

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<br>X | Total P    | rospective  |                 |
|                |                                  | Settlement Ba | ased o | on Cost                         |                          | _                           | Χ                | _          |             | d For New Costs |
|                |                                  |               | BAS    | Budget<br>Unaudited<br>Desk Rev | viewed Cos<br>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                                | -<br>Unaudited  | Cost                     |                             |                             |              |                   |  |  |
|                 |             | -              |                                  | _<br>Desk Revi  | ewed Cost                |                             |                             |              |                   |  |  |
|                 |             | -              |                                  | Desk Audi       | ted Cost                 |                             |                             |              |                   |  |  |
|                 |             | -              |                                  | -<br>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:<br>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    | –<br>Unaudited  | l Cost                   |                             |              |               |                  |  |
|                 |                                |               |      | –<br>Desk Rev   | iewed Cost               |                             |              |               |                  |  |
|                 |                                |               |      | _<br>Desk Aud   | ited Cost                |                             |              |               |                  |  |
|                 |                                |               |      | –<br>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           |  |  |  |
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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                  | <b>Prospective</b>          |                       |                   |  |  |  |
| 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  |                   |  |  |  |
| State Health Office              |                    |                             |                       |                   |  |  |  |



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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                              |                 |             |               |                             | <sup>r</sup> 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 |  |  |
|                              |                     |              |                             | -                    |                  |  |  |
|                              | <b>BASIS:</b>       |              |                             |                      |                  |  |  |
|                              | 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 |                  |  |  |
| State Health Office          |                     |              |                             |                      |                  |  |  |



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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<br>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            |  |  |  |  |
|                               |                                  | -            |                                                 | -                    |                             |  |  |  |  |
|                               | <b>BASIS:</b>                    |              |                                                 |                      |                             |  |  |  |  |
|                               | Budget                           |              |                                                 |                      |                             |  |  |  |  |
|                               | X Unaudited                      | Cost         |                                                 |                      |                             |  |  |  |  |
|                               | Desk Revie                       | ewed Cost    |                                                 |                      |                             |  |  |  |  |
|                               | Desk Audit                       | ted Cost     |                                                 |                      |                             |  |  |  |  |
|                               | Field Audit                      | ed Cost      |                                                 |                      |                             |  |  |  |  |
|                               |                                  |              | /                                               | TR                   |                             |  |  |  |  |
| DISTRIBUTION:<br>Fiscal Agent |                                  |              | ť                                               | AT .                 |                             |  |  |  |  |
| Contract Management           |                                  |              | Rvd                                             | lell Samuel, Adminis | trator                      |  |  |  |  |
| Program Finance               |                                  |              |                                                 | dicaid Program Finar |                             |  |  |  |  |
| State Health Office           |                                  |              |                                                 |                      |                             |  |  |  |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Broward County Health De  | partment     |            | Provider Number: 0279161-93<br>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 |                |  |
| State Health Office       |              |            |                                                 |                      |                |  |



Office of Medicaid Program Finance

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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        |                 |                  |                 |                |
|                                                  |                     | _<br>Desk Reviewed    | Cost            |                  |                 |                |
|                                                  |                     | -<br>Desk Audited Co  | ost             |                  |                 |                |
|                                                  |                     | -<br>Field Audited Co | ost             |                  |                 |                |
|                                                  |                     | -                     |                 |                  |                 |                |
| DISTRIBUTION:                                    |                     |                       |                 | IF               |                 |                |
| Fiscal Agent                                     |                     |                       |                 | ſŇ               |                 |                |
| Contract Manageme                                | nt                  |                       |                 | Rydell Samu      | el, Administrat | or             |
| Program Finance                                  |                     |                       |                 | Medicaid Pro     | ogram Finance   |                |

State Health Office



Office of Medicaid Program 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        |                 |            |               |                      | <b>N</b>      |                |                  |
| Contract              | Managem    | ent             |            |               | -                    | Rydell Samu   | uel, Administi | rator            |
| Program               | Finance    |                 |            |               | -                    | Medicaid Pro  | ogram Finan    | се               |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Calhoun County Health Depa | artment               | Pro             | Provider Number: 0279170-91<br>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 |  |  |
|                            |                       |                 |                                                 |                   |  |  |
|                            | <b>BASIS:</b>         |                 |                                                 |                   |  |  |
|                            | 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                          |                   |  |  |
| State Health Office        |                       |                 |                                                 |                   |  |  |



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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               |

State Health Office



Office of Medicaid Program Finance

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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               |

State Health Office



Office of Medicaid Program Finance

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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               |  |

State Health Office



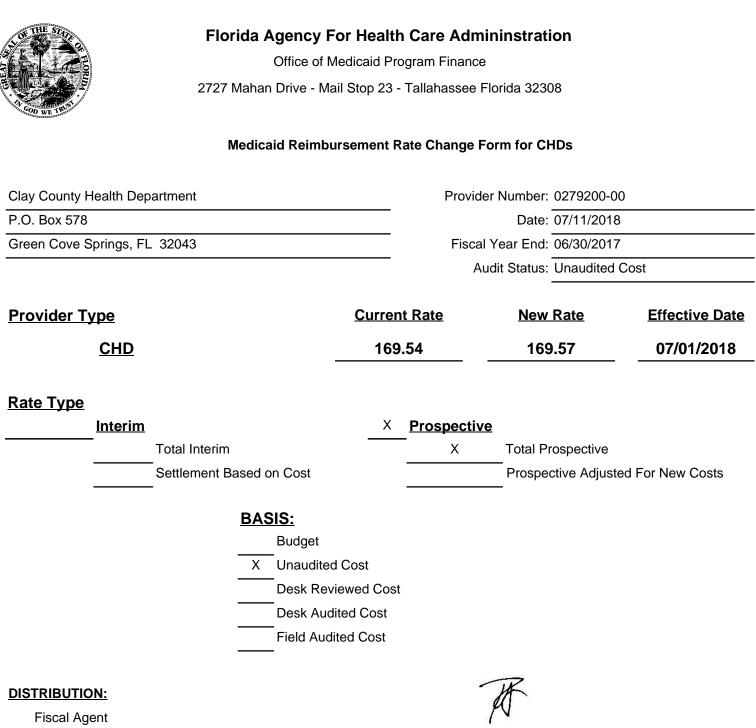
Office of Medicaid Program Finance

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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               |

State Health Office



Contract Management Program Finance

State Health Office

( ヽ Rydell Samuel, Administrator

Medicaid Program Finance



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Clay County Health Departme  | ent                  |                | Provider Number: 0279200-01<br>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              |  |
| State Health Office          |                      |                |                                                 |                      |                  |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Clay County Health Department |                 |               | Provider Number: 0279200-02 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |
|-------------------------------|-----------------|---------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--|
| P.O. Box 578                  |                 |               |                             | 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             | <b>Prospective</b>          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |
| 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           |                 |               |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

| Clay County Health Department |                   |                | Provider Number: 0279200-03<br>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              | <b>Prospective</b>                              |                       |                   |  |
| Total Int                     | erim              |                | Х                                               | Total Prospective     |                   |  |
| Settlem                       | ent Based on Cost |                |                                                 | Prospective Adjust    | ted For New Costs |  |
|                               |                   |                |                                                 | _                     |                   |  |
|                               | <b>BASIS:</b>     |                |                                                 |                       |                   |  |
|                               | Budget            |                |                                                 |                       |                   |  |
|                               | X Unaudited       | Cost           |                                                 |                       |                   |  |
|                               | Desk Revi         | ewed Cost      |                                                 |                       |                   |  |
|                               | Desk Audi         | ted Cost       |                                                 |                       |                   |  |
|                               | Field Audit       | ted Cost       |                                                 |                       |                   |  |
|                               |                   |                |                                                 |                       |                   |  |
| DISTRIBUTION:                 |                   |                | _                                               | TR                    |                   |  |
| Fiscal Agent                  |                   |                | 1                                               | av<br>V               |                   |  |
| Contract Management           |                   |                | Ryc                                             | lell Samuel, Adminis  | trator            |  |
| Program Finance               |                   |                |                                                 | dicaid Program Finar  |                   |  |
| State Health Office           |                   |                |                                                 |                       |                   |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

| Clay County Health Department |               |                | Provider Number: 0279200-04<br>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 |                |                                                 | <ul> <li>Prospective Adjust</li> </ul> | 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               |  |
| State Health Office           |               |                |                                                 |                                        |                   |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Clay County Health Department |                 |           | Provider Number: 0279200-05 |                       |                   |  |
|-------------------------------|-----------------|-----------|-----------------------------|-----------------------|-------------------|--|
| 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         | <b>Prospective</b>          |                       |                   |  |
| 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  |                   |  |
| State Health Office           |                 |           |                             |                       |                   |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Clay County Health Department |                  |           | Provider Number: 0279200-91 |                      |                   |  |
|-------------------------------|------------------|-----------|-----------------------------|----------------------|-------------------|--|
| 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           |                  |           |                             |                      |                   |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Clay County Health Department |               |           | Provider Number: 0279200-92<br>Date: 07/11/2018<br>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         | <b>Prospective</b>                                                             |                       |                   |
| Total Interi                  | m             |           | Х                                                                              | Total Prospective     |                   |
| Settlement                    | Based on Cost |           |                                                                                | Prospective Adjust    | ted For New Costs |
|                               |               |           |                                                                                | _                     |                   |
|                               | <b>BASIS:</b> |           |                                                                                |                       |                   |
|                               | 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               |
| State Health Office           |               |           |                                                                                |                       |                   |



Office of Medicaid Program Finance

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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                  | <b>Prospective</b>          |                                            |                    |  |
| 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<br>Contract Management |                    | 1                           |                                            |                    |  |
| Program Finance                     |                    |                             | lell Samuel, Admini<br>dicaid Program Fina |                    |  |
| i iogiani i manoo                   |                    | Wiet                        |                                            |                    |  |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

| Collier County Health Department | t                 |            | Provider Number: 0279218-01<br>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               |  |
| State Health Office              |                   |            |                                                 |                       |                   |  |



Office of Medicaid Program Finance

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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<br>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:<br>Fiscal Agent    |                  |       | 1                                               |                      |                   |  |
| 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

| Collier County Health Department |                   | Provi       | Provider Number: 0279218-15 |                   |  |
|----------------------------------|-------------------|-------------|-----------------------------|-------------------|--|
| P.O. Box 429                     |                   | _           | 8                           |                   |  |
| Naples, FL 34106-0429            |                   | –<br>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               |  |
| State Health Office              |                   |             |                             |                   |  |



Office of Medicaid Program Finance

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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            |                    | –<br>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:<br>Fiscal Agent    |                    |                    | pa `                        |                   |  |  |
| 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

| 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                  | <b>Prospective</b>          |                       |                   |  |
| 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               |  |
| State Health Office              |                    |                             |                       |                   |  |



Office of Medicaid Program Finance

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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               |  |

State Health Office



Office of Medicaid Program Finance

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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               |  |  |
| State Health Office            |                   |                 |                             |                      |  |  |



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    | 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 |                   |  |
| State Health Office             |                  |        |                  |                      |                   |  |



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            |                         |                   |
|                               | <br>Desk Revi    | ewed Cost       |                         |                   |
|                               | <br>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           |                    |                  |                       |                   |



Office of Medicaid Program Finance

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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               |
| State Health Office         |                    |               |              |                  |                   |



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### Medicaid Reimbursement Rate Change Form for CHDs

| DeSoto County Health Department<br>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      | -<br>Unaudited   | l Cost        |             |              |              |                   |
|                                                            |                |               |        | _<br>Desk Revi   | iewed Cost    |             |              |              |                   |
|                                                            |                |               |        | _<br>Desk Audi   | ited Cost     |             |              |              |                   |
|                                                            |                |               |        | -<br>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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Office of Medicaid Program Finance

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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              | <br>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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Office of Medicaid Program Finance

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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              | <br>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<br>Interim            | х                                                                               | <u>Prospective</u> |                   |                   |
| Total Interim                   |                                                                                 | -                  | Total Prospective |                   |
| Settlement Based on Co          | ost                                                                             |                    |                   | ted For New Costs |
| X Un:<br>De:<br>De:             | dget<br>audited Cost<br>sk Reviewed Cost<br>sk Audited Cost<br>eld Audited Cost |                    |                   |                   |
| DISTRIBUTION:<br>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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#### 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               |

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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        |              |               |               |                  |
|                      |                  |                 | <br>Desk Rev | viewed Cost   |              |               |               |                  |
|                      |                  |                 | <br>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              |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

| Dixie County Health Department<br>149 NE 241ST<br>Cross City, FL 32628 |               |              |               | Provider Number: 0279251-91<br>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             | <b>Prospective</b>                              | <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            |              |               |                                                 |                      |                   |  |



Office of Medicaid Program Finance

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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               |
| State Health Office     |                  |             |               |                  |              |                |                 |



Office of Medicaid Program Finance

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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              |                         |                   |  |
|                              | <br>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                    |                         |                   |  |
|                             | <br>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              |                         |                   |
|                            | <br>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              |                         |                   |
|                            | <br>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              |                         |                   |  |
|                             | <br>Desk Audi       | ited Cost               |                         |                   |  |
|                             | <br>Field Audi      | ted Cost                |                         |                   |  |
|                             |                     |                         |                         |                   |  |
| DISTRIBUTION:               |                     |                         | TR                      |                   |  |
| Fiscal Agent                |                     |                         | ۲N                      |                   |  |
| Contract Management         |                     |                         | Rydell Samuel, Adminis  | strator           |  |
| Program Finance             |                     |                         | Medicaid Program Finar  | nce               |  |

State Health Office



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Duval County Health Depar |                       | Provide          | r Number: (        | 0279269-46       |                  |                |
|---------------------------|-----------------------|------------------|--------------------|------------------|------------------|----------------|
| 515 West Sixth Street     |                       | Date             |                    | : 07/11/2018     |                  |                |
| Jacksonville, FL 32206    |                       |                  | Fiscal             | -<br>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                | <b>Prospective</b> | <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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Office of Medicaid Program 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<br>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<br>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               |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

| Duval County Health Departme                    | ent                 | Prov         | ider Number: 0279269-9  | 91                |
|-------------------------------------------------|---------------------|--------------|-------------------------|-------------------|
| 515 West Sixth Street<br>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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Office of Medicaid Program Finance

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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               | <b>Prospective</b> | <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<br>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<br>Interim                                 | х                                                                                                                                    | Prospective   |                           |                   |  |
| Total Interim                                        | <br>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:<br>Fiscal Agent<br>Contract Management |                                                                                                                                      | Ryd           | F<br>lell Samuel, Adminis | strator           |  |

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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        |             |                        |              |                |
|                     |                   | <br>Desk Rev   | iewed Cost    |             |                        |              |                |
|                     |                   | <br>Desk Aud   | ited Cost     |             |                        |              |                |
|                     |                   | <br>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              |                         |                   |  |
|                               |             | ewed Cost         |                         |                   |  |
|                               | Desk Audi   |                   |                         |                   |  |
|                               | 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<br>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:<br>Fiscal Agent<br>Contract Management |                                                                                                                                        | Ryd                | R<br>lell Samuel, Adminis | strator_          |

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Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

| 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        |            |              |                  |                |
|                      |                   | <br>Desk Revi  | iewed Cost    |            |              |                  |                |
|                      |                   | <br>Desk Aud   | ited Cost     |            |              |                  |                |
|                      |                   | <br>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     |                |

State Health Office

For Information Only



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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            | <b>20</b>       | 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   |                |  |
|                          | -<br>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    |                |  |

State Health Office

For Information Only



Office of Medicaid Program 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            | <b>20</b>       | 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   |                |
|                          | –<br>B          | ASIS:     |               |           |                |                 |                |
|                          | <u> </u>        | Budget    |               |           |                |                 |                |
|                          |                 | Unaudited | d Cost        |           |                |                 |                |
|                          |                 |           | viewed Cost   |           |                |                 |                |
|                          |                 | Desk Aud  |               |           |                |                 |                |
|                          |                 | Field Aud |               |           |                |                 |                |
|                          | —               |           |               |           |                |                 |                |
| DISTRIBUTION:            |                 |           |               |           | TR             |                 |                |
| Fiscal Agent             |                 |           |               |           | μ              |                 |                |
| Contract Manager         | nent            |           |               | 1         | Rydell Samu    | el, Administrat | tor            |
| Program Finance          |                 |           |               | -         |                | gram Finance    |                |

State Health Office

For Information Only



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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              |                    |                             |                      |                   |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### Medicaid Reimbursement Rate Change Form for CHDs

| Franklin County Health Department   |                        | Provider Number: 0279293-01<br>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       |                                                 |                                               |                  |  |
|                                     | <br>Desk Reviewed Cost | t                                               |                                               |                  |  |
|                                     | Desk Audited Cost      |                                                 |                                               |                  |  |
|                                     | Field Audited Cost     |                                                 |                                               |                  |  |
|                                     |                        |                                                 |                                               |                  |  |
| DISTRIBUTION:                       |                        | -                                               | R                                             |                  |  |
| Fiscal Agent<br>Contract Management |                        | 1                                               |                                               |                  |  |
| Program Finance                     |                        |                                                 | dell Samuel, Administ<br>dicaid Program Finar |                  |  |
| State Health Office                 |                        | Med                                             |                                               |                  |  |



Office of Medicaid Program Finance

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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:<br>Fiscal Agent    |                  |           | 1                           | AT .                  |                  |  |
| Contract Management              |                  |           | Rvo                         | dell Samuel, Adminis  | trator           |  |
| Program Finance                  |                  |           |                             | dicaid Program Finar  |                  |  |
| State Health Office              |                  |           |                             | -                     |                  |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| 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      | <b>Prospective</b>          |                       |                   |  |
| Total Inte                       | rim              |        | X                           | Total Prospective     |                   |  |
| Settleme                         | nt Based on Cost |        |                             | Prospective Adjust    | ted For New Costs |  |
|                                  |                  |        |                             | _                     |                   |  |
|                                  | 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               |  |
| State Health Office              |                  |        |                             |                       |                   |  |



Office of Medicaid Program Finance

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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       | <b>Prospective</b> |                      |                   |  |
| 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               |  |
| State Health Office             |                   |         |                    |                      |                   |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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   |                   |  |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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             | <b>Prospective</b> |                      |                   |
| 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 |                   |
| State Health Office            |                   |               |                    |                      |                   |



Office of Medicaid Program Finance

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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          |                  |                      |                   |
|                                  |                |               | ~                | TR                   |                   |
| DISTRIBUTION:<br>Fiscal Agent    |                |               | 1                |                      |                   |
| Contract Management              |                |               | Ryc              | lell Samuel, Adminis | trator            |
| Program Finance                  |                |               |                  | dicaid Program Finar |                   |
| State Health Office              |                |               |                  |                      |                   |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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             | <b>Prospective</b>          |                       |                   |
| 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  |                   |
| State Health Office            |                  |               |                             |                       |                   |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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:<br>Fiscal Agent    |                |         | 1                |                       |                   |  |
| Contract Management              |                |         | Ryc              | dell Samuel, Adminis  | strator           |  |
| Program Finance                  |                |         |                  | dicaid Program Finar  |                   |  |
| State Health Office              |                |         |                  |                       |                   |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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             | <b>Prospective</b> |                       |                   |  |
| 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           |                   |               |                    |                       |                   |  |



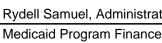
Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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          |                    | <br>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<br>ا                 |                   |
| 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

| 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               |  |  |

State Health Office



Office of Medicaid Program Finance

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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:<br>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 |  |
|                               | <b>DA 010</b>   |        |                             |                      |                   |  |
|                               | 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:<br>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<br>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                  | <b>Prospective</b>          |                       |                |  |
| 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:<br>Fiscal Agent |                    | -                           | R                     |                |  |
| Contract Management           |                    | Rye                         | dell Samuel, Adminis  | trator         |  |
| Program Finance               |                    |                             | dicaid Program Finar  |                |  |
| State Health Office           |                    |                             |                       |                |  |



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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     | <b>Prospective</b>          |                      |                |  |
| 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:<br>Fiscal Agent |                  |       | 1                           | F                    |                |  |
| Contract Management           |                  |       | Ryd                         | lell Samuel, Adminis | trator         |  |
| Program Finance               |                  |       |                             | dicaid Program Finar |                |  |
| State Health Office           |                  |       |                             |                      |                |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Gulf County Health Department |               |               | Provider Number: 0279331-11<br>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   |                   |  |
| State Health Office           |               |               |                                                 |                 |                   |  |



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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:<br>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     |                             |                        |                |  |  |
|                             |               | <br>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  |                |  |  |
| State Health Office         |               |               |               |                             |                        |                |  |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Gulf County Health Department |                 |        | Provider Number: 0279331-30<br>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:<br>Fiscal Agent |                 |        | Ĩ                                               | F                    |                |  |
| 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

| 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               |  |

State Health Office



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#### Medicaid Reimbursement Rate Change Form for CHDs

| Hamilton County Health De | epartment        |                  | Provider Number: 0279340-25<br>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.<br>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            |  |
| State Health Office       |                  |                  |                                                 |                      |                |  |



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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 |  |  |
|                              |                     |               |                           |                    |  |  |
|                              | <b>BASIS:</b>       |               |                           |                    |  |  |
|                              | 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               |  |  |
| State Health Office          |                     |               |                           |                    |  |  |



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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 |  |
|                    |                 |               |               |                  |                       |                   |  |
|                    |                 | <b>BASIS:</b> |               |                  |                       |                   |  |
|                    |                 | 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          |               |               |                  |                       |                   |  |



Office of Medicaid Program Finance

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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               |

State Health Office



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Hendry County Health Departmen | t                | Р              | Provider Number: 0279366-30<br>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:<br>Fiscal Agent  |                  |                | A                                               |                    |  |
| Contract Management            |                  |                | Rydell Samuel, Adminis                          | strator            |  |
| Program Finance                |                  |                | Medicaid Program Fina                           |                    |  |
| State Health Office            |                  |                |                                                 |                    |  |



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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       | <b>Prospective</b> |                      |                   |
| 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:<br>Fiscal Agent |                   |         | 1                  | AT .                 |                   |
| 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

| 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  |                         |                   |
| <br>Desk Aud                      | lited Cost   |                         |                   |
| Field Aud                         |              |                         |                   |
|                                   |              |                         |                   |
| DISTRIBUTION:                     |              | R                       |                   |
| Fiscal Agent                      |              | PU .                    |                   |
| Contract Management               |              | Rydell Samuel, Adminis  | strator           |
| Program Finance                   |              | Medicaid Program Fina   |                   |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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             | <b>Prospective</b> |                       |                   |
|                      | 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             | <b>Prospective</b> | <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:<br>Fiscal Agent |                |             |               |                    | pt -                 |                        |
| Contract Manager              | nent           |             |               | Rv                 | '<br>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                                                       | <br>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<br>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<br>Cost         |                                                 |                    |  |
| DISTRIBUTION:<br>Fiscal Agent<br>Contract Management<br>Program Finance |                                                                                                                                  |                        | Rydell Samuel, Adminis<br>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

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### 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             | <b>Prospective</b>          | <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               |              |               |                             |                       |                   |  |



Office of Medicaid Program Finance

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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              | –<br>Fisca        | al Year End: 06/30/201 | 7                           |                   |  |  |
|                                   |                   | _<br>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               |                   |                        |                             |                   |  |  |



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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     |                 |             |           |                             |              |                |                 |



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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    |                 |             |               |                             |                    |                       |  |



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Indian River County He | alth Department |             |               | Provider Number: 0279412-04 |                |               |                |
|------------------------|-----------------|-------------|---------------|-----------------------------|----------------|---------------|----------------|
| 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    |                 |             |               |                             |                |               |                |



Office of Medicaid Program Finance

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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)

State Health Office



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               |

For Information Only (No Change In Rate)

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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     |                 |             |           |                             |              |               |                 |



Office of Medicaid Program Finance

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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             | –<br>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              |                    |                        |                             |                   |  |  |



Office of Medicaid Program Finance

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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           |                     |                  |                             |                   |  |  |



Office of Medicaid Program Finance

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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             | <b>Prospect</b> | 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          |                 |               |                 |                 |
|                       |                  | <br>Desk Revi   | ewed Cost     |                 |               |                 |                 |
|                       |                  | <br>Desk Audi   | ted Cost      |                 |               |                 |                 |
|                       |                  | —<br>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 |  |
|                  |                  | <b>BASIS:</b>  |              |                         |                    |  |
|                  |                  | Budget         |              |                         |                    |  |
|                  |                  | X Unaudited    | d Cost       |                         |                    |  |
|                  |                  | Desk Rev       | iewed Cost   |                         |                    |  |
|                  |                  | Desk Aud       | ited Cost    |                         |                    |  |
|                  |                  | <br>Field Audi | ited Cost    |                         |                    |  |
|                  |                  |                |              |                         |                    |  |
| DISTRIBUTION:    |                  |                |              | TR                      |                    |  |
| Fiscal Agent     |                  |                |              | M                       |                    |  |
| Contract Mana    | agement          |                |              | Rydell Samuel, Admini   | strator            |  |
| Program Fina     | nce              |                |              | Medicaid Program Fina   | ance               |  |

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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                  |                     | × <b>-</b>   |                             |                   |  |
| <u>Interim</u>             | Lintarim            | X Prospecti  |                             |                   |  |
|                            | I Interim           | X            | Total Prospective           |                   |  |
| Setti                      | ement Based on Cost |              | Prospective Adjus           | ted For New Costs |  |
|                            | <b>BASIS:</b>       |              |                             |                   |  |
|                            | Budget              |              |                             |                   |  |
|                            | X Unaudited         | Cost         |                             |                   |  |
|                            | Desk Revi           | ewed Cost    |                             |                   |  |
|                            | Desk Audit          | ted Cost     |                             |                   |  |
|                            | Field Audit         | ed Cost      |                             |                   |  |
|                            |                     |              |                             |                   |  |
| DISTRIBUTION:              |                     |              | 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

| 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<br>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               |  |

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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     |                             |             |                 |                |
|                   |                 | <br>Desk Rev   | iewed Cost |                             |             |                 |                |
|                   |                 | Desk Aud       | ited Cost  |                             |             |                 |                |
|                   |                 | <br>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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#### 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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#### 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       |                             |                 |                |  |
|                   |                  | <br>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   |                |  |

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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      | _<br>Unaudited  | l Cost        |                             |               |              |                   |
|                  |           |               |        | _<br>Desk Revi  | iewed Cost    |                             |               |              |                   |
|                  |           |               |        | _<br>Desk Audi  | ited Cost     |                             |               |              |                   |
|                  |           |               |        | -<br>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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#### 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        |                             |               |              |                   |
|                  |              |               |        | _<br>Desk Revi  | iewed Cost    |                             |               |              |                   |
|                  |              |               |        | Desk Audi       | ited Cost     |                             |               |              |                   |
|                  |              |               |        | -<br>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               |

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### 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      | _<br>Unaudited  | d Cost        |                             |              |                |                  |  |
|                |                |               |        | _<br>Desk Rev   | iewed Cost    |                             |              |                |                  |  |
|                |                |               |        | _<br>Desk Aud   | ited Cost     |                             |              |                |                  |  |
|                |                |               |        | –<br>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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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 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             | <b>Prospective</b>          |                       |                   |  |  |
|                         | 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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Office of Medicaid Program Finance

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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       |                   |  |

State Health Office

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(No Change In Rate)



Office of Medicaid Program Finance

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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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Office of Medicaid Program Finance

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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      | -<br>Unaudited  | Cost          |                             |               |              |                    |  |
|                    |                             |               |        | _<br>Desk Revi  | iewed Cost    |                             |               |              |                    |  |
|                    |                             |               |        | _<br>Desk Aud   | ited Cost     |                             |               |              |                    |  |
|                    |                             |               |        | –<br>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      | –<br>Unaudited  | d Cost        |                             |               |                  |                |  |
|                 |                             |               |        | _<br>Desk Rev   | iewed Cost    |                             |               |                  |                |  |
|                 |                             |               |        | _<br>Desk Aud   | ited Cost     |                             |               |                  |                |  |
|                 |                             |               |        | –<br>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        |                    |  |  |  |
| State Health Office         |                      |               |                             |                    |  |  |  |



Office of Medicaid Program Finance

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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<br>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:<br>Fiscal Agent          |                                                                                                                                        | P                                | F                                           |                   |
| Contract Management<br>Program Finance |                                                                                                                                        |                                  | ell Samuel, Adminis<br>licaid Program Finar |                   |

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Office of Medicaid Program Finance

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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    |                             |                    |  |  |  |
|                                   | <br>Desk Audit   | ed Cost      |                             |                    |  |  |  |
|                                   | Field Audit      | ed Cost      |                             |                    |  |  |  |
|                                   |                  |              |                             |                    |  |  |  |
| DISTRIBUTION:                     |                  |              | TR                          |                    |  |  |  |
| Fiscal Agent                      |                  |              | / *                         |                    |  |  |  |
| 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

| 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<br>Interim                                 | Х                                                                                                 | <u>Prospective</u> |                          |                   |
| Total Interim                                        |                                                                                                   | - X                | Total Prospective        |                   |
| Settlement Based                                     | on Cost                                                                                           |                    | Prospective Adjust       | ted For New Costs |
| BA                                                   | SIS:<br>Budget<br>Unaudited Cost<br>Desk Reviewed Cost<br>Desk Audited Cost<br>Field Audited Cost |                    | -                        |                   |
| DISTRIBUTION:<br>Fiscal Agent<br>Contract Management |                                                                                                   | Ryde               | F<br>ell Samuel, Adminis | trator            |
| Program Finance                                      |                                                                                                   | Med                | icaid Program Finar      | nce               |

State Health Office



Office of Medicaid Program Finance

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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       | –<br>Unaudited  | d Cost        |                             |                             |                  |                |  |  |
|                    |                                |               |         | –<br>Desk Rev   | iewed Cost    |                             |                             |                  |                |  |  |
|                    |                                |               |         | –<br>Desk Aud   | ited Cost     |                             |                             |                  |                |  |  |
|                    |                                |               |         | –<br>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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State Health Office



Office of Medicaid Program Finance

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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       | _<br>Unaudited  | l Cost        |              |                   |              |                |
|                     |                                |               |         | _<br>Desk Revi  | iewed Cost    |              |                   |              |                |
|                     |                                |               |         | _<br>Desk Aud   | ited Cost     |              |                   |              |                |
|                     |                                |               |         | –<br>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            |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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        |                             |               |                   |                |  |
|                     |                                |               |         | –<br>Desk Rev   | iewed Cost    |                             |               |                   |                |  |
|                     |                                |               |         | –<br>Desk Aud   | ited Cost     |                             |               |                   |                |  |
|                     |                                |               |         | –<br>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            |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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       | _<br>Unaudited  | l Cost        |                             |              |                   |                |  |
|                     |                                |               |         | _<br>Desk Revi  | iewed Cost    |                             |              |                   |                |  |
|                     |                                |               |         | _<br>Desk Aud   | ited Cost     |                             |              |                   |                |  |
|                     |                                |               |         | –<br>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            |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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                                | _<br>Unaudited  | l Cost        |                             |              |                             |                   |  |  |  |
|               |                 |               |                                  | _<br>Desk Revi  | iewed Cost    | t                           |              |                             |                   |  |  |  |
|               |                 |               |                                  | _<br>Desk Audi  | ited Cost     |                             |              |                             |                   |  |  |  |
|               |                 |               |                                  | -<br>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    |              |                             |                   |  |  |  |

State Health Office

For Information Only



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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               |  |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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      | _<br>Unaudited  | Cost          |                             |               |                |                 |  |
|                    |                                  |               |        | _<br>Desk Revi  | iewed Cost    |                             |               |                |                 |  |
|                    |                                  |               |        | _<br>Desk Audi  | ited Cost     |                             |               |                |                 |  |
|                    |                                  |               |        | -<br>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             |                 |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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 <sup>®</sup>        | <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                                | -<br>Unaudited  | Cost          |                             |               |                             |                  |  |  |  |
|                 |               |               |                                  | -<br>Desk Revi  | iewed Cost    |                             |               |                             |                  |  |  |  |
|                 |               |               |                                  | -<br>Desk Audi  | ited Cost     |                             |               |                             |                  |  |  |  |
|                 |               |               |                                  | -<br>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    |               |                             |                  |  |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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                               | _<br>Unaudited  | Cost          |                             |              |                             |                  |  |  |  |
|                    |             |                |                                 | _<br>Desk Revi  | iewed Cost    |                             |              |                             |                  |  |  |  |
|                    |             |                |                                 | _<br>Desk Aud   | ited Cost     |                             |              |                             |                  |  |  |  |
|                    |             |                |                                 | –<br>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

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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<br>Medicaid Program Fina |                   |  |  |  |
| i iogram i manoc               |                   |              | medicalu i rogram i ma                          | 100               |  |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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    | _<br>Unaudited  | d Cost        |                             |               |                 |                 |  |
|                 |                |               |      | –<br>Desk Rev   | iewed Cost    |                             |               |                 |                 |  |
|                 |                |               |      | _<br>Desk Aud   | ited Cost     |                             |               |                 |                 |  |
|                 |                |               |      | –<br>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

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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         |                             |               |               |                |  |
|                           | <br>Field Audit        | ed Cost          |                             |               |               |                |  |
|                           |                        |                  |                             |               |               |                |  |
| DISTRIBUTION:             |                        |                  | ~                           | IR            |               |                |  |
| Fiscal Agent              |                        |                  |                             | RI .          |               |                |  |
| -                         |                        |                  |                             |               |               |                |  |
| Contract Management       |                        |                  |                             |               | Administrato  | <u>or</u>      |  |
| Program Finance           |                        |                  | ivie                        | dicaid Progra | ani Finance   |                |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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               |  |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### Medicaid Reimbursement Rate Change Form for CHDs

| Marion County Health Department     | Prov          | Provider Number: 0279528-12            |                   |  |  |  |
|-------------------------------------|---------------|----------------------------------------|-------------------|--|--|--|
| 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                           | <b>V D</b>    |                                        |                   |  |  |  |
| <u>Interim</u><br>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                  |                   |  |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### Medicaid Reimbursement Rate Change Form for CHDs

| Marion County Health Department     | Prov          | Provider Number: 0279528-30 |                   |  |  |  |
|-------------------------------------|---------------|-----------------------------|-------------------|--|--|--|
| 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><br>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       |                   |  |  |  |

State Health Office

For Information Only



Office of Medicaid Program Finance

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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               |  |  |  |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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               |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### Medicaid Reimbursement Rate Change Form for CHDs

| Martin County Health Dep | partment         |                        |               | Provider Number: 0279536-11<br>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             | <b>Prospective</b>                              | <u>)</u>             |                     |  |
|                          | Total Interim    |                        |               | - X                                             | Total Prospective    | e                   |  |
| ;                        | Settlement Based | on Cost                |               |                                                 | Prospective Adju     | usted For New Costs |  |
|                          | DA               | ele.                   |               |                                                 |                      |                     |  |
|                          |                  | <b>\SIS:</b><br>Budget |               |                                                 |                      |                     |  |
|                          | <u> </u>         | Unaudited              | Cost          |                                                 |                      |                     |  |
|                          |                  |                        | iewed Cost    |                                                 |                      |                     |  |
|                          |                  | <br>Desk Audi          |               |                                                 |                      |                     |  |
|                          |                  | Field Audi             |               |                                                 |                      |                     |  |
|                          |                  |                        | ieu Cosi      |                                                 |                      |                     |  |
| DISTRIBUTION:            |                  |                        |               | -                                               | TR                   |                     |  |
| Fiscal Agent             |                  |                        |               |                                                 | / `                  |                     |  |
| Contract Managemer       | nt               |                        |               |                                                 | dell Samuel, Admir   |                     |  |
| Program Finance          |                  |                        |               | Me                                              | edicaid Program Fin  | ance                |  |
| State Health Office      |                  |                        |               |                                                 |                      |                     |  |



Office of Medicaid Program Finance

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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               |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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><br>X |              | Prospective   |                     |
|                    |             | -<br>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      | -<br>Unaudited   | l Cost        |                       |              |               |                     |
|                    |             |                    |        | _<br>Desk Revi   | iewed Cost    | t                     |              |               |                     |
|                    |             |                    |        | Desk Audi        | ited Cost     |                       |              |               |                     |
|                    |             |                    |        | -<br>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                |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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               |

State Health Office



Office of Medicaid Program Finance

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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               |

State Health Office



Office of Medicaid Program Finance

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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               |

State Health Office



Office of Medicaid Program Finance

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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                 |                    |                        | <b>~ ~</b>              |                   |
| 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

| 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       |               |                |                 |
|                    |             | -             |        | <b>o</b> (      |               | X                |               | rospective     |                 |
|                    |             | Settlement Ba | ased o | on Cost         |               |                  | Prospe        | ctive Adjuste  | d For New Costs |
|                    |             |               | BAS    | SIS:            |               |                  |               |                |                 |
|                    |             |               |        | Budget          |               |                  |               |                |                 |
|                    |             |               | X      | -<br>Unaudited  | Cost          |                  |               |                |                 |
|                    |             |               |        | –<br>Desk Revi  | iewed Cost    |                  |               |                |                 |
|                    |             |               |        | _<br>Desk Aud   | ited Cost     |                  |               |                |                 |
|                    |             |               |        | –<br>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              |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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               |

State Health Office



Office of Medicaid Program Finance

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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               |

State Health Office



Office of Medicaid Program Finance

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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 <b>۷</b>              |                   |
| 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

| 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<br>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               |

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    | 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               |
| State Health Office             |                 |          |             |                      |                   |



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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             |                  |          |             |                      |                   |



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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             |               |               |             |                      |                   |



Office of Medicaid Program Finance

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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               |  |

State Health Office

For Information Only

(No Change In Rate)



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| 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               |

State Health Office



Office of Medicaid Program Finance

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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               |

State Health Office



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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               |

State Health Office



Office of Medicaid Program Finance

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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               |

State Health Office



Office of Medicaid Program Finance

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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         |               | <br>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               |  |

State Health Office



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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<br>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<br>6101 Lake Ellenor Drive<br>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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Office of Medicaid Program Finance

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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<br>Orlando, FL 32804 |                   | _          | 8                       |                   |
|                                              |                   | —<br>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               |
| State Health Office                          |                   |            |                         |                   |



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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<br>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><br>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           |  |

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**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<br>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            |  |

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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><br>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:<br>Fiscal Agent |                          |               |                    | R                    |                    |  |
| Contract Managemer            | nt                       |               | Ryc                | lell Samuel, Adminis | strator            |  |

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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<br>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  |                   |
| State Health Office            |                  |          |                     |                       |                   |



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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             | <b>Prospect</b> | 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<br>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      | _<br>Unaudited  | l Cost       |            |               |               |                  |
|                          |                |               |        | _<br>Desk Revi  | iewed Cost   | :          |               |               |                  |
|                          |                |               |        | _<br>Desk Audi  | ited Cost    |            |               |               |                  |
|                          |                |               |        | -<br>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                      |                         |                    |  |
|                                 | <br>Desk Revi  | iewed Cost                  |                         |                    |  |
|                                 | <br>Desk Audi  | ited Cost                   |                         |                    |  |
|                                 | <br>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 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 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                    |                         |                   |  |
|                                 | <br>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           | <br>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<br>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           | <br>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                    |               |                          | <sup>rv</sup>           |                    |
| 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           | <br>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      | _<br>Unaudited  | l Cost        |            |               |               |                  |
|                   |                |               |        | _<br>Desk Revi  | iewed Cost    |            |               |               |                  |
|                   |                |               |        | _<br>Desk Audi  | ited Cost     |            |               |               |                  |
|                   |                |               |        | –<br>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      | <br>Unaudited   | d Cost                      |                             |               |                |                 |  |
|                   |                                 |               |        | _<br>Desk Rev   | iewed Cost                  |                             |               |                |                 |  |
|                   |                                 |               |        | _<br>Desk Aud   | ited Cost                   |                             |               |                |                 |  |
|                   |                                 |               |        | –<br>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 |                             |                  |                |              |
|                         |                                | <br>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      | _            |
| State Health Office     |                                |               |           |                             |                  |                |              |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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         | <b>Prospective</b>          | <u>)</u>              |                    |  |
|                      | Total Interim                  |                       |           | X                           | Total Prospective     |                    |  |
|                      | Settlement Ba                  | sed on Cost           |           |                             | Prospective Adjus     | sted For New Costs |  |
|                      | _                              |                       |           |                             |                       |                    |  |
|                      |                                | BASIS:                |           |                             |                       |                    |  |
|                      | -                              | Budget<br>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               |  |
| State Health Office  | 1                              |                       |           |                             |                       |                    |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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    |                 |  |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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.<br>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            |                                   |                 |                             |                             |  |  |  |



Office of Medicaid Program Finance

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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       |                             |                   |  |  |
|                            | <br>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               |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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             |               |                 |                             |                |  |  |  |



Office of Medicaid Program Finance

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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           |            | <br>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         |  |  |  |

State Health Office



Office of Medicaid Program 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         |            |                             |                 |                |  |  |
|                      |                                    | <br>Desk Revi  | iewed Cost     |            |                             |                 |                |  |  |
|                      |                                    | Desk Audi      | ited Cost      |            |                             |                 |                |  |  |
|                      |                                    | <br>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    |                |  |  |

State Health Office



Office of Medicaid Program 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        |  |  |  |

State Health Office



Office of 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     |                |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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  |                          |              |                |                |  |
|                          |                                | <br>Field Audi               | ted Cost   |                          |              |                |                |  |
|                          |                                |                              |            |                          |              |                |                |  |
| DISTRIBUTION:            |                                |                              |            |                          | TR           |                |                |  |
| Fiscal Agent             |                                |                              | M          |                          |              |                |                |  |
| Contract Manage          |                                | Rydell Samuel, Administrator |            |                          |              |                |                |  |
| Program Finance          | 9                              |                              |            | Medicaid Program Finance |              |                |                |  |

State Health Office



Office of 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  |                          |               |              |                |  |
|                      |                  | <br>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         |                          |               |              |                |  |
|                      |                 | <br>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       |                              |                       |  |  |  |
|                      |                | <br>Desk Rev | iewed Cost   |                              |                       |  |  |  |
|                      |                | <br>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     |                       |  |  |  |

For Information Only

(No Change In Rate)

State Health Office



Office of Medicaid Program Finance

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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      | _<br>Unaudited  | l Cost                       |                  |                             |                |                 |  |  |  |
|                     |                                   |               |        | -<br>Desk Revi  | iewed Cost                   |                  |                             |                |                 |  |  |  |
|                     |                                   |               |        | -<br>Desk Aud   | ited Cost                    |                  |                             |                |                 |  |  |  |
|                     |                                   |               |        | -<br>Field Audi | ted Cost                     |                  |                             |                |                 |  |  |  |
|                     |                                   |               |        | -               |                              |                  |                             |                |                 |  |  |  |
| DISTRIBUTIO         | <u>)N:</u>                        |               |        |                 |                              |                  | TR                          |                |                 |  |  |  |
| Fiscal Agent        |                                   |               |        |                 |                              |                  | M                           |                |                 |  |  |  |
| Contract Management |                                   |               |        |                 | Rydell Samuel, Administrator |                  |                             |                |                 |  |  |  |
| Program I           | Program Finance                   |               |        |                 |                              |                  | _                           | ogram Financ   |                 |  |  |  |

State Health Office

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(No Change In Rate)



Office of Medicaid Program Finance

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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    |             |                |                             |                |  |  |  |
| State Health Office      |                                   |                |               |             |                |                             |                |  |  |  |



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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                           | <b>-</b>      |        |                              | X             | - Prospecti |              |             |                    |
|                     |                                   | Total Interim |        |                              |               | Χ           |              | rospective  |                    |
|                     |                                   | Settlement B  | ased o | on Cost                      |               |             | Prospe       | ctive Adjus | sted For New Costs |
|                     |                                   |               | BAS    | SIS:                         |               |             |              |             |                    |
|                     |                                   |               |        | Budget                       |               |             |              |             |                    |
|                     |                                   |               | X      | -<br>Unaudited               | l Cost        |             |              |             |                    |
|                     |                                   |               |        | -<br>Desk Revi               | iewed Cost    |             |              |             |                    |
|                     |                                   |               |        | -<br>Desk Aud                | ited Cost     |             |              |             |                    |
|                     |                                   |               |        | -<br>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      | _<br>Unaudited               | Cost          |             |                             |             |                    |  |  |
|                     |                                   |               |        | _<br>Desk Revi               | iewed Cost    |             |                             |             |                    |  |  |
|                     |                                   |               |        | _<br>Desk Aud                | ited Cost     |             |                             |             |                    |  |  |
|                     |                                   |               |        | -<br>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      | -<br>Unaudited  | l Cost                       |             |                             |              |                    |  |  |
|                |                                   |               |        | -<br>Desk Revi  | iewed Cost                   |             |                             |              |                    |  |  |
|                |                                   |               |        | -<br>Desk Aud   | ited Cost                    |             |                             |              |                    |  |  |
|                |                                   |               |        | -<br>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      | _<br>Unaudited               | Cost          |            |                             |             |                    |  |  |
|                     |                                   |               |        | _<br>Desk Revi               | iewed Cost    |            |                             |             |                    |  |  |
|                     |                                   |               |        | _<br>Desk Aud                | ited Cost     |            |                             |             |                    |  |  |
|                     |                                   |               |        | -<br>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               |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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  |             |                 |                             |               |  |  |  |
| State Health Office      |                                   |              |               |             |                 |                             |               |  |  |  |



Office of Medicaid Program 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   | -<br>Unaudited               | l Cost        |                             |                                   |                   |        |  |
|                          |                                   |               |     | _<br>Desk Revi               | iewed Cost    |                             |                                   |                   |        |  |
|                          |                                   |               |     | _<br>Desk Aud                | ited Cost     |                             |                                   |                   |        |  |
|                          |                                   |               |     | -<br>Field Audi              | ted Cost      |                             |                                   |                   |        |  |
|                          |                                   |               |     | _                            |               |                             |                                   |                   |        |  |
| DISTRIBUTIC              | <u>DN:</u>                        |               |     |                              |               |                             | TR                                |                   |        |  |
| Fiscal Ag                | ent                               |               |     |                              |               |                             | 74                                |                   |        |  |
| Contract Management      |                                   |               |     | Rydell Samuel, Administrator |               |                             |                                   |                   |        |  |
| Program                  | Finance                           |               |     |                              |               | Medicaid Program Finance    |                                   |                   |        |  |

State Health Office



Office of 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               |  |  |

State Health Office



Office of Medicaid Program Finance

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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 |                             |                      |            |  |
|                                |                |                                    |                             | _                    |            |  |
|                                | <b>BASIS:</b>  |                                    |                             |                      |            |  |
|                                | 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        |  |
| State Health Office            |                |                                    |                             |                      |            |  |



Office of Medicaid Program Finance

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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      | -<br>Unaudited  | l Cost        |                                    |               |             |                |  |
|                 |                                   |               |        | -<br>Desk Revi  | iewed Cost    |                                    |               |             |                |  |
|                 |                                   |               |        | -<br>Desk Audi  | ited Cost     |                                    |               |             |                |  |
|                 |                                   |               |        | -<br>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         |                |  |

State Health Office



Office of Medicaid Program Finance

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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 |            |  |
| State Health Office        |             |                                    |                             |                      |            |  |



Office of Medicaid Program Finance

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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   | –<br>Unaudited  | d Cost        |                             |               |                |                |  |
|                          |                                   |               |     | –<br>Desk Rev   | iewed Cost    |                             |               |                |                |  |
|                          |                                   |               |     | _<br>Desk Aud   | ited Cost     |                             |               |                |                |  |
|                          |                                   |               |     | –<br>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              |                |  |

State Health Office

Medicaid Program Finance



Office of 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               |  |  |

State Health Office



Office of Medicaid Program Finance

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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                              | –<br>Unaudited  | l Cost        |                             |               |              |                |  |
|                          |                                   |               |                                | _<br>Desk Revi  | iewed Cost    |                             |               |              |                |  |
|                          |                                   |               |                                | _<br>Desk Aud   | ited Cost     |                             |               |              |                |  |
|                          |                                   |               |                                | –<br>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            |  |

State Health Office



Office of Medicaid Program Finance

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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  |                             |                   |  |  |  |
| <br>Field                       | Audited Cost  |                             |                   |  |  |  |
|                                 |               |                             |                   |  |  |  |
| DISTRIBUTION:                   |               | R                           |                   |  |  |  |
| Fiscal Agent                    |               | r v                         |                   |  |  |  |
| Contract Management             |               | Rydell Samuel, Adminis      | strator           |  |  |  |
| Program Finance                 |               | Medicaid Program Fina       | nce               |  |  |  |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

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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             | <b>Prospective</b>               | <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            |  |
| State Health Office      | 9             |             |               |                                  |                       |                |  |



Office of Medicaid Program Finance

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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:<br>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      | –<br>Unaudited  | d Cost     |                             |               |               |                  |  |
|                    |                                 |               |        | _<br>Desk Rev   | iewed Cost |                             |               |               |                  |  |
|                    |                                 |               |        | _<br>Desk Aud   | ited Cost  |                             |               |               |                  |  |
|                    |                                 |               |        | –<br>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               |  |

State Health Office



Office of Medicaid Program Finance

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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  |                   |  |
| State Health Office            |                    |                             |                       |                   |  |



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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         |                         |                    |
|                              | <br>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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Office of Medicaid Program Finance

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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  |                            |                   |
| <br>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       |                       |                      |
|                                | Desk Audited (  | Cost         |                       |                      |
|                                | Field Audited 0 | Cost         |                       |                      |
|                                |                 |              |                       |                      |
| 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      | _<br>Unaudited  | Cost          |          |              |                |                    |
|                |            |               |        | _<br>Desk Revi  | iewed Cost    |          |              |                |                    |
|                |            |               |        | _<br>Desk Aud   | ited Cost     |          |              |                |                    |
|                |            |               |        | –<br>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        |                  |                             |                       |                  |  |
|                               | Desk Revie         |                  |                             |                       |                  |  |
|                               | Desk Audit         | ted Cost         |                             |                       |                  |  |
|                               | Field Audit        | ed Cost          |                             |                       |                  |  |
| DISTRIBUTION:                 |                    |                  | _                           | R                     |                  |  |
| Fiscal Agent                  |                    |                  | ľ                           | V                     |                  |  |
| Contract Management           |                    |                  | Ryd                         | lell Samuel, Administ | trator           |  |
| Program Finance               |                    |                  |                             | dicaid Program Finar  |                  |  |
| State Health Office           |                    |                  |                             |                       |                  |  |



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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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   |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
|                                  | Desk Reviewed Cos  | t                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
|                                  | Desk Audited Cost  |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
| -                                | Field Audited Cost |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
|                                  |                    | _                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
| DISTRIBUTION:<br>Fiscal Agent    |                    | 1                           | to the second se |                  |
| Contract Management              |                    |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
| Program Finance                  |                    |                             | lell Samuel, Administr<br>dicaid Program Finand                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
| State Health Office              |                    | Med                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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 |  |
|                                |                   |                |                             | _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                   |  |
|                                | <b>BASIS:</b>     |                |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |
|                                | Budget            |                |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |
|                                | X Unaudited       | Cost           |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |
|                                | Desk Revi         | ewed Cost      |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |
|                                | Desk Audi         | ted Cost       |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |
|                                | Field Audit       | ted Cost       |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                   |  |
|                                |                   |                |                             | P                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                   |  |
| DISTRIBUTION:                  |                   |                |                             | at the second se |                   |  |
| Fiscal Agent                   |                   |                | 1                           | N                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                   |  |
| Contract Management            |                   |                |                             | lell Samuel, Adminis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                   |  |
| Program Finance                |                   |                | Mee                         | dicaid Program 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

| 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 |                             |                      |                   |  |
|                                 | Desk Audited C   | Cost   |                             |                      |                   |  |
|                                 | Field Audited C  | Cost   |                             |                      |                   |  |
|                                 |                  |        |                             |                      |                   |  |
| DISTRIBUTION:                   |                  |        | -                           | R                    |                   |  |
| Fiscal Agent                    |                  |        | 1                           | av                   |                   |  |
| Contract Management             |                  |        | Ryc                         | lell Samuel, Adminis | trator            |  |
| Program Finance                 |                  |        | Med                         | dicaid Program 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

| 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        |          |               |                |                |
|                        |                 | <br>Desk Rev | iewed Cost    |          |               |                |                |
|                        |                 | <br>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              |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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 |  |
|                             |                      |                  |                   | _                    |                  |  |
|                             | <b>BASIS:</b>        |                  |                   |                      |                  |  |
|                             | 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 |                  |  |
| State Health Office         |                      |                  |                   |                      |                  |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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 |  |  |
|                                |                   |              |                             |                    |  |  |
|                                | <b>BASIS:</b>     |              |                             |                    |  |  |
|                                | Budget            |              |                             |                    |  |  |
|                                | X Unaudited C     | ost          |                             |                    |  |  |
|                                | Desk Review       | ved Cost     |                             |                    |  |  |
|                                | Desk Audite       | d Cost       |                             |                    |  |  |
|                                | Field Audited     | d Cost       |                             |                    |  |  |
|                                |                   |              |                             |                    |  |  |
| DISTRIBUTION:<br>Fiscal Agent  |                   |              | TR                          |                    |  |  |
| Contract Management            |                   |              | Rydell Samuel, Adminis      | strator            |  |  |
| Program Finance                |                   |              | Medicaid Program Fina       |                    |  |  |
| State Health Office            |                   |              | -                           |                    |  |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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               |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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              |
| State Health Office        |                       |             |                  |                      |                  |



Office of Medicaid Program Finance

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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 <sup>,</sup> | 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     | -<br>Unaudited   | Cost      |          |                 |              |                   |
|                     |             | -              |       | Desk Revi        | ewed Cost |          |                 |              |                   |
|                     |             | -              |       | Desk Audi        | ted Cost  |          |                 |              |                   |
|                     |             | -              |       | -<br>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               |

State Health Office



Office of Medicaid Program Finance

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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               |
| State Health Office           |                    |            |                   |                      |                   |



Office of Medicaid Program Finance

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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             | <b>Prospective</b> |                       |                   |  |
| Total Inte                      | rim              |               | X                  | Total Prospective     |                   |  |
| Settleme                        | nt Based on Cost |               |                    | Prospective Adjust    | ted For New Costs |  |
|                                 |                  |               |                    | _                     |                   |  |
|                                 | <b>BASIS:</b>    |               |                    |                       |                   |  |
|                                 | Budget           |               |                    |                       |                   |  |
|                                 | X Unaudited      | Cost          |                    |                       |                   |  |
|                                 | Desk Revi        | ewed Cost     |                    |                       |                   |  |
|                                 | Desk Audi        | ted Cost      |                    |                       |                   |  |
|                                 | Field Audit      | ted Cost      |                    |                       |                   |  |
| DISTRIBUTION:                   |                  |               | -                  | R                     |                   |  |
| Fiscal Agent                    |                  |               | 1                  | e(j                   |                   |  |
| Contract Management             |                  |               | Ryc                | 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

| Walton County Health Department |                    | Provide     | r Number: 0279765-0   | 00                |
|---------------------------------|--------------------|-------------|-----------------------|-------------------|
| 493 North 9th Street            |                    | -           | 8                     |                   |
| Defuniak Springs, FL 32433-9401 |                    | -<br>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 |                   |
| State Health Office             |                    |             |                       |                   |



Office of Medicaid Program Finance

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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:<br>Fiscal Agent   |                |               | 1                |                      |                   |
| Contract Management             |                |               | Ryc              | 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

| 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:<br>Fiscal Agent   |                |               | 1                |                      |                   |
| 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

| 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         |                             |                   |  |
|                                 | <br>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               |  |

State Health Office



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 |             |                                  |                |
| <sup>III</sup>                | Total Interim       |                                                                         | <u> </u>                | X           |             | ospective                        |                |
| _                             |                     | ased on Cost                                                            | _                       |             | _           |                                  | For New Costs  |
|                               |                     | BASIS:<br>Budget<br>X Unaudited<br>Desk Revi<br>Desk Audi<br>Field Audi | iewed Cost<br>ited Cost |             | _           |                                  |                |
| DISTRIBUTION:<br>Fiscal Agent | :                   |                                                                         |                         | -           | F           |                                  |                |
| Contract Ma<br>Program Fin    | -                   |                                                                         |                         |             |             | el, Administrate<br>gram Finance | or             |
| Fillyiani Fill                |                     |                                                                         |                         | INIE        |             | grann i mance                    |                |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

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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  |                             |                     |  |
|                       | <br>Field A              | Audited Cost  |                             |                     |  |
|                       |                          |               |                             |                     |  |
| DISTRIBUTION:         |                          |               | TR                          |                     |  |
| Fiscal Agent          |                          |               | M                           |                     |  |
| Contract Managem      | ent                      |               | Rydell Samuel, Admir        | nistrator           |  |
| Program Finance       |                          |               | Medicaid Program Fir        |                     |  |

State Health Office



Office of Medicaid Program Finance

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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><br>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     | -<br>Unaudited  | l Cost        |                        |               |                |                  |
|               |            | -              |       | _<br>Desk Revi  | iewed Cost    |                        |               |                |                  |
|               |            | -              |       | Desk Audi       | ited Cost     |                        |               |                |                  |
|               |            | -              |       | -<br>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               |

State Health Office



Office of Medicaid Program Finance

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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    |                 |
|                    |                | -<br>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              |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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><br>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   |                    |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

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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   |                   | <br>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 |  |  |
|                              |                   |                  |                             |                    |  |  |
|                              | <b>BASIS:</b>     |                  |                             |                    |  |  |
|                              | 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                |  |  |
| State Health Office          |                   |                  |                             |                    |  |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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                   | <b>Prospective</b> |                    |                     |  |
| Total Interim                |                     | X                  | Total Prospectiv   | /e                  |  |
| Settlement Based o           | on Cost             |                    | Prospective Adj    | usted For New Costs |  |
| BAS                          | SIS:                |                    |                    |                     |  |
|                              | Budget              |                    |                    |                     |  |
| X                            | -<br>Unaudited Cost |                    |                    |                     |  |
|                              | Desk Reviewed Cost  |                    |                    |                     |  |
|                              | Desk Audited Cost   |                    |                    |                     |  |
|                              | Field Audited Cost  |                    |                    |                     |  |
| DISTRIBUTION:                |                     |                    | R                  |                     |  |
| Fiscal Agent                 |                     | 1                  | N N                |                     |  |
| Contract Management          |                     | Ryd                | ell Samuel, Admi   | nistrator           |  |
| Program Finance              |                     | Med                | dicaid Program Fir | nance               |  |

For Information Only (No Change In Rate)

State Health Office



Office of Medicaid Program Finance

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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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State Health Office



Office of Medicaid Program Finance

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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               |  |
| State Health Office               |                    |                             |                      |                   |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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    | <b>-</b>      |        |                 | 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      | _<br>Unaudited  | d Cost        |                             |               |              |                   |
|              |            |               |        | _<br>Desk Rev   | iewed Cost    |                             |               |              |                   |
|              |            |               |        | _<br>Desk Aud   | ited Cost     |                             |               |              |                   |
|              |            |               |        | _<br>Field Audi | ited Cost     |                             |               |              |                   |
|              |            |               |        | _               |               |                             |               |              |                   |
| DISTRIBUTIC  | <u>DN:</u> |               |        |                 |               |                             | TR            |              |                   |
| Fiscal Ag    | ent        |               |        |                 |               |                             | PU            |              |                   |
| -            | Managem    | ent           |        |                 |               |                             | Rydell Samu   | iel, Adminis | strator           |
| Program      | Finance    |               |        |                 |               |                             | Medicaid Pro  |              |                   |

State Health Office



Office of Medicaid Program Finance

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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<br>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              |  |
| State Health Office                        |                       |                |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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             |                    | <br>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      |                   |  |  |
| State Health Office           |                    |                  |                             |                   |  |  |



Office of Medicaid Program Finance

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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        |                             |              |                                |                 |
|               |                                   |                  | <br>Desk Revi | iewed Cost    |                             |              |                                |                 |
|               |                                   |                  | Desk Audi     | ited Cost     |                             |              |                                |                 |
|               |                                   |                  | Field Audi    | ted Cost      |                             |              |                                |                 |
| DISTRIBUTIC   |                                   |                  |               |               |                             | F            |                                |                 |
| Fiscal Ag     | lent<br>Managemer                 | ot               |               |               |                             |              | vol Advoive:-tr                | -to-            |
| Program       | •                                 | n                |               |               |                             |              | uel, Administr<br>ogram Finano |                 |
| . iogiani     |                                   |                  |               |               |                             |              |                                |                 |

For Information Only (No Change In Rate)



Office of Medicaid Program Finance

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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



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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               |  |

State Health Office



Office of Medicaid Program Finance

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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                  | <b>Prospective</b>          |                       |                   |  |
| 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               |  |
| State Health Office             |                    |                             |                       |                   |  |



Office of Medicaid Program Finance

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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<br>X            | Total Prospective                           |                   |  |
|                                                                   |                | ased on Cost                                                            |                         | X                           |                                             | ted For New Costs |  |
|                                                                   |                | BASIS:<br>Budget<br>X Unaudited<br>Desk Revi<br>Desk Audi<br>Field Audi | iewed Cost<br>ited Cost |                             |                                             |                   |  |
| DISTRIBUTION:<br>Fiscal Agent<br>Contract Manage<br>Program Finan | -              |                                                                         |                         |                             | Rell Samuel, Adminis<br>dicaid Program Fina |                   |  |

State Health Office



Office of Medicaid Program Finance

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#### Medicaid Reimbursement Rate Change Form for CHDs

| Brevard County Heath Department |                    |                  |               | Provider Number: 0519251-04 |                |              |                |
|---------------------------------|--------------------|------------------|---------------|-----------------------------|----------------|--------------|----------------|
| 2572 N. Courtenay Park          | way                |                  |               | -<br>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                  | -<br>Unaudited   | Cost          |                             |                |              |                |
|                                 |                    | -<br>Desk Revie  | ewed Cost     |                             |                |              |                |
|                                 |                    | -<br>Desk Audit  | ted Cost      |                             |                |              |                |
|                                 |                    | -<br>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           |        |                 |               | -<br>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      | _<br>Unaudited  | Cost          |                             |              |              |                   |
|                 |                                 |               |        | –<br>Desk Revi  | iewed Cost    |                             |              |              |                   |
|                 |                                 |               |        | _<br>Desk Audi  | ited Cost     |                             |              |              |                   |
|                 |                                 |               |        | –<br>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  |                             |                       |                   |  |
|                            | <br>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                        |                             |                  |                       |  |
|                        | -              | <br>Desk Rev   | iewed Cost                  |                             |                  |                       |  |
|                        | -              | Desk Aud       | ited Cost                   |                             |                  |                       |  |
|                        | _              | <br>Field Audi | ted Cost                    |                             |                  |                       |  |
|                        | _              |                |                             |                             |                  |                       |  |
| DISTRIBUTION:          |                |                |                             | _                           | F                |                       |  |
| Fiscal Agent           |                |                |                             | (                           | N                |                       |  |
| Contract Manager       | nent           |                |                             |                             | dell Samuel, Adr |                       |  |
| Program Finance        |                |                |                             | Me                          | dicaid 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           |  |  |  |
|                                |                                     | -         |                             | _                    |                             |  |  |  |
|                                | <b>BASIS:</b>                       |           |                             |                      |                             |  |  |  |
|                                | 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            |                                     |           |                             |                      |                             |  |  |  |



Office of Medicaid Program Finance

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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         | <b>Prospective</b>          |                       |                   |  |  |
| 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<br>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 |  |
|                           |             |                |                                                 | _                    |                  |  |
|                           | BASIS:      |                |                                                 |                      |                  |  |
|                           | Budget      |                |                                                 |                      |                  |  |
|                           | X Unaudited | Cost           |                                                 |                      |                  |  |
|                           | Desk Revie  | ewed Cost      |                                                 |                      |                  |  |
|                           | Desk Audit  | ted Cost       |                                                 |                      |                  |  |
|                           | Field Audit | ed Cost        |                                                 |                      |                  |  |
|                           |             |                | 000 J                                           |                      |                  |  |
| <b>DISTRIBUTION:</b>      |             |                | -                                               | 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 |  |  |
|                                  |               |           |                             | _                     |                   |  |  |
|                                  | <b>BASIS:</b> |           |                             |                       |                   |  |  |
|                                  | Budget        |           |                             |                       |                   |  |  |
|                                  | X Unaudited   | Cost      |                             |                       |                   |  |  |
|                                  | Desk Revi     | ewed Cost |                             |                       |                   |  |  |
|                                  | Desk Audi     | ted Cost  |                             |                       |                   |  |  |
|                                  | Field Audit   | ted Cost  |                             |                       |                   |  |  |
|                                  |               |           |                             | -                     |                   |  |  |
| DISTRIBUTION:                    |               |           | -                           | IK .                  |                   |  |  |
| Fiscal Agent                     |               |           | (                           |                       |                   |  |  |
| Contract Management              |               |           | Ryc                         | lell Samuel, Adminis  | strator           |  |  |
| Program Finance                  |               |           | Med                         | dicaid Program 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

| Palm Beach County Health Departr | nent          |                | Provider Number: 0520331-89<br>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              | <b>Prospective</b>                              |                      |                   |  |
| Total Inter                      | im            |                | Х                                               | Total Prospective    |                   |  |
| Settlement Based on Cost         |               |                |                                                 | Prospective Adjust   | ted For New Costs |  |
|                                  |               |                |                                                 | -                    |                   |  |
|                                  | <b>BASIS:</b> |                |                                                 |                      |                   |  |
|                                  | Budget        |                |                                                 |                      |                   |  |
|                                  | X Unaudited   | Cost           |                                                 |                      |                   |  |
|                                  | Desk Revi     | ewed Cost      |                                                 |                      |                   |  |
|                                  | Desk Audi     | ted Cost       |                                                 |                      |                   |  |
|                                  | Field Audit   | ted Cost       |                                                 |                      |                   |  |
| DISTRIBUTION:                    |               |                | -                                               | R                    |                   |  |
| Fiscal Agent                     |               |                | ť                                               |                      |                   |  |
| Contract Management              |               |                | Ryd                                             | lell Samuel, Adminis | trator            |  |
| Program Finance                  |               |                | Med                                             | dicaid Program 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

| Palm Beach County Health Departm | nent          |           | Provider Number: 0520331-95<br>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         | <b>Prospective</b>                              |                       |                   |  |
| Total Interi                     | m             |           | Х                                               | Total Prospective     |                   |  |
| Settlement Based on Cost         |               |           | Prospective Adjusted For N                      |                       | ted For New Costs |  |
|                                  |               |           |                                                 | _                     |                   |  |
|                                  | <b>BASIS:</b> |           |                                                 |                       |                   |  |
|                                  | Budget        |           |                                                 |                       |                   |  |
|                                  | X Unaudited   | Cost      |                                                 |                       |                   |  |
|                                  | Desk Revi     | ewed Cost |                                                 |                       |                   |  |
|                                  | Desk Audi     | ted Cost  |                                                 |                       |                   |  |
|                                  | Field Audit   | ted Cost  |                                                 |                       |                   |  |
|                                  |               |           | ~                                               | TR                    |                   |  |
| DISTRIBUTION:<br>Fiscal Agent    |               |           | 1                                               |                       |                   |  |
| Contract Management              |               |           | Ryc                                             | lell Samuel, Adminis  | trator            |  |
| Program Finance                  |               |           |                                                 | dicaid Program Finar  |                   |  |
| State Health Office              |               |           |                                                 |                       |                   |  |



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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               |  |  |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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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Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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> | <b>-</b>         |                | 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          |                             |                  |              |                   |
|               |                |                  | _<br>Desk Revi | iewed Cost    |                             |                  |              |                   |
|               |                |                  | _<br>Desk Aud  | ited Cost     |                             |                  |              |                   |
|               |                |                  | Field Audi     | ted Cost      |                             |                  |              |                   |
| DISTRIBUTIO   | DN:            |                  |                |               |                             | TR               |              |                   |
| Fiscal Ag     |                |                  |                |               |                             | py i             |              |                   |
|               | Manageme       | ent              |                |               |                             | ہ<br>Rydell Samu | ial Adminic  | strator           |
| Program       | -              |                  |                |               |                             | Medicaid Pr      |              |                   |
| 0             |                |                  |                |               |                             |                  | 0            |                   |

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(No Change In Rate)



Office of Medicaid Program Finance

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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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Office of Medicaid Program Finance

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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      | _<br>Unaudited  | l Cost        |                             |               |                 |                |  |
|                   |                |               |        | _<br>Desk Revi  | iewed Cost    |                             |               |                 |                |  |
|                   |                |               |        | _<br>Desk Audi  | ited Cost     |                             |               |                 |                |  |
|                   |                |               |        | -<br>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              |  |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### 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               |

State Health Office

For Information Only

(No Change In Rate)



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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   |                    |

State Health Office



Office of Medicaid Program Finance

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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               |  |  |  |

State Health Office



Office of Medicaid Program Finance

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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  |                              |                  |                |  |  |
|                           | Desk                    | Audited Cost   |                              |                  |                |  |  |
|                           | Field                   | Audited Cost   |                              |                  |                |  |  |
|                           |                         |                |                              |                  |                |  |  |
| DISTRIBUTION:             |                         |                | TR                           |                  |                |  |  |
| Fiscal Agent              |                         |                | / N                          |                  |                |  |  |
| Contract Managemen        | ıt                      |                | Rydell San                   | nuel, Administra | tor            |  |  |
| Program Finance           |                         |                | Medicaid F                   | Program Finance  | 9              |  |  |

State Health Office

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(No Change In Rate)



Office of Medicaid Program Finance

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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   | -<br>Unaudited  | l Cost                       |                              |               |             |                   |  |
|                          |                                 |               |     | -<br>Desk Revi  | iewed Cost                   |                              |               |             |                   |  |
|                          |                                 |               |     | _<br>Desk Audi  | ited Cost                    |                              |               |             |                   |  |
|                          |                                 |               |     | -<br>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               |  |

For Information Only
(No Change In Rate)



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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   | _<br>Unaudited  | l Cost                       |                              |               |             |                    |  |
|                          |                                 |               |     | _<br>Desk Revi  | iewed Cost                   |                              |               |             |                    |  |
|                          |                                 |               |     | _<br>Desk Audi  | ited Cost                    |                              |               |             |                    |  |
|                          |                                 |               |     | -<br>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               |  |

State Health Office



Office of Medicaid Program Finance

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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 |  |  |  |
|                                 | <b>BASIS:</b> |              |                              |                   |  |  |  |
|                                 | Budget        |              |                              |                   |  |  |  |
|                                 | X Unaudited   | Cost         |                              |                   |  |  |  |
|                                 | <br>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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(No Change In Rate)



Office of Medicaid Program Finance

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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   | _<br>Unaudited  | l Cost        |                              |               |             |                   |  |
|                          |                                 |               |     | _<br>Desk Revi  | iewed Cost    |                              |               |             |                   |  |
|                          |                                 |               |     | -<br>Desk Audi  | ited Cost     |                              |               |             |                   |  |
|                          |                                 |               |     | -<br>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   | -<br>Unaudited  | Cost                         |                              |               |             |                   |  |
|                          |                                 |               |     | -<br>Desk Revi  | ewed Cost                    |                              |               |             |                   |  |
|                          |                                 |               |     | _<br>Desk Audi  | ted Cost                     |                              |               |             |                   |  |
|                          |                                 |               |     | -<br>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   | _<br>Unaudited  | l Cost                       |                              |               |                   |                |  |
|                          |                                 |               |     | _<br>Desk Revi  | iewed Cost                   |                              |               |                   |                |  |
|                          |                                 |               |     | _<br>Desk Audi  | ited Cost                    |                              |               |                   |                |  |
|                          |                                 |               |     | -<br>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   | _<br>Unaudited  | l Cost                       |                              |               |                    |                |  |
|                          |                                 |               |     | _<br>Desk Revi  | iewed Cost                   |                              |               |                    |                |  |
|                          |                                 |               |     | _<br>Desk Audi  | ited Cost                    |                              |               |                    |                |  |
|                          |                                 |               |     | -<br>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   | -<br>Unaudited  | Cost                         |                              |               |             |                    |  |
|                          |                                 |               |     | -<br>Desk Revi  | ewed Cost                    |                              |               |             |                    |  |
|                          |                                 |               |     | _<br>Desk Audi  | ted Cost                     |                              |               |             |                    |  |
|                          |                                 |               |     | -<br>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               |  |

State Health Office



Office of Medicaid Program Finance

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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   | _<br>Unaudited  | l Cost                       |                              |               |             |                   |  |
|                          |                                 |               |     | _<br>Desk Revi  | iewed Cost                   |                              |               |             |                   |  |
|                          |                                 |               |     | _<br>Desk Audi  | ited Cost                    |                              |               |             |                   |  |
|                          |                                 |               |     | -<br>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   | _<br>Unaudited  | l Cost                       |          |               |             |                    |
|                          |                                 |               |     | _<br>Desk Revi  | iewed Cost                   |          |               |             |                    |
|                          |                                 |               |     | _<br>Desk Audi  | ited Cost                    |          |               |             |                    |
|                          |                                 |               |     | -<br>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               |

State Health Office



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

#### 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                | _<br>Unaudited Cost     |                          |               |                  |                |  |
|                          |                  | _<br>Desk Reviewed Co   | st                       |               |                  |                |  |
|                          |                  | _<br>Desk Audited Cost  |                          |               |                  |                |  |
|                          |                  | -<br>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      | _<br>Unaudited  | l Cost        |                             |              |              |                    |  |
|                                   |            |               |        | _<br>Desk Revi  | iewed Cost    |                             |              |              |                    |  |
|                                   |            |               |        | _<br>Desk Audi  | ited Cost     |                             |              |              |                    |  |
|                                   |            |               |        | -<br>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               |  |

State Health Office



Office of Medicaid Program Finance

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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      | _<br>Unaudited  | l Cost        |                             |               |              |                    |  |
|                                   |               |               |        | _<br>Desk Revi  | iewed Cost    |                             |               |              |                    |  |
|                                   |               |               |        | _<br>Desk Audi  | ited Cost     |                             |               |              |                    |  |
|                                   |               |               |        | -<br>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               |  |

State Health Office



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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       |                     |                       | —<br>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                   | _<br>Unaudited Cost   |                 |                             |                  |                |  |  |
|                           |                     | _<br>Desk Reviewed (  | Cost            |                             |                  |                |  |  |
|                           |                     | _<br>Desk Audited Co  | st              |                             |                  |                |  |  |
|                           |                     | -<br>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    | <b>-</b>      |        |                 | 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      | -<br>Unaudited  | l Cost        |                             |               |                |                 |  |
|                                   |            |               |        | -<br>Desk Revi  | iewed Cost    |                             |               |                |                 |  |
|                                   |            |               |        | -<br>Desk Audi  | ited Cost     |                             |               |                |                 |  |
|                                   |            |               |        | -<br>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<br>Date: 07/11/2018<br>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        |                      |                 |                                                                                |                |  |  |  |