

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Alachua Cour	Alachua County Health Department					Provider Number: 0279111-00				
224 SE 24th S	Street730	N.E. Waldo Ro	ad, Su	uite 500		Date: 07/11/2018				
Gainesville, F	L 32641					Fiscal Year End: 06/30/2017				
							Audi	it Status:	Unaudited C	Cost
Provider Ty	<u>ype</u>				<u>Curre</u>	nt	Rate	New	Rate	Effective Date
	<u>CHD</u>				14	7.1	9	162	2.95	07/01/2018
Rate Type	Interim				v		Duconcetive			
	Interim	Total Interim			X	<u>+</u>	Prospective X	Total P	rospective	
		Settlement Ba	ased o	on Cost		_	Χ	_		d For New Costs
			BAS	Budget Unaudited Desk Rev	viewed Cos lited Cost	st				
DISTRIBUTIO							P	R		

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

Alachua Cour	ty Health	Department	Alachua County Health Department				Provider Number: 0279111-91				
224 SE 24th S	Street730 I	N.E. Waldo Roa	ad, Su	uite 500			Date: 07/11/2018				
Gainesville, F	L 32641					Fiscal Year End: 06/30/2017					
							Audit Status:	Unaudited	l Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>			-	147	.19	162	2.95	07/01/2018		
Rate Type											
	Interim				Х	Prospect	ive				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	sed c	on Cost			Prospe	ctive Adjus	ted For 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						PN.				
Contract	Managem	ent					Rydell Samu	iel, Adminis	strator		
Program Finance					Medicaid Program Finance						

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Medicaid Reimbursement Rate Change Form for CHDs

Alachua County H	lealth [Department	Alachua County Health Department				Provider Number: 0279111-93				
224 SE 24th Stree	et730 N	I.E. Waldo Road,	Suite 500		Date: 07/11/2			/11/2018			
Gainesville, FL 32	2641				Fiscal Year End: 06/30/2017						
						Audit Status:	Unaudited	Cost			
Provider Type	<u>)</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date			
<u>C</u> I	<u>HD</u>			147	.19	162	2.95	07/01/2018			
Rate Type											
Int	<u>erim</u>			Х	Prospec	<u>tive</u>					
		Total Interim			- x	Total P	rospective				
		Settlement Based	I on Cost			Prospe	ctive Adjust	ed For New Costs			
		BA	<u>\SIS:</u>								
			Budget								
		×	Unaudite	d Cost							
			Desk Rev	viewed Cost							
			Desk Auc	lited Cost							
			Field Aud	lited Cost							
DISTRIBUTION:						TR					
Fiscal Agent						7N					
Contract Man	ageme	ent			Rydell Samuel, Administrator						
Program Finance					Medicaid Program Finance						

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Medicaid Reimbursement Rate Change Form for CHDs

Baker County Health Department	Provi	Provider Number: 0279129-00				
480 West Lowder Street		Date: 07/11/201	8			
Macclenny, FL 32063	Fisc	Fiscal Year End: 06/30/2017				
		Audit Status: Unaudited	l Cost			
Provider Type	Current Rate	New Rate	Effective Date			
CHD	154.88	167.09	07/01/2018			
Rate Type						
<u>Interim</u>	X Prospect	ive				
Total Interim	X	Total Prospective				
Settlement Based on Co	ost	Prospective Adjus	ted For New Costs			
BASIS:						
Bud	lget					
X Una	audited Cost					
Des	k Reviewed Cost					
Des	sk Audited Cost					
Field	d Audited Cost					
DISTRIBUTION: Fiscal Agent		T				
Contract Management		Rydell Samuel, Adminis	strator			
Program Finance	-	Medicaid Program Fina				

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Medicaid Reimbursement Rate Change Form for CHDs

Baker County	Baker County Health Department					Provider Number: 0279129-91				
480 West Low	der Stree	t				Date: 07/11/2018				
Macclenny, Fl	L 32063					Fiscal Year End: 06/30/2017				
							Audit Status	Unaudited	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				154	.88	16	7.09	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased	on Cost			Prospe	ctive Adjuste	ed For New Costs	
			BAS	SIS:						
				Budget						
			X	– Unaudited	l Cost					
				– Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						۲N			
Contract	Managem	ent					Rydell Samu	uel, Administ	rator	
Program Finance					Medicaid Program Finance					

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Departme	ent	Prov	Provider Number: 0279145-00				
1801 North Temple Avenue			Date: 07/11/201	: 07/11/2018			
Starke, FL 32091		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	169.54	169.57	07/01/2018			
Rate Type							
<u>Interim</u>		X Prospect	<u>ive</u>				
Total Int	erim	X	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	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			7N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Department	nt	Prov	Provider Number: 0279145-04				
1801 North Temple Avenue			Date: 07/11/2018				
Starke, FL 32091		Fiso	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	169.54	169.57	07/01/2018			
Rate Type							
Interim		X Prospect	<u>ive</u>				
Total Inte	rim	X	Total Prospective				
Settlemer	nt 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 Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Departme	ent	Prov	Provider Number: 0279145-30				
1801 North Temple Avenue			Date: 07/11/201	07/11/2018			
Starke, FL 32091		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	169.54	169.57	07/01/2018			
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:			R				
Fiscal Agent			[N				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Departmer	nt	Provider Number: 0279145-91					
1801 North Temple Avenue			Date: 07/11/2018				
Starke, FL 32091		Fiscal `	Year End: 06/30/201	7			
		Aud	dit Status: Unaudited	Cost			
Provider Type	Curre	nt Rate	New Rate Effective				
CHD	16	9.54	169.57	07/01/2018			
Rate Type							
Interim	Х	Prospective					
Total Inter	im	x	Total Prospective				
Settlemen	t 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			PV -				
Contract Management		Ry	dell Samuel, Adminis	strator			
Program Finance			dicaid Program Finar				
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Medicaid Reimbursement Rate Change Form for CHDs

Broward Cour	Broward County Health Department				Provider Number: 0279161-00				
780 SW 24th	Street					Date	07/11/2018	3	
Fort Lauderda	ale, FL 333	315			Fiscal Year End: 06/30/2017				
						Audit Status	Unaudited	Cost	
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			169	.54	14	9.33	07/01/2018	
Rate Type									
	Interim			X	- Prospect				
		Total Interim			X		rospective		
		Settlement Base	d on Cost			Prospe	ctive Adjust	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>					- UF			
Fiscal Ag	ent					^r N			
Contract I	Manageme	ent				Rydell Samu	uel, Administ	trator	
Program	Finance					Medicaid Pro	ogram Finar	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Depart	ment		Provider Number: 0279161-01				
780 SW 24th Street				Date: 07/11/2018			
Fort Lauderdale, FL 33315			Fiscal Year End: 06/30/2017				
			Aud	it Status: Unaudited	Cost		
Provider Type		Current Rate		New Rate	Effective Date		
<u>CHD</u>	-	169.54		149.33	07/01/2018		
Rate Type							
<u>Interim</u>		Х <u>Р</u>	<u>rospective</u>				
Total	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 Audito	ed Cost					
DISTRIBUTION:			-	R			
Fiscal Agent			ľ	W.			
Contract Management			Rvd	lell Samuel, Adminis	trator		
Program Finance				dicaid Program Finar			
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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Depart	Broward County Health Department				Provider Number: 0279161-04				
780 SW 24th Street			Date: 07/11/2018 Fiscal Year End: 06/30/2017						
Fort Lauderdale, FL 33315									
			Aud	it Status: Unaudited	Cost				
Provider Type		Current Rate		New Rate	Effective Date				
<u>CHD</u>	-	169.5	4	149.33	07/01/2018				
Rate Type									
<u>Interim</u>		Х <u>і</u>	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							
			/	TR					
DISTRIBUTION: Fiscal Agent			ť	AT .					
Contract Management			Rvd	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 De	partment		Provider Number: 0279161-93 Date: 07/11/2018			
780 SW 24th Street						
Fort Lauderdale, FL 33315			Fiscal Y	ear End: 06/30/2017	7	
			Aud	it Status: Unaudited	Cost	
<u>Provider Type</u>		Current I	Rate	New Rate	Effective Date	
<u>CHD</u>		169.5	4	149.33	07/01/2018	
Rate Type						
<u>Interim</u>		X <u>F</u>	<u>Prospective</u>			
To	otal Interim		Х	Total Prospective		
Settlement Based on Cost		_		ed For New Costs		
		_		_		
	BASIS:					
	Budget					
	X Unaudited	d Cost				
	Desk Rev	iewed Cost				
	Desk Aud	ited Cost				
	Field Audi	ited 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

Calhoun County Health D	Department		P	rovider Number:	0279170-00	
19611 S.R. 20 West Blountstown, FL 32424				Date:	07/11/2018	
			F	Fiscal Year End:	06/30/2017	
				Audit Status:	Unaudited Co	st
Provider Type		<u>Cu</u>	rrent Rate	New	Rate	Effective Date
<u>CHD</u>			140.12	11′	1.46	07/01/2018
Rate Type						
<u>Interim</u>			X <u>Prospe</u>	ective		
	Total Interim	-	>	K 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:				IF		
Fiscal Agent				ſŇ		
Contract Manageme	nt			Rydell Samu	el, Administrat	or
Program Finance				Medicaid Pro	ogram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun Cour	nty Health	Department			Provi	der Number:	0279170-30)
19611 S.R. 20) West					Date:	07/11/2018	
Blountstown, FL 32424				Fisc	al Year End:	06/30/2017		
						Audit Status:	Unaudited (Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			140	.12	11	1.46	07/01/2018
Rate Type								
	Interim			X	_ <u>Prospecti</u> _	<u>ve</u>		
		Total Interim			Χ	Total P	rospective	
		Settlement Base	ed on Cost			Prospe	ctive Adjuste	ed For New Costs
		<u>B</u>	ASIS:					
			Budget					
			X Unaudite	ed Cost				
			Desk Re	viewed Cost				
			Desk Au	dited Cost				
			Field Au	dited Cost				
DISTRIBUTIO	<u>DN:</u>					- AF		
Fiscal Ag	ent					N		
Contract	Managem	ent			-	Rydell Samu	uel, Administi	rator
Program	Finance				-	Medicaid Pro	ogram Finan	се

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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun County Health Depa	artment	Pro	Provider Number: 0279170-91 Date: 07/11/2018			
19611 S.R. 20 West						
Blountstown, FL 32424			scal Year End: 06/30/201	7		
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	140.12	111.46	07/01/2018		
Rate Type						
<u>Interim</u>		X <u>Prospe</u>	<u>ctive</u>			
Tota	al Interim	X	Total Prospective			
Sett	tlement Based on Cost		Prospective Adjust	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			pri			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Finar			
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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health	Department			Provi	der Number:	0279196-00	1
3700 Sovereign Path					Date:	Date: 07/11/2018	
Lecanto, FL 34461-8071				Fisc	al Year End:	06/30/2017	
					Audit Status:	Unaudited C	Cost
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>			141	.86	122	2.72	07/01/2018
Rate Type							
<u>Interir</u>	<u>n</u>		X	Prospecti	ve		
	Total Interim			X	Total P	rospective	
	Settlement Base	ed on Cost			Prospe	ctive Adjuste	d For New Costs
	B	ASIS:					
		Budget					
	_	X Unaudited	d Cost				
		Desk Rev	iewed Cost				
		Desk Aud	lited Cost				
	_	Field Aud	ited Cost				
DISTRIBUTION:					TR		
Fiscal Agent					M		
Contract Manage	ment				Rydell Samu	el, Administra	ator
Program Finance				-	Medicaid Pro	ogram Financ	e

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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department		Prov	vider Number: 0279196-0	01
3700 Sovereign Path		Date: 07/11/2018		
Lecanto, FL 34461-8071	Fis	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	I Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		141.86	122.72	07/01/2018
Rate Type				
Interim		X Prospect	tive	
Total Inte	rim	X	Total Prospective	
Settlemer	t Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited Co	ost		
	Desk Review	ed Cost		
	Desk Audited	l Cost		
	Field Audited	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

Citrus County Health Department		Prov	ider Number: 0279196-0)2	
3700 Sovereign Path			Date: 07/11/201	8	
Lecanto, FL 34461-8071	Fisc	Fiscal Year End: 06/30/2017			
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	141.86	122.72	07/01/2018	
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 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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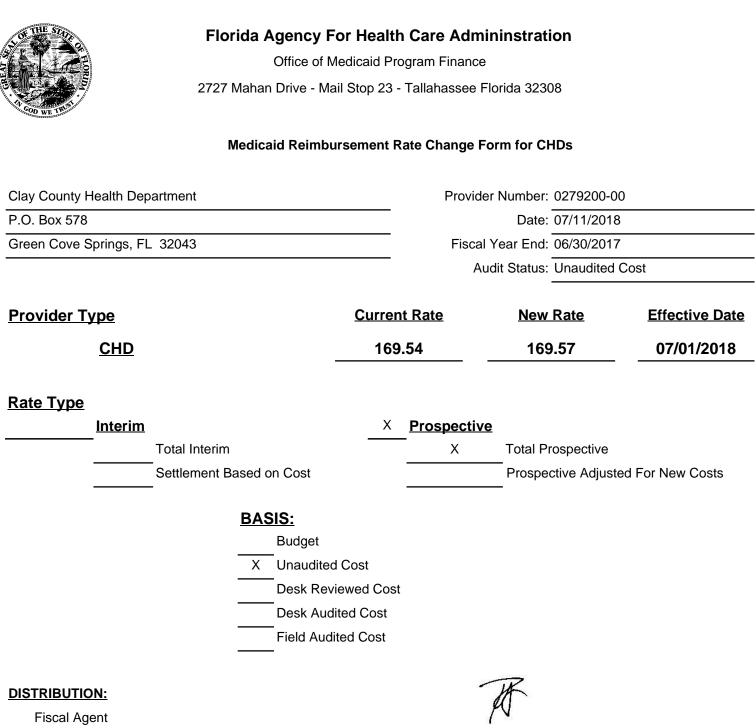
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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department		Prov	ider Number: 0279196-9	90
3700 Sovereign Path		Date: 07/11/201	8	
Lecanto, FL 34461-8071	Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	141.86	122.72	07/01/2018
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 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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Contract Management Program Finance

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(ヽ Rydell Samuel, Administrator

Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Departme	ent		Provider Number: 0279200-01 Date: 07/11/2018			
P.O. Box 578						
Green Cove Springs, FL 32043			Fiscal Year End: 06/30/2017			
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.5		169.57	07/01/2018	
Rate Type						
Interim		X <u> </u>	Prospective			
Tota	I Interim		Х	Total Prospective		
Settl	lement 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			1	N N		
Contract Management			Ryd	ell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-02			
P.O. Box 578				8		
Green Cove Springs, FL 32043			Fiscal Y	'ear End: 06/30/201	7	
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>	-	169	.54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interi	im		X	Total Prospective		
Settlement	t Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
			_	TP		
DISTRIBUTION:			ý	at the second se		
Fiscal Agent			1	N		
Contract Management				dell Samuel, Adminis		
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: 0279200-03 Date: 07/11/2018			
P.O. Box 578						
Green Cove Springs, FL 32043			Fiscal Y	'ear End: 06/30/201	7	
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Current</u>	t Rate	New Rate	Effective Date	
CHD	-	169.	54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Int	erim		Х	Total Prospective		
Settlem	ent Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			_	TR		
Fiscal Agent			1	av 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

Clay County Health Department			Provider Number: 0279200-04 Date: 07/11/2018			
P.O. Box 578						
Green Cove Springs, FL 32043			Fiscal Y	'ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.	54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Interi	m		Х	Total Prospective		
Settlement	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:				R		
Fiscal Agent			1	N .		
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

Clay County Health Department			Provider Number: 0279200-05			
P.O. Box 578			Date: 07/11/2018			
Green Cove Springs, FL 32043			Fiscal Year End: 06/30/2017			
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current	t Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.	54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interi	im		X	Total Prospective		
Settlement	t 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	N		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-91			
P.O. Box 578			Date: 07/11/2018			
Green Cove Springs, FL 32043			Fiscal Year End: 06/30/2017			
			Aud	it Status: Unaudited	Cost	
Provider Type		Current	t Rate	New Rate	Effective Date	
CHD	-	169.	54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	rim		Х	Total Prospective		
Settlemer	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:				R		
Fiscal Agent			1	N		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-92 Date: 07/11/2018 Fiscal Year End: 06/30/2017		
P.O. Box 578					
Green Cove Springs, FL 32043					
			Aud	lit Status: Unaudited	Cost
Provider Type		Current	<u>Rate</u>	New Rate	Effective Date
<u>CHD</u>	-	169.	54	169.57	07/01/2018
Rate Type					
<u>Interim</u>		Х	Prospective		
Total Interi	m		Х	Total Prospective	
Settlement	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			
			_	P	
DISTRIBUTION:				lt -	
Fiscal Agent			1	N	
Contract Management				lell Samuel, Adminis	
Program Finance			Mee	dicaid Program Finar	nce
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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department		Provider	Number: 0279218-	-00	
P.O. Box 429			Date: 07/11/20	07/11/2018	
Naples, FL 34106-0429		Fiscal Year End: 06/30/2017			
		Aud	it Status: Unaudite	d Cost	
Provider Type	Currei	nt Rate	New Rate	Effective Date	
<u>CHD</u>	169	9.54	169.57	07/01/2018	
Rate Type					
Interim	Х	Prospective			
Total Interim		— x	Total Prospective		
Settlement Base	ed on Cost		Prospective Adjus	sted For New Costs	
<u>E</u>	BASIS:				
	Budget				
_	X Unaudited Cost				
-	Desk Reviewed Cos	t			
_	Desk Audited Cost				
-	Field Audited Cost				
DISTRIBUTION:		-	TR		
		ý			
Fiscal Agent Contract Management		1			
Program Finance			lell Samuel, Admini dicaid Program Fina		
i iogiani i manoo		Wiet			

For Information Only (No Change In Rate)

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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department	t		Provider Number: 0279218-01 Date: 07/11/2018			
P.O. Box 429						
Naples, FL 34106-0429			Fiscal Year End: 06/30/2017			
			Aud	lit Status: Unaudited	Cost	
Provider Type	Cu	irrent F	Rate	New Rate	Effective Date	
CHD		169.5	4	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		х <u>р</u>	rospective			
Total Inte	erim –		Х	Total Prospective		
Settleme	ent Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed	Cost				
	Desk Audited Co	ost				
	Field Audited Co	ost				
DISTRIBUTION:			/	IR		
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

Collier County Health Department			Provider Number: 0279218-11			
P.O. Box 429			Date: 07/11/2018 Fiscal Year End: 06/30/2017			
Naples, FL 34106-0429						
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>Cı</u>	urren	t Rate	New Rate	Effective Date	
CHD		169	.54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inter	im .		- x	Total Prospective		
Settlemen	t Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed	Cost				
	Desk Audited C	ost				
	Field Audited Co	ost				
			/	TR		
DISTRIBUTION: 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

Collier County Health Department		Provi	Provider Number: 0279218-15		
P.O. Box 429		_	8		
Naples, FL 34106-0429		– Fisc	Fiscal Year End: 06/30/2017		
		- ,	Audit Status: Unaudited	Cost	
Provider Type	Curr	ent Rate	New Rate	Effective Date	
CHD	1	69.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospecti	ve		
Total Inter	im	X	Total Prospective		
Settlemer	t Based on Cost		Prospective Adjust	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed C	ost			
	Desk Audited Cos	t			
	Field Audited Cos	t			
DISTRIBUTION:			TR		
Fiscal Agent			1		
Contract Management		-	Rydell Samuel, Adminis		
Program Finance			Medicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department		Provi	Provider Number: 0279218-30			
P.O. Box 429		-	8			
Naples, FL 34106-0429		– Fisc	Fiscal Year End: 06/30/2017			
		-	Audit Status: Unaudited	Cost		
Provider Type	Curr	ent Rate	New Rate	Effective Date		
CHD	1	69.54	169.57	07/01/2018		
Rate Type						
Interim	2	× <u>Prospecti</u>	ive			
Total Inte	rim	X	Total Prospective			
Settlemer	it Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed Co	ost				
	Desk Audited Cost	t				
	Field Audited Cost					
			TR			
DISTRIBUTION: Fiscal Agent			pa `			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance		-	Medicaid Program Fina	nce		
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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department		Provider Number: 0279218-91			
P.O. Box 429			8		
Naples, FL 34106-0429		Fiscal Year End: 06/30/2017			
		Aud	dit Status: Unaudited	Cost	
Provider Type	Curre	nt Rate	New Rate	Effective Date	
CHD	16	9.54 _	169.57	07/01/2018	
Rate Type					
Interim	Х	Prospective			
Total Inter	im	— x	Total Prospective		
Settlemer	t 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			dell Samuel, Adminis		
Program Finance		Me	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Depa	artment	Prov	der Number: 0279226-	00	
217 North East Franklin Street	t		Date: 07/11/201	: 07/11/2018	
Lake City, FL 32055		Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		169.54	169.57	07/01/2018	
Rate Type					
Interim		X Prospect	ive		
Total	Interim	X	Total Prospective		
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	l Cost			
	Desk Revi	iewed Cost			
	Desk Audi	ited Cost			
	Field Audi	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			r v		
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 Health Departm	ent		Provider Number: 0279226-09			
217 North East Franklin Street			Date: 07/11/2018			
Lake City, FL 32055			Fiscal Year End: 06/30/2	2017		
			Audit Status: Unaudi	ted Cost		
Provider Type	<u>C</u>	urrent Rate	New Rate	Effective Date		
CHD		169.54	169.57	07/01/2018		
Rate Type						
<u>Interim</u>		X <u>Pros</u> p	<u>pective</u>			
Total Inte	erim		X Total Prospectiv	ve		
Settleme	ent Based on Cost		Prospective Ad	justed For New Costs		
	BASIS:					
	Budget					
	X Unaudited Cos	t				
	Desk Reviewed	d Cost				
	Desk Audited C	Cost				
	Field Audited C	Cost				
			-P			
DISTRIBUTION:			AT			
Fiscal Agent			1 *			
Contract Management			Rydell Samuel, Adm			
Program Finance			Medicaid Program Fi	inance		
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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Departme	ent		Provider	Number: 0279226-9	91	
217 North East Franklin Street			Date: 07/11/2018			
Lake City, FL 32055			Fiscal Y	ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>C</u>	urrent	<u>Rate</u>	New Rate	Effective Date	
CHD		169.	54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	rim		Х	Total Prospective		
Settleme	nt Based on Cost	-		Prospective Adjust	ted For New Costs	
		-		-		
	BASIS:					
	Budget					
	X Unaudited Cost	t				
	Desk Reviewed	d Cost				
	Desk Audited C	Cost				
	Field Audited C	Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	N		
Contract Management			Ryd	ell Samuel, Adminis	trator	
Program Finance				licaid Program Finar		
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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Departme	ent		Provider	Number: 0279226-9	92	
217 North East Franklin Street			Date: 07/11/2018			
Lake City, FL 32055			Fiscal Y	'ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>Cu</u>	urrent	Rate	New Rate	Effective Date	
CHD		169.	54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	rim -		X	Total Prospective		
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed	Cost				
	Desk Audited Co	ost				
	Field Audited Co	ost				
DISTRIBUTION:			_	TR		
Fiscal Agent			ľ	N N		
Contract Management			Ryd	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

Dade County Health Department		Prov	ider Number: 0279234-	00
1350 N.W. 14th Street		Date: 07/11/201	8	
Miami, FL 33125		Fise	cal Year End: 06/30/201	7
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		165.01	169.57	07/01/2018
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 Revi	ewed Cost		
	 Desk Audi	ted Cost		
	Field Audi	ted Cost		
DISTRIBUTION:			R	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Department		Provider	Number: 0279234-3	30
1350 N.W. 14th Street		Date: 07/11/2018	8	
Miami, FL 33125		Fiscal Y	'ear End: 06/30/201	7
		Aud	lit Status: Unaudited	Cost
Provider Type	Currei	nt Rate	New Rate	Effective Date
<u>CHD</u>	165	5.01	169.57	07/01/2018
Rate Type				
<u>Interim</u>	Х	Prospective		
Total Inte	erim	— x	Total Prospective	
Settleme	ent Based on Cost		Prospective Adjust	ted For New Costs
			_	
	BASIS:			
	Budget			
	X Unaudited Cost			
	Desk Reviewed Cos	t		
	Desk Audited Cost			
	Field Audited Cost			
DISTRIBUTION:		-	R	
Fiscal Agent		1	ey.	
Contract Management		Rvc	lell Samuel, Adminis	trator
Program Finance			dicaid Program Finar	
State Health Office				



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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Departme	ent		Provider Nur	mber: 0279234-9	91
1350 N.W. 14th Street			l	Date: 07/11/2018	8
Miami, FL 33125			Fiscal Year	End: 06/30/201	7
			Audit St	atus: Unaudited	Cost
Provider Type		Current Rate	2	New Rate	Effective Date
<u>CHD</u>	-	165.01		169.57	07/01/2018
Rate Type					
<u>Interim</u>		X <u>Pros</u>	pective		
Total I	Interim		X To	otal Prospective	
Settle	ment Based on Cost		Pr	ospective Adjust	ted For New Costs
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ed Cost			
	Field Audite	ed Cost			
			- IV	7	
DISTRIBUTION:			AT		
Fiscal Agent			1		
Contract Management				Samuel, Adminis	
Program Finance			Medica	id Program Finar	nce
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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department 34 South Baldwin Avenue				Prov	vider Number	: 0279242-0	00		
				Date: 07/11/2018			8		
Arcadia, FL 3	3821					Fis	cal Year End	06/30/201	7
							Audit Status	: Unaudited	Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				125	.86	11	5.51	07/01/2018
Rate Type									
	<u>Interim</u>				Х	Prospect	tive		
	-	Total Interim				- x	Total F	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				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIO							TR		
Fiscal Age							1 •		
Contract N	-	ent					Rydell Samu		
Program F	Finance						Medicaid Pr	ogram Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Departmer	nt	Prov	ider Number: 0279242-0)2
34 South Baldwin Avenue		Date: 07/11/2018		
Arcadia, FL 33821	 Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	125.86	115.51	07/01/2018
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 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

DeSoto County Health Departmer	Prov	ider Number: 0279242-0	03	
34 South Baldwin Avenue		Date: 07/11/2018		
Arcadia, FL 33821	Fiso	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	125.86	115.51	07/01/2018
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 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

DeSoto County Health Departmer	nt	Prov	ider Number: 0279242-0)4
34 South Baldwin Avenue		Date: 07/11/2018		
Arcadia, FL 33821	 Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	125.86	115.51	07/01/2018
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	wed Cost		
	Desk Audite	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

DeSoto County Health Department		Provider N	umber: 0279242-1	1
34 South Baldwin Avenue		Date: 07/11/2018		8
Arcadia, FL 33821		Fiscal Yea	ar End: 06/30/201	7
		Audit	Status: Unaudited	Cost
<u>Provider Type</u>	Current	Rate	New Rate	Effective Date
CHD	125.3	86	115.51	07/01/2018
Rate Type Interim	х	<u>Prospective</u>		
Total Interim		-	Total Prospective	
Settlement Based on Co	ost			ted For New Costs
X Un: De: De:	dget audited Cost sk Reviewed Cost sk Audited Cost eld Audited Cost			
DISTRIBUTION: Fiscal Agent		K	R	
Contract Management		Rydel	Samuel, Adminis	trator
Program Finance			aid Program Finar	

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department	nt	Prov	ider Number: 0279242-3	30
34 South Baldwin Avenue		Date: 07/11/2018		
Arcadia, FL 33821	Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	125.86	115.51	07/01/2018
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 Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			[N]	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department	nt	Prov	ider Number: 0279242-9	91
34 South Baldwin Avenue		Date: 07/11/2018		
Arcadia, FL 33821	Fiso	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	125.86	115.51	07/01/2018
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 Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			R	
Fiscal Agent			[N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Dixie County	Health De	partment			Provi	der Number:	0279251-0	0
149 NE 241S	Т					Date:	07/11/2018	3
Cross City, FL 32628				Fisc	al Year End:	06/30/2017	7	
						Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			169	.54	130	0.76	07/01/2018
Rate Type								
	_ <u>Interim</u>			X	Prospecti			
		Total Interim			X		rospective	
		Settlement Base	ed on Cost			Prospe	ctive Adjust	ed For New Costs
		B	ASIS:					
			Budget					
			X Unaudite	d Cost				
			 Desk Rev	viewed Cost				
			 Desk Aud	dited Cost				
				lited Cost				
DISTRIBUTIO	<u>DN:</u>					TR		
Fiscal Ag	ent					M		
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

Dixie County Health Department 149 NE 241ST Cross City, FL 32628				Provider Number: 0279251-91 Date: 07/11/2018			
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>			169	.54	130.76	07/01/2018	
Rate Type							
Interii	<u>n</u>		Х	Prospective	<u>)</u>		
	Total Interim			- X	Total Prospective		
	Settlement Ba	ased 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					PV .		
Contract Manage	ment			Rv	dell Samuel, Adminis	strator	
Program Finance					dicaid Program Fina		
State Health Offic	ce						



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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Dep	artment			Provide	er Number:	0279269-00	
515 West Sixth Street				Date: 07/11/2018			
Jacksonville, FL 32206				Fiscal	Year End:	06/30/2017	
				Αι	udit Status:	Unaudited C	ost
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>		-	169	.54	169	9.57	07/01/2018
Rate Type							
Interim			Х	Prospectiv	<u>e</u>		
	Total Interim			X	Total P	rospective	
	Settlement Based	on Cost			Prospe	ctive Adjusted	d For New Costs
	BA	<u>SIS:</u>					
		Budget					
	Х	Unaudited	Cost				
		Desk Revi	ewed Cost				
		Desk Audi	ted Cost				
		Field Audit	ted Cost				
DISTRIBUTION:				2	IR		
Fiscal Agent					P()		
Contract Managemer	nt			R	ydell Samu	el, Administra	ator
Program Finance				М	edicaid Pro	ogram Financ	e
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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	Prov	ider Number: 0279269-0	01		
515 West Sixth Street			Date: 07/11/201	: 07/11/2018	
Jacksonville, FL 32206	Fise	cal Year End: 06/30/201	7		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.54	169.57	07/01/2018	
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	l Cost			
	Desk Revi	iewed Cost			
	 Desk Audi	ited Cost			
	Field Audi	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			7		
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 Departm	Prov	ider Number: 0279269-0	02		
515 West Sixth Street			Date: 07/11/201	: 07/11/2018	
Jacksonville, FL 32206	Fiso	cal Year End: 06/30/201	7		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.54	169.57	07/01/2018	
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 Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audi	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			۲N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	Prov	ider Number: 0279269-0)3		
515 West Sixth Street			Date: 07/11/201	: 07/11/2018	
Jacksonville, FL 32206	Fiso	cal Year End: 06/30/201	7		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.54	169.57	07/01/2018	
Rate Type					
Interim		X Prospect	ive		
Total	Interim	X	Total Prospective		
Settle	ment 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			(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 Depart	tment	Provi	der Number: 0279269-	04
515 West Sixth Street			Date: 07/11/201	8
Jacksonville, FL 32206	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	ve	
Tot	tal Interim	X	Total Prospective	
Set	ttlement 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	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departr	nent	Provi	der Number: 0279269-	05	
515 West Sixth Street			Date: 07/11/201	: 07/11/2018	
Jacksonville, FL 32206	Fisc	al Year End: 06/30/201	7		
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Tota	al Interim	X	Total Prospective		
Sett	tlement 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			rv,		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departn	nent	Provi	der Number: 0279269-1	1
515 West Sixth Street			Date: 07/11/2018	3
Jacksonville, FL 32206	Fisc	al Year End: 06/30/2017	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospecti		
Tota	al Interim	X	Total Prospective	
Sett	lement Based on Cost		Prospective Adjust	ed For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			r v	
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 Depart	tment	Provi	der Number: 0279269-	43
515 West Sixth Street			Date: 07/11/201	8
Jacksonville, FL 32206	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		169.54	169.57	07/01/2018
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	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	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departm	ient	Prov	ider Number: 0279269-4	45	
515 West Sixth Street			Date: 07/11/201	: 07/11/2018	
Jacksonville, FL 32206	Fiso	cal Year End: 06/30/201	7		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total	l Interim	X	Total Prospective		
Settle	ement 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			۲N		
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 Depar		Provide	r Number: (0279269-46		
515 West Sixth Street		Date		: 07/11/2018		
Jacksonville, FL 32206			Fiscal	- Year End: (06/30/2017	
			Au	dit Status:	Unaudited Cos	st
Provider Type		Curren	t Rate	New I	Rate	Effective Date
<u>CHD</u>		169	.54	169.	.57	07/01/2018
Rate Type						
Interim		Х	Prospective	<u>}</u>		
То	otal Interim		X	Total Pro	ospective	
Se	ettlement Based on Co	ost		Prospec	tive Adjusted F	For New Costs
	BASIS:					
		dget				
	X Una	audited Cost				
	Des	sk Reviewed Cost				
	Des	sk Audited Cost				
	Fiel	ld Audited Cost				
DISTRIBUTION:			-	TR		
Fiscal Agent				7N		
Contract Management			Ry	dell Samue	el, Administrato	or
Program Finance			Me	edicaid Prog	gram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departr	nent	Provi	der Number: 0279269-{	52	
515 West Sixth Street			Date: 07/11/201	07/11/2018	
Jacksonville, FL 32206		Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X <u>Prospect</u>	ve		
Tota	al Interim	X	Total Prospective		
Sett	tlement 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			M		
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 Departm	ient	Prov	ider Number: 0279269-5	53
515 West Sixth Street Jacksonville, FL 32206			Date: 07/11/2018	
		Fiso	cal Year End: 06/30/201	7
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total	l Interim	X	Total Prospective	
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	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

Duval County Health Departr	nent	Prov	ider Number: 0279269-8	39
515 West Sixth Street Jacksonville, FL 32206			Date: 07/11/2018	
		Fisc	cal Year End: 06/30/201	7
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Tota	al Interim	X	Total Prospective	
Sett	tlement 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			N٦	
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	91
515 West Sixth Street Jacksonville, FL 32206			Date: 07/11/2018	
		Fiso	cal Year End: 06/30/201	7
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total	Interim	X	Total Prospective	
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revi	iewed Cost		
	Desk Audi	ited Cost		
	Field Audi	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			N 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 Departr	nent	Provi	der Number: 0279269-9	93	
515 West Sixth Street			Date: 07/11/201	07/11/2018	
Jacksonville, FL 32206		Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	<u>ve</u>		
Tota	al Interim	X	Total Prospective		
Sett	tlement 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			M		
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 Depar	rtment		Provide	r Number: 02	79269-95	
515 West Sixth Street			Date: 0		07/11/2018	
Jacksonville, FL 32206			Fiscal	Year End: 06	/30/2017	
			Au	dit Status: Un	audited Cos	t
Provider Type		Curren	t Rate	<u>New Ra</u>	<u>te</u>	Effective Date
<u>CHD</u>		169	.54	169.57	7	07/01/2018
Rate Type						
<u>Interim</u>		Х	Prospective	<u>)</u>		
То	otal Interim		- x	Total Prosp	pective	
Se	ettlement Based on Cos	st		Prospectiv	e Adjusted F	or New Costs
	BASIS:					
	Budg	get				
	X Una	udited Cost				
	Desl	k Reviewed Cost				
	Desl	k Audited Cost				
	Field	d Audited Cost				
DISTRIBUTION:			-	TR		
Fiscal Agent				rv .		
Contract Management			Ry	dell Samuel,	Administrato	<u>r</u>
Program Finance			Me	edicaid Progra	m Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Depart	ment	Prov	ider Number: 0279269-	96	
515 West Sixth Street			Date: 07/11/201	07/11/2018	
Jacksonville, FL 32206		Fise	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Tot	al Interim	X	Total Prospective		
Set	tlement 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			M		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	ince	

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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: 07/11/201	8
Jacksonville, FL 32206		Fiso	cal Year End: 06/30/201	7
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total	Interim	X	Total Prospective	
Settle	ment Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	d Cost		
	Desk Rev	iewed Cost		
	Desk Aud	lited Cost		
	Field Aud	ited Cost		
DISTRIBUTION:			TR	
Fiscal Agent			rv.	
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 Depart	tment	Prov	ider Number: 0279269-	98	
515 West Sixth Street			Date: 07/11/201	07/11/2018	
Jacksonville, FL 32206		Fiso	cal Year End: 06/30/201	17	
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	ive		
To	otal Interim	X	Total Prospective		
Se	ettlement Based on Cost		Prospective Adjus	sted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	d Cost			
	Desk Rev	viewed Cost			
	Desk Aud	lited Cost			
	Field Aud	ited Cost			
DISTRIBUTION:			TR		
Fiscal Agent			M		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	ance	

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Departmen	t	Prov	ider Number: 0279285-0	00	
P. O. Box 847301 South Lemon Street Bunnell, FL 32110-0847			Date: 07/11/201	e: 07/11/2018	
		Fiso	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	I Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	153.23	147.20	07/01/2018	
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	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

Flagler County Health Departr	ment	Provi	ider Number: 0279285-0)1	
P. O. Box 847301 South Lemon Street			Date: 07/11/201	018	
Bunnell, FL 32110-0847		Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	153.23	147.20	07/01/2018	
Rate Type					
<u>Interim</u>		X <u>Prospect</u>	ive		
Tota	I Interim	X	Total Prospective		
Settle	ement Based on Cost		Prospective Adjust	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi				
	Desk Audit				
	Field Audit				
DISTRIBUTION:			TR		
Fiscal Agent			μ		
Contract Management			Rydell Samuel, Adminis	trator	
Program Finance		-	Medicaid Program Finar		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department		Provider	Number: 0279285-0	02	
P. O. Box 847301 South Lemon Stree	et	Date: 07/11/2		//11/2018	
Bunnell, FL 32110-0847		Fiscal Y	ear End: 06/30/201	7	
		Aud	it Status: Unaudited	l Cost	
Provider Type	Current	t Rate	New Rate	Effective Date	
CHD	153.	23	147.20	07/01/2018	
Rate Type Interim	х	Prospective			
Total Interim	 1	X	Total Prospective		
Settlement E	Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost		_		
DISTRIBUTION: Fiscal Agent Contract Management		Ryd	F lell Samuel, Adminis	strator	

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Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health D	epartment		Provider	Number: 0279285-	03	
P. O. Box 847301 South	Lemon Street			Date: 07/11/201	07/11/2018	
Bunnell, FL 32110-0847	7		Fiscal Y	ear End: 06/30/201	7	
			Aud	t Status: Unaudited	d Cost	
Provider Type		Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>		153	.23	147.20	07/01/2018	
Rate Type						
Interim		Х	Prospective			
	Total Interim		- x	Total Prospective		
Settlement Based on Cost		n Cost		Prospective Adjus	sted For New Costs	
	BASI	IS.		-		
		Budget				
		Unaudited Cost				
		Desk Reviewed Cost				
		Desk Audited Cost				
		Field Audited Cost				
DISTRIBUTION:			~	R		
Fiscal Agent			f	N V		
Contract Manageme	ent		Rvd	ell Samuel, Adminis	strator	
Program Finance				licaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Heal	th Department			Provide	er Number: 02	79285-04	
P. O. Box 847301 S	outh Lemon Street				Date: 07	07/11/2018	
Bunnell, FL 32110-	0847			Fiscal	Year End: 06	/30/2017	
				Αι	udit Status: Un	audited Cos	st
Provider Type			<u>Curren</u>	t Rate	<u>New Ra</u>	te	Effective Date
<u>CHI</u>	<u>)</u>		153	.23	147.20	0	07/01/2018
Rate Type							
Inter	im		Х	Prospective	<u>e</u>		
	Total Interim			- X	Total Prosp	pective	
	Settlement Ba	ased on Cost			Prospectiv	e Adjusted F	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					M		
Contract Manag	jement			R	ydell Samuel, <i>i</i>	Administrato	or
Program Finance	e			M	edicaid Progra	m Finance	—

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Depar	tment	Provi	der Number: 0279285-0)5	
P. O. Box 847301 South Len	non Street		Date: 07/11/201	07/11/2018	
Bunnell, FL 32110-0847		Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	153.23	147.20	07/01/2018	
Rate Type					
<u>Interim</u>		X <u>Prospect</u>	ve		
Tota	al Interim	X	Total Prospective		
Settlement Based on Cost			Prospective Adjust	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie				
	Desk Audit				
	Field Audit				
DISTRIBUTION:			TR		
Fiscal Agent			PU		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance		-	Medicaid Program Finar		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Departm	ent	Prov	ider Number: 0279285-0	06	
P. O. Box 847301 South Lemor	n Street		Date: 07/11/201	07/11/2018	
Bunnell, FL 32110-0847		Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	153.23	147.20	07/01/2018	
Rate Type					
<u>Interim</u>		X <u>Prospect</u>	ive		
Total I	nterim	X	Total Prospective		
Settlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
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	Field Audit				
DISTRIBUTION:			TR		
Fiscal Agent			PU		
Contract Management			Rydell Samuel, Adminis	trator	
Program Finance			Medicaid Program Final		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department		Provider	Number: 0279285-0	07
P. O. Box 847301 South Lemon Street		Date: 07/11/201	07/11/2018	
Bunnell, FL 32110-0847	Fiscal Y	ear End: 06/30/201	7	
		Aud	it Status: Unaudited	l Cost
Provider Type	Current	t Rate	New Rate	Effective Date
CHD	153.	23	147.20	07/01/2018
Rate Type Interim	Х	Prospective		
Total Interim		X	Total Prospective	
Settlement B	ased on Cost		Prospective Adjus	ted For New Costs
	BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost		_	
DISTRIBUTION: Fiscal Agent Contract Management		Ryd	R lell Samuel, Adminis	strator_

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Healt	h Department			Provid	er Number:	0279285-08	
P. O. Box 847301 Se	outh Lemon Street				Date:	07/11/2018	
Bunnell, FL 32110-0)847			Fisca	I Year End:	06/30/2017	
				А	udit Status:	Unaudited Co	st
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CH</u>	<u>)</u>		153	.23	147	.20	07/01/2018
Rate Type							
Inter	<u>im</u>		Х	Prospectiv	<u>/e</u>		
	Total Interim			- x	Total Pro	ospective	
	Settlement Ba	sed on Cost			Prospec	tive Adjusted	For New Costs
		BASIS:					
		Budget					
		X Unaudited	l Cost				
		 Desk Revi	iewed Cost				
		 Desk Aud	ited Cost				
		 Field Audi	ted Cost				
DISTRIBUTION:					TR		
Fiscal Agent					M		
Contract Manag	ement			F	ydell Samue	el, Administrate	or
Program Financ	e			N	ledicaid Pro	gram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health	Department			Provi	der Number:	0279285-09		
P. O. Box 847301 Sou	th Lemon Street				Date:	07/11/2018	07/11/2018	
Bunnell, FL 32110-084	47			Fisc	al Year End:	06/30/2017		
				ŀ	Audit Status:	Unaudited Co	ost	
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date	
<u>CHD</u>			153	.23	147	20	07/01/2018	
Rate Type								
Interim	1		Х	<u>Prospecti</u>	ve			
	Total Interim			- x	Total P	ospective		
Settlement Based on Cost				Prospe	ctive Adjusted	For New Costs		
	- B.	ASIS:						
	<u> </u>	Budget						
		Unaudited	d Cost					
			iewed Cost					
		Desk Aud						
		Field Aud						
DISTRIBUTION:					TR			
Fiscal Agent					PU			
Contract Manager	nent				Rydell Samu	el, Administrat	tor	
Program Finance				-		gram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health	Department			Provid	der Number:	0279285-30	
P. O. Box 847301 Sou	th Lemon Street				Date:	07/11/2018	
Bunnell, FL 32110-084	47			Fisc	al Year End:	06/30/2017	
				ŀ	Audit Status:	Unaudited Co	ost
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>			153	.23	147	20	07/01/2018
Rate Type							
Interim	1		Х	Prospecti	<u>ve</u>		
	Total Interim			- x	Total P	ospective	
Settlement Based on Cost				Prospe	ctive Adjusted	For New Costs	
	– B	ASIS:					
	<u> </u>	Budget					
		Unaudited	d Cost				
			viewed Cost				
		Desk Aud					
		Field Aud					
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DISTRIBUTION:					TR		
Fiscal Agent					μ		
Contract Manager	nent			1	Rydell Samu	el, Administrat	tor
Program Finance				-		gram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Departmen	t	Provider Number: 0279293-00			
139 12th Street			Date: 07/11/201	8	
Apalachicola, FL 32320	Fiscal	Year End: 06/30/201	7		
	Au	dit Status: Unaudited	Cost		
Provider Type	Curre	ent Rate	New Rate	Effective Date	
CHD	16	9.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>	Х	Prospective	<u>)</u>		
Total Inter	im	X	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjust	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed Co	st			
	Desk Audited Cost				
	Field Audited Cost				
		-	R		
DISTRIBUTION:			AT		
Fiscal Agent		0	(•		
Contract Management			dell Samuel, Adminis		
Program Finance		Me	edicaid Program Fina	nce	
State Health Office					



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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Department		Provider Number: 0279293-01 Date: 07/11/2018			
139 12th Street					
Apalachicola, FL 32320	Fiscal Y	/ear End: 06/30/2017	7		
	Aud	lit Status: Unaudited	Cost		
<u>Provider Type</u>	Currer	nt Rate	New Rate	Effective Date	
CHD	169).54	169.57	07/01/2018	
Rate Type					
Interim	Х	Prospective			
Total Interim		– x	Total Prospective		
Settlement Ba	used on Cost		Prospective Adjust	ed For New Costs	
	BASIS:				
	Budget				
	X Unaudited Cost				
	 Desk Reviewed Cost	t			
	Desk Audited Cost				
	Field Audited Cost				
DISTRIBUTION:		-	R		
Fiscal Agent Contract Management		1			
Program Finance			dell Samuel, Administ dicaid Program Finar		
State Health Office		Med			



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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Departmen	nt		Provider Number: 0279293-30			
139 12th Street				Date: 07/11/2018	3	
Apalachicola, FL 32320			Fiscal Y	'ear End: 06/30/2017	7	
			Aud	lit Status: Unaudited	Cost	
Provider Type	<u>Cu</u>	rrent Rat	<u>e</u>	New Rate	Effective Date	
CHD		169.54		169.57	07/01/2018	
Rate Type						
Interim		X Pros	<u>spective</u>			
Total Inte	erim		Х	Total Prospective		
Settleme	nt Based on Cost			Prospective Adjust	ed For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed	Cost				
	Desk Audited Co	ost				
	Field Audited Co	ost				
			/	P		
DISTRIBUTION: Fiscal Agent			1	AT .		
Contract Management			Rvo	dell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office				-		



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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Departmer	nt		Provider Number: 0279293-92			
139 12th Street				8		
Apalachicola, FL 32320			Fiscal Y	'ear End: 06/30/201	7	
			Aud	lit Status: Unaudited	Cost	
<u>Provider Type</u>	<u>Cı</u>	urrent	t Rate	New Rate	Effective Date	
CHD		169.	.54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	rim		X	Total Prospective		
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs	
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	BASIS:					
	Budget					
	X Unaudited Cost	t				
	Desk Reviewed	l Cost				
	Desk Audited C	ost				
	Field Audited Co	ost				
DISTRIBUTION:			_	TR		
Fiscal Agent			1	av		
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

Franklin County Health Departme	nt		Provider	Number: 0279293-9	93	
139 12th Street			Date: 07/11/2018			
Apalachicola, FL 32320			Fiscal Y	'ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>c</u>	Curren	t Rate	New Rate	Effective Date	
CHD		169	.54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	erim		X	Total Prospective		
Settleme	ent Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited Cos	st				
	Desk Reviewe	ed Cost				
	Desk Audited	Cost				
	Field Audited	Cost				
DISTRIBUTION:			-	TR		
Fiscal Agent			1	av		
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

Gadsden County Health Department	Prov	ider Number: 0279307-0	00	
P. O. Box 1000		Date: 07/11/201	: 07/11/2018	
Quincy, FL 32353-1000	Fisc	al Year End: 06/30/201	7	
		Audit Status: Unaudited	l Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	169.54	169.57	07/01/2018	
Rate Type				
<u>Interim</u>	X Prospect	ive		
Total Interim	Х	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		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 Departme	ent		Provider	Number: 0279307-0)1
P. O. Box 1000				8	
Quincy, FL 32353-1000			Fiscal Y	'ear End: 06/30/2017	7
			Aud	it Status: Unaudited	Cost
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>	_	169	.54	169.57	07/01/2018
Rate Type					
<u>Interim</u>		Х	Prospective		
Total Inte	erim		- x	Total Prospective	
Settleme	ent Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited Co	ost			
	Desk Review	ed Cost			
	Desk Audited	Cost			
	Field Audited	Cost			
DISTRIBUTION:			-	IR	
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

Gadsden County Health Department	t		Provider	Number: 0279307-0)2
P. O. Box 1000			Date: 07/11/2018		
Quincy, FL 32353-1000			Fiscal Y	'ear End: 06/30/201	7
			Aud	it Status: Unaudited	Cost
<u>Provider Type</u>		<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>	_	169	.54	169.57	07/01/2018
Rate Type					
Interim		Х	Prospective		
Total Interin	n		- x	Total Prospective	
Settlement	Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited Co	ost			
	Desk Review	ed Cost			
	Desk Audited	Cost			
	Field Audited	Cost			
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DISTRIBUTION: Fiscal Agent			1		
Contract Management			Ryc	lell Samuel, Adminis	trator
Program Finance				dicaid Program Finar	
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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Departme	ent		Provider	Number: 0279307-0)4
P. O. Box 1000				8	
Quincy, FL 32353-1000			Fiscal Year End: 06/30/2017		
			Aud	lit Status: Unaudited	Cost
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>		169	.54	169.57	07/01/2018
Rate Type					
Interim		Х	Prospective		
Total Inte	erim		×	Total Prospective	
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited Co	ost			
	Desk Review	ved Cost			
	Desk Audited	d Cost			
	Field Audited	d Cost			
DISTRIBUTION:			-	IR	
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

Gadsden County Health Department	t		Provider	Number: 0279307-1	12	
P. O. Box 1000			Date: 07/11/2018			
Quincy, FL 32353-1000			Fiscal Y	/ear End: 06/30/201	7	
			Aud	lit Status: Unaudited	Cost	
Provider Type	<u>(</u>	Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>		169	.54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interir	n		- x	Total Prospective		
Settlement	Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited Co	st				
	Desk Reviewe	ed Cost				
	Desk Audited	Cost				
	Field Audited	Cost				
			~	TR		
DISTRIBUTION: Fiscal Agent			1			
Contract Management			Ryc	dell Samuel, Adminis	strator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Departm	ent		Provider	Number: 0279307-3	30	
P. O. Box 1000			Date: 07/11/2018		5	
Quincy, FL 32353-1000			Fiscal Y	'ear End: 06/30/201	7	
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>	_	169.	.54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inte	ərim		×	Total Prospective		
Settleme	ent Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited C	Cost				
	Desk Review	wed Cost				
	Desk Audite	d Cost				
	Field Audited	d Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	N		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office						



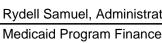
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Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Departm	nent	Prov	ider Number: 0279315-0	00
119 N.E. First Street			Date: 07/11/201	8
Trenton, FL 32693-3459		 Fisc	al Year End: 06/30/201	7
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		123.75	129.00	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	ive	
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	iewed Cost		
	Desk Aud	ited Cost		
	Field Audi	ited Cost		
DISTRIBUTION:			TR	
Fiscal Agent			۲۷ ا	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Departme	nt	Provi	ider Number: 0279315-9	91		
119 N.E. First Street		Date: 07/11/201	: 07/11/2018			
Trenton, FL 32693-3459		Fisc				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	_	123.75	129.00	07/01/2018		
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			/ N			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Departme	nt		Provider	Number: 0279323-0	00
P. O. Box 489			Date: 07/11/2018		
Moore Haven, FL 33471			Fiscal Y	'ear End: 06/30/201	7
			Aud	it Status: Unaudited	Cost
Provider Type		Current Ra	<u>ate</u>	New Rate	Effective Date
CHD	-	124.14		169.57	07/01/2018
Rate Type					
<u>Interim</u>		X <u>Pr</u>	<u>ospective</u>		
Total In	terim		Х	Total Prospective	
Settlem	ent 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			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

Glades County Health Dep	partment		Provider	Number: 0279323-3	80	
P. O. Box 489			Date: 07/11/2018			
Moore Haven, FL 33471			Fiscal Y	ear End: 06/30/2017	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>		124.1	4	169.57	07/01/2018	
Rate Type						
Interim		<u> </u>	Prospective			
Т	otal Interim		Х	Total Prospective		
s	Settlement Based on Cost	-		Prospective Adjust	ed For New Costs	
		-		_		
	BASIS:					
	Budget					
	X Unaudit	ted Cost				
	Desk Re	eviewed Cost				
	Desk Au	udited Cost				
	Field Au	udited Cost				
			/	TR		
DISTRIBUTION: Fiscal Agent			f	AT .		
Contract Managemen	t		Ryd	ell 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 Departmen	t		Provider	Number: 0279323-9	91	
P. O. Box 489			Date: 07/11/2018			
Moore Haven, FL 33471			Fiscal Year End: 06/30/2017			
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>Cı</u>	ırren	t Rate	New Rate	Effective Date	
CHD		124	.14	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	erim		X	Total Prospective		
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed	Cost				
	Desk Audited Co	ost				
	Field Audited Co	ost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	N .		
Contract Management			Ryd	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

Gulf County Health Department			Provider Number: 0279331-00			
2475 Garrison Avenue				8		
Port St. Joe, FL 32456-5265			Fiscal Y	'ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>C</u>	Curren	t Rate	New Rate	Effective Date	
CHD		169.	.54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	rim		X	Total Prospective		
Settlement Based on Cost				Prospective Adjust	ted For New Costs	
	DA 010					
	BASIS:					
	Budget					
	X Unaudited Cos					
	Desk Reviewed					
	Desk Audited (
	Field Audited C	Cost				
DISTRIBUTION:			_	R		
Fiscal Agent			1	N N		
Contract Management			Ryd	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

Gulf County Health Department			Provider Number: 0279331-01			
2475 Garrison Avenue				8		
Port St. Joe, FL 32456-5265			Fiscal Y	ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>Cu</u>	irren	t Rate	New Rate	Effective Date	
CHD		169	.54	169.57	07/01/2018	
Rate Type						
Interim	_	Х	Prospective			
Total Inter	rim		X	Total Prospective		
Settlement Based on Cost				ted For New Costs		
				-		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed	Cost				
	Desk Audited Co	ost				
	Field Audited Co	ost				
DISTRIBUTION: Fiscal Agent			Ĩ	F		
Contract Management			Ryd	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

Gulf County Health Department			Provider Number: 0279331-03 Date: 07/11/2018			
2475 Garrison Avenue						
Port St. Joe, FL 32456-5265			Fiscal Y	ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>Cı</u>	urrent	Rate	New Rate	Effective Date	
CHD		169.	54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inte	erim		Х	Total Prospective		
Settlement Based on Cost				Prospective Adjust	ted For New Costs	
				-		
	BASIS:					
	Budget					
	X Unaudited Cost	t				
	Desk Reviewed	d Cost				
	Desk Audited C	Cost				
	Field Audited C	ost				
DISTRIBUTION:			-	TR		
Fiscal Agent			f			
Contract Management			Ryd	ell Samuel, Adminis	trator	
Program Finance			Med	licaid Program Finar	nce	
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department		Provider Number: 0279331-05			
2475 Garrison Avenue			8		
Port St. Joe, FL 32456-5265	Fiscal `	Year End: 06/30/201	7		
		Aud	dit Status: Unaudited	Cost	
Provider Type	Curre	ent Rate	New Rate	Effective Date	
CHD	16	9.54 _	169.57	07/01/2018	
Rate Type					
Interim	X	Prospective			
Total Inter	im	X	Total Prospective		
Settlement Based on Cost			ted For New Costs		
			_		
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed Co	st			
	Desk Audited Cost				
	Field Audited Cost				
DISTRIBUTION: Fiscal Agent		-	R		
Contract Management		Rye	dell Samuel, Adminis	trator	
Program Finance			dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department			Provider Number: 0279331-07			
2475 Garrison Avenue				8		
Port St. Joe, FL 32456-5265			Fiscal Y	ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>Cı</u>	urren	t Rate	New Rate	Effective Date	
CHD		169	.54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inter	rim		- X	Total Prospective		
Settlement Based on Cost				ted For New Costs		
				_		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed	Cost				
	Desk Audited C	ost				
	Field Audited Co	ost				
DISTRIBUTION: Fiscal Agent			1	F		
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department			Provider Number: 0279331-11 Date: 07/11/2018			
2475 Garrison Avenue						
Port St. Joe, FL 32456-5265			Fiscal Year E	nd: 06/30/201	7	
		Audit Sta	tus: Unaudited	Cost		
Provider Type		Current Rate	<u>N</u>	ew Rate	Effective Date	
<u>CHD</u>	_	169.54		169.57	07/01/2018	
Rate Type						
<u>Interim</u>		X <u>Pros</u>	<u>pective</u>			
Total Int	erim		X Tota	al Prospective		
Settlement Based on Cost			Pro	spective Adjust	ted For New Costs	
	BASIS:					
	Budget	_				
	X Unaudited C					
	Desk Revie	wed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			M			
Contract Management			Rydell Sa	amuel, Adminis	strator	
Program Finance				Program Final		
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department		Prov	Provider Number: 0279331-19				
2475 Garrison Avenue		_	Date: 07/11/2018				
Port St. Joe, FL 32456-5265			cal Year End: 06/30/201	7			
		_	Audit Status: Unaudited	Cost			
Provider Type	Cur	rent Rate	New Rate	Effective Date			
CHD	1	69.54	169.57	07/01/2018			
Rate Type							
Interim		X Prospec	<u>tive</u>				
Total Inte	rim —	Х	Total Prospective				
Settlement Based on Cost			Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited Cost						
	Desk Reviewed C	Cost					
	Desk Audited Cos	st					
	Field Audited Cos	st					
DISTRIBUTION: Fiscal Agent			T				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final				
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Depa	artment			Provider Number: 0279331-21				
2475 Garrison Avenue				Date: 07/11/2018				
Port St. Joe, FL 32456-5265			Fiscal	Year End: 06/30/201	7			
				Αι	udit Status: Unaudited	Cost		
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date		
<u>CHD</u>		-	169	.54	169.57	07/01/2018		
Rate Type								
Interim			Х	Prospective	<u>9</u>			
	Total Interim			- X	Total Prospective			
Settlement Based on Cost				ted For New Costs				
	-							
	BA	<u>SIS:</u>						
		Budget						
	X	Unaudited	Cost					
		Desk Revi	ewed Cost					
		 Desk Audi	ted Cost					
		Field Audi	ted Cost					
DISTRIBUTION:				-	TR			
Fiscal Agent					M			
Contract Manageme	ent			Ry	/dell Samuel, Adminis	trator		
Program Finance					edicaid Program Finar			
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department			Provider Number: 0279331-30 Date: 07/11/2018			
2475 Garrison Avenue						
Port St. Joe, FL 32456-5265			Fiscal Y	ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>C</u>	urren	t Rate	New Rate	Effective Date	
CHD		169	.54	169.57	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	rim		- X	Total Prospective		
Settlement Based on Cost				ted For New Costs		
				-		
	BASIS:					
	Budget					
	X Unaudited Cos	t				
	Desk Reviewed	d Cost				
	Desk Audited C	Cost				
	Field Audited C	Cost				
DISTRIBUTION: Fiscal Agent			Ĩ	F		
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Depart	ment	Prov	rider Number: 0279340-0	00	
P. O. Box 267			Date: 07/11/2018		
Jasper, FL 32052	Fise	cal Year End: 06/30/201	7		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		144.39	114.72	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total I	nterim	x	Total Prospective		
Settler	nent Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	d Cost			
	Desk Rev	iewed Cost			
	Desk Aud	ited Cost			
	Field Audi	ited 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

Hamilton County Health De	epartment		Provider Number: 0279340-25 Date: 07/11/2018			
P. O. Box 267						
Jasper, FL 32052			Fiscal Y	ear End: 06/30/2017	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current F</u>	Rate	New Rate	Effective Date	
<u>CHD</u>		144.3	9	114.72	07/01/2018	
Rate Type						
<u>Interim</u>		Х <u></u>	<u>Prospective</u>			
T	otal Interim		Х	Total Prospective		
Settlement Based on Cost		_		ed For New Costs		
	BASIS:					
	BASIS. Budget					
	X Unaudit					
		eviewed Cost				
		udited Cost				
		udited Cost				
DISTRIBUTION:			-	F		
Fiscal Agent			1	N.		
Contract Management	•			ell Samuel, Adminis		
Program Finance			Med	licaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton Cou	nty Health	Department			Prov	ider Number	: 0279340-3	30
P. O. Box 267	7					Date	: 07/11/201	8
Jasper, FL 32052				Fiso	cal Year End	: 06/30/201	7	
						Audit Status	: Unaudited	Cost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	New	<u> Rate</u>	Effective Date
	<u>CHD</u>			144	.39	11	4.72	07/01/2018
Rate Type								
	Interim			Х	Prospect	ive		
		Total Interim			X	Total P	rospective	
		Settlement Based	I on Cost			Prospe	ective Adjus	ted For New Costs
		BA	<u>\SIS:</u>					
			Budget					
		X	Unaudited	Cost				
			Desk Rev	iewed Cost				
			Desk Aud	ited Cost				
			Field Audi	ted Cost				
DISTRIBUTIC	<u>DN:</u>					TR		
Fiscal Ag	ent					M		
Contract	Manageme	ent				Rydell Samu	uel, Adminis	strator
Program	Finance					Medicaid Pr	ogram Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County He	ealth Department		Provide	r Number: 027934	ł0-91
P. O. Box 267				Date: 07/11/2	2018
Jasper, FL 32052			Fiscal	Year End: 06/30/2	2017
			Au	dit Status: Unaudi	ted Cost
Provider Type		Currer	nt Rate	New Rate	Effective Date
<u>CH</u>	<u>D</u>	144	1.39	114.72	07/01/2018
Rate Type					
Inte	<u>rim</u>	X	Prospective	2	
	Total Interim		X	Total Prospectiv	ve
	Settlement Based or	n Cost		Prospective Ad	justed For New Costs
	BAS	<u>IS:</u>			
		Budget			
	X	Unaudited Cost			
		Desk Reviewed Cos	t		
		Desk Audited Cost			
		Field Audited Cost			
DISTRIBUTION:			-	FR	
Fiscal Agent				rv .	
Contract Manag	gement		Ry	dell Samuel, Adm	inistrator
Program Finan	ce		Me	edicaid Program Fi	inance

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Departr	ment	Prov	ider Number: 0279358-0	00
115 K.D. Revell Road		Date: 07/11/201	: 07/11/2018	
Wauchula, FL 33873	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total	Interim	X	Total Prospective	
Settle	ement 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	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Departr	nent		Provider Number: 0279358	-01		
115 K.D. Revell Road			Date: 07/11/2018			
Wauchula, FL 33873			Fiscal Year End: 06/30/20	17		
			Audit Status: Unaudite	ed Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	169.54	169.57	07/01/2018		
Rate Type						
Interim		X <u>Pros</u>	<u>pective</u>			
Total	Interim		X Total Prospective)		
Settle	ement Based on Cost		Prospective Adju	sted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audite	ed Cost				
			_			
DISTRIBUTION:			-UK			
Fiscal Agent			[N			
Contract Management			Rydell Samuel, Admini	istrator		
Program Finance			Medicaid Program Fina	ance		
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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Dep	partment	Provi	Provider Number: 0279358-09		
115 K.D. Revell Road			Date: 07/11/201	8	
Wauchula, FL 33873	Fisc	al Year End: 06/30/201	7		
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Тс	otal 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 Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			ſŇ		
Contract Management	i	_	Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County He	alth Department			Provide	r Number: 0279358-3	30	
115 K.D. Revell Ro	bad			Date: 07/11/2018			
Wauchula, FL 338	373			Fiscal	Year End: 06/30/201	7	
				Au	dit Status: Unaudited	Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>C</u> H	<u>ID</u>		169	.54	169.57	07/01/2018	
Rate Type							
Inte	<u>erim</u>		Х	Prospective	2		
	Total Interim			- X	Total Prospective		
	Settlement B	ased 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:				-	at		
Fiscal Agent				3	/ `		
Contract Mana	agement			Ry	dell Samuel, Adminis	trator	
Program Finar	nce			Me	edicaid Program Finar	nce	
State Health C	Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Department	Pro	ovider Number: 0279366-	00
P. O. Box 70		Date: 07/11/201	8
LaBelle, FL 33975	Fi	scal Year End: 06/30/201	7
		Audit Status: Unaudited	d Cost
Provider Type	Current Rate	New Rate	Effective Date
CHD	169.54	169.57	07/01/2018
Rate Type			
<u>Interim</u>	X Prospec	<u>ctive</u>	
Total Interim	X	Total Prospective	
Settlement Based on Co	st	Prospective Adjus	ted For New Costs
BASIS:			
Budg	get		
XUna	udited Cost		
Desi	k Reviewed Cost		
Desi	k Audited Cost		
Field	d Audited Cost		
DISTRIBUTION:		TR	
Fiscal Agent		M	
Contract Management		Rydell Samuel, Adminis	strator
Program Finance		Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Departmen	t	Р	Provider Number: 0279366-30 Date: 07/11/2018		
P. O. Box 70					
LaBelle, FL 33975			Fiscal Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost	
Provider Type	Cu	rrent Rate	New Rate	Effective Date	
CHD		169.54	169.57	07/01/2018	
Rate Type					
Interim		X <u>Prosp</u>	<u>ective</u>		
Total Inte	erim –		X Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	sted For New Costs	
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed	Cost			
	Desk Audited Co	st			
	Field Audited Co	st			
			-IP		
DISTRIBUTION: Fiscal Agent			A		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina		
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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Departme	nt		Provider	Number: 0279366-9	92
P. O. Box 70			Date: 07/11/2018		
LaBelle, FL 33975			Fiscal Y	'ear End: 06/30/201	7
			Aud	it Status: Unaudited	Cost
Provider Type	9	Curren	t Rate	New Rate	Effective Date
<u>CHD</u>		169.	54	169.57	07/01/2018
Rate Type					
Interim		Х	Prospective		
Total Int	terim		x	Total Prospective	
Settlem	ent Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited Co	ost			
	Desk Review	ed Cost			
	Desk Audited	Cost			
	Field Audited	Cost			
			-	T	
DISTRIBUTION: Fiscal Agent			1	AT .	
Contract Management			Ryc	lell Samuel, Adminis	trator
Program Finance				dicaid Program Finar	
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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Health Department	Prov	vider Number: 0279374-0	00
300 S. Main St.		Date: 07/11/201	8
Brooksville, FL 34601	Fise	cal Year End: 06/30/201	7
		Audit Status: Unaudited	Cost
Provider Type	Current Rate	New Rate	Effective Date
CHD	143.47	169.57	07/01/2018
Rate Type	× -	_	
<u>Interim</u>	X Prospect		
Total Interim	X	Total Prospective	
Settlement 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			
DISTRIBUTION:		R	
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

Hernando County He	alth Department			Provider	Number: 0279374-9	91
300 S. Main St.					Date: 07/11/2018	8
Brooksville, FL 3460	1			Fiscal `	Year End: 06/30/201	7
				Aud	dit Status: Unaudited	Cost
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>			143	.47	169.57	07/01/2018
Rate Type						
Interi	<u>n</u>		Х	Prospective		
	Total Interim			- X	Total Prospective	
	Settlement Ba	ased 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:				-	R	
Fiscal Agent				1	PU	
Contract Manage	ement			Ry	dell Samuel, Adminis	trator
Program Finance					dicaid Program Finar	
State Health Offic	ce					



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Hea	Ith Department			Provide	r Number: 0279	374-92
300 S. Main St.					Date: 07/11	/2018
Brooksville, FL 34601			Fiscal	Year End: 06/30)/2017	
				Au	dit Status: Unau	dited Cost
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>			143	.47	169.57	07/01/2018
Rate Type						
Interim	1		Х	Prospective	<u>)</u>	
	Total Interim			- x	Total Prospec	tive
	Settlement Bas	sed on Cost			Prospective A	Adjusted For New Costs
					_	
	_	BASIS:				
		Budget				
	-	X Unaudited	Cost			
	-	Desk Revi	ewed Cost			
	-	Desk Audi	ted Cost			
	-	Field Audi	ted Cost			
				-	IR	
DISTRIBUTION: Fiscal Agent					pt -	
Contract Manager	nent			Rv	' dell Samuel, Ad	ministrator
Program Finance					edicaid Program	
State Health Office	Э				-	



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Highlands County Health Departm	ent	Prov	ider Number: 0279382-	00	
7205 South George Boulevard			Date: 07/11/201	: 07/11/2018	
Sebring, FL 33872	 Fiso	al Year End: 06/30/201	7		
			Audit Status: Unaudited	d Cost	
Provider Type	<u>C</u>	Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.54	160.79	07/01/2018	
Rate Type Interim		X <u>Prospect</u>	ive		
Total Inte	rim	X	Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	sted For New Costs	
	BASIS: Budget X Unaudited Cost Desk Reviewe Desk Audited Cost Field Audited Cost	d Cost Cost			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance			Rydell Samuel, Adminis Medicaid Program Fina		

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Highlands County Health Departm	ent	Provi	der Number: 0279382-9	91		
7205 South George Boulevard		_	Date: 07/11/2018			
Sebring, FL 33872			al Year End: 06/30/201	7		
		-	Audit Status: Unaudited	l Cost		
Provider Type	Curr	ent Rate	New Rate	Effective Date		
CHD	1	69.54	160.79	07/01/2018		
Rate Type						
Interim		X <u>Prospecti</u>	ive			
Total Inte	rim	X	Total Prospective			
Settlement Based on Cost			ted For New Costs			
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed C	ost				
	Desk Audited Cos	t				
	Field Audited Cos	t				
DISTRIBUTION:			TR			
Fiscal Agent			(N			
Contract Management		_	Rydell Samuel, Adminis	strator		
Program Finance		-	Medicaid Program Fina	nce		
State Health Office						



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Indian River County H	lealth Departmer	nt		Provider Number: 0279412-00			
1900 27th Street				Date: 07/11/2018			
Vero Beach, FL 3296	60			Fiscal `	Year End: 06/30/201	7	
				Au	dit Status: Unaudited	Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>			168	.98	153.31	07/01/2018	
Rate Type							
Interi	<u>m</u>		Х	Prospective	<u>!</u>		
	Total Interim			- x	Total Prospective		
	Settlement Ba	ased on Cost			Prospective Adjust	ted For New Costs	
		BASIS:					
		Budget					
		X Unaudited	Cost				
			ewed Cost				
		Desk Audi					
		Field Audi					
DISTRIBUTION:				~	TR		
Fiscal Agent					(N		
Contract Manage	ement			Ry	dell Samuel, Adminis	trator	
Program Finance	9			Me	dicaid Program Fina	nce	
State Health Office	се						



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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Depart	ment	Provid	Provider Number: 0279412-01			
1900 27th Street		_	Date: 07/11/201	8		
Vero Beach, FL 32960	– Fisca	al Year End: 06/30/201	7			
		_ ٩	Audit Status: Unaudited	Cost		
Provider Type	Curr	rent Rate	New Rate	Effective Date		
CHD	1	68.98	153.31	07/01/2018		
Rate Type						
Interim		X Prospectiv	ve			
Total Inte	rim	X	Total Prospective			
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed C	ost				
	Desk Audited Cos	t				
	Field Audited Cos	t				
DISTRIBUTION:		8	R			
Fiscal Agent			μ			
Contract Management		F	Rydell Samuel, Adminis	strator		
Program Finance		Ν	Medicaid Program Final	nce		
State Health Office						



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Hea	alth Department			Provider Number: 0279412-02			
1900 27th Street				Date: 07/11/2018			
Vero Beach, FL 32960			Fiscal	Year End:	06/30/2017		
				Αι	udit Status:	Unaudited C	ost
Provider Type			Curren	t Rate	New	Rate	Effective Date
<u>CHD</u>		-	168	.98	153	8.31	07/01/2018
Rate Type							
<u>Interim</u>			Х	Prospective	<u>e</u>		
	Total Interim			- x	Total P	rospective	
	Settlement Base	ed on Cost			Prospe	ctive Adjusted	d For New Costs
	_						
	<u></u>	BASIS:					
	_	Budget	-				
	_	X Unaudited					
	_		ewed Cost				
	_	Desk Audi	ted Cost				
	_	Field Audit	ted Cost				
DISTRIBUTION:					TR		
Fiscal Agent					M		
Contract Managem	ent			R	ydell Samu	el, Administra	ator
Program Finance					-	gram Financ	
State Health Office							



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County He	alth Department			Provider Number: 0279412-03			
1900 27th Street					/2018		
Vero Beach, FL 32960			Fiscal	Year End: 06/30/	/2017		
				Αι	idit Status: Unauc	dited Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		-	168	.98	153.31	07/01/2018	
Rate Type							
<u>Interim</u>			Х	Prospective	<u>e</u>		
	Total Interim			- X	Total Prospect	tive	
	Settlement Bas	ed on Cost			Prospective A	djusted For New Costs	
	-						
	<u>E</u>	BASIS:					
		Budget					
	_	X Unaudited	Cost				
	_	Desk Revi	ewed Cost				
	_	Desk Audi	ted Cost				
	_	Field Audit	ted Cost				
DISTRIBUTION:					TR		
Fiscal Agent					M		
Contract Managem	ent			R	/dell Samuel, Adn	ninistrator	
Program Finance					edicaid Program I		
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County He	alth Department			Provider Number: 0279412-04			
1900 27th Street				Date: 07/11/2018			
Vero Beach, FL 32960			Fiscal	Year End: ()6/30/2017		
				Αι	udit Status: l	Jnaudited Co	ost
Provider Type			<u>Curren</u>	t Rate	<u>New F</u>	<u>{ate</u>	Effective Date
<u>CHD</u>		-	168	.98	153.	31	07/01/2018
Rate Type							
<u>Interim</u>			Х	Prospective	<u>e</u>		
	Total Interim			- x	Total Pro	spective	
	Settlement Bas	ed on Cost			Prospect	ive Adjusted	For New Costs
	-						
	<u> </u>	BASIS:					
	_	Budget					
	_	X Unaudited	Cost				
		Desk Revi	ewed Cost				
	_	Desk Audi	ted Cost				
	-	Field Audit	ted Cost				
DISTRIBUTION:					TR		
Fiscal Agent					M		
Contract Managem	ent			R	ydell Samue	I, Administra	itor
Program Finance					-	ram Finance	
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health De	partment	Prov	ider Number: 0279412-0)5
1900 27th Street			Date: 07/11/2018	8
Vero Beach, FL 32960		Fisc	cal Year End: 06/30/201	7
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	168.98	153.31	07/01/2018
Rate Type				
Interim		X Prospect	ive	
Total	Interim	X	Total Prospective	
Settle	ment 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:			TR	
Fiscal Agent			[N]	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Finar	nce

For Information Only (No Change In Rate)

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Dep	artment	Prov	ider Number: 0279412-3	30
1900 27th Street			Date: 07/11/201	8
Vero Beach, FL 32960	Fiso	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	168.98	153.31	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Ir	nterim	X	Total Prospective	
Settlen	nent 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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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Hea	alth Department			Provider Number: 0279412-91			
1900 27th Street				Date: 07/11/2018			
Vero Beach, FL 32960			Fiscal	Year End:	06/30/2017		
				Αι	udit Status:	Unaudited (Cost
Provider Type			Curren	t Rate	New	<u>Rate</u>	Effective Date
<u>CHD</u>		-	168	.98	153	3.31	07/01/2018
Rate Type							
<u>Interim</u>			Х	Prospective	<u>e</u>		
	Total Interim			- X	Total P	rospective	
	Settlement Base	ed on Cost			Prospe	ctive Adjuste	d For New Costs
	-						
	<u> </u>	BASIS:					
		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 Samu	el, Administr	ator
Program Finance					-	ogram Finand	
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Depar	tment	Provic	Provider Number: 0279412-92			
1900 27th Street		-	Date: 07/11/2018	8		
Vero Beach, FL 32960	– Fisca	al Year End: 06/30/201	7			
		Α	udit Status: Unaudited	Cost		
Provider Type	Curr	ent Rate	New Rate	Effective Date		
CHD	1	68.98	153.31	07/01/2018		
Rate Type						
<u>Interim</u>		X Prospectiv	<u>/e</u>			
Total Inte	erim	X	Total Prospective			
Settleme	ent Based on Cost		Prospective Adjust	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed Co	ost				
	Desk Audited Cos	t				
	Field Audited Cost	t				
DISTRIBUTION:			K			
Fiscal Agent			PU			
Contract Management		F	Rydell Samuel, Adminis	trator		
Program Finance		N	ledicaid Program Finar	nce		
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health De	epartment	Pro	Provider Number: 0279412-96			
1900 27th Street			Date: 07/11/2018			
Vero Beach, FL 32960			scal Year End: 06/30/201	7		
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	_	168.98	153.31	07/01/2018		
Rate Type						
Interim		X <u>Prospec</u>	ctive			
Total	Interim	X	Total Prospective			
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			t			
Fiscal Agent			1			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Final	nce		
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health	Department			Prov	ider Number:	0279421-00	
P. O. Box 310					Date:	07/11/2018	
Marianna, FL 32447				Fisc	cal Year End:	06/30/2017	
					Audit Status:	Unaudited C	Cost
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>			103.	.96	104	4.06	07/01/2018
Rate Type							
<u>Interim</u>			Х	Prospect	ive		
	Total Interim			x	Total P	rospective	
	Settlement Based	on Cost			Prospe	ctive Adjusted	d For New Costs
	BA	<u>SIS:</u>					
		Budget					
	X	Unaudited	Cost				
		 Desk Revi	ewed Cost				
		 Desk Audi	ted Cost				
		— Field Audi	ted Cost				
		—					
DISTRIBUTION:					TR		
Fiscal Agent					7N		
Contract Manageme	ent				Rydell Samu	iel, Administra	ator
Program Finance					Medicaid Pro	ogram Financ	е

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County H	ealth Department		Pro	vider Number: 0279421-	·01	
P. O. Box 310				Date: 07/11/201	: 07/11/2018	
Marianna, FL 324	47		Fis	scal Year End: 06/30/20	17	
				Audit Status: Unaudited	d Cost	
Provider Type			Current Rate	New Rate	Effective Date	
<u>C</u> ł	<u>ID</u>		103.96	104.06	07/01/2018	
Rate Type						
<u>Inte</u>	<u>erim</u>		X Prospec	<u>tive</u>		
	Total Interi	m	X	Total Prospective		
	Settlement	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:				TR		
Fiscal Agent				M		
Contract Mana	agement			Rydell Samuel, Admini	strator	
Program Fina	nce			Medicaid Program Fina	ance	

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Depa	rtment	Provi	der Number: 0279421-	02	
P. O. Box 310			Date: 07/11/201	: 07/11/2018	
Marianna, FL 32447		Fisc	Fiscal Year End: 06/30/2017		
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	103.96	104.06	07/01/2018	
Rate Type		× -			
<u>Interim</u>	Lintarim	X Prospecti			
	I Interim	X	Total Prospective		
Setti	ement 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			M		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance		-	Medicaid Program Fina	nce	

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Depa	artment	Provi	der Number: 0279421-	03	
P. O. Box 310			Date: 07/11/201	: 07/11/2018	
Marianna, FL 32447		Fisc	Fiscal Year End: 06/30/2017		
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	103.96	104.06	07/01/2018	
Rate Type		X Prospecti			
<u>Interim</u>	al Interim	X Prospecti X	Total Prospective		
	tlement Based on Cost			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			ſN		
Contract Management			Rydell Samuel, Admini	strator	
Program Finance			Medicaid Program Fina	ance	

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County He	alth Department			Provide	r Number:	0279421-04	
P. O. Box 310				Date		: 07/11/2018	
Marianna, FL 3244	7			Fiscal Year End: 06/30/2017			
				Au	dit Status:	Unaudited Co	st
Provider Type			Current R	ate	New	Rate	Effective Date
<u>CH</u>	<u>D</u>		103.96		104	.06	07/01/2018
Rate Type							
<u>Inte</u>	<u>rim</u>		<u> </u>	ospective	<u>)</u>		
	Total Interim			Х	Total Pr	ospective	
	Settlement B	ased on Cost			Prospec	ctive Adjusted	For New Costs
		BASIS:					
		Budget					
		X Unaudited	d Cost				
		 Desk Rev	iewed Cost				
		Desk Aud	ited Cost				
		 Field Audi	ited Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent					rv.		
Contract Mana	gement			Ry	dell Samu	el, Administrat	or
Program Finan	се			Me	dicaid Pro	gram Finance	

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Hea	alth Department			Provide	r Number:	0279421-13	
P. O. Box 310				Date: 07/11/2018			
Marianna, FL 32447	7			Fiscal Year End: 06/30/2017			
				Au	dit Status:	Unaudited Co	ost
Provider Type			Current F	Rate	New	Rate	Effective Date
<u>CH</u>	<u>)</u>		103.90	<u> </u>	104	.06	07/01/2018
Rate Type							
Inter	im		X <u>P</u>	rospective	<u>)</u>		
	Total Interim			Х	Total Pr	ospective	
	Settlement Ba	ased on Cost	_		Prospec	tive Adjusted	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				5	r v		
Contract Manag	ement			Ry	dell Samue	el, Administrat	or
Program Financ	e			Me	edicaid Pro	gram Finance	

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County He	ealth Department			Provider Number:	0279421-14		
P. O. Box 310				Date:	: 07/11/2018		
Marianna, FL 3244	47			Fiscal Year End: 06/30/2017			
				Audit Status:	Unaudited Co	ost	
Provider Type			Current Rate	<u>New</u>	Rate	Effective Date	
<u>CH</u>	ID		103.96	104	4.06	07/01/2018	
Rate Type							
<u>Inte</u>	erim_		X Pros	<u>pective</u>			
	Total Interim	I		X Total P	rospective		
	Settlement E	Based on Cost		Prospe	ctive Adjusted	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				M			
Contract Mana	agement			Rydell Samu	el, Administrat	tor	
Program Finar	nce			Medicaid Pro	ogram Finance		

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County H	lealth [Department				Provider Number: 0279421-30			
P. O. Box 310						Date: 07/11/2018			8
Marianna, FL 324	147					Fiscal Year End: 06/30/2017			
							Audit Status:	Unaudited	l Cost
Provider Type	<u>)</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>C</u> ł	<u>HD</u>				103	.96	104	4.06	07/01/2018
Rate Type									
Inte	erim				Х	Prospect	<u>tive</u>		
		Total Interim				- x	Total P	rospective	
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjus	ted For New Costs
			BAS	<u>SIS:</u>					
				Budget					
			Х	_ Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTION:							TR		
Fiscal Agent							γv		
Contract Man	ageme	ent					Rydell Samu	iel, Adminis	strator
Program Fina	ince						Medicaid Pro	ogram Fina	nce

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County H	lealth [Department				Prov	/ider Number:	0279421-9	91
P. O. Box 310						Date: 07/11/2018			8
Marianna, FL 324	447					Fiscal Year End: 06/30/2017			
							Audit Status:	Unaudited	Cost
Provider Type	2				<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>C</u>	<u>HD</u>				103	.96	104	4.06	07/01/2018
Rate Type									
Int	<u>terim</u>				Х	Prospect	<u>tive</u>		
		Total Interim				- x	Total P	rospective	
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjust	ted 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							74		
Contract Man	nageme	ent					Rydell Samu	iel, Adminis	trator
Program Fina	ance						Medicaid Pro	ogram Finar	nce

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Jefferson Cou	unty Health	Department				Provider Number: 0279439-00				
1255 W. Was	hington St	reet				Date:		07/11/2018		
Monticello, FL	32344					Fiscal Year End: 06/30/2017			,	
							Audit Status	Unaudited	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.54	16	9.57	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	Prospect	<u>tive</u>			
	_	Total Interim				- x	Total P	rospective		
		Settlement B	ased o	on Cost			Prospe	ective Adjuste	ed 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, Administ	rator	
Program	Finance						Medicaid Pr	ogram Finan	се	

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Department	Prov	ider Number: 0279439-(04	
1255 W. Washington Street		Date: 07/11/201	8	
Monticello, FL 32344	Fisc	Fiscal Year End: 06/30/2017		
		Audit Status: Unaudited	I Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	169.54	169.57	07/01/2018	
Rate Type				
Interim	X Prospect	<u>ive</u>		
Total Interim	X	Total Prospective		
Settlement Based on Cost		Prospective Adjus	ted For New Costs	
BASIS:				
Budget				
X Unaudit	ted Cost			
Desk R	eviewed Cost			
Desk A	udited Cost			
Field Au	udited Cost			
DISTRIBUTION:		TR		
Fiscal Agent		PV .		
Contract Management		Rydell Samuel, Adminis	strator	
Program Finance		Medicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health	Department		Provider Number: 0279439-30				
1255 W. Washington Stre	et			8			
Monticello, FL 32344							
			Aud	dit Status: Unaudited	Cost		
Provider Type		Curren	it Rate	New Rate	Effective Date		
<u>CHD</u>		169	.54	169.57	07/01/2018		
Rate Type							
<u>Interim</u>		Х	Prospective				
	Total Interim		- X	Total Prospective			
	Settlement Based on Cos	it		Prospective Adjus	ted For New Costs		
	BASIS:						
	Budg	jet					
	X Unau	udited Cost					
	Desk	Reviewed Cost					
	Desk	Audited Cost					
	Field	Audited Cost					
DISTRIBUTION:			-	TR			
Fiscal Agent			1				
Contract Managemer	nt		Ry	dell Samuel, Adminis	trator		
Program Finance			Me	dicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Lee County Health Department		Provi	ider Number: 0279463-0	00	
3920 Michigan Avenue			Date: 07/11/2018		
Fort Myers, FL 33916		Fisc	Fiscal Year End: 06/30/2017		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.54	169.57	07/01/2018	
Rate Type		× -			
<u>Interim</u>		X Prospect			
Total Inte		X	Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			M		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Lee County Health Depart	tment	Prov	ider Number: 0279463-0)1			
3920 Michigan Avenue			Date: 07/11/2018	8			
Fort Myers, FL 33916		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		169.54	169.57	07/01/2018			
Rate Type							
<u>Interim</u>		X Prospect	ive				
т	Fotal Interim	X	Total Prospective				
s	Settlement Based on Cost		Prospective Adjust	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudite	ed Cost					
	Desk Re	viewed Cost					
	Desk Au	dited Cost					
	Field Au	dited Cost					
DISTRIBUTION:			FR				
Fiscal Agent			/ N				
Contract Managemen	ıt		Rydell Samuel, Adminis	trator			
Program Finance			Medicaid Program Finar	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Lee County Hea	ee County Health Department					Prov	/ider Number:	0279463-	04	
3920 Michigan	Avenue						Date	07/11/201	8	
Fort Myers, FL	33916					Fiscal Year End: 06/30/2017				
							Audit Status	Unaudited	d Cost	
<u>Provider Ty</u>	<u>pe</u>				<u>Currer</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.54	169	9.57	07/01/2018	
Rate Type										
Ī	Interim				Х	Prospec	<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					
				_						
DISTRIBUTION	<u>N:</u>						TR			
Fiscal Ager	nt						M			
Contract M	lanageme	ent					Rydell Samu	uel, Adminis	strator	
Program Finance							Medicaid Pro	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Department	:	Prov	ider Number: 0279471-0	00			
2965 Municipal Way			Date: 07/11/201	8			
Tallahassee, FL 32304		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		156.24	150.29	07/01/2018			
Rate Type							
Interim		X Prospect	ive				
Total Ir	iterim	X	Total Prospective				
Settler	nent Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Leon County I	on County Health Department					Prov	vider Number:	0279471-91	l	
2965 Municipa	al Way						Date	07/11/2018		
Tallahassee,	FL 32304					Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited (Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				156	.24	150	0.29	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
Settlement Base			ased o	on Cost		Prospe	ctive Adjuste	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	Managem	ent					Rydell Samu	iel, Administr	ator	
Program	Finance						Medicaid Pro	ogram Financ	ce	

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Medicaid Reimbursement Rate Change Form for CHDs

Levy County Health Departme	ent		Provider Number: 0279480-00				
P. O. Box 4066 South Main S	Street		Date: 07/11/20	18			
Bronson, FL 32621			Fiscal Year End: 06/30/2017				
			Audit Status: Unaudite	ed Cost			
Provider Type		Current Rate	<u>New Rate</u>	Effective Date			
CHD	-	169.54	169.57	07/01/2018			
Rate Type							
<u>Interim</u>		X <u>Pros</u>	spective				
Tota	al Interim		X Total Prospective	9			
Settl	lement Based on Cost		Prospective Adju	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			M				
Contract Management			Rydell Samuel, Admin	istrator			
Program Finance			Medicaid Program Fin				
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Medicaid Reimbursement Rate Change Form for CHDs

Levy County Health Department		Provider	Number: 0279480-9	91
P. O. Box 4066 South Main Street			Date: 07/11/201	8
Bronson, FL 32621		Fiscal Y	ear End: 06/30/201	7
		Aud	it Status: Unaudited	Cost
Provider Type	Curren	nt Rate	New Rate	Effective Date
<u>CHD</u>	169	9.54	169.57	07/01/2018
Rate Type Interim	х	Prospective		
Total Interim		$-\frac{10 \text{ spective}}{X}$	Total Prospective	
	ased on Cost		_	ted For New Costs
	BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost	t	_	
DISTRIBUTION: Fiscal Agent		P	F	
Contract Management Program Finance			ell Samuel, Adminis licaid Program Finar	

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department		Prov	ider Number: 0279498-	00			
P. O. Box 489247 N. Central Stree	t		Date: 07/11/20	18			
Bristol, FL 32321		Fise	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudite	d Cost			
<u>Provider Type</u>		Current Rate	New Rate	Effective Date			
CHD	-	169.54	152.54	07/01/2018			
Rate Type							
Interim		X Prospect					
Total Inte		X	Total Prospective				
Settlemer	nt Based on Cost		Prospective Adjus	sted 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, Admini	strator			
Program Finance			Medicaid Program Fina	ance			

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department		Provider I	Number: 0279498-0)8
P. O. Box 489247 N. Central Street			Date: 07/11/201	8
Bristol, FL 32321		Fiscal Ye	ear End: 06/30/201	7
		Audi	t Status: Unaudited	Cost
Provider Type	Current	t Rate	New Rate	Effective Date
<u>CHD</u>	169.	.54	152.54	07/01/2018
Rate Type Interim	Х	<u>Prospective</u>		
Total Interim		- X	Total Prospective	
Settlement Based	on Cost		Prospective Adjust	ted For New Costs
BA	SIS: Budget Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost		-	
DISTRIBUTION: Fiscal Agent Contract Management		Ryde	F ell Samuel, Adminis	trator
Program Finance		Med	icaid Program Finar	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County	berty County Health Department						Provider Number: 0279498-10				
P. O. Box 489	247 N. Ce	entral Street					Date	07/11/2018	}		
Bristol, FL 32	321					Fiscal Year End: 06/30/2017					
							Audit Status	Unaudited	Cost		
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				169	.54	152	2.54	07/01/2018		
Rate Type											
	<u>Interim</u>				Х	Prospect	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
Settlement Based o			on Cost	n Cost		Prospe	ctive Adjuste	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						γv				
Contract	Contract Management						Rydell Samu	uel, Administ	rator		
Program	Finance						Medicaid Pre	ogram Finan	се		

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County	berty County Health Department					Prov	vider Number	: 0279498-′	14
P. O. Box 489	247 N. Ce	ntral Street					Date	07/11/201	8
Bristol, FL 32	321					Fis	cal Year End	: 06/30/201	7
							Audit Status	: Unaudited	l Cost
<u>Provider Ty</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.54	15	2.54	07/01/2018
Rate Type									
	Interim				Х	Prospect	tive		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on			on Cost	Cost Prospec		ective 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				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Age	ent						/ N		
Contract I	Manageme	ent					Rydell Samu	uel, Adminis	strator
Program	Finance						Medicaid Pr	ogram Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County	berty County Health Department					Provider Number: 0279498-30				
P. O. Box 489	247 N. Ce	entral Street					Date	07/11/201	8	
Bristol, FL 32	321					Fise	cal Year End	: 06/30/201	7	
							Audit Status	: Unaudited	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.54	15	2.54	07/01/2018	
Rate Type										
	Interim				Х	Prospect	ive			
	-	Total Interim				Х	Total P	rospective		
Settlement Based on			on Cost			Prospe	ective Adjust	ted For New Costs		
			BAS	<u>SIS:</u>						
				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						74			
Contract N	Managem	ent					Rydell Samu	uel, Adminis	trator	
Program I	Finance						Medicaid Pr	ogram Finai	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County	berty County Health Department					Provider Number: 0279498-91				
P. O. Box 489	247 N. Ce	ntral Street					Date	: 07/11/201	8	
Bristol, FL 32	321					Fis	cal Year End	: 06/30/201	7	
							Audit Status	: Unaudited	l Cost	
<u>Provider Ty</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date	
	<u>CHD</u>				169	.54	15	2.54	07/01/2018	
Rate Type										
	Interim				Х	Prospect	tive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based or			on Cost	n Cost Prosp		Prospe	ective 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					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Age	ent						/ N			
Contract I	Manageme	ent					Rydell Samu	uel, Adminis	strator	
Program	Finance						Medicaid Pr	ogram Fina	nce	

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee Cou	nty Health	Department	Manatee County Health Department					Provider Number: 0279510-00				
410 Six Avenu	ue East						Date	: 07/11/201	8			
Bradenton, FL	34208					Fiscal Year End: 06/30/2017						
							Audit Status	: Unaudited	d Cost			
Provider Ty	<u>ype</u>				<u>Currer</u>	nt Rate	New	<u>/ Rate</u>	Effective Date			
	<u>CHD</u>				169	.54	16	4.99	07/01/2018			
Rate Type	Interim				x	Prospec	tive					
	-	Total Interim				- <u></u>		Prospective				
		Settlement Ba	ased c	on Cost				-	ted For New Costs			
			BAS	SIS:								
				Budget								
			X	_ Unaudited	l Cost							
				_ Desk Revi	iewed Cost	t						
				_ Desk Audi	ited Cost							
				- Field Audi	ted Cost							
				-								
DISTRIBUTIC	<u>DN:</u>						TR					
Fiscal Ag	ent						M					
Contract	Managem	ent					Rydell Sam	uel, Adminis	strator			
Program	Program Finance					Medicaid Program Finance						

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County Health Departr	nent	Prov	Provider Number: 0279510-01				
410 Six Avenue East			Date: 07/11/201	8			
Bradenton, FL 34208		Fiso	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	169.54	164.99	07/01/2018			
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	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ed Cost					
	Field Audito	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲N				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee Count	Manatee County Health Department					Provider Number: 0279510-30				
410 Six Avenue	e East						Date:	07/11/2018		
Bradenton, FL	34208					Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited C	Cost	
<u>Provider Ty</u>	<u>pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.54	164	4.99	07/01/2018	
Rate Type										
<u>I</u>	Interim				X	_ <u>Prospec</u>	<u>tive</u>			
		Total Interim				Х	Total P	rospective		
-		Settlement Ba	ased c	on Cost			Prospe	ctive Adjuste	d For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTION	<u>N:</u>						TR			
Fiscal Ager	nt						γv			
Contract M	anagem	ent					Rydell Samu	uel, Administr	ator	
Program Finance						Medicaid Pro	ogram Financ	ce		

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County	y Health	Department	Manatee County Health Department					Provider Number: 0279510-91				
410 Six Avenue	East						Date:	07/11/2018				
Bradenton, FL 3	34208					Fiscal Year End: 06/30/2017						
							Audit Status:	Unaudited	Cost			
Provider Typ	<u>)e</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date			
<u>(</u>	<u>CHD</u>				169	.54	164	4.99	07/01/2018			
Rate Type												
<u>h</u>	<u>nterim</u>				Х	Prospec [®]	<u>tive</u>					
		Total Interim				- x	Total P	rospective				
_		Settlement Ba	ased c	on Cost			Prospe	ctive Adjuste	ed For New Costs			
			BAS	SIS:								
				Budget								
			Х	- Unaudited	Cost							
				- Desk Revi	iewed Cost							
				- Desk Audi	ited Cost							
				- Field Audi	ted Cost							
				-								
DISTRIBUTION	<u>l:</u>						TR					
Fiscal Agen	nt						74					
Contract Ma	anageme	ent					Rydell Samu	uel, Administ	rator			
Program Finance						Medicaid Program Finance						

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	/ Health De	epartment	Marion County Health Department					Provider Number: 0279528-00				
1801 S.E. 32n	d Avenuel	P. O. Box 2408	3				Date	: 07/11/2018	3			
Ocala, FL 344	178-2408					Fiscal Year End: 06/30/2017			7			
							Audit Status	: Unaudited	Cost			
<u>Provider Ty</u>	<u>/pe</u>				<u>Curren</u>	t Rate	New	<u> Rate</u>	Effective Date			
	<u>CHD</u>				169	.54	16	9.57	07/01/2018			
Rate Type												
	Interim				X	Prospect	<u>tive</u>					
		Total Interim				X	Total F	rospective				
		Settlement Ba	ased o	on Cost			Prospe	ective Adjust	ed For New Costs			
			BAS	<u>SIS:</u>								
				Budget								
			Х	_ Unaudited	Cost							
				_ Desk Revi	iewed Cost							
				_ Desk Aud	ited Cost							
				– Field Audi	ted Cost							
				_								
DISTRIBUTIO							TR					
Fiscal Age							/ >					
Contract N	•	ent					Rydell Samu					
Program Finance				Medicaid Pr	ogram Finar	nce						

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Departmer	t	Prov	Provider Number: 0279528-01				
1801 S.E. 32nd AvenueP. O. Box	2408		Date: 07/11/201	8			
Ocala, FL 34478-2408		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		169.54	169.57	07/01/2018			
Rate Type							
Interim	_	X Prospect					
Total Int		X	Total Prospective				
Settleme	ent 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			PU				
Contract Management			Bydell Semuel Adminic	strator			
Program Finance			Rydell Samuel, Adminis Medicaid Program Fina				
i iogram i manoc			medicalu i rogram i ma	100			

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	/ Health D	epartment				Provider Number: 0279528-02				
1801 S.E. 32n	d Avenue	P. O. Box 240	8				Date	07/11/2018		
Ocala, FL 344	478-2408					Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited C	Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.54	16	9.57	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	Prospect	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased	on Cost			Prospe	ctive Adjuste	d For New Costs	
			BAS	SIS:						
				Budget						
			Х	_ Unaudited	d Cost					
				– Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						PV.			
Contract N	Managemo	ent					Rydell Samu	uel, Administra	ator	
Program Finance						Medicaid Pro	ogram Financ	e		

Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Depa	rtment		Provider Number: 0279528-04				
1801 S.E. 32nd AvenueP. O). Box 2408			Date: 07	7/11/2018		
Ocala, FL 34478-2408			Fiscal Year End: 06/30/2017				
			Aud	dit Status: U	naudited Cos	st	
Provider Type		Current Rate New		<u>New Ra</u>	ate	Effective Date	
CHD	-	169.54		169.5	7	07/01/2018	
Rate Type		× -					
<u>Interim</u>		<u> </u>	spective				
	tal Interim		Х	Total Pros			
Set	ttlement Based on Cost			Prospectiv	/e Adjusted F	For New Costs	
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ted Cost					
	 Field Audit	ed Cost					
DISTRIBUTION:			~	IR			
Fiscal Agent				RI .			
-							
Contract Management					Administrato	<u>or</u>	
Program Finance			ivie	dicaid Progra	ani Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Departmen	t	Provi	Provider Number: 0279528-05				
1801 S.E. 32nd AvenueP. O. Box	2408		Date: 07/11/201	8			
Ocala, FL 34478-2408		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	169.54	169.57	07/01/2018			
Rate Type							
Interim		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	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			[N]				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department	Prov	Provider Number: 0279528-12				
1801 S.E. 32nd AvenueP. O. Box 2408		Date: 07/11/201	8			
Ocala, FL 34478-2408	Fis	Fiscal Year End: 06/30/2017				
		Audit Status: Unaudited	l Cost			
Provider Type	Current Rate	New Rate	Effective Date			
<u>CHD</u>	169.54	169.57	07/01/2018			
Rate Type	V D					
<u>Interim</u> Total Interim	X Prospect					
Settlement Based on Cost	X	Total Prospective	ted For New Costs			
		——————————————————————————————————————	ted For New Costs			
BASIS:						
Budget	t					
XUnaudi	ited Cost					
Desk R	Reviewed Cost					
Desk A	udited Cost					
Field A	udited Cost					
DISTRIBUTION:		TR				
Fiscal Agent		μ				
Contract Management		Rydell Samuel, Adminis	strator			
Program Finance		Medicaid Program Fina				

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department	Prov	Provider Number: 0279528-30				
1801 S.E. 32nd AvenueP. O. Box 2408		Date: 07/11/201	8			
Ocala, FL 34478-2408	Fiso	Fiscal Year End: 06/30/2017				
		Audit Status: Unaudited	l Cost			
Provider Type	Current Rate	New Rate	Effective Date			
<u>CHD</u>	169.54	169.57	07/01/2018			
Rate Type	X Prospect	ive				
<u>Interim</u> Total Interim	X Prospect	Total Prospective				
Settlement Based on Cost			ted For New Costs			
			lear of new Costs			
BASIS:						
Budge	et					
X Unauc	lited Cost					
Desk I	Reviewed Cost					
Desk /	Audited Cost					
Field A	Audited Cost					
DISTRIBUTION:		TR				
Fiscal Agent		M				
Contract Management		Rydell Samuel, Adminis	strator			
Program Finance		Medicaid Program Fina				

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department		Prov	Provider Number: 0279528-91				
1801 S.E. 32nd AvenueP. O. Box 2	2408		Date: 07/11/201	8			
Ocala, FL 34478-2408		Fiso	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	I Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	169.54	169.57	07/01/2018			
Rate Type							
Interim		X <u>Prospect</u>	<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	ed Cost					
	Field Audite	d Cost					
DISTRIBUTION:			TR				
Fiscal Agent			74				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Departm	ent	Prov	ider Number: 0279536-	00
3441 SE Willoughby Blvd.		Date: 07/11/201	8	
Stuart, FL 34994-5060	Fise	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
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 Revi	ewed Cost		
	Desk Audi	ted Cost		
	Field Audit	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			M	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Dep	partment			Provider Number: 0279536-11 Date: 07/11/2018			
3441 SE Willoughby Blvd							
Stuart, FL 34994-5060				Fiscal	Year End: 06/30/20)17	
				Au	dit Status: Unaudite	ed Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		-	169	.54	169.57	07/01/2018	
Rate Type							
<u>Interim</u>			Х	Prospective	<u>)</u>		
	Total Interim			- X	Total Prospective	e	
;	Settlement Based	on Cost			Prospective Adju	usted For New Costs	
	DA	ele.					
		\SIS: Budget					
	<u> </u>	Unaudited	Cost				
			iewed Cost				
		 Desk Audi					
		Field Audi					
			ieu Cosi				
DISTRIBUTION:				-	TR		
Fiscal Agent					/ `		
Contract Managemer	nt				dell Samuel, Admir		
Program Finance				Me	edicaid Program Fin	ance	
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Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Departme	nt	Prov	ider Number: 0279536-9	91
3441 SE Willoughby Blvd.			Date: 07/11/201	8
Stuart, FL 34994-5060	Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
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	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ted Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			7N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe Count	ty Health [Department				Prov	vider Number	: 0279544-	00
5100 College Road				Date: 07/11/2018			8		
Key West, FL 33040				Fis	cal Year End	: 06/30/201	7		
							Audit Status	: Unaudited	d Cost
Provider Ty	<u>ype</u>				<u>Currer</u>	nt Rate	New	<u>/ Rate</u>	Effective Date
	<u>CHD</u>				169	.54	16	9.57	07/01/2018
Rate Type	Interim				x	Dreenee	411.0		
	Interim	Total Interim				_ <u>Prospec</u> X		Prospective	
		- Settlement Ba	asod o	on Cost		X		-	sted For New Costs
		-	356U (01 0051			F105p6		Sieu I OI New Cosis
			BAS	<u>SIS:</u>					
				Budget					
			Х	- Unaudited	l Cost				
				_ Desk Revi	iewed Cost	t			
				Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIO	<u>)N:</u>						TR		
Fiscal Age	ent						M		
Contract I	Managem	ent					Rydell Sam	uel, Adminis	strator
Program I	Finance						Medicaid Pr	ogram Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Depart	tment	Provi	der Number: 0279544-0	01
5100 College Road		Date: 07/11/201	8	
Key West, FL 33040	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	169.54	169.57	07/01/2018
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 Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			ſN	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Departm	nent	Provi	der Number: 0279544-0	03
5100 College Road		Date: 07/11/201	7/11/2018	
Key West, FL 33040	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	169.54	169.57	07/01/2018
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 C	ost		
	Desk Review	ved Cost		
	Desk Audited	d Cost		
	Field Audited	d 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

Monroe County Health Departm	ient	Prov	ider Number: 0279544-0	04
5100 College Road		Date: 07/11/201	8	
Key West, FL 33040	Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total I	nterim	X	Total Prospective	
Settler	nent 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

Monroe County Health Departm	nent	Prov	ider Number: 0279544-0	08
5100 College Road		Date: 07/11/2018		
Key West, FL 33040	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total I	Interim	X	Total Prospective	
Settler	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			~ ~	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe Coun	ty Health [Department				Prov	vider Number:	0279544-13	3
5100 College	Road					Date: 07/11/2018			
Key West, FL 33040				Fis	cal Year End:	06/30/2017			
							Audit Status:	Unaudited C	Cost
<u>Provider T</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.54	169	9.57	07/01/2018
Rate Type					X	_			
	Interim	Total Interim			X	- Prospect			
		-		o (X		rospective	
		Settlement Ba	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				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						M		
Contract	Managem	ent					Rydell Samu	iel, Administr	ator
Program	Finance						Medicaid Pro	ogram Financ	ce

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Dep	partment	Provi	der Number: 0279544-	30
5100 College Road		Date: 07/11/201	7/11/2018	
Key West, FL 33040	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	169.54	169.57	07/01/2018
Rate Type				
Interim		X Prospect	ve	
Тс	otal Interim	X	Total Prospective	
Se	ettlement 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			٢N	
Contract Management		_	Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Depart	ment	Provi	der Number: 0279544-9	91
5100 College Road		Date: 07/11/201	7/11/2018	
Key West, FL 33040	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X <u>Prospect</u>	ve	
Total	Interim	X	Total Prospective	
Settle	ement 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			ſN	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Depart	ment	Provi	ider Number: 0279544-9	92
5100 College Road		Date: 07/11/201	8	
Key West, FL 33040	Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
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	wed Cost		
	Desk Audite	ed Cost		
	Field Audite	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			۲ ۷	
Contract Management		_	Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Depart	tment	Provi	der Number: 0279544-9	93
5100 College Road		Date: 07/11/201	18	
Key West, FL 33040		Fisc	al Year End: 06/30/201	7
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	ve	
Tota	I 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 Audite	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			٢N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County H	Health D	epartment			Prov	ider Number:	0279552-0	00
P. O. Box 517 Fernandina Beach, FL 32035-0517				Date: 07/11/2018			8	
				Fisc	cal Year End:	06/30/201	7	
						Audit Status:	Unaudited	Cost
Provider Type	e			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>C</u>	<u>CHD</u>			115	.59	127	7.57	07/01/2018
Rate Type								
<u>In</u>	<u>nterim</u>			Х	Prospect	ive		
		Total Interim			- x	Total P	rospective	
_		Settlement Base	d on Cost			Prospe	ctive Adjus	ted For New Costs
		B	ASIS:					
			Budget					
			X Unaudite	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	dited Cost				
			Field Auc	lited Cost				
		_						
DISTRIBUTION:	<u>.</u>					TR		
Fiscal Agent	t					M		
Contract Ma	inageme	ent				Rydell Samu	el, Adminis	trator
Program Fin	ance					Medicaid Pro	ogram Finai	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department			Provider	Number: 0279552-0	01
P. O. Box 517				8	
Fernandina Beach, FL 32035-0517	,		Fiscal Y	ear End: 06/30/201	7
			Aud	it Status: Unaudited	Cost
Provider Type		Current	t Rate	New Rate	Effective Date
CHD	_	115.	.59	127.57	07/01/2018
Rate Type					
Interim		Х	Prospective		
Total Interi	im		- X	Total Prospective	
Settlement	t Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited 0	Cost			
	Desk Revie	wed Cost			
	Desk Audite	ed Cost			
	Field Audite	ed Cost			
DISTRIBUTION:				TR	
Fiscal Agent			1	N	
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

Nassau County Health Department	t		Provider	Number: 0279552-0)4
P. O. Box 517				8	
Fernandina Beach, FL 32035-051	7		Fiscal Y	ear End: 06/30/201	7
			Aud	it Status: Unaudited	Cost
Provider Type		Current	t Rate	New Rate	Effective Date
CHD	_	115.	59	127.57	07/01/2018
Rate Type					
Interim		Х	Prospective		
Total Inter	rim		X	Total Prospective	
Settlemer	nt Based on Cost			Prospective Adjust	ted For New Costs
				-	
	BASIS:				
	Budget				
	X Unaudited 0	Cost			
	Desk Revie	wed Cost			
	Desk Audite	ed Cost			
	Field Audite	ed Cost			
DISTRIBUTION:				IK	
Fiscal Agent			[N .	
Contract Management			Ryd	lell Samuel, Adminis	trator
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

Nassau County Health Department			Provider	Number: 0279552-0	05
P. O. Box 517				8	
Fernandina Beach, FL 32035-0517			Fiscal Y	'ear End: 06/30/201	7
			Aud	it Status: Unaudited	l Cost
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date
CHD	_	115	.59	127.57	07/01/2018
Rate Type					
<u>Interim</u>		Х	Prospective		
Total Interi	m		X	Total Prospective	
Settlement	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:			-	R	
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

Nassau County Health Departmen	ıt		Provider	Number: 0279552-9	95
P. O. Box 517			Date: 07/11/2018		
Fernandina Beach, FL 32035-051	7		Fiscal Y	ear End: 06/30/2017	7
			Aud	it Status: Unaudited	Cost
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date
CHD	-	115.5	9	127.57	07/01/2018
Rate Type					
Interim		Х <u>і</u>	Prospective		
Total Inte	erim		Х	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 Audite	ed Cost			
DISTRIBUTION:			-	R	
Fiscal Agent			f		
Contract Management			Ryd	ell Samuel, Adminis	trator
Program Finance			Med	licaid Program Finar	nce
State Health Office					



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Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health Departn	nent	Provi	der Number: 0279561-0	00	
221 Hospital Drive, N.E.			Date: 07/11/2018		
Ft. Walton Beach, FL 32548	Fisc	al Year End: 06/30/201	7		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	152.78	152.75	07/01/2018	
Rate Type					
Interim		X <u>Prospect</u>	ve		
Total Int	erim	X	Total Prospective		
Settlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ed Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			/ N		
Contract Management		-	Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health Departm	ent	Provi	der Number: 0279561-9	91
221 Hospital Drive, N.E.		Date: 07/11/201	8	
Ft. Walton Beach, FL 32548		Fisc	al Year End: 06/30/201	7
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	152.78	152.75	07/01/2018
Rate Type				
Interim		X <u>Prospect</u>	ve	
Total Inte	erim	X	Total Prospective	
Settlement 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			/ `	
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 Depa	artment	Prov	ider Number: 0279579-0	00
P.O. Box 18791728 N.W. 9th Ave		Date: 07/11/201	Date: 07/11/2018	
Okeechobee , FL 34973-1879	Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	I Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	150.56	147.33	07/01/2018
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 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

Okeechobee County Health Depa	artment	Prov	ider Number: 0279579-0	01
P.O. Box 18791728 N.W. 9th Ave		Date: 07/11/2018		
Okeechobee , FL 34973-1879		Fisc	al Year End: 06/30/201	7
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	150.56	147.33	07/01/2018
Rate Type				
<u>Interim</u>		X <u>Prospect</u>	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 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

Okeechobee County Health Departm	nent	Prov	ider Number: 0279579-(02
P.O. Box 18791728 N.W. 9th Avenue		Date: 07/11/2018		
Okeechobee , FL 34973-1879		Fisc	al Year End: 06/30/201	7
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		150.56	147.33	07/01/2018
Rate Type				
Interim		X Prospect	ive	
Total Interir	n	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 Audi	ted 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

Okeechobee County Health	Department	Prov	ider Number: 0279579-0	03
P.O. Box 18791728 N.W. 9th		Date: 07/11/201)18	
Okeechobee , FL 34973-187	'9	Fisc	cal Year End: 06/30/201	7
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	150.56	147.33	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	ive	
Tota	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	ted 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

Okeechobee County Health Departm	nent	Prov	Provider Number: 0279579-04		
P.O. Box 18791728 N.W. 9th Avenue	e		Date: 07/11/2018		
Okeechobee, FL 34973-1879		 Fisc	al Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		150.56	147.33	07/01/2018	
Rate Type					
Interim		X Prospect	ive		
Total Interin	n	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			M		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Depa	artment	Prov	ider Number: 0279579-3	30	
P.O. Box 18791728 N.W. 9th Avenue Okeechobee , FL 34973-1879			Date: 07/11/201	: 07/11/2018	
		Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	150.56	147.33	07/01/2018	
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 Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audit	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			1 N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Orange County Health Department 6101 Lake Ellenor Drive Orlando, FL 32804		Prov	vider Number: 0279587-	00	
			Date: 07/11/201	e: 07/11/2018	
		Fis	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	tive		
Тс	otal Interim	X	Total Prospective		
Se	ettlement Based on Cost		Prospective Adjus	sted For New Costs	
	BASIS:				
	Budget				
	X Unaudit	ed Cost			
	Desk Re	eviewed Cost			
	Desk Au	udited Cost			
	Field Au	udited Cost			
DISTRIBUTION:			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

Orange County Health Department		Prov	vider Number: 0279587-0	01
6101 Lake Ellenor Drive Orlando, FL 32804		_	8	
		— Fiso	cal Year End: 06/30/201	7
			Audit Status: Unaudited	l Cost
Provider Type	Cur	rent Rate	New Rate	Effective Date
<u>CHD</u>		169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Inter	im —	X	Total Prospective	
Settlemen	t Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited Cost			
	Desk Reviewed C	Cost		
	Desk Audited Cos	st		
	Field Audited Cos	st		
DISTRIBUTION:			TR	
Fiscal Agent			PU	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce
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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Departm	ent	Prov	Provider Number: 0279595-00		
P. O. Box 4503091875 Boggy Creek Road Kissimmee, FL 34745-0309			Date: 07/11/201	e: 07/11/2018	
		Fiso	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	I Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	141.95	169.57	07/01/2018	
Rate Type					
Interim		X Prospect	ive		
Total In	terim	X	Total Prospective		
Settlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk 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 Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Department	t	Provider	Number: 0279595-3	80	
P. O. Box 4503091875 Boggy Cree	k Road		Date: 07/11/2018	07/11/2018	
Kissimmee, FL 34745-0309		Fiscal Y	ear End: 06/30/2017	7	
		Aud	it Status: Unaudited	Cost	
Provider Type	Curren	t Rate	New Rate	Effective Date	
CHD	141.	.95	169.57	07/01/2018	
<u>Rate Type</u> Interim	х	Prospective			
Total Inter	im	X	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjust	ed For New Costs	
	BASIS:BudgetXDesk Reviewed CostDesk Audited CostField Audited Cost				
DISTRIBUTION:		-	R		
Fiscal Agent		1	N		
Contract Management		Ryc	lell Samuel, Adminis	trator	

Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Department		Provider	Number: 0279595-9	92	
P. O. Box 4503091875 Boggy Creek	Road		Date: 07/11/2018	07/11/2018	
Kissimmee, FL 34745-0309		Fiscal Y	'ear End: 06/30/201	7	
		Aud	it Status: Unaudited	Cost	
Provider Type	Current	t Rate	New Rate	Effective Date	
CHD	141.	95	169.57	07/01/2018	
Rate Type Interim	X	Prospective			
Total Interin	m	Х	Total Prospective		
Settlement	Based on Cost		Prospective Adjust	ted For New Costs	
	BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost				
DISTRIBUTION:		-	R		
Fiscal Agent		1	N		
Contract Management		Ryc	lell Samuel, Adminis	trator	

Medicaid Program Finance

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Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health D	epartment		Provider	Number: 0279595-	93	
P. O. Box 4503091875 Bo	oggy Creek Road		Date: 07/11/		7/11/2018	
Kissimmee, FL 34745-0309		Fiscal Y	ear End: 06/30/201	7		
			Aud	it Status: Unaudited	d Cost	
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		141	.95	169.57	07/01/2018	
<u>Rate Type</u> Interim		Х	Prospective			
	Total Interim		- X	Total Prospective		
	Settlement Based on Cost			_	sted For New Costs	
	BASIS:			_		
	Budget					
	X Unaudited	d Cost				
	Desk Rev	viewed Cost				
	Desk Aud	ited Cost				
	Field Aud	ited Cost				
DISTRIBUTION: Fiscal Agent				R		
Contract Managemer	nt		Ryc	lell Samuel, Adminis	strator	

Medicaid Program Finance

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Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department		Provider I	Number: 0279617	-00	
10841 Little Road			Date: 07/11/20	e: 07/11/2018	
New Port Richey, FL 34654		Fiscal Ye	ear End: 06/30/20	17	
		Audi	Status: Unaudite	ed Cost	
<u>Provider Type</u>	Curren	t Rate	New Rate	Effective Date	
CHD	169	.54	169.57	07/01/2018	
Rate Type					
Interim	Х	Prospective			
Total Interim		x	Total Prospective)	
Settlement Base	d on Cost		Prospective Adju	sted For New Costs	
<u>B</u>	ASIS:				
	Budget				
	X Unaudited Cost				
—	Desk Reviewed Cost				
—	Desk Audited Cost				
	Field Audited Cost				
DISTRIBUTION:		ĺ	R		
Fiscal Agent		1	N		
Contract Management			ell Samuel, Admin		
Program Finance		Med	caid Program Fina	ance	

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department			Provide	r Number:	0279617-01	
10841 Little Road			- Date:		e: 07/11/2018	
New Port Richey, FL 34654			Fiscal	Year End:	06/30/2017	
			Au	dit Status:	Unaudited Co	st
Provider Type		Current	t Rate	New	Rate	Effective Date
<u>CHD</u>		169.	54	169).57	07/01/2018
Rate Type						
<u>Interim</u>		X	Prospective	<u>}</u>		
Total Interim			Х	Total Pi	rospective	
Settlement Ba	ased on Cost			Prospe	ctive Adjusted	For New Costs
	BASIS:					
	Budget					
	X Unaudited Co	ost				
	Desk Review	ved Cost				
	Desk Audited	d Cost				
	Field Audited	d Cost				
DISTRIBUTION:			-	IR		
Fiscal Agent				pl)		
Contract Management			р.		al Administrat	~ -
Program Finance					el, Administrat	
			IVIC		gianti mance	

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department		Prov	Provider Number: 0279617-91		
10841 Little Road New Port Richey, FL 34654			Date: 07/11/201	e: 07/11/2018	
		Fisc	cal Year End: 06/30/201	7	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	169.54	169.57	07/01/2018	
Rate Type					
Interim		X Prospect	ive		
Total Inter	im	X	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	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 Reimbursement Rate Change Form for CHDs

Pasco County Health Department			Provider	Number: 0279617-9	92
10841 Little Road			Date: 07/11/2018		
New Port Richey, FL 34654		Fiscal Y	'ear End: 06/30/201	7	
			Aud	lit Status: Unaudited	Cost
Provider Type	<u>(</u>	Curren	t Rate	New Rate	Effective Date
CHD		169	.54	169.57	07/01/2018
Rate Type					
Interim		Х	Prospective		
Total Inte	rim		- x	Total Prospective	
Settlemen	nt Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited Cos	st			
	Desk Reviewe	ed Cost			
	Desk Audited	Cost			
	Field Audited	Cost			
DISTRIBUTION:			~	R	
Fiscal Agent			1	u)	
Contract Management			Ryc	lell Samuel, Adminis	trator
Program Finance				dicaid Program Finar	
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Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County He	ealth Department			Prov	ider Number:	0279625-00	
500 7th Avenue Sc	outh				Date:	07/11/2018	
St. Petersburg, FL 33701				Fisc	al Year End:	06/30/2017	
					Audit Status:	Unaudited C	ost
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CH</u>	ID	-	169.	54	169	9.57	07/01/2018
Rate Type							
Inte	erim		Х	Prospect	ive		
	Total Interim			x	Total P	rospective	
	Settlement Base	ed on Cost			Prospe	ctive Adjusted	d For New Costs
	B	BASIS:					
		Budget					
	_	X Unaudited	Cost				
	_	Desk Revi	ewed Cost				
	_	Desk Audi	ted Cost				
	-	Field Audit	ted Cost				
DISTRIBUTION:					TR		
Fiscal Agent					pl)		
Contract Mana	acmont				T Dudall Ca ::		
Program Finar	-					iel, Administra ogram Finance	
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Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County	y Health [Department				Prov	vider Number:	0279625-9	1
500 7th Avenue	e South					Date:		: 07/11/2018	
St. Petersburg, FL 33701				Fis	cal Year End	06/30/2017	,		
							Audit Status:	Unaudited	Cost
Provider Ty	<u>pe</u>				Curren	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.54	169	9.57	07/01/2018
Rate Type									
<u> </u>	<u>Interim</u>				Х	Prospec	<u>tive</u>		
		Total Interim				- x	Total P	rospective	
-		Settlement Ba	ised c	on Cost			Prospe	ctive Adjuste	ed For New Costs
			BAS	<u>SIS:</u>					
				Budget					
			Х	_ Unaudited	l Cost				
				_ Desk Revi	iewed Cost	:			
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				_					
DISTRIBUTION	<u>N:</u>						TR		
Fiscal Age	nt						74		
Contract N	lanageme	ent					Rydell Samu	uel, Administ	rator
Program F	inance						Medicaid Pro	ogram Finan	се

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	ider Number: 0279633-	00	
1290 Golfview Avenue, 4th Floor		Date: 07/11/201	8		
Bartow, FL 33830-6740	Fiso	Fiscal Year End: 06/30/2017			
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		169.54	169.57	07/01/2018	
Rate Type					
Interim		X Prospect	ive		
Total Interim	ı	X	Total Prospective		
Settlement E	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			M		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	ince	

State Health Office

Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	ider Number: 0279633-0	01	
1290 Golfview Avenue, 4th Floor			Date: 07/11/201	07/11/2018	
Bartow, FL 33830-6740	Fisc	cal Year End: 06/30/201	7		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		169.54	169.57	07/01/2018	
Rate Type					
Interim		X Prospect	<u>ive</u>		
Total Interin	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:			R		
Fiscal Agent			[N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

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Medicaid Program 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: 07/11/201	: 07/11/2018	
Bartow, FL 33830-6740	Fiso	cal Year End: 06/30/201	7		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	<u>ive</u>		
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 Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	vider Number: 0279633-	03
1290 Golfview Avenue, 4th Floor		Date: 07/11/201	18	
Bartow, FL 33830-6740	Fis	cal Year End: 06/30/201	17	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
Rate Type		× -		
<u>Interim</u>	_	X Prospec		
Total Interin		X	Total Prospective	
	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			M	
Contract Management			Rydell Samuel, Admini	strator
Program Finance			Medicaid Program Fina	ance

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Pro	vider Number: 0279633-	04
1290 Golfview Avenue, 4th Floor		Date: 07/11/201	8	
Bartow, FL 33830-6740	 Fi:	scal Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospec	<u>ctive</u>	
Total Interin	n	Х	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			M	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department			Provide	r Number:	0279633-05	
1290 Golfview Avenue, 4th Floor Bartow, FL 33830-6740				Date:	07/11/2018	
			Fiscal	Year End:	06/30/2017	
			Au	dit Status:	Unaudited Co	st
Provider Type		<u>Current</u>	Rate	<u>New I</u>	<u>Rate</u>	Effective Date
CHD		169.5	54	169.	.57	07/01/2018
Rate Type						
<u>Interim</u>		<u> </u>	Prospective	<u>)</u>		
Total Interim			Х	Total Pro	ospective	
Settlement B	ased on Cost	_		Prospec	tive Adjusted	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			3	<u>rv</u>		
Contract Management			Ry	dell Samue	el, Administrato	or
Program Finance			Me	edicaid Prog	gram Finance	—

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Pro	vider Number: 0279633-	30
1290 Golfview Avenue, 4th Floor		Date: 07/11/201	8	
Bartow, FL 33830-6740	 Fis	scal Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospec	tive	
Total Interin	n	Х	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 Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			rv	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Pro	vider Number: 0279633-	90
1290 Golfview Avenue, 4th Floor		Date: 07/11/201	8	
Bartow, FL 33830-6740	Fis	scal Year End: 06/30/201	7	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	169.54	169.57	07/01/2018
Rate Type				
Interim		X Prospec	tive	
Total Interin	n	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 Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			^{rv}	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Pro	vider Number: 0279633-	95
1290 Golfview Avenue, 4th Floor		Date: 07/11/201	18	
Bartow, FL 33830-6740	 Fis	scal Year End: 06/30/201	17	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>		X Prospec	tive	
Total Interim	1	Х	Total Prospective	
Settlement E	Based on Cost		Prospective Adjus	sted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	ewed Cost		
	Desk Audit	ed Cost		
	Field Audit	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			rv	
Contract Management			Rydell Samuel, Admini	strator
Program Finance			Medicaid Program Fina	ance

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam Coun	ty Health I	Department				Prov	/ider Number:	0279641-0	0
2801 Kennedy	y Street					Date:		: 07/11/2018	
Palatka, FL 32177				Fis	cal Year End	06/30/2017	7		
							Audit Status	Unaudited	Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.54	16	9.57	07/01/2018
Rate Type									
	<u>Interim</u>				Х	Prospec:	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs
			BAS	<u>SIS:</u>					
				Budget					
			Х	_ Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				– Field Audi	ted Cost				
				-					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						7N		
Contract	Managem	ent					Rydell Samu	uel, Administ	trator
Program	Finance						Medicaid Pro	ogram Finar	ice

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Departmen	Putnam County Health Department			Provider Number: 0279641-01				
2801 Kennedy Street			Date	07/11/2018				
Palatka, FL 32177			Fiscal Year End: 06/30/2017					
			Audit Status:	Unaudited C	Cost			
<u>Provider Type</u>		Current Rate	New	Rate	Effective Date			
CHD	-	169.54	169	9.57	07/01/2018			
Rate Type								
Interim		X <u>Pros</u> p	<u>bective</u>					
Total Inte	rim		X Total P	rospective				
Settlemer	nt Based on Cost		Prospe	ctive Adjuste	d For New Costs			
	BASIS:							
	Budget							
	X Unaudited	Cost						
	Desk Revie	ewed Cost						
	Desk Audit	ed Cost						
	Field Audit	ed Cost						
DISTRIBUTION:			T					
Fiscal Agent			/ `					
Contract Management				iel, Administra				
Program Finance			Medicaid Pro	ogram Financ	e			

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam Coun	Putnam County Health Department				Provider Number: 0279641-03					
2801 Kenned	y Street						Date	07/11/2018		
Palatka, FL 3	2177					Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited C	Cost	
<u>Provider T</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.54	16	9.57	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	Prospect	tive			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	d 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, Administr	ator	
Program	Finance						Medicaid Pro	ogram Financ	e	

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health De	utnam County Health Department			Provider Number: 0279641-04			
2801 Kennedy Street				Date: 07/11/2018			
Palatka, FL 32177				Fiscal Year End: 06/30/2017			
				Αι	udit Status: Una	udited Cost	t
Provider Type Curren			t Rate	New Rate	2	Effective Date	
<u>CHD</u>		-	169	.54	169.57		07/01/2018
Rate Type							
<u>Interim</u>			Х	Prospective	<u>e</u>		
	Total Interim			- X	Total Prospe	ctive	
	Settlement Based	on Cost			Prospective	Adjusted F	or New Costs
	RΔ	<u>\SIS:</u>					
		Budget					
	X	Unaudited	Cost				
			ewed Cost				
		 Desk Audi					
		Field Audit	ted Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent					M		
Contract Managemer	nt			R	ydell Samuel, Ad	dministrato	r
Program Finance				M	edicaid Program	n Finance	_
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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health	utnam County Health Department			Provider Number: 0279641-91			
2801 Kennedy Street				Date: 07/11/2018			
Palatka, FL 32177				Fiscal Year End: 06/30/2017			
				Au	dit Status: Unaudited	d Cost	
Provider Type Curren			t Rate	New Rate	Effective Date		
<u>CHD</u>			169	.54	169.57	07/01/2018	
Rate Type							
Interim			Х	Prospective	<u>)</u>		
	Total Interim			X	Total Prospective		
	Settlement Ba	sed on Cost			Prospective Adjus	sted For New Costs	
	_						
		BASIS:					
	-	Budget X Unaudited	Cost				
	-						
	-		ewed Cost				
	-	Desk Audi					
	-	Field Audit	ted Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent					/ `		
Contract Managem	nent			Ry	dell Samuel, Adminis	strator	
Program Finance				Me	edicaid Program Fina	ince	
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Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County I	t. Johns County Health Department			Provider Number: 0279650-00				
1955 US 1 South					Date:	07/11/2018		
St. Augustine, FL	32086			Fiscal Year End: 06/30/2017				
				ŀ	Audit Status:	Unaudited C	Cost	
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date	
<u>C</u> ł	<u>ID</u>	-	169	.54	169	9.57	07/01/2018	
Rate Type								
Inte	<u>erim</u>		Х	Prospective Street Prospective ProspectiProspective Prospective Prospective Prospective Pr	ve			
	Total Interim			- X	Total P	rospective		
	Settlement B	ased on Cost			Prospe	ctive Adjusted	d For New Costs	
		BASIS:						
		Budget						
		X Unaudited	Cost					
		Desk Revi	ewed Cost					
		Desk Audi	ted Cost					
		Field Audi	ted Cost					
DISTRIBUTION:					TR			
Fiscal Agent					M			
Contract Man	agement			F	Rydell Samu	uel, Administra	ator	
Program Fina	nce			_		ogram Financ		

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Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County Health Depart	t. Johns County Health Department			Provider Number: 0279650-91			
1955 US 1 South			Date: 07/11/2018				
St. Augustine, FL 32086		F	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	d Cost			
Provider Type Curre		Current Rate	New Rate	Effective Date			
CHD	_	169.54	169.57	07/01/2018			
Rate Type							
Interim		X <u>Prospe</u>	<u>ective</u>				
Total Ir	nterim	>	C Total Prospective				
Settlement Based on Cost			Prospective Adjus	ted For New Costs			
	BASIS:						
	BASIS. Budget						
	X Unaudited	Cost					
	Desk Revie						
	Desk Audit						
	Field Audite						
DISTRIBUTION:			T				
Fiscal Agent			/ `				
Contract Management			Rydell Samuel, Adminis				
Program Finance			Medicaid Program Fina	nce			
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health De	partment	Provi	Provider Number: 0279668-00			
5150 NW Milner Drive			Date: 07/11/201	8		
Port Saint Lucie, FL 34963	3	Fisc	Fiscal Year End: 06/30/2017			
			Audit Status: Unaudited	Cost		
<u>Provider Type</u>		Current Rate	New Rate	Effective Date		
<u>CHD</u>		169.54	169.57	07/01/2018		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Тс	otal Interim	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			۲ <u>۷</u>			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departm	nent		Provider Number: 0279668-01				
5150 NW Milner Drive			Date: 07/11/2018				
Port Saint Lucie, FL 34963			Fiscal Year End: 06/30/2017				
				d Cost			
Provider Type Cur			New Rate	Effective Date			
CHD	_	169.54	169.57	07/01/2018			
Rate Type							
Interim		X <u>Pros</u> p	<u>pective</u>				
Total In	terim		X Total Prospective				
Settlement Based on Cost			Prospective Adjusted F				
	BASIS:						
	Budget						
	X Unaudited 0	Cost					
	Desk Revie	wed Cost					
	Desk Audite	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			- UT				
Fiscal Agent			/ N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	ince			
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Hea	alth Department		Pro	Provider Number: 0279668-02				
5150 NW Milner Driv	e			Date: 07/	11/2018			
Port Saint Lucie, FL	34963		 Fis	Fiscal Year End: 06/30/2017				
				Audit Status: Una	audited Cost			
Provider Type			Current Rate	New Rat	te Effective Date			
CHE	<u>)</u>		169.54	169.57	07/01/2018			
Rate Type								
Interi	im		X <u>Prospec</u>	tive				
	Total Interim		X	Total Prosp	ective			
Settlement Based on Cost			Prospective Adjusted For N					
		BASIS:						
		Budget						
		X Unaudite	d Cost					
		Desk Rev	viewed Cost					
		Desk Auc	lited Cost					
		Field Aud	lited Cost					
DISTRIBUTION:				TR				
Fiscal Agent				rv.				
Contract Manag	ement			Rydell Samuel, A	dministrator			
Program Financ	e			Medicaid Program	n Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Hea	St. Lucie County Health Department				Provider Number: 0279668-03				
5150 NW Milner Driv	e				Date:	07/11/2018			
Port Saint Lucie, FL	34963			Fiscal	Year End:	06/30/2017			
				Αι	udit Status:	Unaudited Co	st		
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date		
CHE	<u>)</u>		169.5	4	169	.57	07/01/2018		
Rate Type									
<u>Interi</u>			<u> </u>	Prospectiv					
	Total Interim		_	Х	Total Pr	ospective			
	Settlement Ba	ased on Cost	_		Prospec	ctive Adjusted	For New Costs		
		BASIS:							
		Budget							
		X Unaudited	l Cost						
		 Desk Revi	iewed Cost						
		Desk Audi	ited Cost						
		 Field Audi	ted Cost						
DISTRIBUTION:				2	TR				
Fiscal Agent					M				
Contract Manag	ement			R	ydell Samu	el, Administrat	or		
Program Financ	е			M	edicaid Pro	gram Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Hea	alth Department		Prov	Provider Number: 0279668-04				
5150 NW Milner Driv	e			Date: 07/11	/2018			
Port Saint Lucie, FL	34963		Fise	Fiscal Year End: 06/30/2017				
				Audit Status: Unau	dited Cost			
Provider Type			Current Rate	New Rate	Effective Date			
CHE	<u>)</u>		169.54	169.57	07/01/2018			
Rate Type								
Interi	im		X Prospect	<u>ive</u>				
	Total Interim		X	Total Prospec	tive			
Settlement Based on Cost			Prospective Adjusted For N					
		BASIS:						
		Budget						
		X Unaudited	d Cost					
		Desk Rev	riewed Cost					
		Desk Aud	lited Cost					
		Field Aud	ited Cost					
DISTRIBUTION:				TR				
Fiscal Agent				PN .				
Contract Manag	ement			Rydell Samuel, Adr	ministrator			
Program Financ	e			Medicaid Program	Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County He	St. Lucie County Health Department				Provider Number: 0279668-05				
5150 NW Milner Driv	ve				Date:	07/11/2018			
Port Saint Lucie, FL	34963			Fiscal	Year End:	06/30/2017			
				Au	dit Status:	Unaudited Co	st		
Provider Type			Current R	ate	New	Rate	Effective Date		
<u>CHI</u>	<u>2</u>		169.54	<u>ا</u>	169	.57	07/01/2018		
Rate Type									
<u>Inter</u>	<u>'im</u>		<u> </u>	rospective	<u>)</u>				
	Total Interim			Х	Total Pr	ospective			
	Settlement B	ased on Cost	_		Prospec	tive 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					7N				
Contract Manag	jement			Ry	dell Samue	el, Administrato	or		
Program Financ	e			Me	edicaid Pro	gram Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Hea	Lucie County Health Department					0279668-11		
5150 NW Milner Drive	Э				Date:	07/11/2018		
Port Saint Lucie, FL	34963			Fisca	I Year End:	06/30/2017		
				A	udit Status:	Unaudited Co	ost	
Provider Type			Current	Rate	New	Rate	Effective Date	
<u>CHD</u>			169.54 16		169	.57	07/01/2018	
Rate Type								
<u>Interin</u>			X	Prospectiv				
	Total Interim			Χ	Total Pr	ospective		
Settlement Based on Cost					Prospec	ctive Adjusted	For New Costs	
		BASIS:						
		Budget						
		X Unaudited	Cost					
		Desk Rev	iewed Cost					
		Desk Aud	ited Cost					
		 Field Audi	ted Cost					
DISTRIBUTION:					TR			
Fiscal Agent			M					
Contract Manage		Rydell Samuel, Administrator						
Program Finance	9			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County He	ealth Department		Provide	r Number: (0279668-12			
5150 NW Milner Dr	ive				Date:	07/11/2018		
Port Saint Lucie, Fl	_ 34963			Fiscal	Year End: (06/30/2017		
				Au	dit Status:	Unaudited Co	st	
Provider Type			Current	Rate	New F	Rate	Effective Date	
<u>CH</u>	<u>D</u>		169.5416		169.	.57	07/01/2018	
Rate Type								
<u>Inte</u>			<u> </u>	Prospective				
	Total Interim		_	Х	Total Pro	ospective		
			Prospec	tive Adjusted	For New Costs			
		BASIS:						
		Budget						
		X Unaudited	Cost					
		Desk Rev	iewed Cost					
		Desk Aud	ited Cost					
		 Field Audi	ted Cost					
DISTRIBUTION:				-	TR			
Fiscal Agent			γV					
Contract Mana		Rydell Samuel, Administrator						
Program Finan	ce			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County He	alth Department		Provide	er Number:	0279668-30			
5150 NW Milner Driv	/e				Date:	07/11/2018		
Port Saint Lucie, FL	34963			Fiscal	Year End:	06/30/2017		
				Αι	udit Status:	Unaudited Co	st	
<u>Provider Type</u>			<u>Current</u>	Rate	New	Rate	Effective Date	
<u>CHI</u>	<u>)</u>		169.5416		169	.57	07/01/2018	
Rate Type								
<u>Inter</u>			<u> </u>	Prospective				
	Total Interim		_	Х	Total Pr	ospective		
	_		Prospec	ctive Adjusted	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			M					
Contract Manag		Rydell Samuel, Administrator						
Program Financ	e			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Hea	Ith Department		Prov	ider Number: 02796	68-91			
5150 NW Milner Driv	e			Date: 07/11/2	2018			
Port Saint Lucie, FL	34963		Fise	cal Year End: 06/30/2	2017			
				Audit Status: Unaud	ited Cost			
Provider Type			Current Rate	New Rate	Effective Date			
CHD	<u>)</u>		169.54		07/01/2018			
Rate Type								
<u>Interi</u>	<u>m</u>		X Prospect	ive				
	Total Interim		X	Total Prospect	ive			
	Settlement Ba	sed on Cost		Prospective Ac	djusted 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				PN .				
Contract Manage	ement			Rydell Samuel, Administrator				
Program Finance	e			Medicaid Program Finance				

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(No Change In Rate)

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	nta Rosa County Health Department					Prov	vider Number:	0279676-00				
P.O. Box 929							Date:	07/11/2018				
Milton, FL 32	572-0929					Fis	Fiscal Year End: 06/30/2017					
							Audit Status:	Unaudited C	ost			
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date			
	<u>CHD</u>			120.95		100	0.95	07/01/2018				
Rate Type												
	Interim				X	_ <u>Prospec</u>						
		Total Interim				X	Total P	rospective				
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjusted	d 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 Agent							M					
Contract Management					Rydell Samuel, Administrator							
Program I	Program Finance						_	ogram Financ				

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Hea	nta Rosa County Health Department					Provider Number: 0279676-01				
P.O. Box 929					Date: 07	/11/2018				
Milton, FL 32572-0929				Fiscal	Year End: 06	/30/2017				
				Au	dit Status: Ur	naudited Cos	st			
Provider Type			<u>Curren</u>	t Rate	<u>New Ra</u>	<u>ite</u>	Effective Date			
<u>CHD</u>			120.95 100.		100.9	5	07/01/2018			
Rate Type										
Interim			Х	Prospective	2					
	Total Interim			- x	Total Pros	pective				
Settlement Based on Cost					Prospectiv	e Adjusted I	For New Costs			
	-				_					
	<u>B/</u>	ASIS:								
		Budget								
		C Unaudited	l Cost							
		Desk Revi	iewed Cost							
		Desk Audi	ited Cost							
		Field Audi	ted Cost							
DISTRIBUTION:				-	TR					
Fiscal Agent					<i>P</i> ()					
Contract Manageme	Rydell Samuel, Administrator									
Program Finance	Me	edicaid Progra	am Finance							
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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	nta Rosa County Health Department					Provi	ider Number:	0279676-	02
P.O. Box 929							Date	07/11/201	8
Milton, FL 32	572-0929					Fisc	al Year End	06/30/201	7
							Audit Status	Unaudited	d Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				120.95 100		0.95	07/01/2018	
Rate Type							_		
	Interim	-			X	- Prospecti			
		Total Interim				Χ		rospective	
		Settlement B	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs
			BAS	SIS:					
				Budget					
			X	- Unaudited	l Cost				
				- Desk Revi	iewed Cost				
				- Desk Aud	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIO	<u>N:</u>						TR		
Fiscal Age	ent						7N		
Contract Management				Rydell Samuel, Administrator					
Program I	Program Finance						Medicaid Pro	ogram Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	nta Rosa County Health Department					Provi	der Number:	0279676-	03		
P.O. Box 929							Date	07/11/201	18		
Milton, FL 32	572-0929					Fisc	Fiscal Year End: 06/30/2017				
						,	Audit Status	Unaudited	d Cost		
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				120.95 100		0.95	07/01/2018			
Rate Type						_					
	Interim	Tradition			X	- Prospecti					
		Total Interim				X		rospective			
		Settlement B	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs		
			BAS	SIS:							
				Budget							
			Х	_ Unaudited	Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						7N				
Contract Management				Rydell Samuel, Administrator							
Program I	Program Finance						Medicaid Pro	ogram Fina	ance		

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	nta Rosa County Health Department					Provi	der Number:	: 0279676-	04		
P.O. Box 929							Date	: 07/11/201	8		
Milton, FL 325	572-0929					Fisc	Fiscal Year End: 06/30/2017				
							Audit Status	: Unaudited	d Cost		
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date		
	<u>CHD</u>				120.95 100		0.95	07/01/2018			
Rate Type											
	Interim				X	- Prospecti					
		Total Interim				Χ		rospective			
		Settlement B	ased o	on Cost			Prospe	ective Adjus	sted For New Costs		
			BAS	SIS:							
				Budget							
			X	- 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	Contract Management				Rydell Samuel, Administrator						
Program F	Program Finance						Medicaid Pro	ogram Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	nta Rosa County Health Department					Prov	ider Number:	0279676-	05		
P.O. Box 929							Date	07/11/201	18		
Milton, FL 32	572-0929					Fisc	Fiscal Year End: 06/30/2017				
							Audit Status	Unaudite	d Cost		
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				120.95 100		0.95	07/01/2018			
Rate Type					X	_	_				
	Interim	Tradition			X	- Prospect					
		Total Interim		_		X		rospective			
		Settlement B	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs		
			BAS	SIS:							
				Budget							
			Х	_ Unaudited	Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>)N:</u>						TR				
Fiscal Age	ent						74				
Contract Management				Rydell Samuel, Administrator							
Program I	Program Finance						Medicaid Pre	ogram Fina	ance		

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Hea	nta Rosa County Health Department					Provider Number: 0279676-30				
P.O. Box 929					Date:	07/11/2018				
Milton, FL 32572-0929				Fiscal	Year End:	06/30/2017				
				Au	dit Status:	Unaudited Co	ost			
Provider Type			<u>Curren</u>	t Rate	New Rate Effect					
CHD		-	120.95		100.	.95	07/01/2018			
Rate Type										
Interim			Х	Prospective	2					
	Total Interim			- x	Total Pro	ospective				
Settlement Based on Cost					Prospec	tive Adjusted	For New Costs			
	-									
	B	BASIS:								
		Budget								
		X Unaudited	Cost							
		Desk Revi	ewed Cost							
		Desk Audi	ted Cost							
	_	Field Audit	ted Cost							
DISTRIBUTION:				-	TR					
Fiscal Agent					P()					
Contract Manageme	Rydell Samuel, Administrator									
Program Finance	Me	edicaid Prog	gram Finance							
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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	nta Rosa County Health Department					Provi	der Number:	0279676-9	91	
P.O. Box 929							Date	07/11/201	8	
Milton, FL 32	572-0929					Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited	l Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	ate <u>New Rate</u> <u>Effect</u>			
	<u>CHD</u>			120.95 10		10	0.95	07/01/2018		
Rate Type										
	<u>Interim</u>				Х	Prospecti	ve			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost						Prospe	ctive Adjus	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>DN:</u>						TR			
Fiscal Ag	ent						74			
Contract Management				Rydell Samuel, Administrator						
Program	Finance					Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Depa	artment	Provi	der Number: 0279684-	00		
P. O. Box 2658			Date: 07/11/201	8		
Sarasota, FL 34230-2658		Fisc	Fiscal Year End: 06/30/2017			
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	164.03	151.12	07/01/2018		
Rate Type						
Interim		X Prospecti	ve			
Tota	I Interim	X	Total Prospective			
Settl	ement Based on Cost		Prospective Adjus	sted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			rv.			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance		-	Medicaid Program Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Departm	nent	Provider Number: 0279684-91				
P. O. Box 2658			Date: 07/11/2018			
Sarasota, FL 34230-2658			Fiscal Year End: 06/30/2017			
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>Current</u>	Rate	New Rate	Effective Date		
CHD	-	164.	03	151.12	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total In	iterim		Х	Total Prospective		
Settlem		Prospective Adjusted 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			
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

Sarasota Cour	Sarasota County Health Department					Provid	der Number:	0279684-9	92	
P. O. Box 265	8						Date:	07/11/201	8	
Sarasota, FL	34230-26	58				Fiscal Year End: 06/30/2017				
						ŀ	Audit Status:	Unaudited	d Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
CHD				164.03		151	.12	07/01/2018		
Rate Type										
	<u>Interim</u>				Х	Prospecti	ve			
	-	Total Interim				X	Total P	rospective		
		Settlement B	ased o	on Cost		Prospective Adjusted For New Costs				
			BAS	<u>SIS:</u>						
				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						(N			
Contract N	Managemo	ent				<u> </u>	Rydell Samu	el, Adminis	strator	
Program Finance					I	Medicaid Pro	gram Fina	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Dep	partment	Provider Number: 0279684-93				
P. O. Box 2658			Date: 07/11/2018			
Sarasota, FL 34230-2658			Fiscal Year End: 06/30/2017			
			Aud	it Status: Unaudited	Cost	
Provider Type	Current	Rate	Effective Date			
<u>CHD</u>	-	164.	03	151.12	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Tota	al Interim		Х	Total Prospective		
Sett		Prospective Adjusted For New Costs				
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			ť	u)		
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Seminole Cou	Seminole County Health Department					Pro	vider Number:	0279692-00	1	
400 West Airp	ort Boulev	vard					Date:	07/11/2018		
Sanford, FL 3	32773					Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited C	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				124	.88	130).22	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost				Prospe	ctive Adjuste	d 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						۲N			
Contract	Managem	ent					Rydell Samu	el, Administra	ator	
Program Finance						Medicaid Pro	ogram Financ	e		

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Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Departm	ent	Prov	ider Number: 0279692-3	30		
400 West Airport Boulevard			Date: 07/11/201	8		
Sanford, FL 32773		Fiso	Fiscal Year End: 06/30/2017			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	124.88	130.22	07/01/2018		
Rate Type						
Interim		X <u>Prospect</u>	ive			
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 Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			74			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Seminole Cou	Seminole County Health Department					Pro	vider Number:	0279692-9	00	
400 West Airp	ort Boule	vard					Date	07/11/2018	3	
Sanford, FL 3	32773					Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited	Cost	
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				124	.88	130	0.22	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	<u>Prospec</u>	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost			Prospective Adjusted For New C			ed For New Costs				
			BAS	SIS:						
				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						ΓN.			
Contract	Managem	ent					Rydell Samu	uel, Adminis	trator	
Program	Finance						Medicaid Pro	ogram Finar	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health Department	Prov	vider Number: 0279706-	01			
P. O. Box 98		Date: 07/11/201	8			
Bushnell, FL 33513	Fis	Fiscal Year End: 06/30/2017				
		Audit Status: Unaudited	d Cost			
<u>Provider Type</u>	Current Rate	New Rate	Effective Date			
<u>CHD</u>	169.54	155.79	07/01/2018			
Rate Type						
Interim	X Prospect	tive				
Total Interim	X	Total Prospective				
Settlement Based on Cos	st	Prospective Adjus	ted For New Costs			
BASIS:						
Budg	get					
X Unau	udited Cost					
Desk	Reviewed Cost					
Desk	Audited Cost					
 Field	Audited Cost					
DISTRIBUTION:		R				
Fiscal Agent		r v				
Contract Management		Rydell Samuel, Adminis	strator			
Program Finance		Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health	Department			Provider Number: 0279706-91			
P. O. Box 98					Date: 07/11/201	8	
Bushnell, FL 33513				Fiscal Year End: 06/30/2017			
				Aud	dit Status: Unaudited	Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>			169	.54	155.79	07/01/2018	
Rate Type							
Interim	<u>l</u>		Х	Prospective	<u>.</u>		
	Total Interim			- X	Total Prospective		
Settlement Based on Cost				Prospective Adjusted For New Cos			
	_				_		
		BASIS:					
		Budget					
		X Unaudited	l Cost				
		Desk Revi	iewed Cost				
		Desk Audi	ited Cost				
		Field Audi	ted Cost				
DISTRIBUTION:				-	R		
Fiscal Agent					P()		
Contract Managen	nent			Ry	dell Samuel, Adminis	strator	
Program Finance				Me	dicaid Program Fina	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health Departm	nent		Provider Number: 0279706-92			
P. O. Box 98				Date: 07/11/2018	8	
Bushnell, FL 33513			Fiscal Year End: 06/30/2017			
			Aud	it Status: Unaudited	Cost	
Provider Type	Current Ra	<u>nte</u>	New Rate	Effective Date		
CHD	-	169.54		155.79	07/01/2018	
Rate Type						
<u>Interim</u>		X <u>Pr</u>	<u>ospective</u>			
Total	Interim		Х	Total Prospective		
Settle			Prospective Adjust	ted For New Costs		
				-		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION: Fiscal Agent			1	R		
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

Taylor County	Taylor County Health Department					Pro	vider Number:	0279722-00	0	
1215 Peacock	< Street						Date	07/11/2018	}	
Perry, FL 323	347					Fiscal Year End: 06/30/2017				
							Audit Status	Unaudited	Cost	
<u>Provider Tr</u>	<u>ype</u>				Curren	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				113	.38	110	6.98	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>ctive</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	d Cost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						۲N			
Contract	Managem	ent					Rydell Samu	uel, Administ	rator	
Program	Finance						Medicaid Pre	ogram Finan	се	

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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department		Prov	Provider Number: 0279722-01				
1215 Peacock Street			Date: 07/11/201	8			
Perry, FL 32347		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	113.38	116.98	07/01/2018			
Rate Type							
Interim		X Prospect	ive				
Total Inte	rim	X	Total Prospective				
Settlement Based on Cos			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 Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department		Prov	Provider Number: 0279722-30			
1215 Peacock Street		Date: 07/11/201	8			
Perry, FL 32347		Fisc	al Year End: 06/30/201	7		
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	_	113.38	116.98	07/01/2018		
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	ed 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

Union County Health Department		Provider Number: 0279731-00			
495 East Main Street		Date: 07/11/2018			
Lake Butler, FL 32054		Fiscal	Year End: 06/30/201	7	
		Au	dit Status: Unaudited	Cost	
Provider Type	Curre	ent Rate	New Rate	Effective Date	
CHD	16	9.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>	Х	Prospective	<u>!</u>		
Total Inte	erim	x	Total Prospective		
Settleme	ent 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:		-	R		
Fiscal Agent			<i>M</i>		
Contract Management		Ry	dell Samuel, Adminis	strator	
Program Finance			dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Departme	ent	Prov	vider Number: 0279731-	01
495 East Main Street			Date: 07/11/201	8
Lake Butler, FL 32054		Fise	cal Year End: 06/30/201	7
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		169.54	169.57	07/01/2018
Rate Type				
Interim		X Prospect		
Total I	nterim	X	Total Prospective	
Settler	ment 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			M	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health De	epartment	Prov	ider Number: 0279731-	03
495 East Main Street			Date: 07/11/201	8
Lake Butler, FL 32054		Fis	cal Year End: 06/30/201	7
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		169.54	169.57	07/01/2018
Rate Type		Y B		
<u>Interim</u>	Total Interim	X Prospect		
	-		Total Prospective	
	Settlement Based on Cost		Prospective Adjus	sted For New Costs
	BASIS:			
	Budget	t		
	X Unaudi	ited Cost		
	Desk R	Reviewed Cost		
	Desk A	udited Cost		
	Field A	udited Cost		
DISTRIBUTION:			TR	
Fiscal Agent			M	
Contract Manageme	ent		Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department	Р	rovider Number: 0279731-	04
495 East Main Street		Date: 07/11/201	8
Lake Butler, FL 32054	F	Fiscal Year End: 06/30/201	7
		Audit Status: Unaudited	d Cost
Provider Type	Current Rate	New Rate	Effective Date
<u>CHD</u>	169.54	169.57	07/01/2018
Rate Type			
<u>Interim</u>	X Prospe		
Total Interim	>>	Total Prospective	
Settlement Based on Co	st	Prospective Adjus	ted For New Costs
BASIS:			
Bud	get		
X Una	udited Cost		
Des	k Reviewed Cost		
Des	k Audited Cost		
 Field	d Audited Cost		
DISTRIBUTION:		TR	
Fiscal Agent		PU	
Contract Management		Rydell Samuel, Adminis	strator
Program Finance		Medicaid Program Fina	

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department		Prov	vider Number: 02797	31-30
495 East Main Street			Date: 07/11/2	2018
Lake Butler, FL 32054		Fis	cal Year End: 06/30/2	2017
			Audit Status: Unaud	ited Cost
Provider Type	<u>C</u>	Current Rate	New Rate	Effective Date
CHD		169.54	169.57	07/01/2018
Rate Type				
Interim		X Prospec		
Total Inte		X	Total Prospecti	ve
Settlemer	t Based on Cost		Prospective Ac	justed For New Costs
	BASIS:			
	Budget			
	X Unaudited Cos	st		
	Desk Reviewe	d Cost		
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DISTRIBUTION:			TR	
Fiscal Agent			M	
Contract Management			Rydell Samuel, Adm	ninistrator
Program Finance			Medicaid Program F	

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Medicaid Reimbursement Rate Change Form for CHDs

Union County	Health De	epartment				Prov	vider Number	: 0279731-	-91
495 East Mair	n Street						Date	: 07/11/20	18
Lake Butler, F	L 32054					Fis	cal Year End	: 06/30/20	17
							Audit Status	: Unaudite	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	<u> / Rate</u>	Effective Date
	<u>CHD</u>				169	.54	16	9.57	07/01/2018
Rate Type									
	Interim				X	Prospect	<u>tive</u>		
		Total Interim				Х	Total F	Prospective	;
		Settlement Ba	ased o	on Cost			Prospe	ective Adju	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						M		
Contract	Managem	ent					Rydell Sam	uel, Admini	istrator
Program	Finance						Medicaid Pr	ogram Fina	ance

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departmen	Provi	Provider Number: 0279749-00			
P. O. Box 9190		Date: 07/11/201	: 07/11/2018		
Daytona Beach, FL 32120	Fisc	al Year End: 06/30/201	7		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.54	169.57	07/01/2018	
Rate Type					
<u>Interim</u>		X <u>Prospect</u>	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	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

Volusia County Health Departm	nent		Provider Number: 0279749-15			
P. O. Box 9190			Date: 07/11/2018			
Daytona Beach, FL 32120			Fiscal Y	ear End: 06/30/2017	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current R</u>	ate	New Rate	Effective Date	
CHD	-	169.54		169.57	07/01/2018	
Rate Type						
Interim		X <u>P</u>	<u>rospective</u>			
Total	Interim		Х	Total Prospective		
Settle	ment Based on Cost			Prospective Adjust	ed For New Costs	
				_		
	BASIS:					
	Budget	_				
	X Unaudited					
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	Field Audit	ed Cost				
DISTRIBUTION:			_	R		
Fiscal Agent			ľ	V		
Contract Management			Ryd	lell Samuel, Administ	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department		Provider Number: 0279749-92		
P. O. Box 9190	Date: 07/11/2018			
Daytona Beach, FL 32120		Fiscal Y	'ear End: 06/30/2017	
		Aud	lit Status: Unaudited (Cost
Provider Type	Curre	nt Rate	New Rate	Effective Date
CHD	169	9.54	169.57	07/01/2018
Rate Type				
Interim	Х	Prospective		
Total Interim		X	Total Prospective	
Settlement Ba	sed on Cost		Prospective Adjuste	ed For New Costs
			_	
	BASIS:			
-	Budget			
	X Unaudited Cost			
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	Desk Audited Cost			
-	Field Audited Cost			
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DISTRIBUTION: Fiscal Agent		1	to the second se	
Contract Management				
Program Finance			lell Samuel, Administr dicaid Program Finand	
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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departme	nt		Provider Number: 0279749-93			
P. O. Box 9190			Date: 07/11/2018			
Daytona Beach, FL 32120			Fiscal Y	'ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD	-	169.	54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Int	erim		Х	Total Prospective		
Settlem	ent Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
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DISTRIBUTION:				at the second se		
Fiscal Agent			1	N		
Contract Management				lell Samuel, Adminis		
Program Finance			Mee	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departmen	nt		Provider Number: 0279749-97			
P. O. Box 9190			Date: 07/11/2018			
Daytona Beach, FL 32120			Fiscal Y	′ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>C</u>	urren	t Rate	New Rate	Effective Date	
CHD		169	.54	169.57	07/01/2018	
Rate Type						
Interim		X	Prospective			
Total Inte	erim		X	Total Prospective		
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited Cos	t				
	Desk Reviewed	d Cost				
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DISTRIBUTION:			-	R		
Fiscal Agent			1	av		
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

Wakulla County Health	Department			Prov	ider Number:	0279757-00	
48 Oak Street				Date: 0		07/11/2018	
Crawfordville, FL 3232	27			Fiso	cal Year End:	06/30/2017	
					Audit Status:	Unaudited C	ost
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>			132	.60	161	1.67	07/01/2018
Rate Type							
Interim	<u>1</u>		Х	Prospect	ive		
	Total Interim			- x	Total P	rospective	
	Settlement Base	d on Cost			Prospe	ctive Adjustec	For New Costs
	<u>B</u> /	ASIS:					
		Budget					
		Unaudited	d Cost				
		 Desk Rev	iewed Cost				
		 Desk Aud	ited Cost				
		Field Aud	ited Cost				
DISTRIBUTION:					TR		
Fiscal Agent					74		
Contract Manager	nent				Rydell Samu	el, Administra	itor
Program Finance					Medicaid Pro	ogram Finance	e

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Depar	rtment		Provider	Number: 0279757-0	1	
48 Oak Street			Date: 07		07/11/2018	
Crawfordville, FL 32327			Fiscal Y	ear End: 06/30/2017	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current R</u>	ate	New Rate	Effective Date	
CHD	-	132.60)	161.67	07/01/2018	
Rate Type						
<u>Interim</u>		Х <u>Р</u>	<u>rospective</u>			
Tota	al Interim		Х	Total Prospective		
Settl	lement Based on Cost			Prospective Adjust	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			ť	N V		
Contract Management			Ryd	ell Samuel, Administ	trator	
Program Finance				licaid Program Finan		
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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Departme	ent	F	Provider Number: 0279757-02			
48 Oak Street			Date: 07/11/2018			
Crawfordville, FL 32327			Fiscal Year End: 06/30/201	7		
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	_	132.60	161.67	07/01/2018		
Rate Type						
<u>Interim</u>		X Prosp	ective			
Total Int	erim		X Total Prospective			
Settleme	ent Based on Cost		Prospective Adjus	sted For New Costs		
	BASIS:					
	Budget					
	X Unaudited C	ost				
	Desk Review	ved Cost				
	Desk Audite	d Cost				
	Field Audited	d Cost				
DISTRIBUTION: Fiscal Agent			TR			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina			
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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County He	ealth De	partment			Prov	ider Number:	0279757-0	03
48 Oak Street						Date:	07/11/201	8
Crawfordville, FL 3	32327				Fisc	cal Year End:	06/30/201	7
						Audit Status:	Unaudited	Cost
Provider Type				<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CH</u>	<u>ID</u>			132	.60	161	1.67	07/01/2018
Rate Type								
Inte	<u>erim</u>			Х	Prospect	<u>ive</u>		
	То	otal Interim			- x	Total P	rospective	
	S	ettlement Base	d on Cost			Prospe	ctive Adjus	ted For New Costs
		<u>B</u> /	ASIS:					
			Budget					
		>	Unaudited	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	lited Cost				
			Field Aud	ited Cost				
DISTRIBUTION:						TR		
Fiscal Agent						7V		
Contract Mana	agement					Rydell Samu	iel, Adminis	strator
Program Finar	nce					Medicaid Pro	ogram Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Depa	ırtment		Provider	Number: 0279757-0	4
48 Oak Street			Date: 07/11/2018		
Crawfordville, FL 32327			Fiscal Y	ear End: 06/30/2017	7
			Aud	it Status: Unaudited	Cost
Provider Type		Current Ra	<u>ite</u>	New Rate	Effective Date
<u>CHD</u>	-	132.60		161.67	07/01/2018
Rate Type					
Interim		X <u>Pr</u>	<u>ospective</u>		
Tota	al Interim		Х	Total Prospective	
Sett	tlement 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			f	A)	
Contract Management			Ryd	ell Samuel, Administ	trator
Program Finance			Med	licaid Program Finar	nce
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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County He	ealth D	Department				Prov	vider Number:	0279757-3	30
48 Oak Street							Date:	07/11/201	8
Crawfordville, FL 3	32327					Fis	cal Year End:	06/30/201	7
							Audit Status:	Unaudited	Cost
Provider Type					Curren	t Rate	New	Rate	Effective Date
<u>C</u> H	<u>HD</u>			-	132	.60	16 [,]	1.67	07/01/2018
Rate Type									
Inte	<u>erim</u>				Х	Prospect	tive		
		Total Interim				- x	Total P	rospective	
		Settlement Bas	sed o	n Cost			Prospe	ctive Adjus	ted For New Costs
			BAS	<u>81S:</u>					
				Budget					
		-	Х	- Unaudited	Cost				
		-		Desk Revi	ewed Cost				
		-		Desk Audi	ted Cost				
		-		- Field Audit	ted Cost				
		-		-					
DISTRIBUTION:							TR		
Fiscal Agent							۲٩		
Contract Mana	ageme	ent					Rydell Samu	iel, Adminis	strator
Program Finar	nce						Medicaid Pro	ogram Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Departm	ent		Provider	Number: 0279757-9	91
48 Oak Street				8	
Crawfordville, FL 32327			Fiscal Y	'ear End: 06/30/2017	7
			Aud	it Status: Unaudited	Cost
Provider Type		Current F	ate	New Rate	Effective Date
CHD	-	132.60)	161.67	07/01/2018
Rate Type					
<u>Interim</u>		х <u>р</u>	<u>rospective</u>		
Total Ir	nterim		Х	Total Prospective	
Settler	nent Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audit	ted Cost			
				-7	
DISTRIBUTION:			-	IF.	
Fiscal Agent			[N	
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

Wakulla County Health Departmer	nt		Provider	Number: 0279757-9	92	
48 Oak Street			Date: 07/11/2018			
Crawfordville, FL 32327			Fiscal Y	/ear End: 06/30/201	7	
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date	
CHD	-	132.	60	161.67	07/01/2018	
Rate Type						
Interim		Х	Prospective			
Total Inte	rim		X	Total Prospective		
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	e(j		
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

Walton County Health Department		Provide	r Number: 0279765-0	00
493 North 9th Street		-	8	
Defuniak Springs, FL 32433-9401		- Fiscal	Year End: 06/30/201	7
		- Au	dit Status: Unaudited	Cost
Provider Type	Curre	ent Rate	New Rate	Effective Date
CHD	16	69.54	169.57	07/01/2018
Rate Type				
<u>Interim</u>	>	Prospective	2	
Total Interi	m	x	Total Prospective	
Settlement	Based on Cost		Prospective Adjust	ted For New Costs
			_	
	BASIS:			
	Budget			
	X Unaudited Cost			
	Desk Reviewed Co	ost		
	Desk Audited Cost			
	Field Audited Cost			
DISTRIBUTION:		-	TR	
Fiscal Agent			p()	
Contract Management		Ry	dell Samuel, Adminis	trator
Program Finance		<u> </u>	edicaid Program Finar	
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Medicaid Reimbursement Rate Change Form for CHDs

Walton County Health Department			Provider	Number: 0279765-3	30
493 North 9th Street			Date: 07/11/2018		
Defuniak Springs, FL 32433-9401			Fiscal Y	ear End: 06/30/201	7
			Aud	it Status: Unaudited	Cost
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>		169	.54	169.57	07/01/2018
Rate Type					
<u>Interim</u>		Х	Prospective		
Total Interi	m		x	Total Prospective	
Settlement	Based on Cost			Prospective Adjust	ted For New Costs
				-	
	BASIS:				
	Budget				
	X Unaudited Co	ost			
	Desk Review	ved Cost			
	Desk Audited	d Cost			
	Field Audited	d Cost			
			-	ĪR	
DISTRIBUTION: 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

Walton County Health Department			Provider	Number: 0279765-9	91
493 North 9th Street			Date: 07/11/2018		
Defuniak Springs, FL 32433-9401			Fiscal Y	ear End: 06/30/201	7
			Aud	it Status: Unaudited	Cost
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>		169	.54	169.57	07/01/2018
Rate Type					
<u>Interim</u>		Х	Prospective		
Total Interi	m		×	Total Prospective	
Settlement	Based on Cost			Prospective Adjust	ted For New Costs
				-	
	BASIS:				
	Budget				
	X Unaudited Co	ost			
	Desk Review	ved Cost			
	Desk Audited	d Cost			
	Field Audited	l Cost			
			-	TR	
DISTRIBUTION: Fiscal Agent			1		
Contract Management			Ryd	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

Washington County Health Depart	ment	Prov	ider Number: 0279773-0	00	
1338 South Boulevard			Date: 07/11/201	8	
Chipley, FL 32428		Fiso	Fiscal Year End: 06/30/2017		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		155.85	145.26	07/01/2018	
Rate Type					
Interim		X Prospect	ive		
Total Inte	erim	X	Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	 Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audit	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			(N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Washington Cou	nty Health Departme	nt		Provider	· Number:	0279773-01	
1338 South Boul	evard				Date:	07/11/2018	
Chipley, FL 324	28			Fiscal `	Year End:	06/30/2017	
				Aud	dit Status:	Unaudited Co	st
Provider Typ	<u>e</u>		<u>Current</u>	Rate	New	Rate	Effective Date
<u>c</u>	CHD		155.8	5	145	.26	07/01/2018
Rate Type	<u>iterim</u>		Х	Prospective			
^{III}	Total Interim		<u> </u>	X		ospective	
_		ased on Cost	_		_		For New Costs
		BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	iewed Cost ited Cost		_		
DISTRIBUTION: Fiscal Agent	:			-	F		
Contract Ma Program Fin	-					el, Administrate gram Finance	or
Fillyiani Fill				INIE		grann i mance	

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Hea	alth Department	Prov	vider Number: 0279773	3-04	
1338 South Boulevard			Date: 07/11/20	07/11/2018	
Chipley, FL 32428		Fis	Fiscal Year End: 06/30/2017		
			Audit Status: Unaudite	ed Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		155.85	145.26	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospec			
	Total Interim	X	Total Prospectiv		
	Settlement Based on Cost		Prospective Adju	usted For New Costs	
	BASIS:				
	Budge	t			
	X Unaud	lited Cost			
	Desk F	Reviewed Cost			
	Desk /	Audited Cost			
	 Field A	Audited Cost			
DISTRIBUTION:			TR		
Fiscal Agent			M		
Contract Managem	ent		Rydell Samuel, Admir	nistrator	
Program Finance			Medicaid Program Fir		

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Medicaid Reimbursement Rate Change Form for CHDs

Washington C	ounty Hea	Ith Department	:			Prov	vider Number:	0279773-12	2
1338 South B	oulevard					Date:		: 07/11/2018	
Chipley, FL 3	2428					Fis	cal Year End	06/30/2017	
							Audit Status	Unaudited (Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				155	.85	14	5.26	07/01/2018
Rate Type					v				
	Interim	Total Interim			X	_ <u>Prospect</u> X		roopootivo	
		-		a O a at				rospective	
		Settlement Ba	sed c	on Cost			Prospe	ective Adjuste	ed For New Costs
			BAS	<u>SIS:</u>					
				Budget					
		-	Х	- Unaudited	l Cost				
		-		_ Desk Revi	iewed Cost				
		-		Desk Audi	ited Cost				
		-		- Field Audi	ted Cost				
		-		-					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						M		
Contract	Manageme	ent					Rydell Samu	uel, Administr	ator
Program	Finance						Medicaid Pre	ogram Finano	ce

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Medicaid Reimbursement Rate Change Form for CHDs

Washington C	County Hea	Ith Department			Provid	ler Number:	0279773-30)
1338 South B	oulevard				Date:		: 07/11/2018	
Chipley, FL 3	2428				Fisca	al Year End:	06/30/2017	
					A	udit Status:	Unaudited C	Cost
<u>Provider Tr</u>	<u>ype</u>			<u>Current</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			155.	85	14	5.26	07/01/2018
Rate Type	Intorim			х	Processi	10		
	<u>Interim</u>	Total Interim			Prospectiv		rospective	
		- Settlement Based	d on Cost					d For New Costs
		-						
		<u>B</u> /	ASIS:					
			Budget					
		>	Unaudited	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	lited Cost				
			Field Aud	ited Cost				
DISTRIBUTIC	<u>DN:</u>					TR		
Fiscal Ag	ent					[N		
Contract	Manageme	ent			F	Rydell Samu	el, Administr	ator
Program	Finance				Ν	Medicaid Pro	ogram Financ	ce

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County H	lealth Department	Prov	ider Number: 0279773-	99
1338 South Boulevar	d		Date: 07/11/201	8
Chipley, FL 32428		Fiso	al Year End: 06/30/201	7
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		155.85	145.26	07/01/2018
Rate Type				
Interi	<u>m</u> Total Interim	X Prospect		
	Settlement Based on Cost		Total Prospective	ated For Now Costs
				sted For New Costs
	BASIS:			
	Budget			
	X Unaudite	d Cost		
	Desk Rev	viewed Cost		
	Desk Aud	dited Cost		
	Field Aud	lited Cost		
DISTRIBUTION:			TR	
Fiscal Agent			M	
Contract Manage	ement		Rydell Samuel, Adminis	strator
Program Finance	9		Medicaid Program Fina	

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Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Department		Pro	Provider Number: 0290068-00			
597 West 11th Street			Date: 07/11/201	07/11/2018		
Panama City, FL 32401-2330		 Fi:	scal Year End: 06/30/201	7		
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	112.41	96.43	07/01/2018		
Rate Type						
Interim		X <u>Prospec</u>	<u>ctive</u>			
Total Int	terim	X	Total Prospective			
Settlem	ent 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:			UK			
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

Bay County Health Department		Provider	Number: 029006	8-96	
597 West 11th Street			Date: 07/11/2	: 07/11/2018	
Panama City, FL 32401-2330		Fiscal Y	ear End: 06/30/2	017	
		Aud	it Status: Unaudit	ed Cost	
Provider Type	Curren	t Rate	New Rate	Effective Date	
CHD	112.	.41	96.43	07/01/2018	
Rate Type					
Interim	X	Prospective			
Total Interim		X	Total Prospectiv	/e	
Settlement Based o	on Cost		Prospective Adj	usted For New Costs	
BAS	SIS:				
	Budget				
X	- Unaudited Cost				
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	Field Audited Cost				
DISTRIBUTION:			R		
Fiscal Agent		1	N N		
Contract Management		Ryd	ell Samuel, Admi	nistrator	
Program Finance		Med	dicaid Program Fir	nance	

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Medicaid Reimbursement Rate Change Form for CHDs

Lafayette County Health Department	Prov	ider Number: 0290343-0	00
P.O. Box 1806		Date: 07/11/201	8
Mayo, FL 32066	Fisc	cal Year End: 06/30/201	7
		Audit Status: Unaudited	Cost
Provider Type	Current Rate	New Rate	Effective Date
CHD	169.54	169.57	07/01/2018
Rate Type			
<u>Interim</u>	X Prospect		
Total Interim	X	Total Prospective	
Settlement Based on Cost		Prospective Adjus	ted For New Costs
BASIS:			
Budget			
X Unaudite	d Cost		
Desk Re	viewed Cost		
Desk Au	dited Cost		
Field Aud	dited 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

Lafayette County Health Departmer	nt	Provider Number: 0290343-91			
P.O. Box 1806			Date: 07/11/2018	8	
Mayo, FL 32066		Fiscal Y	ear End: 06/30/2017	7	
		Aud	it Status: Unaudited	Cost	
Provider Type	Current	t Rate	New Rate	Effective Date	
<u>CHD</u>	169.	54	169.57	07/01/2018	
Rate Type					
Interim	Х	Prospective			
Total Inter	im	- x	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjust	ted For New Costs	
			_		
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed Cost				
	Desk Audited Cost				
	Field Audited Cost				
DISTRIBUTION:		-	R		
Fiscal Agent		ſ	N		
Contract Management		Ryd	ell Samuel, Adminis	trator	
Program Finance		Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Madison Cour	nty Health	Department				Prov	vider Number:	0290408-0	00
801 S.W. Smi	th Street					Date		: 07/11/2018	
Madison, FL	32340					Fiscal Year End: 06/30/2017			7
							Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169.	.54	16	7.55	07/01/2018
Rate Type							_		
	Interim	-			X	Prospect			
		Total Interim				X		rospective	
		Settlement Ba	ased c	on Cost			Prospe	ctive Adjus	ted For New Costs
			BAS	<u>SIS:</u>					
				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						PU		
-	Managem	ent					Rydell Samu	iel, Adminis	strator
Program	Finance						Medicaid Pro		

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Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Depa	artment		Provider Number: 0290408-01			
801 S.W. Smith Street Madison, FL 32340			Date: 07/11/2018			
			Fiscal Y	ear End: 06/30/2017	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current Rat	<u>e</u>	New Rate	Effective Date	
<u>CHD</u>	_	169.54		167.55	07/01/2018	
Rate Type						
<u>Interim</u>		X <u>Pro</u> s	<u>spective</u>			
Tota	al Interim		Х	Total Prospective		
Sett	tlement Based on Cost			Prospective Adjust	ed For New Costs	
				-		
	BASIS:					
	Budget					
	X Unaudited (Cost				
	Desk Revie	ewed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
			/	T		
DISTRIBUTION:			ý	at the second se		
Fiscal Agent			1	Ν.		
Contract Management				ell Samuel, Adminis		
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Departm	nent	Pro	Provider Number: 0290408-30			
801 S.W. Smith Street			Date: 07/11/2018			
Madison, FL 32340		 Fis	scal Year End: 06/30/201	7		
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	_	169.54	167.55	07/01/2018		
Rate Type						
Interim		X <u>Prospec</u>	tive			
Total Ir	nterim	x	Total Prospective			
Settler	nent 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:			R			
Fiscal Agent			PU			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final			
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Medicaid Reimbursement Rate Change Form for CHDs

Suwannee Co	Suwannee County Health Department				Prov	/ider Number	: 0518328-00)
P. O. Box 603	30					Date	: 07/11/2018	
Live Oak, FL	32060				Fiscal Year End: 06/30/2017			
						Audit Status	: Unaudited (Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date
	<u>CHD</u>			144	.06	16	5.18	07/01/2018
Rate Type								
	Interim			Х	Prospect	<u>tive</u>		
		Total Interim			- x	Total P	Prospective	
		Settlement Based	on Cost			Prospe	ective Adjuste	d For New Costs
		BA	<u>SIS:</u>					
			Budget					
		X	Unaudited	l Cost				
			 Desk Revi	iewed Cost				
			Desk Audi	ited Cost				
			Field Audi	ted Cost				
DISTRIBUTIC						F		
Fiscal Ag	lent Managemer	ot					vol Advoive:-tr	-to-
Program	•	n					uel, Administr ogram Finano	
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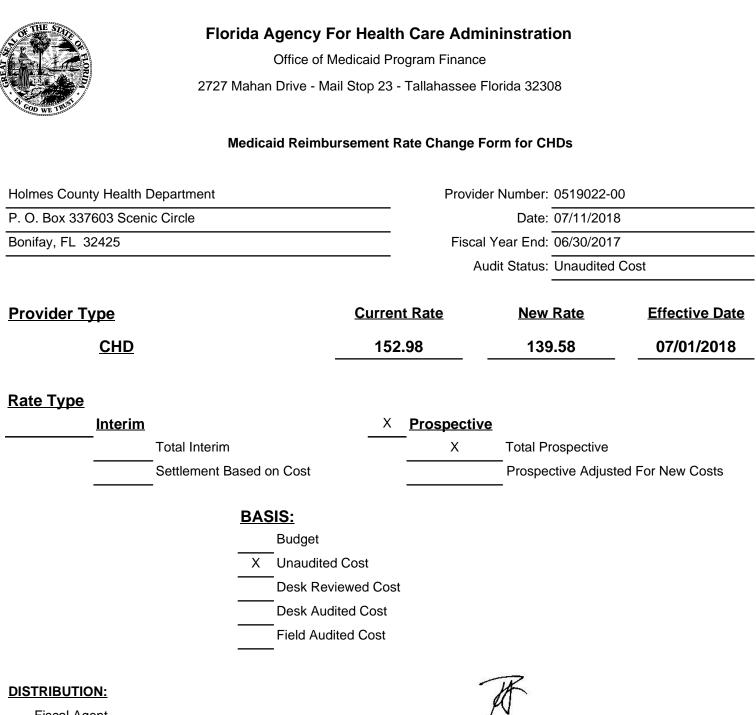


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Medicaid Reimbursement Rate Change Form for CHDs

Suwannee County Health	Suwannee County Health Department					Provider Number: 0518328-91			
P. O. Box 6030				Date: 07/11/2018					
Live Oak, FL 32060				Fiscal Year End: 06/30/2017					
				Au	idit Status: Unau	dited Cost			
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date			
<u>CHD</u>		_	144	.06	165.18	07/01/2018			
Rate Type									
<u>Interim</u>			Х	Prospective	2				
т	otal Interim			- x	Total Prospec	tive			
s	Settlement Based or	n Cost			Prospective A	Adjusted For New Costs			
	BAS	IS:							
		Budget							
	X	Unaudited C	Cost						
		Desk Revie	wed Cost						
		Desk Audite	ed Cost						
		Field Audite	ed Cost						
DISTRIBUTION:				-	IR				
Fiscal Agent					<i>P</i> ()				
Contract Managemen	t			Ry	/dell Samuel, Ad	ministrator			
Program Finance				M	edicaid Program	Finance			
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

Holmes County Health Department		Prov	ider Number: 0519022-1	15	
P. O. Box 337603 Scenic Circle			Date: 07/11/201	: 07/11/2018	
Bonifay, FL 32425		Fisc	Fiscal Year End: 06/30/2017		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		152.98	139.58	07/01/2018	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total Inter	im	X	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			rv,		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Holmes County Health Department		Provider Number: 0519022-95			
P. O. Box 337603 Scenic Circle		Date: 07/11/2018			
Bonifay, FL 32425		Fiscal Year End: 06/30/2017			
		Auc	dit Status: Unaudited	Cost	
Provider Type	Curre	nt Rate	New Rate	Effective Date	
<u>CHD</u>	152	2.98	139.58	07/01/2018	
Rate Type					
<u>Interim</u>	Х	Prospective			
Total Interi	m	X	Total Prospective		
Settlement	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	PN		
Contract Management		Ryc	dell Samuel, Adminis	strator	
Program Finance		Me	dicaid Program Fina	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Dep	partment	Prov	Provider Number: 0519251-00			
2572 N. Courtenay Parkwa	ły		Date: 07/11/20	: 07/11/2018		
Merritt Island, FL 32953-47	147	Fis	Fiscal Year End: 06/30/2017			
			Audit Status: Unaudite	d Cost		
Provider Type Cu		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	151.38	169.57	07/01/2018		
Rate Type						
<u>Interim</u>		X Prospec				
	otal Interim	X	Total Prospective			
Se	ettlement 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			M			
Contract Management			Rydell Samuel, Admini	strator		
Program Finance			Medicaid Program Fina			

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Hea	ath Department			Provider Number: 0519251-01			
2572 N. Courtenay	Parkway				Date: 07/11/201	07/11/2018	
Merritt Island, FL 3	2953-4147			Fiscal Year End: 06/30/2017		7	
				Auc	lit Status: Unaudited	l Cost	
Provider Type			<u>Current</u>	t Rate	New Rate	Effective Date	
<u>CH</u>	<u>D</u>		151.	38	169.57	07/01/2018	
Rate Type			v	Dreeneetius			
<u>Inte</u>	Total Interim		X	Prospective X	Total Prospective		
		ased on Cost		X		ted For New Costs	
		BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	iewed Cost ited Cost				
DISTRIBUTION: Fiscal Agent Contract Manage Program Finan	-				Rell Samuel, Adminis dicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department				Provider Number: 0519251-04			
2572 N. Courtenay Park	way			- Date:		: 07/11/2018	
Merritt Island, FL 32953	-4147			Fiscal Year End: 06/30/2017			
				Auc	dit Status: Ur	audited Cos	st
Provider Type			<u>Curren</u>	t Rate	<u>New Ra</u>	<u>ite</u>	Effective Date
<u>CHD</u>		-	151.	.38	169.5	7	07/01/2018
Rate Type							
<u>Interim</u>			X	Prospective			
	Total Interim			X	Total Pros	pective	
	Settlement Based o	on Cost			Prospectiv	e Adjusted F	For New Costs
	BAS	<u> 815:</u>					
		Budget					
	X	- Unaudited	Cost				
		- Desk Revie	ewed Cost				
		- Desk Audit	ted Cost				
		- Field Audit	ed Cost				
		-					
DISTRIBUTION:				-	R		
Fiscal Agent				(N		
Contract Manageme	ent				dell Samuel,		or
Program Finance				Me	dicaid Progra	m Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard Count	Brevard County Heath Department					Provider Number: 0519251-05			
2572 N. Court	enay Park	way				- Date:		07/11/2018	
Merritt Island,	FL 32953	3-4147				Fiscal Year End: 06/30/2017			
							Audit Status	Unaudited	l Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				151	.38	16	9.57	07/01/2018
Rate Type									
	Interim				Х	Prospect	ve		
	-	Total Interim				X	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs
			BAS	SIS:					
				Budget					
			Х	_ Unaudited	Cost				
				– Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				– Field Audi	ted Cost				
				_					
DISTRIBUTIO	<u>N:</u>						TR		
Fiscal Age	ent						7		
Contract N	Manageme	ent				-	Rydell Samu	iel, Adminis	strator
Program F	Finance						Medicaid Pro	ogram Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Dep	artment	Provi	Provider Number: 0519251-91			
2572 N. Courtenay Parkwa	y		Date: 07/11/201	07/11/2018		
Merritt Island, FL 32953-41	147	Fisc	Fiscal Year End: 06/30/2017			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	151.38	169.57	07/01/2018		
Rate Type						
<u>Interim</u>		X Prospecti				
	otal 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			7V			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance		-	Medicaid Program Fina	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Dep	partment		Provider Number: 0519251-92			
2572 N. Courtenay Parkwa	ay			Date: 07/11/201	07/11/2018	
Merritt Island, FL 32953-4	147		Fiscal Year End: 06/30/2017			
			Auc	lit Status: Unaudited	Cost	
Provider Type		Curren	nt Rate	New Rate	Effective Date	
<u>CHD</u>		151	.38	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		X	Prospective			
т	otal Interim		Х	Total Prospective		
S	Settlement Based on Cost	t		Prospective Adjus	ted For New Costs	
	BASIS:					
	Budg	et				
	X Unau	dited Cost				
	Desk	Reviewed Cost	:			
	Desk	Audited Cost				
	 Field	Audited Cost				
DISTRIBUTION:			_	R		
Fiscal Agent			(N		
Contract Managemen	t			dell Samuel, Adminis		
Program Finance			Me	dicaid Program Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath			Provider Number: 0519251-93				
2572 N. Courtenay Pa	rkway			- Date:		07/11/2018	
Merritt Island, FL 329	53-4147			Fiscal Year End: 06/30/2017			
				Auc	lit Status: Unau	dited Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>			151	.38	169.57	07/01/2018	
Rate Type							
<u>Interin</u>	1		X	Prospective			
	Total Interim			Х	Total Prospec	tive	
	Settlement Bas	ed on Cost			Prospective A	djusted For New Costs	
	<u>E</u>	BASIS:					
		Budget					
	_	X Unaudited	Cost				
	-	 Desk Rev	iewed Cost				
	-	Desk Aud	ited Cost				
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DISTRIBUTION:				_	F		
Fiscal Agent				(N		
Contract Manager	nent				dell Samuel, Adr		
Program Finance				Me	dicaid Program	Finance	

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Depar	Palm Beach County Health Department				Provider Number: 0520331-00			
P. O. Box 29			Date: 07/11/2018					
West Palm Beach, FL 33402			Fiscal Year End: 06/30/2017					
			Aud	it Status: Unaudited	Cost			
Provider Type Curre			Rate	New Rate	Effective Date			
<u>CHD</u>		169.54		169.57	07/01/2018			
Rate Type								
<u>Interim</u>		Х	Prospective					
Total Inte	erim		Х	Total Prospective				
Settleme	nt Based on Cost	-		Prospective Adjust	ted 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	V				
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

Palm Beach County Health Departm	ient		Provider Number: 0520331-09				
P. O. Box 29			Date: 07/11/2018				
West Palm Beach, FL 33402			Fiscal Y	'ear End: 06/30/201	7		
			Aud	lit Status: Unaudited	Cost		
Provider Type <u>Curre</u>			t Rate	New Rate	Effective Date		
<u>CHD</u>		169.	54	169.57	07/01/2018		
Rate Type							
<u>Interim</u>		Х	Prospective				
Total Interi	n		Х	Total Prospective			
Settlement Based on Cost			Prospective Ac		ted For New Costs		
				_			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audit	ted Cost					
DISTRIBUTION:			-	R			
Fiscal Agent			1	N			
Contract Management			Ryc	lell Samuel, Adminis	trator		
Program Finance				dicaid Program Finar			
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health	Department		Provider Number: 0520331-45 Date: 07/11/2018			
P. O. Box 29						
West Palm Beach, FL 33402	2		Fiscal Y	ear End: 06/30/2017	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.	54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Tota	al Interim		Х	Total Prospective		
Settlement Based on Cost			Prospective Adjusted Fo		ed For New Costs	
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	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
			000 J			
DISTRIBUTION:			-	IF.		
Fiscal Agent			[N		
Contract Management			Ryd	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

Palm Beach County Health Departn	nent		Provider Number: 0520331-50				
P. O. Box 29			Date: 07/11/2018				
West Palm Beach, FL 33402			Fiscal Y	'ear End: 06/30/201	7		
			Aud	lit Status: Unaudited	Cost		
Provider Type		Current	t Rate	New Rate	Effective Date		
CHD		169.	54	169.57	07/01/2018		
Rate Type							
<u>Interim</u>		Х	Prospective				
Total Interi	m		Х	Total Prospective			
Settlement Based on Cost			Prospective Adjusted For N		ted For New Costs		
				_			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audit	ted Cost					
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DISTRIBUTION:			-	IK .			
Fiscal Agent			(
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

Palm Beach County Health Departr	nent		Provider Number: 0520331-89 Date: 07/11/2018			
P. O. Box 29						
West Palm Beach, FL 33402			Fiscal Y	ear End: 06/30/201	7	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD	-	169.	54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inter	im		Х	Total Prospective		
Settlement Based on Cost				Prospective Adjust	ted For New Costs	
				-		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			ť			
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

Palm Beach County Health Departm	nent		Provider Number: 0520331-95 Date: 07/11/2018			
P. O. Box 29						
West Palm Beach, FL 33402			Fiscal Y	/ear End: 06/30/201	7	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current	t Rate	New Rate	Effective Date	
CHD	-	169.	54	169.57	07/01/2018	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interi	m		Х	Total Prospective		
Settlement Based on Cost			Prospective Adjusted For N		ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
			~	TR		
DISTRIBUTION: Fiscal Agent			1			
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health De	partment	Provi	der Number: 0520446-0	00			
514 East Grace Street			Date: 07/11/201	8			
Punta Gorda, FL 33950		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		136.30	106.17	07/01/2018			
Rate Type							
<u>Interim</u>		X <u>Prospect</u>	ve				
To	tal Interim	X	Total Prospective				
Settlement Based on Cost			Prospective Adjust	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audit	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			ſŇ				
Contract Management		<u>.</u>	Rydell Samuel, Adminis	trator			
Program Finance			Medicaid Program Finar	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department	F	Provider Number: 0520446-	-09
514 East Grace Street		Date: 07/11/20	18
Punta Gorda, FL 33950		Fiscal Year End: 06/30/20	17
		Audit Status: Unaudite	d Cost
<u>Provider Type</u>	Current Rate	New Rate	Effective Date
CHD	136.30	106.17	07/01/2018
Rate Type			
<u>Interim</u>	X_ <u>Prosp</u>	<u>bective</u>	
Total Interim		X Total Prospective	
Settlement Based on Cos	st	Prospective Adjus	sted For New Costs
BASIS:			
Budg	get		
XUna	udited Cost		
Desl	k Reviewed Cost		
Desl	k Audited Cost		
Field	d Audited Cost		
DISTRIBUTION:		R	
Fiscal Agent		PU	
Contract Management		Rydell Samuel, Admini	strator
Program Finance		Medicaid Program Fina	

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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte Cou	unty Health	Department			Prov	ider Number	: 0520446-9	91
514 East Gra	ce Street					Date	: 07/11/201	8
Punta Gorda,	FL 33950				Fiscal Year End: 06/30/2017			
						Audit Status	: Unaudited	l Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	<u> Rate</u>	Effective Date
	<u>CHD</u>			136	.30	10	6.17	07/01/2018
Rate Type				X	_	_		
	<u>Interim</u>	-		X	- Prospect			
		Total Interim	_		X		rospective	
		Settlement Based	on Cost			Prospe	ective Adjus	ted For New Costs
		BA	<u>SIS:</u>					
			Budget					
		X	Unaudited	Cost				
			_ Desk Revi	iewed Cost				
			_ Desk Aud	ited Cost				
			Field Audi	ted Cost				
DISTRIBUTIO	DN:					TR		
Fiscal Ag						py i		
	Manageme	ent				ہ Rydell Samu	ial Adminic	strator
Program	-					Medicaid Pr		
0							0	

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Medicaid Reimbursement Rate Change Form for CHDs

Hillsborough County Health Depa	rtment	Provi	der Number: 0557269-0	00		
1105 E. Kennedy Boulevard			Date: 07/11/201	: 07/11/2018		
Tampa, FL 33602		Fisc	Fiscal Year End: 06/30/2017			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	153.59	169.57	07/01/2018		
Rate Type						
Interim		X <u>Prospect</u>	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	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

Hillsborough (County He	alth Departme	nt			Prov	ider Number:	0557269-90		
1105 E. Kenn	edy Boule	vard				Date: 07/11/20		07/11/2018		
Tampa, FL 3	3602					Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited C	ost	
<u>Provider T</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				153	.59	169	9.57	07/01/2018	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive 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						۲N			
Contract	Managem	ent					Rydell Samu	iel, Administra	itor	
Program	Finance						Medicaid Pro	ogram Finance	e	

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County He	ealth Dep	partment			Prov	ider Number	0563234-0	00
P. O. Box 1305	421 Wes	t Main Street				Date	07/11/2018	8
Tavares, FL 32	2778-130	5			Fiscal Year End: 06/30/2017			7
						Audit Status	Unaudited	Cost
Provider Ty	<u>pe</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			169	.54	169	9.57	07/01/2018
Rate Type								
<u>I</u>	Interim			X	Prospect	<u>ive</u>		
		Total Interim			Х	Total P	rospective	
-		Settlement Base	d on Cost			Prospe	ctive Adjust	ted For New Costs
		<u>B</u>	ASIS:					
			Budget					
			X Unaudited	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	lited Cost				
		—	Field Aud	ited Cost				
DISTRIBUTION	<u>N:</u>					TR		
Fiscal Ager	nt					M		
Contract M	anageme	ent				Rydell Samu	iel, Adminis	trator
Program Fi	inance					Medicaid Pro	ogram Finar	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Department		Provider	Number: 0563234-	01
P. O. Box 1305421 West Main Street			Date: 07/11/201	18
Tavares, FL 32778-1305		Fiscal `	Year End: 06/30/201	17
		Auc	dit Status: Unaudited	d Cost
Provider Type	Currer	nt Rate	New Rate	Effective Date
CHD	169).54	169.57	07/01/2018
Rate Type	, and the second s			
<u>Interim</u>	<u></u>	_ <u>Prospective</u>		
Total Interim		X	Total Prospective	
Settlement Bas	ed on Cost		Prospective Adjus	sted For New Costs
<u> </u>	BASIS:			
	Budget			
-	X Unaudited Cost			
-	Desk Reviewed Cos	t		
-	Desk Audited Cost			
-	Field Audited Cost			
-				
DISTRIBUTION:		-	TR	
Fiscal Agent		ĺ	ev.	
Contract Management		Ryc	dell Samuel, Admini	strator
Program Finance			dicaid Program Fina	

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Department		Provi	ider Number: 0563234-9	94			
P. O. Box 1305421 West Main St	reet		Date: 07/11/201	8			
Tavares, FL 32778-1305		Fisc	Fiscal Year End: 06/30/2017				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	ent Rate <u>New Rate</u> Effect				
<u>CHD</u>	_	169.54 169.57		07/01/2018			
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 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

Escambia County Health	Department		Provider Numbe	er: 0600181-00			
1295 West Fairfield Drive			Dat	e: 07/11/2018			
Pensacola, FL 32501			Fiscal Year En	d: 06/30/2017			
			Audit Status: Unaudited Cost				
Provider Type		<u>Current</u>	Rate Ne	w Rate	Effective Date		
<u>CHD</u>		148.^	148.19 156.89		07/01/2018		
Rate Type							
Interim		Х	Prospective				
т	Total Interim		X Total	Prospective			
s	Settlement Based on Cos	-	Prosp	pective Adjusted	For New Costs		
	BASIS:						
	Budg	jet					
	X Unau	udited Cost					
	Desk	Reviewed Cost					
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	Field	Audited Cost					
DISTRIBUTION:			TR				
Fiscal Agent			/ N				
Contract Managemen	ıt		Rydell San	nuel, Administra	tor		
Program Finance			Medicaid F	Program Finance	9		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	cambia County Health Department					Prov	/ider Number:	0600181-	01	
1295 West Fai	irfield Driv	e					Date:	07/11/201	8	
Pensacola, FL	. 32501					Fis	cal Year End:	06/30/201	7	
						Audit Status: Unaudited Cost				
<u>Provider Ty</u>	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148.19 156		6.89	07/01/2018		
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	•	Total Interim				- x	Total P	rospective		
Settlement Based on Cost							Prospe	ctive Adjus	ted For New Costs	
			BAS	SIS:						
				Budget						
			Х	- Unaudited	l Cost					
				- Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>N:</u>						TR			
Fiscal Age	ent						M			
Contract Management					Rydell Samuel, Administrator					
Program F	Program Finance						Medicaid Pro	ogram Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	cambia County Health Department					Prov	/ider Number:	0600181-	03	
1295 West Fa	irfield Driv	e					Date	07/11/201	8	
Pensacola, FL	32501					Fis	cal Year End	06/30/201	7	
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148.19156		6.89	07/01/2018		
Rate Type										
	Interim				X	_ <u>Prospec</u>	<u>tive</u>			
		Total Interim				Х	Total P	rospective		
Settlement Based 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					
				_						
DISTRIBUTIC	<u>)N:</u>						TR			
Fiscal Age	ent						M			
Contract Management					Rydell Samuel, Administrator					
Program	Program Finance						Medicaid Pro	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Departme	nt	Prov	ider Number: 0600181-0	04			
1295 West Fairfield Drive			Date: 07/11/201	8			
Pensacola, FL 32501		Fiso	cal Year End: 06/30/201	7			
			Audit Status: Unaudited Cost				
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		148.19	156.89	07/01/2018			
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 Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			r v				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	cambia County Health Department					Prov	/ider Number:	0600181-0	05	
1295 West Fa	irfield Driv	e					Date	07/11/201	8	
Pensacola, FL	32501					Fis	cal Year End	06/30/201	7	
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148.19156		6.89	07/01/2018		
Rate Type										
	Interim				X	_ <u>Prospec</u>	<u>tive</u>			
		Total Interim				Χ	Total P	rospective		
Settlement Based on Cost							Prospe	ctive Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				- Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIC	<u>)N:</u>						TR			
Fiscal Age	ent						M			
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 Cou	cambia County Health Department					Prov	vider Number:	0600181-0	70	
1295 West Fa	irfield Driv	e					Date:	07/11/201	8	
Pensacola, FL	32501					Fis	cal Year End:	06/30/201	7	
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148.19 156		6.89	07/01/2018		
Rate Type										
	Interim				Х	Prospect	tive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost							Prospe	ctive Adjus	ted For New Costs	
			BAS	SIS:						
				Budget						
			Х	- Unaudited	Cost					
				- Desk Revi	ewed Cost					
				_ Desk Audi	ted Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						M			
Contract Management					Rydell Samuel, Administrator					
Program I	Program Finance						Medicaid Pro	ogram Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	cambia County Health Department					Prov	/ider Number:	0600181-0	09	
1295 West Fa	irfield Driv	e					Date	07/11/201	8	
Pensacola, FL	32501					Fis	cal Year End	06/30/201	7	
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148.1915		6.89	07/01/2018		
Rate Type										
	Interim				X	Prospec	<u>tive</u>			
		Total Interim				Х	Total P	rospective		
Settlement Based on Cost						Prospe	ctive Adjus	ted For New Costs		
			BAS	SIS:						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						M			
Contract Management					Rydell Samuel, Administrator					
Program I	Program Finance						Medicaid Pro	ogram Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	cambia County Health Department					Prov	/ider Number:	0600181-	16	
1295 West Fa	irfield Driv	e					Date	07/11/201	8	
Pensacola, FL	32501					Fis	cal Year End	06/30/201	7	
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148.19 150		6.89	07/01/2018		
Rate Type										
	Interim				Х	Prospect	<u>tive</u>			
	-	Total Interim				- X	Total P	rospective		
Settlement Based 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						M			
Contract Management					Rydell Samuel, Administrator					
Program I	Program Finance						Medicaid Pro	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	cambia County Health Department					Prov	/ider Number:	0600181-	20	
1295 West Fa	irfield Driv	'e					Date:	07/11/201	8	
Pensacola, FL	32501					Fis	cal Year End:	06/30/201	7	
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148.19 156.89			6.89	07/01/2018	
Rate Type										
	Interim				Х	Prospect	tive			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost							Prospe	ctive Adjus	sted For New Costs	
			BAS	SIS:						
				Budget						
			Х	- Unaudited	Cost					
				- Desk Revi	ewed Cost					
				_ Desk Audi	ted Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						M			
Contract Management					Rydell Samuel, Administrator					
Program I	Program Finance						Medicaid Pro	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	cambia County Health Department					Prov	/ider Number:	0600181-2	25	
1295 West Fa	irfield Driv	e					Date	07/11/201	8	
Pensacola, FL	32501					Fis	cal Year End	06/30/201	7	
						Audit Status: Unaudited Cost				
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148.19156		6.89	07/01/2018		
Rate Type										
	Interim				X	Prospect	<u>tive</u>			
		Total Interim				X	Total P	rospective		
Settlement Based on Cost							Prospe	ctive Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				_						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						M			
Contract Management					Rydell Samuel, Administrator					
Program I	Program Finance						Medicaid Pro	ogram Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	cambia County Health Department					Prov	/ider Number:	0600181-	26
1295 West Fa	irfield Driv	e					Date:	07/11/201	8
Pensacola, FL	. 32501					Fis	cal Year End:	06/30/201	7
							Audit Status:	Unaudited	d Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				148.19 156.8			6.89	07/01/2018
Rate Type									
	<u>Interim</u>				Х	Prospect	<u>tive</u>		
	-	Total Interim				- x	Total P	rospective	
Settlement Based on Cost							Prospe	ctive 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 Management					Rydell Samuel, Administrator				
Program I	Program Finance						Medicaid Pro	ogram Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health	n Department		Prov	ider Number:	0600181-29		
1295 West Fairfield Driv	e		-	Date:	07/11/2018		
Pensacola, FL 32501							
			-	Audit Status:	Unaudited Co	st	
Provider Type		Curre	ent Rate	New	Rate	Effective Date	
<u>CHD</u>		14	18.19	156	.89	07/01/2018	
Rate Type							
Interim		Х	< Prospect	ive			
	Total Interim		X	Total Pr	ospective		
	Settlement Based	on Cost		Prospec	ctive Adjusted	For New Costs	
	BA	SIS:					
		Budget					
	X	_ Unaudited Cost					
		_ Desk Reviewed Co	st				
		_ Desk Audited Cost					
		- Field Audited Cost					
		-					
DISTRIBUTION:				TR			
Fiscal Agent				PV.			
Contract Manageme	ent			Rydell Samu	el, Administrate	or	
Program Finance			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department						Prov	/ider Number	: 0600181-	31	
1295 West Fairfield Drive							Date	: 07/11/201)7/11/2018	
Pensacola, FL 32501						Fiscal Year End: 06/30/2017				
							Audit Status	: Unaudited	d Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date	
	<u>CHD</u>				148	.19	15	6.89	07/01/2018	
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	<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						M			
Contract I	Managem	ent					Rydell Samu	uel, Adminis	strator	
Program Finance							Medicaid Pr	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department						Prov	/ider Number:	0600181-	32	
1295 West Fairfield Drive							Date	07/11/201	07/11/2018	
Pensacola, FL 32501						Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited	d Cost	
Provider Type	<u>e</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
<u>c</u>	<u>HD</u>				148	.19	150	6.89	07/01/2018	
Rate Type										
<u>In</u>	<u>iterim</u>				Х	Prospec	<u>tive</u>			
		Total Interim				- x	Total P	rospective		
		Settlement Ba	ised o	on Cost			Prospe	ctive Adjus	sted 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						7N			
Contract Ma	nageme	ent					Rydell Samu	iel, Adminis	strator	
Program Finance							Medicaid Pro	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health	Department		Pro	ovider Number:	0600181-33			
1295 West Fairfield Drive	9			Date:	07/11/2018			
Pensacola, FL 32501			— Fi	Fiscal Year End: 06/30/2017				
			_	Audit Status:	Unaudited Cos	st		
Provider Type		Cui	rrent Rate	New	Rate	Effective Date		
<u>CHD</u>			148.19	156	5.89	07/01/2018		
Rate Type								
<u>Interim</u>			X <u>Prospe</u>	<u>ctive</u>				
	Total Interim	_	X	Total Pr	rospective			
	Settlement Based of	on Cost		Prospe	ctive Adjusted	For New Costs		
	BAS	SIS:						
		Budget						
	X	_ Unaudited Cost						
		_ Desk Reviewed (Cost					
		_ Desk Audited Co	st					
		- Field Audited Co	st					
		-						
DISTRIBUTION:				TR				
Fiscal Agent				PN.				
Contract Manageme	ent			Rydell Samu	el, Administrato	or		
Program Finance				Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department						Prov	vider Number:	0600181-91		
1295 West Fairfield Drive							Date:	07/11/2018		
Pensacola, FL 32501						Fiscal Year End: 06/30/2017				
							Audit Status:	Unaudited C	Cost	
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				148	.19	150	6.89	07/01/2018	
Rate Type						_	_			
	Interim	-			X	- Prospec				
		Total Interim		_		X		rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	d 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						7N			
Contract	Managem	ent					Rydell Samu	iel, Administr	ator	
Program	Finance						Medicaid Pro	ogram Financ	ce	

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Dep	partment	I	Provider Number: 0600181-92 Date: 07/11/2018 Fiscal Year End: 06/30/2017				
1295 West Fairfield Drive							
Pensacola, FL 32501							
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	148.19	156.89	07/01/2018			
Rate Type							
<u>Interim</u>		X <u>Pros</u> p	<u>pective</u>				
Tota	I Interim		X Total Prospective				
Settl	lement Based on Cost		Prospective Adjusted				
	BASIS:						
	Budget						
	X Unaudited 0	Cost					
	Desk Revie	wed Cost					
	Desk Audite	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			UF				
Fiscal Agent			<u>[N</u>				
Contract Management			Rydell Samuel, Admini	strator			
Program Finance			Medicaid Program Fina	ance			
State Health Office							