medicaid Program Final	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Union County	Health De	partment				Prov	ider Number:	0279731-9	91
495 East Mair	n Street					Date: 07/01/2021			
Lake Butler, FL 32054				Fise	cal Year End	: 06/30/202	20		
							Audit Status:	Unaudited	d Cost
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166	.59	16	5.27	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs
			BAS	SIS:					
				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						7V		
Contract	Manageme	ent					Rydell Samu	iel, Adminis	strator
Program	Finance						Medicaid Pro	ogram Fina	ince

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### Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departmer	nt	Prov	ider Number: 0279749-0	00		
P. O. Box 9190			Date: 07/01/2021			
Daytona Beach, FL 32120	Fise	cal Year End: 06/30/202	0			
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		159.76	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		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 Rev	iewed Cost				
	Desk Aud	ited Cost				
	Field Audi	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			1			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departi	ment		Provider Number: 0279749-15			
P. O. Box 9190				Date: 07/01/202	1	
Daytona Beach, FL 32120			Fiscal Y	'ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current R	<u>ate</u>	New Rate	Effective Date	
CHD	-	159.76		165.26	07/01/2021	
Rate Type						
<u>Interim</u>		X <u>Pı</u>	<u>ospective</u>			
Total	Interim		Х	Total Prospective		
Settlement Based on Cost			Prospective Adjusted Fe		ed For New Costs	
				-		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			ľ	N		
Contract Management			Ryd	ell Samuel, Adminis	trator	
Program Finance				licaid Program Finar		
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#### Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departm	nent		Provider Number: 0279749-92 Date: 07/01/2021			
P. O. Box 9190						
Daytona Beach, FL 32120			Fiscal Y	'ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	-	159.7	/6	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total	Interim		Х	Total Prospective		
Settle	ment Based on Cost	-		Prospective Adjust	ed For New Costs	
		-		-		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			~	R		
Fiscal Agent			f	N		
Contract Management			Ryd	ell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office						



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#### Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department	nt		Provider Number: 0279749-93			
P. O. Box 9190				Date: 07/01/202	1	
Daytona Beach, FL 32120			Fiscal Y	/ear End: 06/30/2020	0	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current	Rate	New Rate	Effective Date	
<u>CHD</u>	-	159.7	6	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х <u></u>	Prospective			
Total Int	erim		Х	Total Prospective		
Settleme	ent Based on Cost	_		Prospective Adjust	ted For New Costs	
		_		_		
	<b>BASIS:</b>					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			_	R		
Fiscal Agent			1	V		
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

Volusia County Health Department	nt		Provider Number: 0279749-97 Date: 07/01/2021			
P. O. Box 9190						
Daytona Beach, FL 32120			Fiscal Y	/ear End: 06/30/202	0	
			Aud	it Status: Unaudited	Cost	
Provider Type Curre			<u>Rate</u>	New Rate	Effective Date	
<u>CHD</u>	-	159.	76	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	<b>Prospective</b>			
Total Int	erim		X	Total Prospective		
Settleme			Prospective Adjus	ted For New Costs		
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
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	Field Audit	ted Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1			
Contract Management			Ryc	lell Samuel, Adminis	strator	
Program Finance			Med	dicaid Program Finar	nce	
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### Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health De	partment	Prov	vider Number: 0279757-	00			
48 Oak Street			Date: 07/01/2021				
Crawfordville, FL 32327		Fis					
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		117.51	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospec	tive				
т	otal Interim	X	Total Prospective				
S	Settlement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudi	ted Cost					
	Desk R	eviewed Cost					
	Desk A	udited Cost					
	Field A	udited Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲N				
Contract Management	t		Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Finance				

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#### Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Departmen	Provider Number: 0279757-01					
48 Oak Street			Date: 07/01/2021			
Crawfordville, FL 32327			Fiscal \	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost	
Provider Type Curre			t Rate	New Rate	Effective Date	
CHD	-	117.	51	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inter	im		Х	Total Prospective		
Settlemer			Prospective Adjus	ted For New Costs		
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	BASIS:					
	Budget					
	X Unaudited					
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	el)		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Fina	nce	
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#### Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department	Provider Number: 0279757-02					
48 Oak Street			Date: 07/01/2021			
Crawfordville, FL 32327			Fiscal Y	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost	
Provider Type Curre			t Rate	New Rate	Effective Date	
<u>CHD</u>	-	117.	.51	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	<b>Prospective</b>			
Total Inter	im		Х	Total Prospective		
Settlement			Prospective Adjus	ted For New Costs		
				_		
	BASIS:					
	Budget	_				
	X Unaudited					
	Desk Revie					
	Desk Audit					
	Field Audit	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	V		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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#### Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Departmen	Provider Number: 0279757-03					
48 Oak Street			Date: 07/01/2021			
Crawfordville, FL 32327			Fiscal Y	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost	
Provider Type Curre			t Rate	New Rate	Effective Date	
CHD	-	117.	51	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inter	im		Х	Total Prospective		
Settlement 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:			-	R		
Fiscal Agent			1	u ·		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Fina	nce	
State Health Office						



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#### Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department	Provider Number: 0279757-04					
48 Oak Street			Date: 07/01/2021			
Crawfordville, FL 32327			Fiscal \	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost	
Provider Type Curre			t Rate	New Rate	Effective Date	
CHD	-	117.	.51	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	<b>Prospective</b>			
Total Inter	im		Х	Total Prospective		
Settlemen			Prospective Adjus	ted For New Costs		
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
			-	IR		
DISTRIBUTION: Fiscal Agent			1			
Contract Management			Ryc	lell Samuel, Adminis	strator	
Program Finance			Med	dicaid Program Fina	nce	
State Health Office						



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#### Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department	Provider Number: 0279757-30					
48 Oak Street			Date: 07/01/2021			
Crawfordville, FL 32327			Fiscal Y	/ear End: 06/30/202	0	
			Aud	lit Status: Unaudited	Cost	
Provider Type Curre			t Rate	New Rate	Effective Date	
<u>CHD</u>	-	117.	.51	165.26	07/01/2021	
Rate Type						
<u>Interim</u>		Х	<b>Prospective</b>			
Total Inter	im		Х	Total Prospective		
Settlement 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:			-	R		
Fiscal Agent			1	u ·		
Contract Management			Ryc	lell Samuel, Adminis	strator	
Program Finance			Med	dicaid Program Finar	nce	
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#### Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Departr	ment		Provider Number: 0279757-91				
48 Oak Street			Date: 07/01/2021				
Crawfordville, FL 32327			Fiscal Y	'ear End: 06/30/2020	)		
			Aud	it Status: Unaudited	Cost		
Provider Type Curr			<u>ate</u>	New Rate	Effective Date		
<u>CHD</u>	-	117.51		165.26	07/01/2021		
Rate Type							
<u>Interim</u>		X <u>P</u> I	<u>rospective</u>				
Total I	Interim		Х	Total Prospective			
Settler			Prospective Adjust	ed For New Costs			
				-			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			-	R			
Fiscal Agent			1	V			
Contract Management			Ryd	lell Samuel, Administ	trator		
Program Finance				dicaid Program Finan			
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#### Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department			Provider Number: 0279757-92				
48 Oak Street			Date: 07/01/2021				
Crawfordville, FL 32327			Fiscal Y	/ear End: 06/30/2020	0		
			Aud	it Status: Unaudited	Cost		
Provider Type Cur			Rate	New Rate	Effective Date		
CHD	-	117.5	j1	165.26	07/01/2021		
Rate Type							
Interim		Х <u>I</u>	Prospective				
Total Inter	im		Х	Total Prospective			
Settlemen	-		Prospective Adjust	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			ť				
Contract Management			Ryd	lell Samuel, Adminis	trator		
Program Finance				dicaid Program Finar			
State Health Office							



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### Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health E	Department	Prov	ider Number: 0279773-0	00	
1338 South Boulevard			Date: 07/01/202	21	
Chipley, FL 32428		Fiso	Fiscal Year End: 06/30/2020		
			Audit Status: Unaudited	l Cost	
Provider Type	Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	162.38	165.26	07/01/2021	
Rate Type					
<u>Interim</u>		X Prospect	<u>ive</u>		
Tot	al Interim	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 Audite	ed 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

Washington County Health Department					Pro	vider Number:	0279773-0	01		
1338 South Bo	oulevard					Date: 07/01/2021			:1	
Chipley, FL 32	2428					Fiscal Year End: 06/30/2020				
						Audit Status		Unaudited	l Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
CHD				162	.38	16	5.26	07/01/2021		
Rate Type										
	<u>Interim</u>				Х	Prospec	tive			
	•	Total Interim				- x	Total P	rospective		
Settlement Based on Cost				Prospe	ctive Adjus	sted For New Costs				
			BAS	SIS:						
				Budget						
			X	– Unaudited	d Cost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIO	<u>N:</u>						TR			
Fiscal Age	ent						7N			
Contract N	Manageme	ent					Rydell Samu	iel, Adminis	strator	
Program Finance						Medicaid Pro	ogram Fina	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department					Pro	vider Number:	0279773-	04	
1338 South Be	oulevard					Date: 07/01/2021			21
Chipley, FL 3	2428					Fis	scal Year End	06/30/202	20
							Audit Status:	Unaudited	d Cost
<u>Provider Ty</u>	<u>ype</u>				Curren	t Rate	New	Rate	Effective Date
<u>CHD</u>				162	.38	16	5.26	07/01/2021	
Rate Type									
	<u>Interim</u>				Х	Prospec	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cost				Prospe	ctive Adjus	sted For New Costs			
			BAS	SIS:					
				Budget					
			X	 Unaudited	d Cost				
				_ Desk Rev	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ited Cost				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Age	ent						M		
Contract I	Manageme	ent					Rydell Samu	iel, Adminis	strator
Program	Finance						Medicaid Pro	ogram Fina	ance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Depart	Washington County Health Department			2
1338 South Boulevard			Date: 07/01/202	1
Chipley, FL 32428		Fise	cal Year End: 06/30/202	0
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	162.38	165.26	07/01/2021
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total Inte	rim	X	Total Prospective	
Settlement Based on Cost			Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	wed Cost		
	Desk Audite	ed Cost		
	Field Audite	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			7N	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Finar	nce

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#### Medicaid Reimbursement Rate Change Form for CHDs

Washington C	Washington County Health Department					Pro	vider Number:	0279773-	30	
1338 South B	oulevard						Date:	07/01/202	21	
Chipley, FL 3	2428					Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited	d Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				162	.38	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost		on Cost			Prospective Adjusted For New Costs					
			BAS	SIS:						
			<u></u>	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						M			
Contract I	Manageme	ent					Rydell Samu	iel, Adminis	strator	
Program	Finance						Medicaid Pro	ogram Fina	ince	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Depart	ment	Provi	ider Number: 0279773-9	99		
1338 South Boulevard			Date: 07/01/2021 Fiscal Year End: 06/30/2020			
Chipley, FL 32428		Fiso				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		162.38	165.26	07/01/2021		
Rate Type						
Interim		X Prospect	ive			
Total Inte	erim	X	Total Prospective			
Settlement Based on Cost			Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	wed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			۲ <b>۷</b>			
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 Department		Provi	Provider Number: 0290068-00 Date: 07/01/2021			
597 West 11th Street						
Panama City, FL 32401-2330		Fisc	al Year End: 06/30/202	0		
			Audit Status: Unaudited	Cost		
Provider Type	Current Rate	New Rate	Effective Date			
CHD		166.59	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X <u>Prospecti</u>	ve			
Total Inte	erim	X	Total Prospective			
Settleme	nt Based on Cost		Prospective Adjusted For New Costs			
	BASIS:					
	Budget					
	X Unaudited Co	ost				
	Desk Review	ed Cost				
	Desk Audited	Cost				
	Field Audited	Cost				
DISTRIBUTION:			TR			
Fiscal Agent			M			
Contract Management		I	Rydell Samuel, Adminis	strator		
Program Finance		-	Medicaid Program Final			
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#### Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Department		Prov	ider Number: 0290068-	96		
597 West 11th Street			Date: 07/01/2021			
Panama City, FL 32401-2330		Fise	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	l Cost		
Provider Type	Current Rate	New Rate	Effective Date			
<u>CHD</u>		166.59	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total I	nterim	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	ited Cost				
	Field Audi	ited 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

Lafayette County Health Departme	ent	Prov	ider Number: 0290343-0	00			
P.O. Box 1806			Date: 07/01/202	1			
Mayo, FL 32066		Fiso	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	l Cost			
Provider Type	Current Rate	New Rate	Effective Date				
CHD		166.59	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
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			7N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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#### Medicaid Reimbursement Rate Change Form for CHDs

Lafayette County Health Departmen	t	Provider	Number: 0290343-9	91	
P.O. Box 1806		-	Date: 07/01/202	1	
Mayo, FL 32066		Fiscal Year End: 06/30/2020			
		Aud	t Status: Unaudited	Cost	
Provider Type	ent Rate	New Rate	Effective Date		
CHD	16	6.59	165.26	07/01/2021	
Rate Type Interim	Х	<u>Prospective</u>			
Total Interin		<u></u> χ	Total Prospective		
	Based on Cost			ted For New Costs	
	BASIS: Budget X Unaudited Cost Desk Reviewed Co Desk Audited Cost Field Audited Cost		_		
DISTRIBUTION: Fiscal Agent		P	R		
Contract Management		Rvd	ell Samuel, Adminis	strator	
Program Finance			licaid Program Final		

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(No Change In Rate)

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#### Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Departm	ent	Prov	ider Number: 0290408-0	00		
801 S.W. Smith Street			Date: 07/01/202	1		
Madison, FL 32340		Fis	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	_	166.59	165.27	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total In	terim	X	Total Prospective			
Settlement Based on Cos			Prospective Adjusted For New Co			
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audite	ed Cost				
	Field Audite	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

Madison County Health Departm	ent	Provi	der Number: 0290408-0	)1			
801 S.W. Smith Street			Date: 07/01/202	1			
Madison, FL 32340		 Fisc	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	166.59	165.27	07/01/2021			
Rate Type							
<u>Interim</u>		X <u>Prospect</u>	ve				
Total In	terim	X	Total Prospective				
Settlement Based on Co			Prospective Adjusted For New Costs				
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audite	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

Madison County He	Madison County Health Department				Prov	ider Number:	0290408-30	
801 S.W. Smith Str	reet					Date:	07/01/2021	
Madison, FL 3234	0				Fiscal Year End: 06/30/2020			
						Audit Status:	Unaudited C	Cost
Provider Type				Current	t Rate	New	Rate	Effective Date
<u>CH</u>	D			166.	59	165	5.27	07/01/2021
Rate Type								
Inte	erim			Х	Prospect	ive		
	Total Interim				x	Total P	rospective	
	Settlement B	ased o	n Cost			Prospe	ctive Adjustee	d 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						/ N		
Contract Mana	gement					Rydell Samu	el, Administra	ator
Program Finar	ice					Medicaid Pro	ogram Financ	e

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#### Medicaid Reimbursement Rate Change Form for CHDs

Suwannee County Health Department					Prov	ider Number:	0518328-0	00	
P. O. Box 603	30					Date: 07/01/2021			
Live Oak, FL	32060					Fis	cal Year End	06/30/202	0
							Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				151	.22	16	5.26	07/01/2021
Rate Type									
	<u>Interim</u>				Х	Prospect	ive		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cos		on Cost			Prospective Adjusted 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						7N		
Contract	Managem	ent					Rydell Samu	iel, Adminis	trator
Program	Finance						Medicaid Pro	ogram Finai	nce

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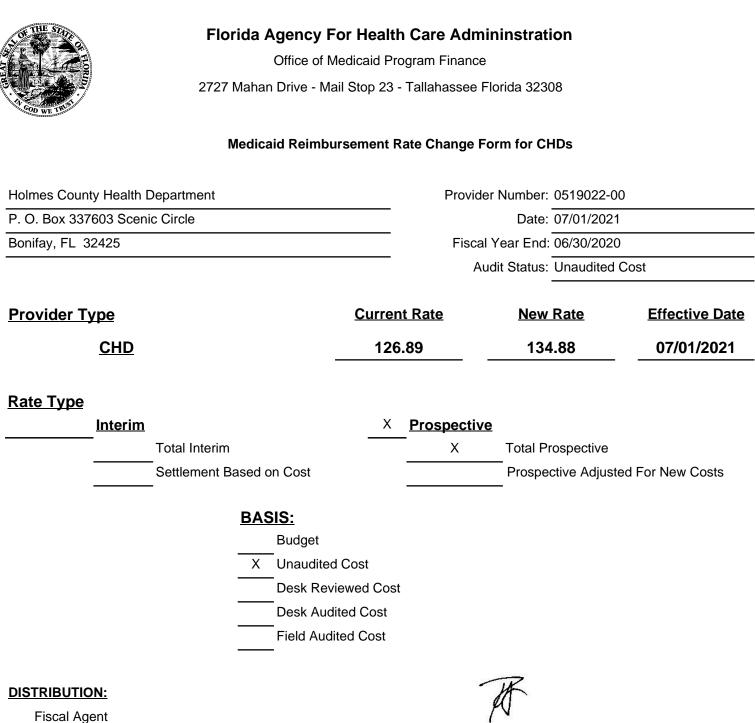
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#### Medicaid Reimbursement Rate Change Form for CHDs

Suwannee Co	Suwannee County Health Department					Provid	der Number:	0518328-91		
P. O. Box 603	30					Date: 07/01/2021				
Live Oak, FL	32060					Fisc	al Year End:	06/30/2020		
						A	Audit Status:	Unaudited C	ost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>New l</u>	Rate	Effective Date	
	<u>CHD</u>				151	.22	165	.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospective ProspectiProspective Prospective Prospective Prospective Prospecti	ve			
	-	Total Interim				- x	Total Pro	ospective		
		Settlement Ba	ased o	on Cost			Prospec	tive Adjustec	For New Costs	
			BAS	SIS:						
				Budget						
			Х	_ Unaudited	l Cost					
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				– Desk Aud	ited Cost					
				– Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						r v			
Contract	Manageme	ent				F	Rydell Samue	el, Administra	itor	
Program	Finance					ľ	Medicaid Prog	gram Finance	Э	

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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

Holmes County Health Department		Provider Number: 0519022-15				
P. O. Box 337603 Scenic Circle			Date: 07/01/20	21		
Bonifay, FL 32425		Fiscal Year End: 06/30/2020				
		Aud	it Status: Unaudite	ed Cost		
Provider Type	Current	t Rate	New Rate	Effective Date		
CHD	126.	.89	134.88	07/01/2021		
Rate Type						
Interim	Х	Prospective				
Total Interim		X	Total Prospective	9		
Settlement Based on	Cost		Prospective Adju	sted For New Costs		
BASI	<u>S:</u>					
I	Budget					
X	Unaudited Cost					
	Desk Reviewed Cost					
	Desk Audited Cost					
	Field Audited Cost					
DISTRIBUTION: Fiscal Agent		Ĩ	F			
Contract Management		Ryd	ell Samuel, Admin	istrator		
Program Finance			licaid Program Fin			

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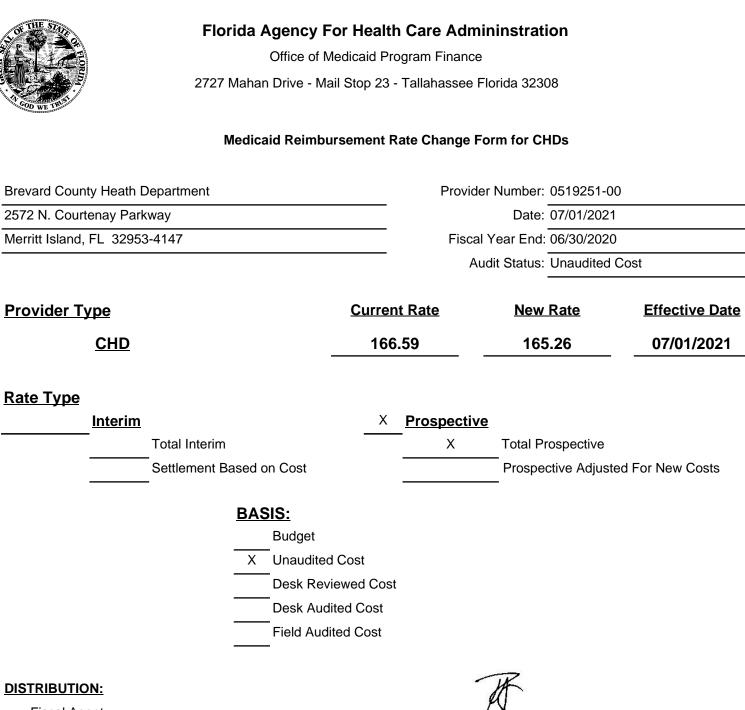
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#### Medicaid Reimbursement Rate Change Form for CHDs

Holmes County H	plmes County Health Department				Provider Number: 0519022-95				
P. O. Box 33760	3 Scenic Circle				Date: (	07/01/2021			
Bonifay, FL 324	25			Fiscal Year End: 06/30/2020					
				Au	dit Status: l	Jnaudited Cos	st		
Provider Typ	<u>e</u>		<u>Current</u>	Rate	New F	<u>Rate</u>	Effective Date		
<u>c</u>	CHD	-	126.8	89	134.	88	07/01/2021		
Rate Type	iterim		х	Prospective					
<sup>III</sup>	Total Interim			X	z Total Pro	spective			
	Settlement Ba	used on Cost	-			•	For New Costs		
		BASIS: Budget X Unaudited Desk Revie Desk Audit Field Audit	ewed Cost ted Cost						
DISTRIBUTION: Fiscal Agent	t			-	F				
Contract Ma	-					l, Administrato	or		
Program Fin	ance			Me	edicaid Prog	gram Finance			

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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

Brevard County Heath Department	evard County Heath Department				Provider Number: 0519251-01				
2572 N. Courtenay Parkway				Date: 07/01/202	1				
Merritt Island, FL 32953-4147			Fiscal Year End: 06/30/2020						
			Audit	Status: Unaudited	Cost				
Provider Type		Current Rat	<u>e</u>	New Rate	Effective Date				
<u>CHD</u>	_	166.59		165.26	07/01/2021				
Rate Type									
<u>Interim</u>		X <u>Pro</u>	<u>spective</u>						
Total Interim			Х	Total Prospective					
Settlement Ba	ased on Cost			Prospective Adjust	ted For New Costs				
	BASIS:								
	Budget								
	X Unaudited C	Cost							
	Desk Review	wed Cost							
	Desk Audite	ed Cost							
	Field Audite	d Cost							
DISTRIBUTION:			M	R					
Fiscal Agent			M	t					
Contract Management			Rydel	I Samuel, Adminis	trator				
Program Finance			Medic	aid Program Finar	nce				

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#### Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department		Provi	der Number: 0519251-0	)4			
2572 N. Courtenay Parkway			Date: 07/01/202	1			
Merritt Island, FL 32953-4147		Fisc	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	166.59	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total Inter	im	X	Total Prospective				
Settlemer	t Based on Cost		Prospective Adjust	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			/ N				
Contract Management		-	Rydell Samuel, Adminis	trator			
Program Finance			Medicaid Program Finar	nce			

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#### Medicaid Reimbursement Rate Change Form for CHDs

Brevard Coun	evard County Heath Department					Provider Number: 0519251-05				
2572 N. Cour	tenay Park	way					Date:	07/01/202	1	
Merritt Island,	FL 32953	3-4147				Fiscal Year End: 06/30/2020				
							Audit Status:	Unaudited	Unaudited Cost	
Provider T	уре				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	Prospect	<u>ive</u>			
	-	Total Interim				- x	Total P	rospective		
		- Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ted For New Costs	
		-		210.						
			BAS	Budget						
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				_	iewed Cost					
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				_						
				Field Audi	ted Cost					
DISTRIBUTIO	<u>DN:</u>						"At			
Fiscal Ag	ent						[ N			
Contract	Manageme	ent					Rydell Samu	iel, Adminis	trator	
Program	Finance						Medicaid Pro	ogram Finar	nce	

Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department		Provi	der Number: 0519251-9	91			
2572 N. Courtenay Parkway			Date: 07/01/202	1			
Merritt Island, FL 32953-4147		Fisc	Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	166.59	165.26	07/01/2021			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total Inter	im	X	Total Prospective				
Settlemen	t Based on Cost		Prospective Adjust	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			/ N				
Contract Management			Rydell Samuel, Adminis	trator			
Program Finance			Medicaid Program Finar	nce			

State Health Office



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

Brevard Coun	revard County Heath Department					Prov	ider Number	: 0519251-	92	
2572 N. Court	tenay Park	way					Date	07/01/202	21	
Merritt Island,	FL 32953	-4147				Fiscal Year End: 06/30/2020				
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166.59		16	5.26	07/01/2021	
Rate Type										
	Interim				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ective Adjus	sted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			X	Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Aud	ited Cost					
				- Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						[ N			
Contract I	Contract Management						Rydell Samu	uel, Adminis	strator	
Program	Finance						Medicaid Pre	ogram Fina	ance	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department	evard County Heath Department				Provider Number: 0519251-93				
2572 N. Courtenay Parkway				Date: 07	/01/2021				
Merritt Island, FL 32953-4147			Fiscal Year End: 06/30/2020						
			Au	dit Status: Ur	naudited Cos	t			
Provider Type		<u>Current</u>	t Rate	<u>New Ra</u>	<u>ite</u>	Effective Date			
CHD		166.	59	165.2	6	07/01/2021			
Rate Type									
<u>Interim</u>		X	Prospective	<u>)</u>					
Total Interim			Х	Total Pros	pective				
Settlement Ba	ased on Cost			Prospectiv	e Adjusted F	or New Costs			
	BASIS:								
	Budget								
	X Unaudited C	ost							
	Desk Review	ved Cost							
	Desk Audited	d Cost							
	Field Audited	d Cost							
DISTRIBUTION:			-	TR					
Fiscal Agent			5	rv .					
Contract Management			Ry	dell Samuel,	Administrato	<u>r</u>			
Program Finance			Me	edicaid Progra	am Finance				

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#### Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Hea	Im Beach County Health Department				Provider Number: 0520331-00				
P. O. Box 29				Date: 07	7/01/2021				
West Palm Beach, FL 3	33402		— Fi	Fiscal Year End: 06/30/2020					
			_	Audit Status: U	naudited Cost	t			
Provider Type		<u>Cu</u>	rrent Rate	New R	ate	Effective Date			
<u>CHD</u>		166.59		165.2	26	07/01/2021			
Rate Type									
<u>Interim</u>			X Prospec	<u>ctive</u>					
	Total Interim	_	X	Total Pros	spective				
	_ Settlement Based c -	on Cost		Prospectiv	ve Adjusted F	or New Costs			
	BAS	<u>SIS:</u>							
		Budget							
	X	Unaudited Cost							
		- Desk Reviewed (	Cost						
		- Desk Audited Co	st						
		- Field Audited Cos	st						
		-							
DISTRIBUTION:				TR					
Fiscal Agent				rv,					
Contract Managem	Contract Management				Rydell Samuel, Administrator				
Program Finance				Medicaid Progr	am Finance				

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#### Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Departr	ment		Provider Number: 0520331-09				
P. O. Box 29			Date: 07/01/2021				
West Palm Beach, FL 33402			Fiscal Year End: 06/30/2020				
			Audit Status: Unaudited Cost				
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date		
CHD	-	166.	59	165.26	07/01/2021		
Rate Type							
<u>Interim</u>		Х	Prospective				
Total Inter	im		Х	Total Prospective			
Settlemen	t Based on Cost	-		Prospective Adjus	ted For New Costs		
		-		_			
	<b>BASIS:</b>						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audit	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			~	R			
Fiscal Agent			1	W .			
Contract Management			Ryc	lell Samuel, Adminis	trator		
Program Finance				dicaid Program Finar			
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#### Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach C	Im Beach County Health Department				Provider Number: 0520331-45				
P. O. Box 29						Date:	07/01/2021		
West Palm Be	ach, FL 3	3402			Fiscal Year End: 06/30/2020				
					Audit Status: Unaudited Cost				
<u>Provider Ty</u>	<u>/pe</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date	
CHD				166.59		165	5.26	07/01/2021	
Rate Type									
	<u>Interim</u>			Х	<u>Prospecti</u>	<u>ve</u>			
		Total Interim			- x	Total P	rospective		
		Settlement Based	on Cost			Prospe	ctive Adjuste	ed For New Costs	
		BA	<u>SIS:</u>						
			Budget						
		X	Unaudited	d Cost					
			Desk Rev	iewed Cost					
			Desk Aud	lited Cost					
			Field Aud	ited Cost					
						R			
DISTRIBUTIO						AT			
Fiscal Age						/ `			
Contract N	-	ent			-	-	el, Administi		
Program F	-inance				I	Medicaid Pro	ogram Finan	ce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach C	Im Beach County Health Department					Provider Number: 0520331-50				
P. O. Box 29						Date: 07/01/2021				
West Palm Be	ach, FL 3	3402				Fiscal Year End: 06/30/2020				
						A	udit Status:	Unaudited	l Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
<u>CHD</u>					166.59		16	165.26 07/		
Rate Type										
	<u>Interim</u>				Х	Prospectiv	<u>/e</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						
			X	- Unaudited	l Cost					
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				- Desk Audi	ited Cost					
				- Field Audi	ted Cost					
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DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						ΓV			
Contract N	Contract Management					Rydell Samuel, Administrator				
Program Finance					N	ledicaid Pro	ogram Fina	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Departm	nent	Provider Number: 0520331-89						
P. O. Box 29			Date: 07/01/2021					
West Palm Beach, FL 33402			Fiscal Year End: 06/30/2020					
			Aud	lit Status: Unaudited	Cost			
Provider Type		Current	Rate	New Rate	Effective Date			
<u>CHD</u>	-	166.	59	165.26	07/01/2021			
Rate Type								
<u>Interim</u>		Х	Prospective					
Total Interi	im		Х	Total Prospective				
Settlement			Prospective Adjust	ted For New Costs				
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	BASIS:							
	Budget							
	X Unaudited	Cost						
	Desk Revie	ewed Cost						
	Desk Audit	ted Cost						
	Field Audit	ed Cost						
DISTRIBUTION:			-	R				
Fiscal Agent			1	W				
Contract Management		Ryc	lell Samuel, Adminis	trator				
Program Finance			Medicaid Program Finance					
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#### Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach C	County Hea	alth Department			Provi	der Number:	0520331-9	5		
P. O. Box 29						Date:	07/01/2021	1		
West Palm Be	each, FL 3	3402			Fiscal Year End: 06/30/2020					
						Audit Status:	Unaudited	Cost		
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>			166	.59	16	5.26	07/01/2021		
Rate Type										
	Interim			X	Prospecti					
		Total Interim			Χ	Total P	rospective			
		Settlement Based	on Cost			Prospe	ctive Adjust	ed For New Costs		
		BA	<u>SIS:</u>							
			Budget							
		X	Unaudited	d Cost						
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			 Desk Aud	ited Cost						
			Field Audi	ited Cost						
			_							
DISTRIBUTIC	<u>)N:</u>					TR				
Fiscal Ag	ent					M				
Contract I	Manageme	ent				Rydell Samu	el, Administ	trator		
Program	Finance				-	Medicaid Pro	ogram Finar	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Depa	artment	Provi	der Number: 0520446-0	00				
514 East Grace Street			Date: 07/01/202	1				
Punta Gorda, FL 33950		Fisc	Fiscal Year End: 06/30/2020					
			Audit Status: Unaudited	Cost				
Provider Type		Current Rate	New Rate	Effective Date				
<u>CHD</u>	-	98.93	148.20	07/01/2021				
Rate Type								
Interim		X <u>Prospect</u>	ive					
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	ed Cost						
	Field Audite	ed Cost						
DISTRIBUTION:			TR					
Fiscal Agent			[N					
Contract Management			Rydell Samuel, Adminis	trator				
Program Finance			Medicaid Program Final	nce				

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#### Medicaid Reimbursement Rate Change Form for CHDs

Charlotte Cou	Charlotte County Health Department						Provid	ler Numl	ber: 0520446	-09	
514 East Gra	ce Street					-		D	ate: 07/01/202	21	
Punta Gorda,	FL 33950	)				Fiscal Year End: 06/30/2020					
						-	А	udit Sta	tus: Unaudite	d Cost	
Provider T	<u>ype</u>				Curre	en	t Rate	<u>N</u>	ew Rate	<u>E</u> 1	ffective Date
	<u>CHD</u>				9	8.9	93		148.20	(	07/01/2021
Rate Type	Interim				X	<	Prospectiv	10			
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		B	SASI	<u>S:</u>							
			E	Budget							
			χı	Unaudited	l Cost						
				Desk Revi	iewed Co	st					
			[	Desk Audi	ited Cost						
			F	Field Audi	ted Cost						
DISTRIBUTIO	<u>DN:</u>						-	TR			
Fiscal Ag	ent							py			
•		ent					R	Rydell Sa	amuel, Admini	istrator	
Program	Contract Management Program Finance								Program Fina		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Charlotte Cou	Charlotte County Health Department						Provi	der N	umber:	0520446-9	1	
514 East Grad	ce Street					_			Date:	07/01/2021		
Punta Gorda,	FL 33950	)				_	Fiscal Year End: 06/30/2020					
						_		Audit	Status:	Unaudited	Cost	
Provider T	<u>ype</u>				<u>Curi</u>	ren	t Rate		New	<u>Rate</u>	Effective Da	<u>ate</u>
	<u>CHD</u>				ę	98.	93		148	3.20	07/01/202	1
Rate Type	Interim					х	<u>Prospecti</u>	ivo				
	- -	Total Interim				~	- X		Total Pr	ospective		
		- Settlement Base	ed or	n Cost						•	ed For New Costs	
		-										
		B	BAS	<u>IS:</u>								
				Budget								
			Х	Unaudited	l Cost							
				Desk Revi	iewed C	ost						
				Desk Audi	ited Cos	t						
				Field Audi	ted Cos	t						
DISTRIBUTIC	DN:							Th	R			
Fiscal Ag	ent							R				
-		ent						Rydel	l Samu	el, Administ	rator	
Program	Contract Management Program Finance						-			gram Finan		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Hillsborough (	lillsborough County Health Department						ider Number:	: 0557269-0	00
1105 E. Kenn	edy Boule	vard					Date	07/01/202	1
Tampa, FL 3	3602					Fis	cal Year End	: 06/30/202	0
							Audit Status	Unaudited	Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166	166.59 16			07/01/2021
Rate Type	last o nivos				v	Ducana			
	Interim	Total Interim			X	Prospect		rospective	
		- Settlement Ba	eod c	on Cost		X		-	ted For New Costs
		-	1360 0	0050			F105p6		lear of new Costs
			BAS	<u>SIS:</u>					
				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	Managem	ent					Rydell Samu	uel, Adminis	trator
Program	Program Finance						Medicaid Pre	ogram Finar	nce

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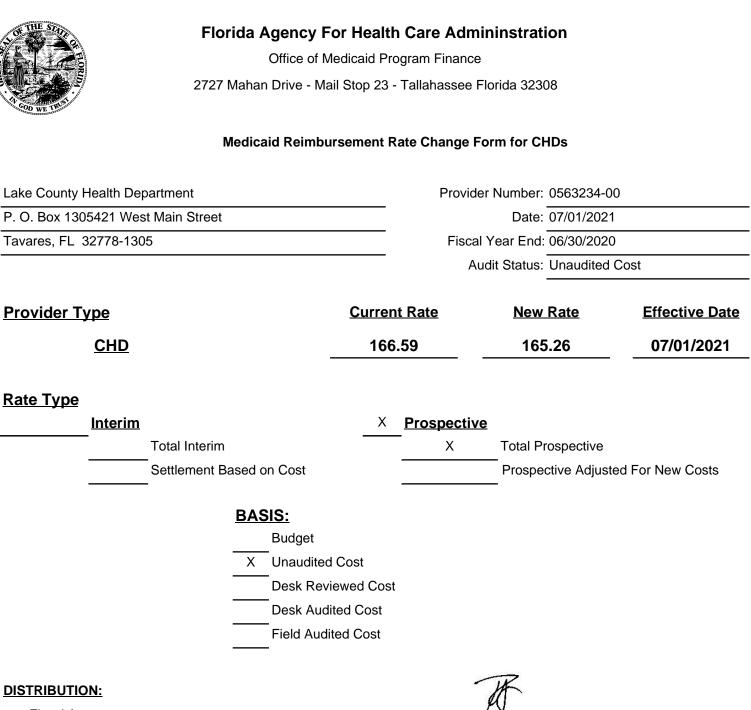
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#### Medicaid Reimbursement Rate Change Form for CHDs

Hillsborough County Health Departme	nt	Prov	ider Number: 0557269-	90				
1105 E. Kennedy Boulevard			Date: 07/01/202	21				
Tampa, FL 33602		Fis	Fiscal Year End: 06/30/2020					
			Audit Status: Unaudited	Cost				
Provider Type		Current Rate	New Rate	Effective Date				
<u>CHD</u>	_	166.59	166.59 165.26					
Rate Type								
Interim		X Prospect	ive					
Total Interim		X	Total Prospective					
Settlement B	ased on Cost		Prospective Adjus	ted For New Costs				
	BASIS: Budget							
	X Unaudited (	Cost						
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	Field Audite							
DISTRIBUTION:			F					
Fiscal Agent Contract Management			T Dudell Comunal Administ					
Program Finance			Rydell Samuel, Adminis Medicaid Program Fina					

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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

Lake County Health Department		Provi	der Number: 0563234-0	01		
P. O. Box 1305421 West Main Str	reet		Date: 07/01/202	1		
Tavares, FL 32778-1305		Fiso	Fiscal Year End: 06/30/2020			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		166.59	165.26	07/01/2021		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total Inte	erim	X	Total Prospective			
Settleme	ent Based on Cost		Prospective Adjus	ted For New Costs		
	<b>BASIS:</b>					
	Budget					
	X Unaudited	l Cost				
	Desk Revi	iewed Cost				
	Desk Audi	ited Cost				
	Field Audi	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			۲N			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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(No Change In Rate)



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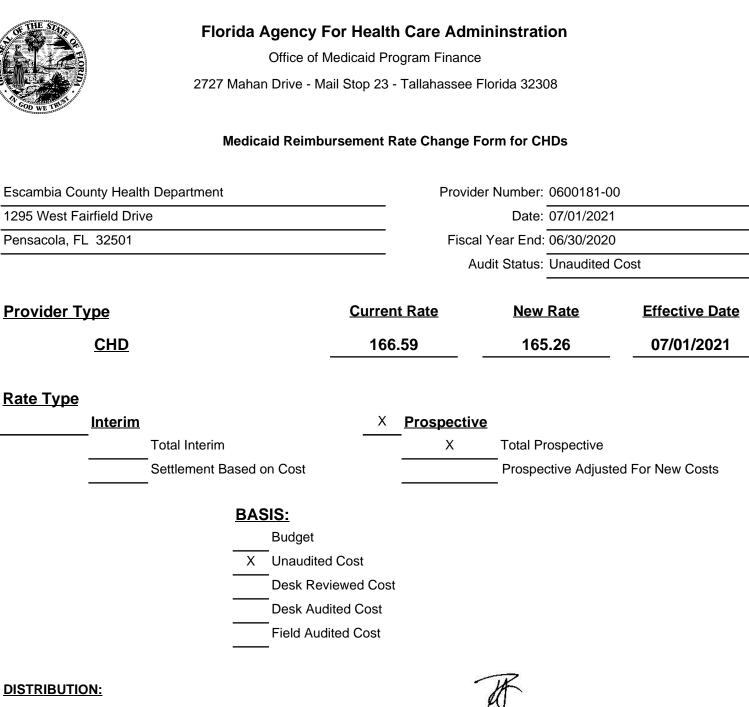
#### Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Department	nt	Prov	der Number: 0563234-	94
P. O. Box 1305421 West Main	Street		Date: 07/01/202	:1
Tavares, FL 32778-1305		Fiso	cal Year End: 06/30/202	20
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		166.59	165.26	07/01/2021
Rate Type		X B		
<u>Interim</u>	Interim	X Prospect		
			Total Prospective	
	ment Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revi	ewed Cost		
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	Field Audi	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			M	
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

Escambia Co	Escambia County Health Department						er Number:	0600181-0	)1		
1295 West Fa	airfield Driv	/e					Date:	07/01/202	1		
Pensacola, Fl	_ 32501					Fiscal Year End: 06/30/2020					
						А	udit Status:	Unaudited	Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				166	.59	16	5.26	07/01/2021		
Rate Type											
	Interim				X	Prospectiv	<u>/e</u>				
		Total Interim				Х	Total P	rospective			
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ted For New Costs		
			BAS	SIS:							
				Budget							
			Х	– Unaudited	d Cost						
				– Desk Revi	iewed Cost						
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DISTRIBUTIC	<u>DN:</u>						TR				
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Contract	Managem	ent				F	Rydell Samu	iel, Adminis	trator		
Program	Finance					Ī	ledicaid Pro	ogram Finar	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	Escambia County Health Department						ider Number:	0600181-0	3		
1295 West Fa	airfield Driv	e					Date:	07/01/2021	1		
Pensacola, Fl	_ 32501					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				166	.59	16	5.26	07/01/2021		
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:							
			<u></u>	Budget							
			X	-	Cost						
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				_ Field Audi	ted Cost						
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DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						۲٩				
Contract	Managem	ent					Rydell Samu	iel, Administ	trator		
Program	Finance						Medicaid Pro	ogram Finar	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	Escambia County Health Department						ler Number:	0600181-0	)4		
1295 West Fa	airfield Driv	'e					Date:	07/01/202	1		
Pensacola, Fl	_ 32501					Fiscal Year End: 06/30/2020					
						A	udit Status:	Unaudited	Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				166	.59	165	5.26	07/01/2021		
Rate Type											
	<u>Interim</u>				Х	Prospectiv	<u>/e</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							
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				– Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ted Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						7N				
Contract	Managem	ent				F	Rydell Samu	el, Adminis	trator		
Program	Program Finance						ledicaid Pro	gram Fina	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-05				
1295 West Fa	airfield Driv	'e					Date	07/01/202	1	
Pensacola, Fl	32501					Fisc	al Year End	: 06/30/202	0	
						,	Audit Status:	Unaudited	l Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				X	Prospecti				
		Total Interim				X	Total P	rospective		
Settlement Based or			on Cost			Prospe	ctive Adjus	ted For New Costs		
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	Cost					
				_ Desk Revi	iewed Cost					
				- Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						74			
Contract Management						_	Rydell Samu	uel, Adminis	strator	
Program	Program Finance						Medicaid Pro	ogram Fina	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-07					
1295 West Fa	airfield Driv	e					Date:	07/01/2021			
Pensacola, Fl	_ 32501					Fisca	I Year End:	06/30/2020			
						Audit Status: Unaudited Cost					
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date		
	<u>CHD</u>			166.59			165.26 07/01/202				
Rate Type											
	<u>Interim</u>				Х	Prospectiv	<u>'e</u>				
	-	Total Interim				- x	Total P	ospective			
Settlement Base			ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs		
			BAS	SIS:							
				Budget							
			X	– Unaudited	d Cost						
				– Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				-							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						۲N N				
Contract Management						R	ydell Samu	el, Administr	ator		
Program	Program Finance						ledicaid Pro	gram Financ	ce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	Escambia County Health Department						Provider Number: 0600181-09				
1295 West Fa	airfield Driv	e					Date:	07/01/2021			
Pensacola, Fl	_ 32501					Fiscal Year End: 06/30/2020					
							Audit Status:	Unaudited	Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				166	.59	16	5.26	07/01/2021		
Rate Type											
	<u>Interim</u>				Х	Prospect	ive				
	-	Total Interim				- x	Total P	rospective			
Settlement Base			ased o	on Cost			Prospe	ctive Adjust	ed For New Costs		
			BAS	SIS:							
			<u></u>	Budget							
			X	-	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				-							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						۲٩				
Contract Management							Rydell Samu	el, Administ	rator		
Program	Finance						Medicaid Pro	ogram Finan	се		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-16					
1295 West Fa	airfield Driv	'e					Date:	07/01/2021	1		
Pensacola, Fl	_ 32501					Fisca	al Year End:	06/30/2020	)		
						Audit Status: Unaudited Cost					
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>			166.59			165.26 07/01/202				
Rate Type											
	<u>Interim</u>				Х	Prospectiv	<u>/e</u>				
	-	Total Interim				- x	Total P	rospective			
Settlement Bas			ased o	on Cost			Prospe	ctive Adjust	ed For New Costs		
			BAS	SIS:							
				Budget							
			X	 Unaudited	Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				_ Field Audi	ted Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						M				
Contract	Managem	ent				F	Rydell Samu	el, Administ	trator		
Program	Program Finance						ledicaid Pro	gram Finan	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-20					
1295 West Fa	airfield Driv	'e					Date:	07/01/202	1		
Pensacola, Fl	_ 32501					Fisca	al Year End:	06/30/2020	0		
						Audit Status: Unaudited Cost					
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>			166.59			165.26 07/01/202				
Rate Type											
	<u>Interim</u>				Х	Prospectiv	<u>/e</u>				
	-	Total Interim				- x	Total P	rospective			
Settlement Base			ased o	on Cost			Prospe	ctive Adjust	ted For New Costs		
			BAS	SIS:							
				Budget							
			Х	– Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>DN:</u>						TR				
Fiscal Ag	ent						74				
Contract	Managem	ent				F	Rydell Samu	el, Adminis	trator		
Program	Program Finance						ledicaid Pro	ogram Finar	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-25				
1295 West Fa	airfield Driv	'e					Date	07/01/202	1	
Pensacola, Fl	32501					Fisc	al Year End	06/30/202	0	
							Audit Status:	Unaudited	l Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	Interim				X	Prospecti	<u>ve</u>			
		Total Interim				Χ	Total P	rospective		
Settlement Based or			on Cost			Prospe	ctive Adjus	ted For New Costs		
			BAS	<u>SIS:</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						/ N			
Contract Management						_	Rydell Samu	iel, Adminis	strator	
Program	Program Finance						Medicaid Pro	ogram Fina	nce	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-26					
1295 West Fa	airfield Driv	'e					Date	07/01/202	1		
Pensacola, Fl	32501					Fisc	al Year End	: 06/30/202	0		
						,	Audit Status:	Unaudited	Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				166	.59	16	5.26	07/01/2021		
Rate Type											
	<u>Interim</u>				Х	<u>Prospecti</u>	ve				
	-	Total Interim				- x	Total P	rospective			
Settlement Based o			on Cost			Prospe	ective Adjus	ted For New Costs			
			BAS	<u> 815:</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						/ N				
Contract Management						_	Rydell Samı	iel, Adminis	strator		
Program	Finance						Medicaid Pro	ogram Fina	nce		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	Escambia County Health Department						Provider Number: 0600181-29				
1295 West Fa	airfield Driv	e					Date:	07/01/2021			
Pensacola, Fl	_ 32501					Fis	cal Year End	06/30/2020			
							Audit Status:	Unaudited	Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				166	.59	16	5.26	07/01/2021		
Rate Type											
	<u>Interim</u>				Х	Prospect	ive				
	-	Total Interim				- x	Total P	rospective			
Settlement Base			ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs		
			BAS	SIS:							
			<u></u>	Budget							
			X	_	d Cost						
				_ Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						rv.				
Contract Management							Rydell Samu	el, Administ	rator		
Program	Finance						Medicaid Pro	ogram Finan	се		

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-31					
1295 West Fa	airfield Driv	'e					Date:	07/01/2021			
Pensacola, Fl	_ 32501					Fisca	l Year End:	06/30/2020			
						Audit Status: Unaudited Cost					
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date		
	<u>CHD</u>			166.59			165.26 07/01/202				
Rate Type											
	<u>Interim</u>				Х	Prospectiv	<u>'e</u>				
	-	Total Interim				- x	Total Pr	ospective			
Settlement Base			ased o	on Cost			Prospe	ctive Adjuste	d For New Costs		
			BAS	SIS:							
				Budget							
			X	– Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>DN:</u>						TR				
Fiscal Ag	ent						۲N				
Contract	Managem	ent				R	ydell Samu	el, Administra	ator		
Program	Program Finance						ledicaid Pro	gram Financ	ce		

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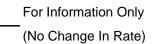
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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-32				
1295 West Fa	airfield Driv	'e					Date:	07/01/2021		
Pensacola, Fl	_ 32501					Fisca	al Year End	: 06/30/2020	)	
						A	udit Status:	Unaudited	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	Interim				X	Prospectiv	<u>/e</u>			
		Total Interim				X	Total P	rospective		
	Settlement Based on Co			on Cost			Prospe	ctive Adjust	ed For New Costs	
			BAS	SIS:						
				Budget						
			X	_ Unaudited	Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						1 N			
Contract Management						R	Rydell Samu	iel, Administ	trator	
Program	Finance					N	ledicaid Pro	ogram Finar	ice	

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health	Department		Provider Number: 0600181-33					
1295 West Fairfield Drive				Date: 07/01/20	)21			
Pensacola, FL 32501			Fiscal Year End: 06/30/2020					
			Audit Status: Unaudited Cost					
Provider Type		<u>Curre</u>	nt Rate	New Rate	Effective Date			
<u>CHD</u>		166.59		165.26	07/01/2021			
Rate Type								
<u>Interim</u>		Х	Prospective					
т	otal Interim		— x	Total Prospective	е			
s	Settlement Based or	n Cost		Prospective Adju	usted For New Costs			
	BAS	<u>IS:</u>						
		Budget						
	X	Unaudited Cost						
		Desk Reviewed Cos	t					
		Desk Audited Cost						
		Field Audited Cost						
DISTRIBUTION:				R				
Fiscal Agent			ľ	V				
Contract Managemen	t		Ryd	ell Samuel, Admir	nistrator			
Program Finance			Medicaid Program Finance					

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#### Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healt	h Department				Provider Number: 0600181-91				
1295 West Fa	airfield Driv	'e					Date	07/01/202	1	
Pensacola, Fl	32501					Fise	cal Year End	: 06/30/202	0	
							Audit Status	Unaudited	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021	
Rate Type										
	<u>Interim</u>				Х	<b>Prospect</b>	ive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based o			on Cost			Prospe	ective Adjus	ted For New Costs		
			BAS	<u> 815:</u>						
				Budget						
			X	Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
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DISTRIBUTIC							TR			
Fiscal Ag							/ •			
Contract Management							Rydell Samu			
Program	Program Finance						Medicaid Pro	ogram Finai	nce	

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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: 07/01/2021			
						Fiscal Year End: 06/30/2020			
						Audit Status:		Unaudited Cost	
Provider Type				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				166	.59	16	5.26	07/01/2021
Rate Type							_		
	Interim	Tables			X	-			
		Total Interim		•		X		rospective	
	Settlement Based on Cost					Prospective Adjusted For New Costs			
			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 Agent						7N			
Contract Management						Rydell Samuel, Administrator			
Program Finance						Medicaid Program Finance			

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