

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Alachua Cour	achua County Health Department						Provider Number: 0279111-00				
224 SE 24th S	Street730	N.E. Waldo Roa	ad, Suite	e 500		Date: 07/01/2019					
Gainesville, F	L 32641					Fiscal Year End: 06/30/2018			18		
					Audit Status:			Unaudited	d Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>			_	162	.95	160	6.57	07/01/2019		
Rate Type	Interim				Х	Prospec	tivo				
	- -	Total Interim				- X		rospective			
	Settlement Base		sed on			Prospective Adjusted For New Costs					
			BASI	<u>S:</u>							
				Budget							
		-	χι	Jnaudited (Cost						
		-	C	Desk Revie	wed Cost						
		-	C	Desk Audite	ed Cost						
		-	F	Field Audite	ed Cost						
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						74				
Contract	Managem	ent					Rydell Samu	iel. Admini	strator		

Rydell Samuel, Administrator Medicaid Program Finance

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Program Finance State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Alachua County	Health I	Department	Alachua County Health Department						Provider Number: 0279111-91					
224 SE 24th Stre	eet730 N	N.E. Waldo Road	d, Suite	500			Date:	07/01/2019)					
Gainesville, FL 3	32641					Fiscal Year End: 06/30/2018								
							Audit Status:	Unaudited	Cost					
Provider Typ	e				<u>Curren</u>	t Rate	New	Rate	Effective Date					
<u>c</u>	<u>CHD</u>			-	162	.95	160	6.57	07/01/2019					
Rate Type														
In	<u>nterim</u>				Х	Prospec	<u>tive</u>							
		Total Interim				- x	Total P	rospective						
Settlement Based on Cost			Cost	Prosp			ctive Adjuste	ed For New Costs						
		<u>E</u>	BASIS	<u>):</u>										
			В	udget										
		_	X Uı	naudited	Cost									
		_	De	esk Revie	ewed Cost									
		_	De	esk Audit	ted Cost									
		_	Fi	eld Audit	ed Cost									
		_												
DISTRIBUTION:	<u>:</u>						TR							
Fiscal Agent	t						7N							
Contract Ma	nageme	ent					Rydell Samu	el, Administ	rator					
Program Fin	nance						Medicaid Pro	ogram Finan	ce					

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Medicaid Reimbursement Rate Change Form for CHDs

Alachua County	Health I	Department	Alachua County Health Department						Provider Number: 0279111-93					
224 SE 24th Stre	eet730 N	N.E. Waldo Road	d, Sui	ite 500			Date:	07/01/2019						
Gainesville, FL	32641					Fiscal Year End: 06/30/2018								
							Audit Status:	Unaudited C	Cost					
Provider Typ	<u>)e</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date					
<u>(</u>	<u>CHD</u>			-	162	.95	160	6.57	07/01/2019					
Rate Type														
lr	<u>nterim</u>				Х	Prospec	<u>tive</u>							
		Total Interim				- x	Total P	rospective						
Settlement Based on Cost		n Cost	Pros		Prospe	ctive Adjuste	d For New Costs							
		<u>E</u>	BAS	<u>IS:</u>										
				Budget										
		-	Х	Unaudited	Cost									
		_		Desk Revi	ewed Cost									
		_		Desk Audi	ted Cost									
		_		Field Audit	ed Cost									
		_												
DISTRIBUTION	<u>:</u>						TR							
Fiscal Agen	t						7N							
Contract Ma	anageme	ent					Rydell Samu	iel, Administr	ator					
Program Fir	nance						Medicaid Pro	ogram Financ	ce					

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Medicaid Reimbursement Rate Change Form for CHDs

Baker County Health Dep	partment			Provider Number: 0279129-00				
480 West Lowder Street				Date: 07/01/2019				
Macclenny, FL 32063				Fiscal Year End: 06/30/2018				
					Audit Status:	Unaudited C	ost	
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date	
<u>CHD</u>		-	167.	.09	14	5.12	07/01/2019	
Rate Type								
<u>Interim</u>			Х	Prospect	ive			
	Total Interim			X	Total P	rospective		
	Settlement Based	on Cost			Prospe	ctive Adjusted	d For New Costs	
	BA	SIS:						
		Budget						
	X	_ Unaudited	Cost					
		– Desk Revie	wed Cost					
		_ Desk Audit	ed Cost					
		– Field Audite	ed Cost					
		_						
DISTRIBUTION:					TR			
Fiscal Agent					rv ,			
Contract Manageme	nt			-	Rydell Samu	iel, Administra	ator	
Program Finance					Medicaid Pro	ogram Financ	е	

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Medicaid Reimbursement Rate Change Form for CHDs

Baker County Health Department		Provi	Provider Number: 0279129-01				
480 West Lowder Street			Date: 07/01/2019				
Macclenny, FL 32063		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	167.09	145.12	07/01/2019			
Rate Type							
Interim		X Prospect	ive				
Total Inte	rim	X	Total Prospective				
Settlemer	nt Based on Cost		Prospective Adjust	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			/ N				
Contract Management			Rydell Samuel, Adminis	trator			
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Baker County	Health De	epartment			Provider Number: 0279129-11				
480 West Low	der Street	t			Date: 07/01/20				
Macclenny, FL	32063				Fiscal Year End: 06/30/2018				
					A	udit Status:	Unaudited C	cost	
Provider Ty	<u>/pe</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			167.	.09	145	5.12	07/01/2019	
Rate Type	Interim			Х	Dreeneeti	<i>/</i> 0			
	Interim	Total Interim			Prospectiv		rospective		
		- Settlement Base	ed on Cost		X		•	d For New Costs	
		-	eu un cust			F105pe			
		E	BASIS:						
			Budget						
		_	X Unaudite	ed Cost					
		_	Desk Re	viewed Cost					
		_	Desk Au	dited Cost					
		—	Field Aud	dited Cost					
		_							
DISTRIBUTIO	<u>N:</u>					TR			
Fiscal Age	ent					M			
Contract I	Managem	ent			F	Rydell Samu	el, Administra	ator	
Program I	Finance				N	ledicaid Pro	ogram Financ	e	

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Hea	alth Department			Provider Number: 0279145-00				
1801 North Temple	Avenue				Date:	07/01/2019		
Starke, FL 32091				Fiscal Year End: 06/30/2018				
				Au	dit Status:	Unaudited Cos	st	
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date	
<u>CHI</u>	<u>)</u>		169.	57	166	.57	07/01/2019	
Rate Type								
Inter	im		Х	Prospective	2			
	Total Interim			Х	Total Pr	ospective		
Settlement Base		sed on Cost			Prospec	ctive Adjusted	For New Costs	
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		Desk Revi	iewed Cost					
		Desk Audi	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:				~	TR			
Fiscal Agent					/ N			
Contract Manag	ement			Ry	dell Samu	el, Administrato	or	
Program Financ	e			Me	edicaid Pro	gram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford Count	radford County Health Department						Provider Number: 0279145-04				
1801 North Ten	nple Aven	ue				Date: 07/01/2019					
Starke, FL 320	91					Fiscal Year End: 06/30/2018					
							Audit Status	Unaudited (Cost		
<u>Provider Ty</u>	<u>pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				169	.57	16	6.57	07/01/2019		
<u>Rate Type</u>											
<u> </u>	Interim				Х	Prospect	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
Settlement Based on C			on Cost			Prospe	ective Adjuste	d For New Costs			
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	Cost						
				_ Desk Revi	iewed Cost						
				- Desk Aud	ited Cost						
				- Field Audi	ted Cost						
				-							
DISTRIBUTION	<u>N:</u>						TR				
Fiscal Ager	nt						γv				
Contract M	lanagemer	nt					Rydell Samu	uel, Administr	ator		
Program Fi	inance						Medicaid Pr	ogram Finand	ce		

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford Cour	Bradford County Health Department						Provider Number: 0279145-30				
1801 North Te	emple Aver	nue				Date: 07/01/2					
Starke, FL 32	2091					Fiscal Year End: 06/30/2018					
							Audit Status	Unaudited (Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				169	.57	160	6.57	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospect	ive				
	-	Total Interim				- x	Total P	rospective			
Settlement Based on C			on Cost			Prospe	ective Adjuste	ed For New Costs			
			BAS	SIS:							
				Budget							
			X	 Unaudited	Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				_ Field Audi	ted Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						74				
Contract	Manageme	ent					Rydell Samu	uel, Administr	ator		
Program	Finance						Medicaid Pro	ogram Finand	ce		

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Departm	ient	Provi	Provider Number: 0279145-91				
1801 North Temple Avenue			Date: 07/01/201	9			
Starke, FL 32091		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	169.57	166.57	07/01/2019			
Rate Type							
Interim		X <u>Prospect</u> i	ive				
Total In	terim	X	Total Prospective				
Settlem	ent Based on Cost		Prospective Adjust	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited C	Cost					
	Desk Review	wed Cost					
	Desk Audite	ed Cost					
	Field Audite	d Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲N				
Contract Management		_	Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Finar	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Depa	artment	Provi	Provider Number: 0279161-00				
780 SW 24th Street			Date: 07/01/201	9			
Fort Lauderdale, FL 33315		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		149.33	128.07	07/01/2019			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Tota	al Interim	X	Total Prospective				
Sett	lement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	l Cost					
	Desk Revi	iewed Cost					
	Desk Audi	ited Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			[N]				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Dep	partment		Provider Number: 0279161-01					
780 SW 24th Street			Date: 07/01/2019					
Fort Lauderdale, FL 33315			Fiscal Year End: 06/30/2018					
			Audit Status: Unaudited Cost					
Provider Type		Current Ra	te	Effective Date				
<u>CHD</u>	-	149.33		128.07	07/01/2019			
Rate Type								
Interim		X <u>Pro</u>	<u>ospective</u>					
То	otal Interim		Х	Total Prospective				
Se			Prospective Adjust	ed For New Costs				
	BASIS:							
	Budget							
	X Unaudited	Cost						
	Desk Revi	ewed Cost						
	Desk Audi	ted Cost						
	Field Audit	ted Cost						
DISTRIBUTION:			-	R				
Fiscal Agent			ļu -	V				
Contract Management			Ryde	ell Samuel, Administ	trator			
Program Finance				caid Program Finar				
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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health De	partment		Provider Number: 0279161-04			
780 SW 24th Street			Date: 07/01/2019			
Fort Lauderdale, FL 33315	5		Fiscal Y	ear End: 06/30/2018	3	
			Aud	it Status: Unaudited	Cost	
Provider Type Cur			nt Rate <u>New Rate</u>		Effective Date	
<u>CHD</u>		149.33		128.07	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Pr</u>	<u>ospective</u>			
Тс	otal Interim		Х	Total Prospective		
Settlement Based on Cost				Prospective Adjust	ed For New Costs	
				-		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			~	R		
Fiscal Agent			f	AV .		
Contract Management			Ryd	ell Samuel, Administ	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

Broward County Health Dep	partment		Provider Number: 0279161-93 Date: 07/01/2019			
780 SW 24th Street						
Fort Lauderdale, FL 33315			Fiscal Y	ear End: 06/30/2018	3	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current Ra	ate	New Rate	Effective Date	
CHD		149.33		128.07	07/01/2019	
Rate Type						
Interim		X <u>Pr</u>	<u>ospective</u>			
Тс	otal Interim		Х	Total Prospective		
Settlement Based on Cost				Prospective Adjust	ed For New Costs	
				-		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			-	TK		
Fiscal Agent			[N .		
Contract Management			Ryd	ell Samuel, Administ	trator	
Program Finance			Med	licaid Program Finar	nce	
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun Coun	ity Health	Department				Provi	der Number:	: 0279170-0	0
19611 S.R. 20) West					Date: 07/01/2019			
Blountstown, F	FL 32424					Fisc	al Year End	06/30/2018	3
							Audit Status	Unaudited	Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				111	.46	120	0.36	07/01/2019
Rate Type									
	Interim				Х	Prospecti	ve		
	-	Total Interim				- x	Total P	rospective	
		Settlement B	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs
			BAS	SIS:					
				Budget					
			Х	– Unaudited	d Cost				
				– Desk Rev	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ited Cost				
				_					
DISTRIBUTIO							T		
Fiscal Age							1 •		
Contract N	•	ent				-	Rydell Samu		
Program I	Finance						Medicaid Pro	ogram Finar	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun Cour	nty Health	Department			Prov	vider Number:	0279170-30	1
19611 S.R. 20) West					Date	07/01/2019	
Blountstown,	FL 32424				Fiscal Year End: 06/30/2018			
						Audit Status:	Unaudited C	Cost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			111	.46	120	0.36	07/01/2019
Rate Type								
	Interim			X	Prospect			
		Total Interim			X		rospective	
		Settlement Based	on Cost			Prospe	ctive Adjuste	d For New Costs
		BA	SIS:					
			Budget					
		x	Unaudited	l Cost				
			 Desk Revi	iewed Cost				
			 Desk Aud	ited Cost				
			Field Audi	ted Cost				
DISTRIBUTIC	DN:					IK		
Fiscal Ag	ent					M		
Contract	Manageme	ent				Rydell Samu	uel, Administra	ator
Program	Finance					Medicaid Pro	ogram Financ	ce

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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun Count	ty Health	Department				Prov	vider Number:	0279170-9	91
19611 S.R. 20	West					Date: 07/01/2019			9
Blountstown, F	L 32424					Fiscal Year End: 06/30/2018			
							Audit Status:	Unaudited	Cost
Provider Ty	<u>pe</u>				Curren	nt Rate	New	Rate	Effective Date
	<u>CHD</u>				111	.46	12	0.36	07/01/2019
Rate Type									
	<u>Interim</u>				X	Prospec	<u>tive</u>		
		Total Interim				Х	Total P	rospective	
-		Settlement Ba	sed c	on Cost			Prospe	ctive Adjust	ted For New Costs
			BAS	<u>SIS:</u>					
				Budget					
		-	Х	- Unaudited	l Cost				
		-		_ Desk Revi	iewed Cost	:			
		-		_ Desk Audi	ited Cost				
		-		- Field Audi	ted Cost				
		-		-					
DISTRIBUTIO	<u>N:</u>						TR		
Fiscal Age	nt						M		
Contract M	lanageme	ent					Rydell Samu	iel, Adminis	trator
Program F	inance						Medicaid Pro	ogram Finar	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Departm	nent	Prov	ider Number: 0279196-0	00	
3700 Sovereign Path			Date: 07/01/201	07/01/2019	
Lecanto, FL 34461-8071		Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		122.72	166.57	07/01/2019	
Rate Type					
<u>Interim</u>		X Prospect	<u>ive</u>		
Tota	l Interim	X	Total Prospective		
Settlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	l Cost			
	Desk Revi	iewed Cost			
	Desk Audi	ited Cost			
	Field Audi	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			<u> </u>		
Contract Management			Rydell Samuel, Adminis	trator	
Program Finance		Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department		Prov	ider Number: 0279196-	01	
3700 Sovereign Path			Date: 07/01/201	07/01/2019	
Lecanto, FL 34461-8071		Fise	cal Year End: 06/30/201	8	
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		122.72	166.57	07/01/2019	
Rate Type		X Prospect	ive		
<u>Interim</u> Total Inte	arim	X Prospect	Total Prospective		
	nt Based on Cost			ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audi	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			M		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department		Provider	Number: 0279196-0	02
3700 Sovereign Path			Date: 07/01/201	9
Lecanto, FL 34461-8071		Fiscal \	/ear End: 06/30/201	8
		Auc	lit Status: Unaudited	Cost
Provider Type	Curren	t Rate	New Rate	Effective Date
CHD	122	.72	166.57	07/01/2019
Rate Type				
<u>Interim</u>	X	_ <u>Prospective</u>		
Total Interim		Χ	Total Prospective	
Settlement Based or	n Cost		Prospective Adjus	ted For New Costs
BAS	<u>IS:</u>			
	Budget			
X	Unaudited Cost			
	Desk Reviewed Cost			
	Desk Audited Cost			
	Field Audited Cost			
DISTRIBUTION:		-	R	
Fiscal Agent		1	ev.	
Contract Management		Rvo	dell Samuel, Adminis	strator
Program Finance			dicaid Program Fina	

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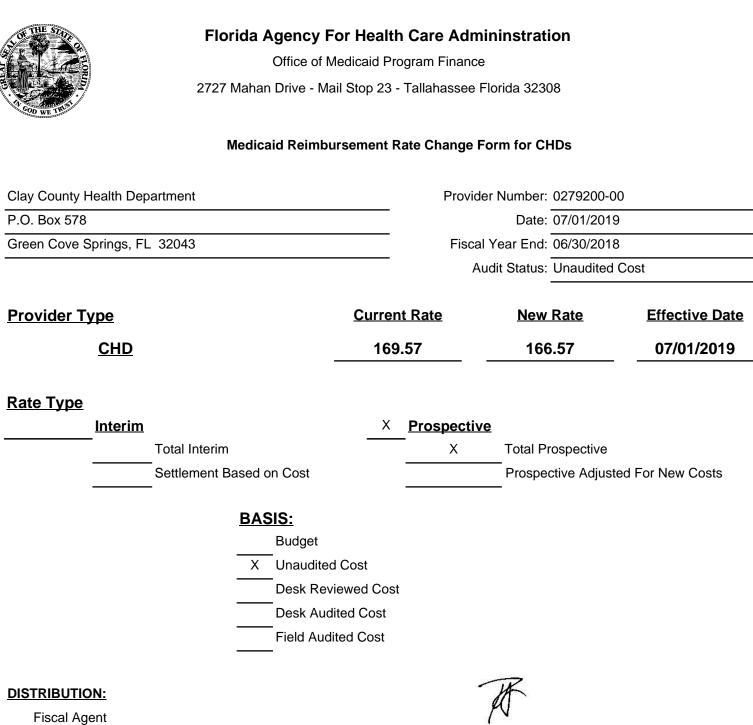
Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department		Prov	rider Number: 0279196-9	91	
3700 Sovereign Path			Date: 07/01/201	/01/2019	
Lecanto, FL 34461-8071		Fise	Fiscal Year End: 06/30/2018		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	_	122.72	166.57	07/01/2019	
Rate Type					
Interim		X Prospect	ive		
Total Inte	erim	X	Total Prospective		
Settlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	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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Contract Management

Program Finance State Health Office

Rydell Samuel, Administrator Medicaid Program Finance



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-01 Date: 07/01/2019			
P.O. Box 578						
Green Cove Springs, FL 32043			Fiscal Y	ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type C			Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.	57	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inte	erim		Х	Total Prospective		
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audite	ed Cost				
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DISTRIBUTION: Fiscal Agent			1	A		
Contract Management			Rvo	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office				-		



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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-02 Date: 07/01/2019			
P.O. Box 578						
Green Cove Springs, FL 32043			Fiscal Y	'ear End: 06/30/2018	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type <u>C</u>		Current Ra	ite	New Rate	Effective Date	
<u>CHD</u>	_	169.57		166.57	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Pro</u>	<u>ospective</u>			
Total Inte	erim		Х	Total Prospective		
Settleme	ent 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			1	el j		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-03 Date: 07/01/2019			
P.O. Box 578						
Green Cove Springs, FL 32043			Fiscal Y	ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type <u>C</u>		Current R	ate	New Rate	Effective Date	
<u>CHD</u>	_	169.57		166.57	07/01/2019	
Rate Type						
Interim		X <u>Pr</u>	ospective			
Total Inte	ərim		Х	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	ed Cost				
	Field Audite	d Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	N		
Contract Management				lell Samuel, Adminis		
Program Finance			Med	dicaid Program Finar	nce	
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-04			
P.O. Box 578			Date: 07/01/2019			
Green Cove Springs, FL 32043			Fiscal Year End: 06/30/2018			
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD	-	169.	57	166.57	07/01/2019	
Rate Type						
Interim		Х	Prospective			
Total Inter	rim		Х	Total Prospective		
Settlemen	t Based on Cost			Prospective Adjust	ted For New Costs	
	BASIS:					
	Budget	0				
	X Unaudited					
	Desk Revie					
	Desk Audit					
	Field Audito	ed Cost				
DISTRIBUTION: Fiscal Agent			Ĩ	F		
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

Clay County Health Department		Provider Number: 0279200-05				
P.O. Box 578			Date: 07/01/2019			
Green Cove Springs, FL 32043			Fiscal Year End: 06/30/2018			
			Aud	it Status: Unaudited	Cost	
Provider Type		Curren	t Rate	New Rate	Effective Date	
CHD		169.	.57	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inter	rim		X	Total Prospective		
Settlemen	t Based on Cost			Prospective Adjust	ted For New Costs	
	BASIS:			_		
	Budget					
	X Unaudited Co	ost				
	 Desk Review					
	Desk Audited					
	Field Audited					
DISTRIBUTION:			_	R		
Fiscal Agent			1	N .		
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-91		
P.O. Box 578		Date: 07/01/2019			
Green Cove Springs, FL 32043			Fiscal Y	ear End: 06/30/2018	8
			Aud	it Status: Unaudited	Cost
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date
CHD	_	169.	57	166.57	07/01/2019
Rate Type					
<u>Interim</u>		Х	Prospective		
Total Inter	rim		Х	Total Prospective	
Settlemer	nt Based on Cost	-		Prospective Adjust	ted For New Costs
	BASIS:				
	Budget				
	X Unaudited C	Cost			
	Desk Review	wed Cost			
	Desk Audite	ed Cost			
	Field Audite	d Cost			
				10000000000	
DISTRIBUTION:			-	R	
Fiscal Agent			[N .	
Contract Management			Ryd	lell Samuel, Adminis	trator
Program Finance			Med	dicaid Program Finar	nce
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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department			Provider Number: 0279200-92			
P.O. Box 578			Date: 07/01/2019			
Green Cove Springs, FL 32043			Fiscal Y	ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current R</u>	<u>ate</u>	New Rate	Effective Date	
<u>CHD</u>	-	169.57	,	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х <u>Р</u>	rospective			
Total Inte	erim		Х	Total Prospective		
Settleme	ent 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			1			
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Mee	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department		Provider	Number: 0279218-	00	
P.O. Box 429			Date: 07/01/201	/2019	
Naples, FL 34106-0429		Fiscal Year End: 06/30/2018			
		Aud	dit Status: Unaudited	d Cost	
Provider Type	Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>	169	.57	166.57	07/01/2019	
Rate Type					
<u>Interim</u>	X	Prospective			
Total Interim		X	Total Prospective		
Settlement Base	ed on Cost		Prospective Adjus	sted For New Costs	
B	ASIS:				
	Budget				
—	X Unaudited Cost				
—	Desk Reviewed Cost				
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	Field Audited Cost				
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DISTRIBUTION:		-	TR		
Fiscal Agent			ev.		
Contract Management		Rve	dell Samuel, Adminis	strator	
Program Finance			dicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department		Provider Number: 0279218-01			
P.O. Box 429		Date: 07/01/2019 Fiscal Year End: 06/30/2018			
Naples, FL 34106-0429					
		Auc	lit Status: Unaudited	Cost	
Provider Type	Curre	nt Rate	New Rate	Effective Date	
<u>CHD</u>	169	9.57	166.57	07/01/2019	
Rate Type					
Interim	Х	Prospective			
Total Inter	im	_ x	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjust	ted For New Costs	
			_		
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed Cos	t			
	Desk Audited Cost				
	Field Audited Cost				
DISTRIBUTION:		-	R		
Fiscal Agent		1	N		
Contract Management		Ryc	lell Samuel, Adminis	trator	
Program Finance			dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Departmen	nt		Provider Number: 0279218-11			
P.O. Box 429			Date: 07/01/2019			
Naples, FL 34106-0429			Fiscal Y	'ear End: 06/30/2018	3	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current I	Rate	New Rate	Effective Date	
CHD	-	169.5	7	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х <u></u>	Prospective			
Total In	terim		Х	Total Prospective		
Settlem	ent 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	W		
Contract Management			Rvc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Departme	ent		Provider Number: 0279218-15			
P.O. Box 429			Date: 07/01/2019			
Naples, FL 34106-0429			Fiscal Y	'ear End: 06/30/2018	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current F	late	New Rate	Effective Date	
<u>CHD</u>	-	169.57	7	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		х <u>р</u>	<u>rospective</u>			
Total Ir	nterim		Х	Total Prospective		
Settlen	nent Based on Cost			Prospective Adjust	ted For New Costs	
		_		_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
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Fiscal Agent			1	N		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Mee	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department			Provider Number: 0279218-30			
P.O. Box 429			Date: 07/01/2019			
Naples, FL 34106-0429			Fiscal Y	ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>C</u>	urren	t Rate	New Rate	Effective Date	
CHD		169	.57	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inter	im		- x	Total Prospective		
Settlemen	t Based on Cost			Prospective Adjust	ted For New Costs	
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	BASIS:					
	Budget					
	X Unaudited Cos	t				
	Desk Reviewed	d Cost				
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DISTRIBUTION: Fiscal Agent			1	R		
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

Collier County Health Depart	tment		Provider Number: 0279218-91			
P.O. Box 429			Date: 07/01/2019			
Naples, FL 34106-0429			Fiscal Y	ear End: 06/30/2018	3	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current F	late	New Rate	Effective Date	
<u>CHD</u>	-	169.5	7	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		х <u>р</u>	<u>rospective</u>			
Tota	al Interim		Х	Total Prospective		
Set	tlement Based on Cost			Prospective Adjust	ed For New Costs	
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	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
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	Field Audito	ed Cost				
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DISTRIBUTION:			¢			
Fiscal Agent			1	873		
Contract Management				ell Samuel, Administ		
Program Finance			Med	licaid Program Finan	ice	
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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Departm	ent	Provi	der Number: 0279226-0	00
217 North East Franklin Street		Date: 07/01/201	e: 07/01/2019	
Lake City, FL 32055		Fisc	al Year End: 06/30/201	8
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	169.57	166.57	07/01/2019
Rate Type				
Interim		X Prospect	ive	
Total Inte	erim	X	Total Prospective	
Settlement Based on Cost			Prospective Adjus	ted For New Costs
	BASIS: Budget			
	X Unaudited	Cost		
		ewed Cost		
	Desk Audit			
	Field Audit			
DISTRIBUTION:			TR	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance Medicaid Program Finance				nce

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(No Change In Rate)



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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Department		Provider	Number: 0279	226-09
217 North East Franklin Street			Date: 07/01	/2019
Lake City, FL 32055		Fiscal `	/ear End: 06/30)/2018
		Aud	lit Status: Unau	dited Cost
<u>Provider Type</u>	Curren	t Rate	New Rate	Effective Date
CHD	169	.57	166.57	07/01/2019
Rate Type				
<u>Interim</u>	Х	Prospective		
Total Interim		X	Total Prospec	tive
Settlement Based on	Cost		Prospective A	Adjusted For New Costs
BASI	<u>S:</u>			
ł	Budget			
X	Unaudited Cost			
I	Desk Reviewed Cost			
I	Desk Audited Cost			
	Field Audited Cost			
DISTRIBUTION:		/	IR	
Fiscal Agent			ey.	
Contract Management		Rve	dell Samuel, Ad	ministrator
Program Finance			dicaid Program	

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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Departm	nent		Provider Number: 0279226-91				
217 North East Franklin Street			Date: 07/01/2019				
Lake City, FL 32055			Fiscal Y	ear End: 06/30/2018	8		
			Aud	it Status: Unaudited	Cost		
Provider Type	<u>(</u>	Current	Rate	New Rate	Effective Date		
CHD		169.	57	166.57	07/01/2019		
Rate Type							
<u>Interim</u>		Х	Prospective				
Total Inte	erim		Х	Total Prospective			
Settleme	ent Based on Cost	-		Prospective Adjust	ted For New Costs		
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	BASIS:						
	Budget						
	X Unaudited Co	st					
	Desk Reviewe	ed Cost					
	Desk Audited	Cost					
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DISTRIBUTION:			ý	AT .			
Fiscal Agent			1	N			
Contract Management				lell Samuel, Adminis			
Program Finance			Med	dicaid Program Finar	nce		
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Hea	Ith Department			Provider Number: 0279226-92			
217 North East Frankl	in Street			Date: 07/01/2019			
Lake City, FL 32055			Fiscal Y	/ear End: 06/30/2018	8		
				Auc	lit Status: Unaudited	Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>			169	.57	166.57	07/01/2019	
Rate Type							
<u>Interin</u>	<u>n</u>		X	Prospective			
	Total Interim			Х	Total Prospective		
	Settlement Ba	ased on Cost			Prospective Adjust	ted For New Costs	
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		BASIS:					
		Budget					
		X Unaudited	Cost				
		Desk Revi	ewed Cost				
		Desk Audi	ted Cost				
		Field Audi	ted Cost				
DISTRIBUTION: Fiscal Agent				- 1	R		
Contract Manager	ment			Ryc	dell Samuel, Adminis	trator	
Program Finance					dicaid Program Finar		
State Health Offic	e						



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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Departmen	t	Provi	ider Number: 0279234-0	00
1350 N.W. 14th Street		Date: 07/01/201	9	
Miami, FL 33125	Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD	-	169.57	166.57	07/01/2019
Rate Type				
<u>Interim</u>		X Prospect	ive	
Total Ir	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:			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

Dade County Health Departme	ent		Provider Number: 0279234-30			
1350 N.W. 14th Street				Date: 07/01/2019	9	
Miami, FL 33125			Fiscal Ye	ear End: 06/30/2018	3	
		Audit	Status: Unaudited	Cost		
Provider Type		Current Rat	<u>e</u>	New Rate	Effective Date	
<u>CHD</u>	-	169.57		166.57	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Pro</u>	<u>spective</u>			
Total	Interim		Х	Total Prospective		
Settle	ement Based on Cost			Prospective Adjust	ed For New Costs	
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
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DISTRIBUTION:			Í	YF.		
Fiscal Agent			7	v		
Contract Management			Ryde	ell Samuel, Administ	trator	
Program Finance			Medi	caid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Departme	ent	I	Provider Number: 0279234-91			
1350 N.W. 14th Street			Date: 07/01/20	19		
Miami, FL 33125			Fiscal Year End: 06/30/20	18		
			Audit Status: Unaudite	ed Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	169.57	166.57	07/01/2019		
Rate Type						
<u>Interim</u>		X <u>Pros</u> p	<u>pective</u>			
Total	Interim		X Total Prospective	9		
Settle	ement Based on Cost		Prospective Adju	sted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			. At			
Fiscal Agent			/ N			
Contract Management			Rydell Samuel, Admin	istrator		
Program Finance			Medicaid Program Fina	ance		
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department			Provider I	Number: 0279242	-00
34 South Baldwin Avenue Arcadia, FL 33821			Date: 07/01/2019		19
			Fiscal Y	ear End: 06/30/20	18
		_	Audi	t Status: Unaudite	ed Cost
Provider Type	<u>Cur</u>	rent R	<u>ate</u>	New Rate	Effective Date
<u>CHD</u>	1	15.51		135.66	07/01/2019
Rate Type					
Interim		X <u>P</u>	rospective		
Total Interim			Х	Total Prospective	e
Settlement Ba	ased on Cost	_		Prospective Adju	usted For New Costs
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed C	Cost			
	Desk Audited Cos	st			
	Field Audited Cos	st			
DISTRIBUTION:			P	R	
Fiscal Agent			1		
Contract Management Program Finance				ell Samuel, Admin licaid Program Fin	

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Departmen	t	F	Provider Number:	0279242-02		
34 South Baldwin Avenue			Date:		07/01/2019	
Arcadia, FL 33821			Fiscal Year End:	06/30/2018		
			Audit Status:	Unaudited C	Cost	
Provider Type	<u>(</u>	Current Rate	New	Rate	Effective Date	
<u>CHD</u>		115.51	135	.66	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Prosp</u>	<u>ective</u>			
Total Inte	rim		X Total Pr	ospective		
Settleme	nt Based on Cost		Prospec	ctive Adjusted	d For New Costs	
	BASIS:					
	Budget					
	X Unaudited Co	st				
	Desk Reviewe	ed Cost				
	Desk Audited	Cost				
	Field Audited	Cost				
DISTRIBUTION:			TR			
Fiscal Agent			(`			
Contract Management			Rydell Samue			
Program Finance			Medicaid Pro	gram Financ	e	

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department	nt	Prov	ider Number: 0279242-0)3
34 South Baldwin Avenue		Date: 07/01/2019		
Arcadia, FL 33821	Fisc	cal Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	115.51	135.66	07/01/2019
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	trator
Program Finance			Medicaid Program Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Departmen	nt	Prov	ider Number: 0279242-0)4
34 South Baldwin Avenue		Date: 07/01/201	: 07/01/2019	
Arcadia, FL 33821	— Fiso	cal Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost
Provider Type	Cur	rent Rate	New Rate	Effective Date
CHD	1	15.51	135.66	07/01/2019
Rate Type				
Interim	_	X Prospect		
Total Inte	erim	X	Total Prospective	
Settleme	ent 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			rv.	
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	y Health [Department				Provi	der Number:	0279242-1	1
34 South Baldwin Avenue				Date: 07/01/2		07/01/201	01/2019		
Arcadia, FL 33821				Fisc	al Year End:	06/30/201	8		
						/	Audit Status:	Unaudited	Cost
<u>Provider Ty</u>	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				115	.51	13	5.66	07/01/2019
Rate Type									
	<u>Interim</u>				Х	<u>Prospecti</u>	ve		
		Total Interim				- x	Total P	rospective	
		Settlement B	ased o	on Cost			Prospe	ctive Adjust	ted For New Costs
			BAS	<u>SIS:</u>					
				Budget					
			X	- Unaudited	l Cost				
				- Desk Revi	iewed Cost				
				- Desk Aud	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIO							TR		
Fiscal Age							(`		
Contract N	-	ent				-	Rydell Samu		
Program F	Finance						Medicaid Pro	ogram Finar	nce

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Depa	artment		Provider Number: 0279242-30			
34 South Baldwin Avenue Arcadia, FL 33821			Date: 07/01/2019			
			Fiscal Y	ear End: 06/30/2018	3	
		Aud	it Status: Unaudited	Cost		
Provider Type		<u>Current R</u>	ate	New Rate	Effective Date	
<u>CHD</u>	-	115.51		135.66	07/01/2019	
Rate Type						
Interim		х <u>Р</u>	<u>ospective</u>			
То	tal Interim		Х	Total Prospective		
Se	ettlement Based on Cost			Prospective Adjuste	ed For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			_	R		
Fiscal Agent			ľ	V		
Contract Management			Ryd	lell Samuel, Administ	rator	
Program Finance				dicaid Program Finan		
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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department	nt	Prov	Provider Number: 0279242-91 Date: 07/01/2019 Fiscal Year End: 06/30/2018			
34 South Baldwin Avenue						
Arcadia, FL 33821		Fisc				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	115.51	135.66	07/01/2019		
Rate Type						
<u>Interim</u>		X Prospect	<u>ive</u>			
Total Inte	erim	X	Total Prospective			
Settlement Based on Cos			Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			/ N			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Dixie County Health Department						Provider Number: 0279251-00				
149 NE 241S	Т						Date	07/01/2019)	
Cross City, FL	32628					Fiscal Year End: 06/30/2020				
							Audit Status	Unaudited	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				130	.76	124	4.87	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospec	tive			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs	
			BAS	SIS:						
				Budget						
			X	Unaudited	d Cost					
				– Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						7N			
Contract	Managem	ent					Rydell Samu	uel, Administ	rator	
Program	Finance						Medicaid Pre	ogram Finan	ice	

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Medicaid Reimbursement Rate Change Form for CHDs

Dixie County Health De	epartment			Provider Number: 0279251-91			
149 NE 241ST				Date: 07/01/2019			
Cross City, FL 32628				Fiscal Year End: 06/30/2020			
				Au	dit Status: Unaudited	Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		-	130	.76	124.87	07/01/2019	
Rate Type							
Interim			Х	Prospective	2		
	Total Interim			- x	Total Prospective		
Settlement Based on Cost				Prospective Adjusted For New			
	—						
	<u>I</u>	BASIS:					
		Budget					
	-	X Unaudited	Cost				
	-	Desk Revi	ewed Cost				
	-	Desk Audi	ted Cost				
	-	Field Audit	ted Cost				
DISTRIBUTION:				-	IR		
Fiscal Agent					PU .		
Contract Management				Ry	dell Samuel, Adminis	strator	
Program Finance				Me	edicaid Program Fina	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Dep	artment			Provider Number: 0279269-00			
515 West Sixth Street				Date: 07/01/2019			
Jacksonville, FL 32206				Fiscal Year End: 06/30/2018			
				Αι	udit Status: Unaudit	ed Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		-	169	.57	166.57	07/01/2019	
Rate Type							
<u>Interim</u>			Х	Prospective	<u>e</u>		
	Total Interim			- X	Total Prospectiv	/e	
Settlement Based on Cost				Prospective Adjusted For New C			
	D./						
	<u>B</u>	ASIS:					
		Budget	0				
	X						
			ewed Cost				
		Desk Audi					
		Field Audit	ted Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent					74		
Contract Managemer	nt			R	ydell Samuel, Admi	nistrator	
Program Finance				Μ	edicaid Program Fi	nance	
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department						Prov	vider Number:	0279269-0	1
515 West Sixt	h Street						Date	07/01/2019)
Jacksonville, F	L 32206					Fiscal Year End: 06/30/2018			
							Audit Status	Unaudited	Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	160	6.57	07/01/2019
Rate Type									
	<u>Interim</u>				Х	Prospec:	<u>tive</u>		
		Total Interim				- x	Total P	rospective	
Settlement Based on Cost		on Cost	Prospec		ctive Adjuste	ed For New Costs			
			BAS	SIS:					
				Budget					
			Х	– Unaudited	l Cost				
				_ Desk Rev	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ted Cost				
				_					
DISTRIBUTIO	<u>N:</u>						TR		
Fiscal Age	ent						7V		
Contract Management							Rydell Samu	uel, Administ	rator
Program Finance						Medicaid Pro	ogram Finan	се	

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department		Provi	Provider Number: 0279269-02			
515 West Sixth Street			Date: 07/01/201	9		
Jacksonville, FL 32206		Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	169.57	166.57	07/01/2019		
Rate Type						
Interim		X <u>Prospect</u>	ive			
Total Int	erim	x	Total Prospective			
Settleme	ent Based on Cost	Prospective Adjusted For Nev				
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			۲N			
Contract Management		_	Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department		Provi	Provider Number: 0279269-03			
515 West Sixth Street			Date: 07/01/201	9		
Jacksonville, FL 32206		Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	169.57	166.57	07/01/2019		
Rate Type						
Interim		X <u>Prospect</u>	ive			
Total Inte	erim	x	Total Prospective			
Settleme	ent Based on Cost	Prospective Adjusted For New				
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			۲ <u>۷</u>			
Contract Management			Rydell Samuel, Adminis	strator		
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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	ent	Prov	Provider Number: 0279269-04 Date: 07/01/2019 Fiscal Year End: 06/30/2018			
515 West Sixth Street						
Jacksonville, FL 32206		Fise				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		169.57	166.57	07/01/2019		
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 Audi	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 Departme	ent	Prov	Provider Number: 0279269-05			
515 West Sixth Street			Date: 07/01/2019			
Jacksonville, FL 32206		Fise	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		169.57	166.57	07/01/2019		
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	d Cost				
	Desk Rev	iewed Cost				
	Desk Aud	lited Cost				
	Field Audi	ited Cost				
DISTRIBUTION:			TR			
Fiscal Agent			۲N			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department						Provi	der Number:	0279269-1	1
515 West Sixt	h Street						Date	07/01/2019	9
Jacksonville, I	FL 32206					Fiscal Year End: 06/30/2018			
							Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	160	6.57	07/01/2019
Rate Type									
	<u>Interim</u>				Х	Prospecti	ve		
	-	Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs
			BAS	SIS:					
				Budget					
			X	- Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ted Cost				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						7N		
Contract I	Managem	ent				-	Rydell Samı	uel, Administ	trator
Program	Finance					-	Medicaid Pro	ogram Finar	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County	Duval County Health Department						Provider Number: 0279269-43			
515 West Sixt	h Street						Date:	07/01/2019		
Jacksonville, I	FL 32206					Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited C	ost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.57	160	6.57	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost		on Cost	Prospe		ctive Adjusted	d For New Costs				
			BAS	SIS:						
				Budget						
			X	– Unaudited	d Cost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						rv ,			
Contract	Managem	ent					Rydell Samu	iel, Administra	ator	
Program	Finance						Medicaid Pro	ogram Financo	е	

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departm	ient	Prov	Provider Number: 0279269-45			
515 West Sixth Street			Date: 07/01/201	9		
Jacksonville, FL 32206		Fiso				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		169.57	166.57	07/01/2019		
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	Cost				
	Desk Rev	iewed Cost				
	Desk Audi	ited Cost				
	Field Audi	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			74			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Finar	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departmer	nt	Prov	ider Number: 0279269-4	46		
515 West Sixth Street			Date: 07/01/201	9		
Jacksonville, FL 32206		Fiso	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	169.57	166.57	07/01/2019		
Rate Type						
Interim		X <u>Prospect</u>	ive			
Total Ir	nterim	X	Total Prospective			
Settlen	nent Based on Cost	et Prospective Adjusted For N				
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			[N]			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departmer	nt	Prov	ider Number: 0279269-5	52		
515 West Sixth Street			Date: 07/01/201	9		
Jacksonville, FL 32206		Fiso	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	169.57	166.57	07/01/2019		
Rate Type						
Interim		X <u>Prospect</u>	ive			
Total Ir	nterim	X	Total Prospective			
Settlen	nent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			[N]			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County	ouval County Health Department					Prov	vider Number:	0279269-5	3
515 West Sixt	h Street						Date	07/01/2019)
Jacksonville, F	L 32206					Fiscal Year End: 06/30/2018			
						Audit Status:		Unaudited	Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	160	6.57	07/01/2019
Rate Type									
	<u>Interim</u>				Х	Prospec	<u>tive</u>		
	•	Total Interim				- x	Total P	rospective	
Settlement Based on Cost		on Cost	Pr		Prospe	ctive Adjust	ed For New Costs		
			BAS	SIS:					
				Budget					
			X	– Unaudited	d Cost				
				_ Desk Rev	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ited Cost				
				_					
DISTRIBUTIO	N:						TR		
Fiscal Age	ent						74		
Contract N	Contract Management						Rydell Samu	iel, Administ	rator
Program Finance							Medicaid Pro	ogram Finan	ICE

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County	ouval County Health Department					Prov	vider Number:	0279269-8	9
515 West Sixt	h Street						Date	07/01/2019)
Jacksonville, F	L 32206					Fiscal Year End: 06/30/2018			
							Audit Status:	Unaudited	Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	160	6.57	07/01/2019
Rate Type									
	<u>Interim</u>				Х	Prospec	<u>tive</u>		
	•	Total Interim				- x	Total P	rospective	
Settlement Based on Cost		on Cost	P		Prospe	ctive Adjust	ed For New Costs		
			BAS	SIS:					
				Budget					
			X	– Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ted Cost				
				_					
DISTRIBUTIO	<u>N:</u>						TR		
Fiscal Age	ent						74		
Contract N	Contract Management						Rydell Samu	uel, Administ	rator
Program Finance							Medicaid Pro	ogram Finan	ICE

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Departme	nt	Prov	ider Number: 0279269-9	91		
515 West Sixth Street			Date: 07/01/201	9		
Jacksonville, FL 32206		Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	169.57		07/01/2019		
Rate Type						
<u>Interim</u>		X Prospect	<u>ive</u>			
Total I	nterim	X	Total Prospective			
Settle	ment Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	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

Duval County	Duval County Health Department					Prov	vider Number:	0279269-93		
515 West Sixt	h Street						Date	07/01/2019		
Jacksonville, I	FL 32206					Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited C	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.57	160	6.57	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on C		on Cost	Pros		Prospe	ctive Adjusted	d For New Costs			
			BAS	SIS:						
				Budget						
			X	– Unaudited	d Cost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						7V			
Contract	Contract Management						Rydell Samu	iel, Administra	ator	
Program Finance							Medicaid Pro	ogram Financ	е	

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department		Provi	der Number: 0279269-9	95		
515 West Sixth Street			Date: 07/01/201	9		
Jacksonville, FL 32206		 Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	169.57		07/01/2019		
Rate Type						
Interim		X Prospecti	ive			
Total Inte	erim	X	Total Prospective			
Settleme	ent Based on Cost		Prospective Adjust	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 Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department		Provi	Provider Number: 0279269-96				
515 West Sixth Street			Date: 07/01/201	9			
Jacksonville, FL 32206		 Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	169.57		07/01/2019			
Rate Type							
Interim		X <u>Prospecti</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 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

Duval County Health Departme	ent	Prov	ider Number: 0279269-9	97			
515 West Sixth Street			Date: 07/01/2019	9			
Jacksonville, FL 32206		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	169.57	166.57	07/01/2019			
Rate Type							
Interim		X Prospect					
	Interim	X	Total Prospective				
Settlement 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			rv,				
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 Department		Provi	der Number: 0279269-9	98		
515 West Sixth Street			Date: 07/01/201	9		
Jacksonville, FL 32206		Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	169.57		07/01/2019		
Rate Type						
Interim		X <u>Prospect</u>	ive			
Total Inte	erim	x	Total Prospective			
Settleme	ent Based on Cost	Cost Prospective		ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			۲N			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County	lagler County Health Department					Provider Number: 0279285-00				
P. O. Box 8473	301 South	Lemon Street	:				Date:	07/01/2019		
Bunnell, FL 32	2110-0847	7				Fiscal Year End: 06/30/2018				
						Audit Sta		Unaudited	Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				147	.20	152	2.32	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
		Total Interim				- x	Total P	rospective		
Settlement Based on Cost		on Cost		Prospe		ctive Adjuste	ed For New Costs			
		-	BAS	sic.						
				Budget						
				- Unaudited	Cost					
				_	iewed Cost					
				_ Desk Audi						
				- Field Audi						
				-						
DISTRIBUTIO	N:						TR			
Fiscal Age							PU			
Contract N		ent					Rydell Samu	iel. Administ	rator	
	Program Finance						Medicaid Pro			

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County	lagler County Health Department					Provider Number: 0279285-01				
P. O. Box 8473	01 South	Lemon Street	:				Date	: 07/01/201	9	
Bunnell, FL 32	110-0847	7				Fiscal Year End: 06/30/2018				
							Audit Status	: Unaudited	d Cost	
Provider Ty	<u>pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				147	.20	15	2.32	07/01/2019	
Rate Type										
<u> </u>	<u>Interim</u>				Х	Prospect	<u>tive</u>			
		Total Interim				- X	Total F	rospective		
Settlement Based on Cost			Prospective Adjusted For New			ted For New Costs				
			BAS	SIS:						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Aud	ited Cost					
				- Field Audi	ted Cost					
				_						
DISTRIBUTION	<u>N:</u>						TR			
Fiscal Age	nt						74			
Contract Management						Rydell Samu	uel, Adminis	strator		
Program Finance							Medicaid Pr	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department	F	rovider Number: 0279285-0	2		
P. O. Box 847301 South Lemon Street		Date: 07/01/2019)		
Bunnell, FL 32110-0847		Fiscal Year End: 06/30/2018			
		Audit Status: Unaudited	Cost		
Provider Type	Current Rate	New Rate	Effective Date		
<u>CHD</u>	147.20	152.32	07/01/2019		
Rate Type Interim Total Interim	X Prosp	<u>ective</u> X Total Prospective			
Settlement Based on Cost		Prospective Adjust	ed For New Costs		
X Un De De	dget naudited Cost esk Reviewed Cost esk Audited Cost eld Audited Cost				
DISTRIBUTION:		F			
Fiscal Agent Contract Management		1 Dudoll Somuol Administ	rotor		
contract management		Rydell Samuel, Administ	lialui		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County He	alth Department			Provider	Number: 0279285-0)3	
P. O. Box 847301	South Lemon Stree	et			Date: 07/01/201	2019	
Bunnell, FL 3211	0-0847			Fiscal Year End: 06/30/2018			
				Aud	dit Status: Unaudited	Cost	
Provider Type	<u>.</u>		Current	t Rate	New Rate	Effective Date	
<u>CI</u>	HD		147.	20	152.32	07/01/2019	
Rate Type							
Int	<u>erim</u>		Х	Prospective			
	Total Interim	l		Х	Total Prospective		
	Settlement E	Based on Cost			Prospective Adjust	ted For New Costs	
		BASIS:					
		Budget					
		X Unaudited	l Cost				
		Desk Rev	iewed Cost				
		Desk Aud	ited Cost				
		Field Audi	ted Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent				1			
Contract Man	agement			Ry	dell Samuel, Adminis	trator	
Program Fina	nce			Me	dicaid Program Finar	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health	Department			Provid	er Number:	0279285-04	
P. O. Box 847301 So	uth Lemon Street			Date:		: 07/01/2019	
Bunnell, FL 32110-08	347			Fiscal Year End: 06/30/2018			
				А	udit Status:	Unaudited Co	st
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>CHD</u>			147	.20	152	.32	07/01/2019
Rate Type							
Interii	<u>m</u>		Х	<u>Prospectiv</u>	<u>'e</u>		
	Total Interim			- x	Total Pre	ospective	
Settlement Based on Cost				Prospec	tive Adjusted	For New Costs	
		BASIS:					
	-	Budget					
	-	X Unaudited	Cost				
	-	 Desk Rev	iewed Cost				
	-	 Desk Aud	ited Cost				
	-	 Field Audi	ted Cost				
	-						
DISTRIBUTION:				,	TR		
Fiscal Agent					M		
Contract Manage	ement			R	ydell Samue	el, Administrate	or
Program Finance)			N	ledicaid Pro	gram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County He	alth Department			Provider	Number: 0279285-0)5	
P. O. Box 847301	South Lemon Stree	t			Date: 07/01/201	19	
Bunnell, FL 3211)-0847			Fiscal Year End: 06/30/2018			
				Auc	dit Status: Unaudited	Cost	
Provider Type			Current	t Rate	New Rate	Effective Date	
<u>CI</u>	<u>HD</u>		147.	20	152.32	07/01/2019	
Rate Type							
<u>Int</u>	<u>erim</u>		X	Prospective			
	Total Interim			Х	Total Prospective		
	Settlement B	ased on Cost			Prospective Adjust	ted For New Costs	
		BASIS:					
		Budget					
		X Unaudited	l Cost				
		Desk Revi	iewed Cost				
		Desk Audi	ited Cost				
		Field Audi	ted Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent				1			
Contract Man	agement			Ryo	dell Samuel, Adminis	strator	
Program Fina	nce			Me	dicaid Program Finai	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Healt	h Department			Provide	er Number:	0279285-06		
P. O. Box 847301 Sc	outh Lemon Street			Date:		: 07/01/2019		
Bunnell, FL 32110-0	847			Fiscal Year End: 06/30/2018				
				A	udit Status:	Unaudited Co	st	
Provider Type			<u>Curren</u>	t Rate	<u>New l</u>	Rate	Effective Date	
CHD	<u>)</u>		147	.20	152	.32	07/01/2019	
Rate Type								
Interi	im		Х	Prospectiv	<u>e</u>			
	Total Interim			- x	Total Pro	ospective		
Settlement Based on Cost			Prospective Adjusted For New Costs					
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		 Desk Revi	iewed Cost					
		 Desk Aud	ited Cost					
		 Field Audi	ted Cost					
DISTRIBUTION:				J.	TR			
Fiscal Agent					M			
Contract Manage	ement			R	ydell Samue	l, Administrate	or	
Program Finance	е			M	edicaid Prog	gram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health	Department			Provid	er Number:	0279285-07		
P. O. Box 847301 Sou	uth Lemon Street			Date:		: 07/01/2019		
Bunnell, FL 32110-08	347			Fiscal Year End: 06/30/2018				
				A	udit Status:	Unaudited Co	st	
Provider Type			<u>Curren</u>	t Rate	<u>New l</u>	Rate	Effective Date	
<u>CHD</u>			147	.20	152	.32	07/01/2019	
Rate Type								
Interin	<u>n</u>		Х	<u>Prospectiv</u>	<u>e</u>			
	Total Interim			- x	Total Pro	ospective		
Settlement Based on Cost				Prospec	tive Adjusted	For New Costs		
		BASIS:						
	-	Budget						
	-	X Unaudited	d Cost					
	-	 Desk Rev	iewed Cost					
	-	 Desk Aud	ited Cost					
	-	 Field Audi	ited Cost					
	-							
DISTRIBUTION:					TR			
Fiscal Agent					M			
Contract Manage	ment			R	ydell Samue	l, Administrat	or	
Program Finance				N	ledicaid Prog	gram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health	Department			Provide	er Number: (0279285-08		
P. O. Box 847301 So	uth Lemon Street			Date:		: 07/01/2019		
Bunnell, FL 32110-08	347			Fiscal Year End: 06/30/2018				
				A	udit Status:	Jnaudited Co	st	
Provider Type			<u>Curren</u>	t Rate	New F	Rate	Effective Date	
<u>CHD</u>			147	.20	152.	32	07/01/2019	
Rate Type								
Interii	<u>n</u>		Х	<u>Prospectiv</u>	<u>e</u>			
	Total Interim			- x	Total Pro	ospective		
Settlement Based on Cost			Prospective Adjusted For New Costs					
		BASIS:						
		Budget						
	-	X Unaudited	Cost					
	-	 Desk Rev	iewed Cost					
	-	 Desk Aud	ited Cost					
	-	 Field Audi	ted Cost					
	-							
DISTRIBUTION:					TR			
Fiscal Agent					M			
Contract Manage	ment			R	ydell Samue	I, Administrate	or	
Program Finance				M	ledicaid Prog	gram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Healt	h Department			Provide	er Number: 0	279285-09		
P. O. Box 847301 Sc	outh Lemon Street			- Date:		: 07/01/2019		
Bunnell, FL 32110-0	847			Fiscal Year End: 06/30/2018				
				Au	udit Status: L	Jnaudited Cos	st	
Provider Type			<u>Curren</u>	t Rate	New R	late	Effective Date	
CHD	<u>)</u>		147	.20	152.3	32	07/01/2019	
Rate Type								
Interi	<u>m</u>		Х	Prospectiv	<u>e</u>			
	Total Interim			- x	Total Pro	spective		
Settlement Based on Cost				Prospect	ive Adjusted I	For New Costs		
		BASIS:						
		Budget						
		X Unaudited	d Cost					
		 Desk Rev	iewed Cost					
		 Desk Aud	ited Cost					
		 Field Audi	ited Cost					
DISTRIBUTION:				2	TR			
Fiscal Agent					M			
Contract Manage	ement			R	ydell Samuel	, Administrate	or	
Program Finance	Э			M	edicaid Prog	ram Finance	_	

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department		Provider Number: 0279285-30				
P. O. Box 847301 South Lemon Street		Date:	07/01/2019			
Bunnell, FL 32110-0847		Fiscal Year End: 06/30/2018				
		Audit Status:	Unaudited Co	st		
Provider Type	Current Rat	e <u>New</u>	Rate	Effective Date		
<u>CHD</u>	147.20	152	2.32	07/01/2019		
Rate Type Interim	× <u>Pro</u>	<u>spective</u>				
Total Interim		X Total P	rospective			
Settlement Based on Cost		Prospe	ctive Adjusted	For New Costs		
	5: Budget Inaudited Cost Desk Reviewed Cost Desk Audited Cost Tield Audited Cost					
DISTRIBUTION:		T				
Fiscal Agent Contract Management		l Dydoll Some	ol Administrati	or		
contract management		Ryueli Salilu	el, Administrate			

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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Department	Prov	vider Number: 0279293-	00	
139 12th Street		Date: 07/01/201	9	
Apalachicola, FL 32320	Fis	Fiscal Year End: 06/30/2018		
		Audit Status: Unaudited	d Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	169.57	166.57	07/01/2019	
Rate Type				
Interim	X Prospect			
Total Interim	X	Total Prospective		
Settlement Based on Cost		Prospective Adjus	ted For New Costs	
BASIS:				
Budge	t			
X Unaud	ited Cost			
Desk F	Reviewed Cost			
Desk A	Audited Cost			
Field A	udited 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

Franklin County Health Departme	ent		Provider Number: 0279293-01			
139 12th Street				9		
Apalachicola, FL 32320			Fiscal Year End: 06/30/2018			
			Aud	it Status: Unaudited	Cost	
Provider Type Curre		Current	Rate	New Rate	Effective Date	
CHD		169.	57	166.57	07/01/2019	
Rate Type						
Interim		Х	Prospective			
Total Inte	erim		Х	Total Prospective		
Settlement Based on Cost				Prospective Adjust	ted For New Costs	
				-		
	BASIS:					
	Budget					
	X Unaudited Co	ost				
	Desk Reviewe	ed Cost				
	Desk Audited	Cost				
	Field Audited	Cost				
DISTRIBUTION:			_	R		
Fiscal Agent						
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Department	nt		Provider Number: 0279293-30			
139 12th Street				9		
Apalachicola, FL 32320			Fiscal Year End: 06/30/2018			
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>C</u>	urren	t Rate	New Rate	Effective Date	
<u>CHD</u>		169	.57	166.57	07/01/2019	
Rate Type						
Interim		X	Prospective			
Total Inte	erim		X	Total Prospective		
Settlement Based on Cost			Prospective Adjust	ted For New Costs		
				_		
	BASIS:					
	Budget					
	X Unaudited Cos	t				
	Desk Reviewed	d Cost				
	Desk Audited 0	Cost				
	Field Audited C	Cost				
DISTRIBUTION:			-	TR		
Fiscal Agent			1	N.		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Departr	ment		Provider	Number: 0279293-9	2	
139 12th Street				Date: 07/01/2019		
Apalachicola, FL 32320			Fiscal Y	'ear End: 06/30/2018	3	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current Ra	<u>ite</u>	New Rate	Effective Date	
<u>CHD</u>	-	169.57		166.57	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Pr</u>	<u>ospective</u>			
Total	Interim		Х	Total Prospective		
Settle	ment Based on Cost			Prospective Adjust	ed For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audit	ed Cost				
			/	TP		
DISTRIBUTION: Fiscal Agent			1	AT .		
Contract Management			Rvc	lell Samuel, Administ	trator	
Program Finance				dicaid Program Finan		
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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Dep	partment		Provider	Number: 0279293-9	3	
139 12th Street				Date: 07/01/2019		
Apalachicola, FL 32320			Fiscal Y	ear End: 06/30/2018	3	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current Ra	<u>ate</u>	New Rate	Effective Date	
CHD	-	169.57		166.57	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Pr</u>	<u>ospective</u>			
Тс	otal Interim		Х	Total Prospective		
Se	ettlement Based on Cost			Prospective Adjust	ed For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
			/	IR		
DISTRIBUTION: Fiscal Agent			ť			
Contract Management			Ryd	lell Samuel, Administ	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department		Provide	Number: 02	279307-00	
P. O. Box 1000		Date:		e: 07/01/2019	
Quincy, FL 32353-1000		Fiscal `	Year End: 06	6/30/2018	
		Au	dit Status: U	naudited Cos	t
Provider Type	Curren	t Rate	<u>New Ra</u>	ate	Effective Date
<u>CHD</u>	169	.57	166.5	57	07/01/2019
Rate Type	Y				
Interim	<u> </u>	_ <u>Prospective</u>			
Total Interim		Χ	Total Pros	-	
Settlement Based o	n Cost		Prospectiv —	/e Adjusted F	or New Costs
BAS	SIS:				
	Budget				
X	Unaudited Cost				
	- Desk Reviewed Cost				
	- Desk Audited Cost				
	- Field Audited Cost				
	-				
DISTRIBUTION:		-	TR		
Fiscal Agent			M		
Contract Management		Rv	dell Samuel,	Administrato	r
Program Finance			dicaid Progra		_

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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Departm	ent		Provider	Number: 0279307-0)1	
P. O. Box 1000				9		
Quincy, FL 32353-1000			Fiscal Year End: 06/30/2018			
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	_	169.	57	166.57	07/01/2019	
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 Revie	wed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	N .		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department	t		Provider	Number: 0279307-0)2	
P. O. Box 1000			Date: 07/01/2019			
Quincy, FL 32353-1000			Fiscal Y	'ear End: 06/30/2018	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>	_	169	.57	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interir	m		×	Total Prospective		
Settlement	Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited C	ost				
	Desk Review	ved Cost				
	Desk Audited	d Cost				
	Field Audited	d Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	u)		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Departmen	ıt		Provider	Number: 0279307-0)4	
P. O. Box 1000			Date: 07/01/2019			
Quincy, FL 32353-1000			Fiscal Y	/ear End: 06/30/201	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>	-	169	.57	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interi	m		X	Total Prospective		
Settlement	Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audit	ed Cost				
			/	TR		
DISTRIBUTION: Fiscal Agent			1			
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Fina		
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Departmen	nt		Provider	Number: 0279307-1	12	
P. O. Box 1000			Date: 07/01/2019			
Quincy, FL 32353-1000			Fiscal Y	/ear End: 06/30/201	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.	.57	166.57	07/01/2019	
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	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audite	ed Cost				
			-	TP		
DISTRIBUTION:			ļ	at the second se		
Fiscal Agent			1	N.		
Contract Management				dell Samuel, Adminis		
Program Finance			Mee	dicaid Program Finar	nce	
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Departm	ent		Provider	Number: 0279307-3	30
P. O. Box 1000				9	
Quincy, FL 32353-1000			Fiscal Y	/ear End: 06/30/2018	8
			Aud	lit Status: Unaudited	Cost
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date
<u>CHD</u>	_	169.	57	166.57	07/01/2019
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 Revie	wed Cost			
	Desk Audite	ed Cost			
	Field Audite	ed Cost			
DISTRIBUTION:			-	R	
Fiscal Agent			1	Z	
Contract Management			Ryc	lell Samuel, Adminis	trator
Program Finance				dicaid Program Finar	
State Health Office					



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Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Departme	ent	Provi	der Number: 0279315-0	00
119 N.E. First Street			Date: 07/01/201	9
Trenton, FL 32693-3459		Fisc	al Year End: 06/30/201	8
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		129.00	166.57	07/01/2019
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	l Cost		
	Desk Revi	iewed Cost		
	Desk Audi	ited Cost		
	Field Audi	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			۲N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Department	t		Provider	Number: 0279315-9	91
119 N.E. First Street				9	
Trenton, FL 32693-3459			Fiscal Y	ear End: 06/30/201	8
			Aud	it Status: Unaudited	Cost
Provider Type	<u>Cu</u>	urrent	t Rate	New Rate	Effective Date
CHD		129.	00	166.57	07/01/2019
Rate Type					
<u>Interim</u>		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 Co	ost			
	Field Audited Co	ost			
DISTRIBUTION:			-	R	
Fiscal Agent			f	al l	
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

Glades County Health Department	:	Provi	der Number: 0279323-0	00		
P. O. Box 489		_	Date: 07/01/2019			
Moore Haven, FL 33471		– Fisc	al Year End: 06/30/201	8		
		- ,	Audit Status: Unaudited	Cost		
Provider Type	Curr	ent Rate	New Rate	Effective Date		
CHD	1	69.57	166.57	07/01/2019		
Rate Type						
Interim		X Prospecti	ve			
Total Inte	rim	X	Total Prospective			
Settlemen	nt 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:			at			
Fiscal Agent			/ *			
Contract Management		-	Rydell Samuel, Adminis			
Program Finance			Medicaid Program Finar	nce		
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Department	nt		Provider	Number: 0279323-3	30
P. O. Box 489				9	
Moore Haven, FL 33471			Fiscal Y	ear End: 06/30/2018	8
			Aud	it Status: Unaudited	Cost
Provider Type		Current I	Rate	New Rate	Effective Date
CHD	_	169.5	7	166.57	07/01/2019
Rate Type					
<u>Interim</u>		х <u></u>	Prospective		
Total Int	erim		Х	Total Prospective	
Settleme	ent Based on Cost	_		Prospective Adjust	ted For New Costs
		_		-	
	BASIS:				
	Budget				
	X Unaudited C	ost			
	Desk Review	ved Cost			
	Desk Audite	d Cost			
	Field Audited	d Cost			
			_	P	
DISTRIBUTION:			ý	A Contraction	
Fiscal Agent			1		
Contract Management				lell Samuel, Adminis	
Program Finance			Med	dicaid Program Finar	ICE
State Health Office					



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Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Departn	nent		Provider	Number: 0279323-9	1
P. O. Box 489				Date: 07/01/2019	9
Moore Haven, FL 33471		Fiscal Y	'ear End: 06/30/2018	3	
			Aud	it Status: Unaudited	Cost
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date
CHD	-	169.5	7	166.57	07/01/2019
Rate Type					
<u>Interim</u>		Х <u>I</u>	Prospective		
Total	Interim		Х	Total Prospective	
Settle	ement Based on Cost	-		Prospective Adjust	ed For New Costs
		_		_	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
			_	P	
DISTRIBUTION:			ý	a l	
Fiscal Agent			1		
Contract Management				lell Samuel, Administ	
Program Finance			Med	dicaid Program Finar	ice
State Health Office					



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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Departmen	t	Р	Provider Number: 0279331-00 Date: 07/01/2019			
2475 Garrison Avenue						
Port St. Joe, FL 32456-5265			Fiscal Year End: 06/23/201	8		
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	169.57	166.57	07/01/2019		
Rate Type						
<u>Interim</u>		X <u>Prosp</u> e	<u>ective</u>			
Total	Interim	>	K Total Prospective			
Settle	ment Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			M			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Final	nce		
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department		Prov	ider Number: 0279331-0	01	
2475 Garrison Avenue			Date: 07/01/2019		
Port St. Joe, FL 32456-5265	Fiso	cal Year End: 06/23/201	8		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.57	166.57	07/01/2019	
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	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

Gulf County Health Departr	nent		Provider	Number: 0279331-0	3	
2475 Garrison Avenue			Date: 07/01/2019			
Port St. Joe, FL 32456-526		Fiscal Y	ear End: 06/23/2018	3		
			Aud	it Status: Unaudited	Cost	
Provider Type		Current R	ate	New Rate	Effective Date	
CHD		169.57		166.57	07/01/2019	
Rate Type						
Interim		Х <u>Р</u>	<u>ospective</u>			
Тс	otal Interim		Х	Total Prospective		
Se	ettlement Based on Cost			Prospective Adjust	ed For New Costs	
	54010			_		
	BASIS:					
	Budget					
	X Unaudited					
		iewed Cost				
	Desk Aud					
	Field Audi	ited Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			[N		
Contract Management			Ryd	ell Samuel, Administ	trator	
Program Finance			Med	licaid Program Finan	ice	
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department	Prov	ider Number: 0279331-0	05		
2475 Garrison Avenue			Date: 07/01/2019		
Port St. Joe, FL 32456-5265	Fiso	cal Year End: 06/23/201	8		
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		169.57	166.57	07/01/2019	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total Ir	nterim	X	Total Prospective		
Settlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudite	d Cost			
	Desk Rev	viewed Cost			
	Desk Auc	dited Cost			
	Field Aud	lited Cost			
DISTRIBUTION:			TR		
Fiscal Agent			r v		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Depart	Prov	ider Number: 0279331-	07	
2475 Garrison Avenue			Date: 07/01/201	19
Port St. Joe, FL 32456-52	Fis	cal Year End: 06/23/201	18	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		169.57	166.57	07/01/2019
Rate Type				
<u>Interim</u>		X Prospect	ive	
т	otal Interim	X	Total Prospective	
s	Settlement Based on Cost		Prospective Adjus	sted For New Costs
	BASIS:			
	Budget			
	X Unaudite	d Cost		
	Desk Rev	viewed Cost		
	Desk Aud	dited Cost		
	Field Auc	lited Cost		
DISTRIBUTION:			TR	
Fiscal Agent			r v	
Contract Management	t		Rydell Samuel, Admini	strator
Program Finance			Medicaid Program Fina	ance

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Departr	ment		Provider	Number: 0279331-1	1	
2475 Garrison Avenue			Date: 07/01/2019			
Port St. Joe, FL 32456-526		Fiscal Y	ear End: 06/23/2018	3		
		Aud	it Status: Unaudited	Cost		
Provider Type		Current Ra	ate	New Rate	Effective Date	
<u>CHD</u>		169.57		166.57	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Pr</u>	<u>ospective</u>			
To	otal Interim		Х	Total Prospective		
Se	ettlement Based on Cost			Prospective Adjust	ed For New Costs	
	-			_		
	BASIS:					
	Budget					
	X Unaudited					
		viewed Cost				
	Desk Aud					
	Field Aud	lited Cost				
DISTRIBUTION:				R		
Fiscal Agent			1	N		
Contract Management			Ryd	ell Samuel, Administ	trator	
Program Finance			Mec	licaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Depart	Provider	Number: 0279331-1	9			
2475 Garrison Avenue			Date: 07/01/2019			
Port St. Joe, FL 32456-52		Fiscal Y	'ear End: 06/23/2018	3		
			Aud	lit Status: Unaudited	Cost	
Provider Type		Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>		169	.57	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
т	otal Interim		- x	Total Prospective		
S	Settlement Based on	Cost		Prospective Adjust	ed For New Costs	
		_				
	BASIS					
		Budget				
		Inaudited Cost				
		Desk Reviewed Cost				
		Desk Audited Cost				
	F	ield Audited Cost				
DISTRIBUTION:				R		
Fiscal Agent			1	N.		
Contract Managemen	t			lell Samuel, Adminis		
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Departmen	t		Provider Number: 0279331-21 Date: 07/01/2019			
2475 Garrison Avenue						
Port St. Joe, FL 32456-5265			Fiscal Year End: 06/23/2	2018		
			Audit Status: Unaudi	ted Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	169.57	166.57	07/01/2019		
Rate Type						
<u>Interim</u>		X <u>Pros</u>	<u>pective</u>			
Total	Interim		X Total Prospectiv	ve		
Settle	ment Based on Cost		Prospective Ad	justed 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, Admi	inistrator		
Program Finance			Medicaid Program Fi	inance		
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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Departm	nent		Provider	Number: 0279331-3	0	
2475 Garrison Avenue			Date: 07/01/2019			
Port St. Joe, FL 32456-526		Fiscal Y	ear End: 06/23/2018	3		
		Aud	it Status: Unaudited	Cost		
Provider Type		<u>Current R</u>	ate	New Rate	Effective Date	
CHD		169.57	,	166.57	07/01/2019	
Rate Type						
Interim		Х <u>Р</u>	<u>rospective</u>			
То	otal Interim		Х	Total Prospective		
Se	ettlement Based on Cost			Prospective Adjust	ed For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited					
		iewed Cost				
	Desk Audi					
	Field Audi	ted Cost				
DISTRIBUTION:			_	R		
Fiscal Agent			[N		
Contract Management			Ryd	lell Samuel, Administ	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department				Pro	vider Number:	0279340-00	0		
P. O. Box 267	,						Date	07/01/2019)
Jasper, FL 32	2052					Fis	scal Year End	06/30/2018	1
							Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				114	.72	16	5.29	07/01/2019
Rate Type									
	Interim				Х	Prospec	tive		
	-	Total Interim				- X	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs
			BAS	<u>SIS:</u>					
				Budget					
			X	_ Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						/ N		
Contract	Managem	ent					Rydell Samu	uel, Administ	rator
Program	Finance						Medicaid Pro	ogram Finan	се

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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton Cou	nty Health	Department			Provi	der Number:	0279340-25	
P. O. Box 267	,					Date:	07/01/2019	
Jasper, FL 32	2052				Fisc	al Year End:	06/30/2018	
						Audit Status:	Unaudited Co	ost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			114.	.72	165	5.29	07/01/2019
Rate Type	Interim			х	<u>Prospecti</u>	ve		
	-	Total Interim					rospective	
		Settlement Base	d on Cost				-	For New Costs
			ASIS: Budget Unaudited Desk Rev Desk Aud Field Aud	viewed Cost lited Cost				
	ent Manageme	ent			-	-	el, Administra	
Program	rinance				l	iviedicald Pro	ogram Finance)

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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department	Prov	ider Number: 0279340-3	30
P. O. Box 267		Date: 07/01/201	9
Jasper, FL 32052	Fise	cal Year End: 06/30/201	8
		Audit Status: Unaudited	Cost
Provider Type	Current Rate	New Rate	Effective Date
CHD	114.72	165.29	07/01/2019
Rate Type Interim	X Prospect	ive	
Total Interim	X	Total Prospective	
Settlement Based on Cost			ted For New Costs
BASIS: Budget X Unaudited C Desk Review Desk Audited Field Audited	ved Cost d Cost		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance		Rydell Samuel, Adminis Medicaid Program Final	

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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton Cou	lamilton County Health Department					Prov	vider Number	: 0279340-	91
P. O. Box 267	7						Date	: 07/01/201	9
Jasper, FL 32	2052					Fis	cal Year End	: 06/30/201	8
							Audit Status	: Unaudited	d Cost
Provider T	<u>ype</u>				<u>Currer</u>	nt Rate	New	<u> Rate</u>	Effective Date
	<u>CHD</u>				114	.72	16	5.29	07/01/2019
Rate Type	Interim				х	<u>Prospec</u>	tivo		
	- -	Total Interim				- X		rospective	
		- Settlement Bas	ed o	n Cost				-	sted For New Costs
		-						, 	
		E	BAS	<u>IS:</u>					
				Budget					
		_	Х	Unaudited	l Cost				
		_		Desk Revi	iewed Cost	t			
		_		Desk Audi	ited Cost				
		_		Field Audi	ted Cost				
		—							
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag							M		
-	Manageme	ent					Rydell Sam	uel, Adminis	strator
Program	Finance						Medicaid Pr		

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County	lardee County Health Department					Prov	ider Number:	0279358-00		
115 K.D. Reve	ell Road						Date:	07/01/2019		
Wauchula, FL	33873					Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited C	ost	
<u>Provider Ty</u>	<u>/pe</u>				Current	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169.	.57	160	6.57	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
		Total Interim				x	Total P	rospective		
		Settlement Ba	ased	on Cost			Prospe	ctive Adjusted	d For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	Unaudited	d Cost					
				– Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIO	<u>N:</u>						TR			
Fiscal Age	ent						۲N			
Contract N	Managem	ent					Rydell Samu	iel, Administra	ator	
Program F	Finance						Medicaid Pro	ogram Financo	е	

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee Count	Hardee County Health Department				Provi	ider Number	: 0279358-0)1
115 K.D. Reve	ell Road					Date	: 07/01/2019	9
Wauchula, FL	33873				Fiscal Year End: 06/30/2018			3
						Audit Status	: Unaudited	Cost
Provider Ty	<u>ype</u>			Curren	t Rate	New	<u>v Rate</u>	Effective Date
	<u>CHD</u>			169	.57	16	6.57	07/01/2019
Rate Type								
	Interim			X	Prospect	ive		
		Total Interim			X	Total F	rospective	
		Settlement Base	d on Cost			Prospe	ective Adjust	ed For New Costs
		<u>B</u>	ASIS:					
			Budget					
			C Unaudited	d Cost				
			Desk Rev	iewed Cost				
			Desk Aud	lited Cost				
			Field Aud	ited Cost				
DISTRIBUTIO	N.					TR		
Fiscal Ag						p()		
-		t						
Program	Manageme Finance	7111			-	Rydell Samu Medicaid Pr		
Filograffi	i mance					Medicalu FI	ogram i mar	

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Department		Provider Number	0279358-09		
115 K.D. Revell Road		Date	07/01/2019		
Wauchula, FL 33873		Fiscal Year End: 06/30/2018			
		Audit Status	Unaudited Cos	t	
Provider Type	Current Ra	te <u>New</u>	Rate	Effective Date	
CHD	169.57	160	6.57	07/01/2019	
Rate Type					
Interim	X <u>Pro</u>	<u>ospective</u>			
Total Interim		X Total P	rospective		
Settlement Based on	Cost	Prospe	ctive Adjusted F	or New Costs	
BASIS	<u>S:</u>				
В	Budget				
<u> </u>	Inaudited Cost				
D	Desk Reviewed Cost				
D	Desk Audited Cost				
F	ield Audited Cost				
DISTRIBUTION:		TR			
Fiscal Agent		M			
Contract Management		Rydell Samu	uel, Administrato	r	
Program Finance		Medicaid Pro	ogram Finance	—	

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Department	Prov	ider Number: 0279358-	30		
115 K.D. Revell Road		Date: 07/01/201	9		
Wauchula, FL 33873	Fiso	Fiscal Year End: 06/30/2018			
		Audit Status: Unaudited	d Cost		
Provider Type	Current Rate	New Rate	Effective Date		
<u>CHD</u>	169.57	166.57	07/01/2019		
Rate Type					
<u>Interim</u>	X Prospect	ive			
Total Interim	X	Total Prospective			
Settlement Based on Cos	st	Prospective Adjus	ted For New Costs		
BASIS:					
Budg	get				
XUna	udited Cost				
Desi	k Reviewed Cost				
Dest	k Audited Cost				
Field	Audited Cost				
DISTRIBUTION:		TR			
Fiscal Agent		M			
Contract Management		Rydell Samuel, Adminis	strator		
Program Finance		Medicaid Program Fina			

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Medicaid Reimbursement Rate Change Form for CHDs

Hendry Count	lendry County Health Department					Prov	/ider Numbe	er: 0279366	-00
P. O. Box 70							Dat	e: 07/01/20	19
LaBelle, FL 3	3975					Fiscal Year End: 06/30/2018			18
							Audit Statu	s: Unaudite	d Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	Ne	w Rate	Effective Date
	<u>CHD</u>				169	.57	1	66.57	07/01/2019
Rate Type							_		
	Interim				X	_ <u>Prospec</u>		-	
		Total Interim				X		Prospective	
		Settlement Bas	sed o	n Cost			Prosp	pective Adju	sted For New Costs
			BAS	<u>IS:</u>					
				Budget					
		-	Х	Unaudited	l Cost				
		-		Desk Revi	iewed Cost				
		-		Desk Audi	ited Cost				
		-		Field Audi	ted Cost				
		-		-					
DISTRIBUTIO	<u>)N:</u>						TR		
Fiscal Age	ent						M		
Contract I	Manageme	ent					Rydell San	nuel, Admini	strator
Program I	Finance						Medicaid F	Program Fina	ance

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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Departmer	lendry County Health Department				Provider Number: 0279366-30			
P. O. Box 70				Date: 07/01/201	9			
LaBelle, FL 33975			Fiscal Y	ear End: 06/30/201	8			
			Aud	it Status: Unaudited	Cost			
Provider Type		Current Rate		New Rate	Effective Date			
<u>CHD</u>		169.	57	166.57	07/01/2019			
Rate Type								
<u>Interim</u>		Х	Prospective					
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 C	ost						
	Field Audited Co	ost						
DISTRIBUTION:			-	R				
Fiscal Agent			1					
Contract Management			Ryd	lell Samuel, Adminis	trator			
Program Finance			Med	dicaid Program Finar	nce			
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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Departr	lendry County Health Department				Provider Number: 0279366-92			
P. O. Box 70				Date: 07/01/2019	9			
LaBelle, FL 33975			Fiscal Y	ear End: 06/30/2018	3			
			Aud	it Status: Unaudited	Cost			
Provider Type		Current Rate		New Rate	Effective Date			
<u>CHD</u>	-	169.	57	166.57	07/01/2019			
Rate Type								
<u>Interim</u>		Х	Prospective					
Total	Interim		Х	Total Prospective				
Settle	ement Based on Cost			Prospective Adjust	ed For New Costs			
				-				
	BASIS:							
	Budget							
	X Unaudited	Cost						
	Desk Revie	ewed Cost						
	Desk Audit	ed Cost						
	Field Audit	ed Cost						
DISTRIBUTION:			~	R				
Fiscal Agent			f	N				
Contract Management			Ryd	ell Samuel, Administ	trator			
Program Finance				licaid Program Finar				
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Medicaid Reimbursement Rate Change Form for CHDs

Hernando Cou	lernando County Health Department					Prov	vider Number:	0279374-00)
300 S. Main S	t.						Date	07/01/2019	
Brooksville, FL	_ 34601					Fis	cal Year End	06/30/2018	
							Audit Status:	Unaudited (Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	13	9.95	07/01/2019
Rate Type	Interim				х	Prospos	tivo		
		Total Interim				-Prospec X		rospective	
		Settlement Ba	sed o	on Cost				•	ed For New Costs
		-	BAS X	Budget Unaudited	iewed Cost				
		-		Field Audi	ted Cost				
DISTRIBUTIO Fiscal Age							TH		
Contract N		ent					Rydell Samu	ıel, Administr	rator
Program I	Finance							ogram Finan	

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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Heal	ernando County Health Department				Provider Number: 0279374-91			
300 S. Main St.					Date: 07/01/20	19		
Brooksville, FL 34601				Fiscal	Year End: 06/30/20	18		
				Au	dit Status: Unaudite	ed Cost		
Provider Type		Current Rate		New Rate	Effective Date			
<u>CHD</u>		-	169	.57	139.95	07/01/2019		
Rate Type								
Interim			Х	Prospective	2			
	Total Interim			- x	Total Prospective	9		
	_ Settlement Bas	sed on Cost			Prospective Adju	sted 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					p()			
Contract Managem	nent			Ry	dell Samuel, Admin	istrator		
Program Finance				Me	edicaid Program Fina	ance		
State Health Office	•							



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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Health Departm	nent	Provider Number: 0279374-92			
300 S. Main St.		-	Date: 07/01/201	9	
Brooksville, FL 34601		- Fisca	I Year End: 06/30/201	8	
		- A	udit Status: Unaudited	Cost	
Provider Type		ent Rate	New Rate	Effective Date	
<u>CHD</u>	10	69.57	139.95	07/01/2019	
Rate Type					
Interim	>	< 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 Cost	:			
	Field Audited Cost				
DISTRIBUTION:			R		
Fiscal Agent			P()		
Contract Management		R	ydell Samuel, Adminis	trator	
Program Finance		N	ledicaid Program Finai	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Highlands Co	ighlands County Health Department					Prov	/ider Number:	0279382-0	00		
7205 South G	eorge Bou	llevard					Date	07/01/2019	9		
Sebring, FL 3	3872					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited	Cost		
Provider Type <u>Cu</u>		<u>Curren</u>	urrent Rate <u>New Rate</u>		Rate	Effective Date					
	<u>CHD</u>				160	.79	12	7.71	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospect	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
Settlement Based on Cost			on Cost			Prospe	ctive Adjust	ted For New Costs			
			BAS	<u>SIS:</u>							
				Budget							
			X	_ Unaudited	Cost						
				_ Desk Revi	ewed Cost						
				_ Desk Audi	ted Cost						
				– Field Audi	ted Cost						
				-							
DISTRIBUTIC	<u> </u>						TR				
Fiscal Ag	ent						γN				
Contract I	Contract Management					Rydell Samuel, Administrator					
Program	Program Finance						Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Highlands County Health Departm	ent	Pro	Provider Number: 0279382-91				
7205 South George Boulevard			Date: 07/01/201	9			
Sebring, FL 33872		Fis	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type	Current Rate	New Rate	Effective Date				
<u>CHD</u>	-	160.79	127.71	07/01/2019			
Rate Type Interim		X <u>Prospec</u>	tive				
Total Inte	erim	X	Total Prospective				
	nt Based on Cost			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			PU				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina				

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River Coun	ty Health Departme	ent	Prov	Provider Number: 0279412-00				
1900 27th Street				Date: 07/01/201	9			
Vero Beach, FL 3	2960		Fise	Fiscal Year End: 06/30/2018				
				Audit Status: Unaudited	l Cost			
Provider Type Cu		Current Rate	New Rate	Effective Date				
CHD			153.31	148.06	07/01/2019			
Rate Type								
Inte	<u>erim</u>		X Prospect	ive				
	Total Interim	ı	X	Total Prospective				
Settlement Based on Cost				Prospective Adjus	ted For New Costs			
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		Desk Rev	iewed Cost					
		Desk Aud	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:				TR				
Fiscal Agent				(N				
Contract Mana	agement			Rydell Samuel, Administrator				
Program Fina	nce			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Heal	th Department		Provider Number: 0279412-01					
1900 27th Street				Date: 07/01/2019				
Vero Beach, FL 32960				Fiscal Year End: 06/30/2018				
				Au	dit Status: Unaudited	Cost		
Provider Type <u>Cu</u>			<u>Curren</u>	it Rate	New Rate	Effective Date		
<u>CHD</u>			153	.31	148.06	07/01/2019		
Rate Type								
<u>Interim</u>			Х	Prospective	2			
	Total Interim			X	Total Prospective			
Settlement Based on Cost					Prospective Adjust	ted For New Costs		
	BA	<u>ASIS:</u>						
		Budget						
	Х	Unaudited	l Cost					
		Desk Revi	iewed Cost					
		Desk Audi	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:				-	R			
Fiscal Agent					pr)			
Contract Management				Rydell Samuel, Administrator				
Program Finance				Me	edicaid Program Finar	nce		
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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Dep	partment	Prov	ider Number: 0279412-0)2			
1900 27th Street			Date: 07/01/201	9			
Vero Beach, FL 32960		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	_	153.31	148.06	07/01/2019			
Rate Type							
Interim		X Prospect					
Total I	nterim	X	Total Prospective				
Settler	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			rv.				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River C	ndian River County Health Department						Provider Number: 0279412-03				
1900 27th Stre	eet					Date: 07/01/2019					
Vero Beach, F	L 32960					Fiscal Year End: 06/30/2018					
							Audit Status	Unaudited	d Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				153	.31	14	8.06	07/01/2019		
Rate Type					X	_					
	Interim	Total lataria			X	_ <u>Prospect</u>					
		Total Interim		o (X		rospective			
		Settlement B	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	- Unaudited	l Cost						
				– Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>)N:</u>						TR				
Fiscal Age	ent						PV.				
Contract I	Contract Management						Rydell Samu	iel, Adminis	strator		
Program I	Program Finance						Medicaid Pro	ogram Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River Co	ndian River County Health Department					Provider Number: 0279412-04				
1900 27th Stree	et					Date: 07/01/2019				
Vero Beach, FL	32960					Fiscal Year End: 06/30/2018				
						Audit Status:		Unaudited	d Cost	
<u>Provider Typ</u>	pe				<u>Curren</u>	t Rate	New	Rate	Effective Date	
2	<u>CHD</u>				153	.31	14	8.06	07/01/2019	
Rate Type										
<u> </u>	nterim				Х	Prospec	<u>tive</u>			
		Total Interim				- x	Total P	rospective		
_		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs	
			BAS	SIS:						
				Budget						
			X	- Unaudited	d Cost					
				- Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				- Field Audi	ited Cost					
				-						
DISTRIBUTION	<u>l:</u>						TR			
Fiscal Ager	nt						7V			
Contract M	Contract Management					Rydell Samuel, Administrator				
Program Finance							Medicaid Program Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River C	ndian River County Health Department					Provider Number: 0279412-05				
1900 27th Stre	eet						Date	07/01/201	9	
Vero Beach, F	L 32960					Fiscal Year End: 06/30/2018				
							Audit Status	Unaudited	d Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
CHD					153.31		14	8.06	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospect	tive			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				_						
DISTRIBUTIO	<u>N:</u>						TR			
Fiscal Age	ent						74			
Contract N	Contract Management					Rydell Samuel, Administrator				
Program Finance						Medicaid Program Finance				

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Heal	th Department		Provider Number: 0279412-30					
1900 27th Street				Date: 07/01/2019				
Vero Beach, FL 32960				Fiscal Year End: 06/30/2018				
				Au	dit Status: Unaudited	Cost		
Provider Type <u>Cu</u>			<u>Curren</u>	it Rate	New Rate	Effective Date		
<u>CHD</u>			153	.31	148.06	07/01/2019		
Rate Type								
<u>Interim</u>			Х	Prospective	2			
	Total Interim			- x	Total Prospective			
Settlement Based on Cost					Prospective Adjust	ted For New Costs		
	BA	<u>ASIS:</u>						
		Budget						
	Х	Unaudited	l Cost					
		Desk Revi	iewed Cost					
		Desk Audi	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:				-	IR			
Fiscal Agent					<i>p</i> ()			
Contract Management				Rydell Samuel, Administrator				
Program Finance				Me	edicaid Program Finar	nce		
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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Dep	partment	Prov	ider Number: 0279412-s	91			
1900 27th Street			Date: 07/01/201	9			
Vero Beach, FL 32960		Fiso	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		153.31	148.06	07/01/2019			
Rate Type							
Interim		X Prospect					
Total Ir		X	Total Prospective				
Settlen	nent 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			74				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Depa	artment	Prov	vider Number: 0279412-	92			
1900 27th Street			Date: 07/01/2019				
Vero Beach, FL 32960		Fis	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type	9	Current Rate	New Rate	Effective Date			
<u>CHD</u>		153.31	148.06	07/01/2019			
Rate Type							
Interim		X Prospect					
Total Ir	nterim	X	Total Prospective				
Settler	nent Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited Co	ost					
	Desk Reviewe	ed Cost					
	Desk Audited	Cost					
	Field Audited	Cost					
DISTRIBUTION:			TR				
Fiscal Agent			rv,				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River C	ndian River County Health Department					Provider Number: 0279412-96				
1900 27th Stre	eet					Date: 07/01/2019				
Vero Beach, F	L 32960					Fiscal Year End: 06/30/2018				
							Audit Status	Unaudited	d Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
CHD					153.31		148	8.06	07/01/2019	
Rate Type										
	Interim				Х	Prospect	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs	
			BAS	SIS:						
				Budget						
			Х	- Unaudited	l Cost					
				– Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				_						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						74			
Contract N	Contract Management					Rydell Samuel, Administrator				
Program I	Program Finance						Medicaid Program Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health	Department			Provi	ider Number:	0279421-00	
P. O. Box 310				- Date:		e: 07/01/2019	
Marianna, FL 32447				Fiscal Year End: 06/30/2018			
					Audit Status:	Unaudited C	Cost
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date
<u>CHD</u>		-	104.	06	166	6.57	07/01/2019
Rate Type							
<u>Interim</u>			Х	Prospect	ive		
	Total Interim			Х	Total P	rospective	
	Settlement Based	on Cost			Prospe	ctive Adjuste	d For New Costs
	BA	<u>SIS:</u>					
		Budget					
	X	Unaudited	Cost				
		 Desk Revie	ewed Cost				
		 Desk Audit	ted Cost				
		Field Audit	ed Cost				
		_					
DISTRIBUTION:					TR		
Fiscal Agent					74		
Contract Managem	ent				Rydell Samu	el, Administra	ator
Program Finance					Medicaid Pro	ogram Financ	е

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health	Department			Provider Number: 0279421-01			
P. O. Box 310					Date: 07/01/20	/2019	
Marianna, FL 32447			Fiscal	Year End: 06/30/20	018		
				Αι	udit Status: Unaudit	ed Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		-	104	.06	166.57	07/01/2019	
Rate Type							
Interim			Х	Prospective	<u>e</u>		
	Total Interim			- x	Total Prospectiv	re	
	Settlement Base	ed on Cost			Prospective Adj	usted For New Costs	
	-						
	<u>B</u>	ASIS:					
		Budget					
		X Unaudited	Cost				
		Desk Revi	ewed Cost				
		Desk Audi	ted Cost				
		Field Audit	ted Cost				
					TR		
DISTRIBUTION:					at		
Fiscal Agent					/ *		
Contract Manageme	ent				ydell Samuel, Admir		
Program Finance				Μ	edicaid Program Fir	nance	
State Health Office							



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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Departm	Prov	Provider Number: 0279421-02				
P. O. Box 310			Date: 07/01/2019			
Marianna, FL 32447		Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		104.06	166.57	07/01/2019		
Rate Type						
Interim		X Prospect	ive			
Total In	terim	X	Total Prospective			
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audi	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			rv.			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department	Prov	ider Number: 0279421-0	03	
P. O. Box 310		Date: 07/01/201	: 07/01/2019	
Marianna, FL 32447	Fiso	cal Year End: 06/30/201	8	
		Audit Status: Unaudited	Cost	
Provider Type	Current Rate	New Rate	Effective Date	
<u>CHD</u>	104.06	166.57	07/01/2019	
Rate Type Interim	X <u>Prospect</u>	ive		
Total Interim	<u>rrospect</u> X	Total Prospective		
Settlement Based on Cost			ted For New Costs	
BASIS: Budget X Unaudited Desk Revie Desk Audit Field Audit	ewed Cost ted Cost			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance		Rydell Samuel, Adminis Medicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department	Prov	Provider Number: 0279421-04		
P. O. Box 310		Date: 07/01/201	: 07/01/2019	
Marianna, FL 32447	Fiso	Fiscal Year End: 06/30/2018		
		Audit Status: Unaudited	Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	104.06	166.57	07/01/2019	
Rate Type Interim	X <u>Prospect</u>	ive		
Total Interim	<u></u>	Total Prospective		
Settlement Based on Cost			ted For New Costs	
BASIS: Budget X Unaudited Desk Revi Desk Audit	ewed Cost ted Cost			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance		Rydell Samuel, Adminis Medicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department	Prov	vider Number: 0279421-	13	
P. O. Box 310		Date: 07/01/201	: 07/01/2019	
Marianna, FL 32447	Fis	cal Year End: 06/30/201	8	
		Audit Status: Unaudited	l Cost	
Provider Type	Current Rate	New Rate	Effective Date	
<u>CHD</u>	104.06	166.57	07/01/2019	
Rate Type Interim	X <u>Prospec</u>	ive		
Total Interim	<u>rrospect</u>	Total Prospective		
Settlement Based on Cost			ted For New Costs	
Desk Aud	d Cost viewed Cost dited Cost dited Cost			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance		Rydell Samuel, Adminis Medicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department	Prov	ider Number: 0279421-	14
P. O. Box 310		Date: 07/01/201	9
Marianna, FL 32447	Fisc	cal Year End: 06/30/201	8
		Audit Status: Unaudited	l Cost
Provider Type	Current Rate	New Rate	Effective Date
CHD	104.06	166.57	07/01/2019
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 Unaudited	Cost		
Desk Revi	ewed Cost		
Desk Audi	ted Cost		
Field Audit	ted Cost		
DISTRIBUTION:		R	
Fiscal Agent		PV	
Contract Management		Rydell Samuel, Adminis	strator
Program Finance		Medicaid Program Fina	

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department	Prov	Provider Number: 0279421-30		
P. O. Box 310		Date: 07/01/201	: 07/01/2019	
Marianna, FL 32447	Fise	cal Year End: 06/30/201	8	
		Audit Status: Unaudited	Cost	
Provider Type	Current Rate	New Rate	Effective Date	
CHD	104.06	166.57	07/01/2019	
Rate Type Interim	X <u>Prospect</u>	ive		
Total Interim	<u>rrospect</u> X	Total Prospective		
Settlement Based on Cost			ted For New Costs	
BASIS: Budget X Unaudited Desk Revi Desk Audit Field Audit	ewed Cost ted Cost			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance		Rydell Samuel, Adminis Medicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Dep	partment		Provider Nu	umber: 0279421-9	1	
P. O. Box 310			Date:		e: 07/01/2019	
Marianna, FL 32447			Fiscal Yea	r End: 06/30/2018	3	
			Audit S	Status: Unaudited	Cost	
Provider Type		Current Rat	<u>e</u>	New Rate	Effective Date	
CHD	-	104.06		166.57	07/01/2019	
Rate Type Interim		X Pro	spective			
	tal Interim	<u> </u>		otal Prospective		
Se	ttlement Based on Cost				ed For New Costs	
	BASIS:					
	Budget					
	X Unaudited					
	Desk Revie					
	Desk Audit					
	Field Audit	ed Cost				
DISTRIBUTION:			the	R		
Fiscal Agent			/ •			
Contract Management				Samuel, Adminis		
Program Finance			IVIEDIC	aid Program Finar	ice	

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Departm	ent	Prov	rider Number: 0279439-0	00	
1255 W. Washington Street			Date: 07/01/201	: 07/01/2019	
Monticello, FL 32344		Fiso	cal Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.57	166.57	07/01/2019	
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	ed Cost			
	Field Audite	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			(N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Department	Prov	ider Number: 0279439-	04	
1255 W. Washington Street		Date: 07/01/201	: 07/01/2019	
Monticello, FL 32344	Fise	Fiscal Year End: 06/30/2018		
		Audit Status: Unaudited	l Cost	
Provider Type	Current Rate	New Rate	Effective Date	
<u>CHD</u>	169.57	166.57	07/01/2019	
Rate Type	V Droopoot			
<u>Interim</u> Total Interim	X Prospect	Total Prospective		
Settlement Based on Cost			ted For New Costs	
			sied for new Cosis	
BASIS:				
Budge	et			
XUnaud	dited Cost			
Desk	Reviewed Cost			
Desk /	Audited Cost			
Field /	Audited Cost			
DISTRIBUTION:		TR		
Fiscal Agent		M		
Contract Management		Rydell Samuel, Adminis	strator	
Program Finance		Medicaid Program Fina		

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Department		Provider Numb	er: 0279439-3	30	
1255 W. Washington Street		Da	te: 07/01/201	: 07/01/2019	
Monticello, FL 32344		Fiscal Year End: 06/30/2018			
		Audit Stat	us: Unaudited	Cost	
Provider Type	Current R	ate Ne	ew Rate	Effective Date	
<u>CHD</u>	169.57	<u> </u>	66.57	07/01/2019	
Rate Type	V D				
<u>Interim</u> Total Interim	<u> </u>	rospective X Tota	I Prospective		
Settlement Based on Cos				ted For New Costs	
		F103	pective Aujus	lear of New Costs	
BASIS:					
Budg	get				
XUnau	udited Cost				
Desk	k Reviewed Cost				
Desk	k Audited Cost				
Field	Audited Cost				
DISTRIBUTION:		TR			
Fiscal Agent		py			
Contract Management		Rydell Sa	muel, Adminis	trator	
Program Finance			Program Final		

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Medicaid Reimbursement Rate Change Form for CHDs

Lee County Health Department		Provi	Provider Number: 0279463-00				
3920 Michigan Avenue			Date: 07/01/201	9			
Fort Myers, FL 33916		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	169.57	166.57	07/01/2019			
Rate Type							
Interim		X <u>Prospect</u>	ve				
Total Inte	rim	X	Total Prospective				
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited (Cost					
	Desk Revie	wed Cost					
	Desk Audite	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			r v				
Contract Management		_	Rydell Samuel, Administrator				
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Lee County H	lealth Depa	artment				Provider Number: 0279463-01				
3920 Michigar	n Avenue						Date	07/01/201	9	
Fort Myers, Fl	L 33916					Fiscal Year End: 06/30/2018				
							Audit Status	: Unaudited	l Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date	
	<u>CHD</u>				169	.57	16	6.57	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
		Settlement B	ased o	on Cost			Prospe	ective Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	d Cost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						1 N			
Contract Management						Rydell Samuel, Administrator				
Program Finance							Medicaid Pr	ogram Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Lee County H	ealth Depa	artment				Provider Number: 0279463-04					
3920 Michigar	n Avenue						Date	07/01/201	9		
Fort Myers, Fl	L 33916					Fiscal Year End: 06/30/2018					
							Audit Status	Unaudited	Cost		
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				169	.57	160	6.57	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospect	ive				
	-	Total Interim				- X	Total P	rospective			
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs		
			BAS	SIS:							
				Budget							
			X	_ Unaudited	d Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						7 N				
Contract Management						Rydell Samuel, Administrator					
Program Finance							Medicaid Pro	ogram Finai	nce		

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Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Leon County I	Health De	partment	Leon County Health Department						Provider Number: 0279471-00				
2965 Municipa	al Way						Date	07/01/2019					
Tallahassee, I	FL 32304					Fiscal Year End: 06/30/2018							
							Audit Status:	Unaudited C	Cost				
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date				
	<u>CHD</u>				150	.29	15	9.06	07/01/2019				
Rate Type													
	<u>Interim</u>				Х	Prospect	tive						
	-	Total Interim				- x	Total P	rospective					
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	d For New Costs				
			BAS	SIS:									
				Budget									
			X	– Unaudited	d Cost								
				_ Desk Rev	iewed Cost								
				_ Desk Aud	ited Cost								
				– Field Audi	ited Cost								
				_									
DISTRIBUTIC	<u>DN:</u>						TR						
Fiscal Ag	ent						74						
Contract	Managem	ent					Rydell Samu	iel, Administra	ator				
Program Finance							Medicaid Pro	ogram Financ	e				

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Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Department		Provi	Provider Number: 0279471-91				
2965 Municipal Way			Date: 07/01/201	9			
Tallahassee, FL 32304		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	150.29	159.06	07/01/2019			
Rate Type							
Interim		X Prospect	ive				
Total Inte	erim	Χ	Total Prospective				
Settleme	ent 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:			F				
Fiscal Agent			1				
Contract Management		-	Rydell Samuel, Adminis				
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Levy County H	lealth Dep	artment				Pro	ovider	Number:	0279480-0	0
P. O. Box 406	6 South M	ain Street						Date:	07/01/2019	9
Bronson, FL 3	32621					Fiscal Year End: 06/30/2018				
							Aud	dit Status:	Unaudited	Cost
Provider Type			<u>Curre</u>	nt Rate		New	<u>Rate</u>	Effective Date		
	<u>CHD</u>				169	9.57	. <u>–</u>	166	6.57	07/01/2019
Rate Type										
	Interim				X	Prospec	ctive			
	-	Total Interim				— x		Total P	rospective	
		Settlement Bas	sed o	n Cost				Prospe	ctive Adjust	ed For New Costs
		<u> </u>	BAS	IS:						
				Budget						
		-	Х	Unaudited	l Cost					
		-		Desk Revi	iewed Cos	t				
		-		Desk Audi	ited Cost					
		_		Field Audi	ted Cost					
							/	T		
DISTRIBUTIO	<u>N:</u>							ar		
Fiscal Age	ent						- 1	Ň		
Contract N	Contract Management						Ry	dell Samu	el, Adminis	trator
Program F	Program Finance						Me	dicaid Pro	ogram Finar	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Levy County Health Department		Prov	Provider Number: 0279480-91				
P. O. Box 4066 South Main Street			Date: 07/01/201	9			
Bronson, FL 32621		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	_	169.57	166.57	07/01/2019			
Rate Type							
Interim		X Prospect	ive				
Total Inte	erim	x	Total Prospective				
Settlement Based on Cost			Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited Co	ost					
	Desk Review	ved Cost					
	Desk Audited	d Cost					
	Field Audited	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

Liberty County Health Departm	nent	Prov	Provider Number: 0279498-00				
P. O. Box 489247 N. Central S	Street		Date: 07/01/201	9			
Bristol, FL 32321		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		152.54	144.88	07/01/2019			
Rate Type		× -					
<u>Interim</u>	La Cardina	X Prospect					
	Interim	X	Total Prospective				
Settle	ement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			M				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department		Prov	Provider Number: 0279498-08				
P. O. Box 489247 N. Central Stree	t		Date: 07/01/2019				
Bristol, FL 32321		Fis	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	152.54	144.88	07/01/2019			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total Inte	rim	X	Total Prospective				
Settlement Based on Cost			Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited C	cost					
	Desk Review	ved Cost					
	Desk Audite	d Cost					
	Field Audited	d Cost					
DISTRIBUTION:			TR				
Fiscal Agent			ſN				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County	y Health D	epartment				Provider Number: 0279498-10					
P. O. Box 489	247 N. Ce	entral Street					Date	07/01/2019			
Bristol, FL 32	321					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited	Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				152	.54	144	4.88	07/01/2019		
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							
			Х	Unaudited	d Cost						
				_ Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				Field Audi	ited Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						7N				
Contract	Managem	ent					Rydell Samu	uel, Administ	rator		
Program Finance							Medicaid Pro	ogram Finan	ce		

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County	y Health D	epartment				Provider Number: 0279498-14				
P. O. Box 489	247 N. Ce	entral Street					Date	07/01/2019		
Bristol, FL 32	321					Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited (Cost	
<u>Provider Ty</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				152	.54	144	4.88	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospec	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased	on Cost			Prospe	ctive Adjuste	ed For New Costs	
			BAS	SIS:						
				Budget						
			X	– Unaudited	d Cost					
				– Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ited Cost					
				_						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						PN .			
Contract	Managem	ent				Rydell Samuel, Administrator				
Program	Program Finance						Medicaid Pro	ogram Finan	се	

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department		Prov	Provider Number: 0279498-30				
P. O. Box 489247 N. Central Stree	t		Date: 07/01/2019				
Bristol, FL 32321		Fise	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	_	152.54	144.88	07/01/2019			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total Inte	rim	X	Total Prospective				
Settlement Based on Cost			Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited C	Cost					
	Desk Review	wed Cost					
	Desk Audite	d Cost					
	Field Audite	d Cost					
DISTRIBUTION:			TR				
Fiscal Agent			ſN				
Contract Management			Rydell Samuel, Administrator				
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County	iberty County Health Department						vider Number:	0279498-9	1			
P. O. Box 489	247 N. Ce	entral Street					Date	07/01/2019)			
Bristol, FL 32	321					Fiscal Year End: 06/30/2018						
						Audit Status: Unaudited Cost						
<u>Provider Ty</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date			
	<u>CHD</u>				152.54 144			4.88	07/01/2019			
Rate Type												
	<u>Interim</u>				Х	Prospec	<u>tive</u>					
	-	Total Interim				- x	Total P	rospective				
Settlement Based on				on Cost			Prospe	Prospective Adjusted For New Costs				
			BAS	SIS:								
				Budget								
			X	– Unaudited	d Cost							
				– Desk Rev	iewed Cost							
				_ Desk Aud	ited Cost							
				– Field Audi	ited Cost							
				_								
DISTRIBUTIC	<u>DN:</u>						TR					
Fiscal Ag	ent						7N					
Contract Management						Rydell Samuel, Administrator						
Program	Program Finance						Medicaid Program Finance					

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County He	lanatee County Health Department					ider Number:	0279510-00		
410 Six Avenue Eas	st					Date:	07/01/2019		
Bradenton, FL 3420)8				Fiscal Year End: 06/30/2018				
						Audit Status:	Unaudited Co	ost	
Provider Type				Current	t Rate	New	Rate	Effective Date	
<u>CHI</u>	<u>D</u>			164.99117		7.92	07/01/2019		
Rate Type									
Inter	<u>'im</u>			Х	Prospect	ive			
	Total Interim				X	Total P	rospective		
	Settlement B	ased o	n Cost			Prospe	ctive Adjusted	For New Costs	
		BAS	<u>SIS:</u>						
			Budget						
		Х	- Unaudited	l Cost					
			- Desk Revi	iewed Cost					
			- Desk Audi	ited Cost					
			- Field Audi	ted Cost					
			-						
DISTRIBUTION:						TR			
Fiscal Agent						/ N			
Contract Management					Rydell Samuel, Administrator				
Program Finance	Program Finance						ogram Finance	ł	

State Health Office

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(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

Manatee Cou	nty Health	Department			Prov	ider Number	: 0279510-0 ²	1		
410 Six Aven	ue East					Date	: 07/01/2019			
Bradenton, Fl	_ 34208				Fis	Fiscal Year End: 06/30/2018				
						Audit Status	: Unaudited (Cost		
<u>Provider T</u>	<u>ype</u>			<u>Curren</u>	t Rate	New	<u>v Rate</u>	Effective Date		
	<u>CHD</u>			164	.99	11	7.92	07/01/2019		
Rate Type										
	Interim			X	_Prospect	ive				
		Total Interim			Х	Total F	rospective			
		Settlement Base	ed on Cost			Prospe	ective Adjuste	ed For New Costs		
		B	ASIS:							
			Budget							
			X Unaudited	d Cost						
			Desk Rev	iewed Cost						
			Desk Aud	ited Cost						
			Field Aud	ited Cost						
						F				
Fiscal Ag		t								
Contract Management Program Finance					Rydell Samuel, Administrator Medicaid Program Finance					
Filograffi						Medicalu FI	ogram i man			

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee Cou	Ianatee County Health Department						vider Number:	0279510-30	D	
410 Six Aven	ue East					Date: 07/01/2019				
Bradenton, FL	34208					Fiscal Year End: 06/30/2018				
							Audit Status	Unaudited	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			164.991		11	7.92	07/01/2019		
Rate Type										
	Interim				X	Prospect	<u>tive</u>			
		Total Interim				X	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			X	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						۲N			
Contract Management						Rydell Samuel, Administrator				
Program	Program Finance						Medicaid Pre	ogram Finan	се	

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee Cour	Ianatee County Health Department						ider Number	0279510-9	91	
410 Six Avenu	ue East						Date	07/01/2019	9	
Bradenton, FL	34208					Fiscal Year End: 06/30/2018				
							Audit Status	Unaudited	Cost	
<u>Provider Ty</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			164.99 1		11	7.92	07/01/2019		
Rate Type										
	Interim				X	_ <u>Prospect</u>				
		Total Interim				X	Total P	rospective		
		Settlement B	ased o	on Cost			Prospe	ctive Adjust	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	Cost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ted Cost					
				_						
DISTRIBUTIC	<u>)N:</u>						TR			
Fiscal Age	ent						74			
Contract Management						Rydell Samuel, Administrator				
Program	Program Finance						Medicaid Pr	ogram Finar	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department		Pro	vider Number: 0279528-	-00			
1801 S.E. 32nd AvenueP. O. Box 2408	3		Date: 07/01/20	19			
Ocala, FL 34478-2408		Fis	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudite	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	_	169.57	.57 166.57 07/0				
Rate Type							
<u>Interim</u>		X <u>Prospec</u>	<u>tive</u>				
Total Interim		X	Total Prospective	•			
Settlement Ba	ased 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, Admini	istrator			
Program Finance			Medicaid Program Fina				

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department		Provider Number: 0279528-01					
1801 S.E. 32nd AvenueP. O. Box 2408			Date: 07/01/201	9			
Ocala, FL 34478-2408		Fiscal Year End: 06/30/2018					
		Audit Status: Unaudited Cost					
Provider Type	Curren	<u>it Rate</u>	Effective Date				
CHD	169	.57	166.57	07/01/2019			
<u>Rate Type</u> Interim	х	Prospective					
Total Interim		- x	Total Prospective				
Settlement Based	on Cost		Prospective Adjust	ted For New Costs			
	SIS: Budget Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost						
DISTRIBUTION: Fiscal Agent		1	R				
Contract Management		Ryc	lell Samuel, Adminis	trator			

Program Finance

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Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Marion County Health Department						vider Number:	0279528-02				
1801 S.E. 32n	d Avenue	P. O. Box 2408	В				Date	07/01/2019				
Ocala, FL 344	178-2408					Fiscal Year End: 06/30/2018						
						Audit Status: Unaudited Cost						
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date			
	<u>CHD</u>				169.57 166.			6.57	07/01/2019			
Rate Type												
	<u>Interim</u>				Х	Prospect	tive					
	•	Total Interim				- x	Total P	rospective				
Settlement Based on C				on Cost			Prospe	Total Prospective Prospective Adjusted For New Costs				
			BAS	SIS:								
				Budget								
			X	– Unaudited	d Cost							
				_ Desk Rev	iewed Cost							
				_ Desk Aud	ited Cost							
				– Field Audi	ited Cost							
				_								
DISTRIBUTIO	N:						TR					
Fiscal Age	ent						PV.					
Contract Management						Rydell Samuel, Administrator						
Program F	Program Finance						Medicaid Program Finance					

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Marion County Health Department						vider Number:	0279528-04	L			
1801 S.E. 32n	d Avenue	P. O. Box 240	8				Date	07/01/2019				
Ocala, FL 344	478-2408					Fiscal Year End: 06/30/2018						
						Audit Status: Unaudited Cost						
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date			
	<u>CHD</u>				169	<u>69.57 166.57 0</u>			07/01/2019			
Rate Type												
	<u>Interim</u>				Х	Prospect	<u>tive</u>					
	-	Total Interim				- x	Total P	rospective				
Settlement Based on Co				on Cost			Prospe	Total Prospective Prospective Adjusted For New Costs				
			BAS	SIS:								
				Budget								
			Х	_ Unaudited	d Cost							
				– Desk Rev	iewed Cost							
				_ Desk Aud	ited Cost							
				– Field Audi	ited Cost							
				_								
DISTRIBUTIO	<u>N:</u>						TR					
Fiscal Age	ent						γv					
Contract Management						Rydell Samuel, Administrator						
Program F	Program Finance						Medicaid Pro	ogram Financ	e			

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Marion County Health Department						/ider Number:	0279528-05	5			
1801 S.E. 32n	d Avenue	P. O. Box 240	8				Date:	07/01/2019				
Ocala, FL 344	478-2408					Fiscal Year End: 06/30/2018						
						Audit Status: Unaudited Cost						
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date			
	<u>CHD</u>				169	169.57 166.57			07/01/2019			
Rate Type												
	<u>Interim</u>				Х	Prospect	<u>tive</u>					
	-	Total Interim				- x	Total P	rospective				
Settlement Based on C				on Cost			Prospe	Total Prospective Prospective Adjusted For New Costs				
			BAS	SIS:								
				Budget								
			X	– Unaudited	d Cost							
				– Desk Rev	iewed Cost							
				_ Desk Aud	ited Cost							
				– Field Audi	ited Cost							
				_								
<u>DISTRIBUTIO</u>	<u>)N:</u>						TR					
Fiscal Age	ent						γv					
Contract Management						Rydell Samuel, Administrator						
Program F	Program Finance						Medicaid Pro	ogram Finand	ce			

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Narion County Health Department						/ider Number:	0279528-12				
1801 S.E. 32n	d Avenue	P. O. Box 2408	8				Date	07/01/2019				
Ocala, FL 344	478-2408					Fiscal Year End: 06/30/2018						
						Audit Status: Unaudited Cost						
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date			
	<u>CHD</u>				169	69.57 166.57 0			07/01/2019			
Rate Type												
	<u>Interim</u>				Х	Prospec	<u>tive</u>					
	-	Total Interim				- x	Total P	rospective				
Settlement Based on Co				on Cost			Prospe	Total Prospective Prospective Adjusted For New Costs				
			BAS	SIS:								
				Budget								
			X	_ Unaudited	d Cost							
				_ Desk Rev	iewed Cost							
				_ Desk Aud	ited Cost							
				– Field Audi	ited Cost							
				_								
<u>DISTRIBUTIO</u>	<u>)N:</u>						TR					
Fiscal Age	ent						M					
Contract Management						Rydell Samuel, Administrator						
Program F	Program Finance						Medicaid Pro	ogram Financ	ce			

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	Narion County Health Department						/ider Number:	0279528-30)		
1801 S.E. 32n	d Avenue	P. O. Box 2408	3				Date	07/01/2019			
Ocala, FL 344	178-2408					Fiscal Year End: 06/30/2018					
						Audit Status: Unaudited Cost					
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				169	169.57 166.57			07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospec:	<u>tive</u>				
		Total Interim				- x	Total P	rospective			
Settlement Based on C				on Cost			Prospe	tal Prospective ospective Adjusted For New Costs			
			BAS	SIS:							
				Budget							
			X	– Unaudited	d Cost						
				– Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
<u>DISTRIBUTIO</u>	<u>N:</u>						TR				
Fiscal Age	ent						rv ,				
Contract Management						Rydell Samuel, Administrator					
Program F	Program Finance						Medicaid Pro	ogram Financ	e		

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County	/ Health D	epartment				Prov	vider Number:	0279528-91			
1801 S.E. 32n	d Avenue	P. O. Box 2408	В				Date	07/01/2019			
Ocala, FL 344	178-2408					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited (Cost		
Provider Type Cur			<u>Curren</u>	rent Rate <u>New Rate</u>			Effective Date				
	<u>CHD</u>				169.57		166.57		07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospect	tive				
	•	Total Interim				- x	Total P	rospective			
Settlement Based on Cost				on Cost			Prospe	ctive Adjuste	ed For New Costs		
			BAS	SIS:							
				Budget							
			X	– Unaudited	d Cost						
				_ Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
DISTRIBUTIO	N:						TR				
Fiscal Age	ent						PV.				
Contract N	Manageme	ent				Rydell Samuel, Administrator					
Program F	Finance						Medicaid Pro	ogram Finand	ce		

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Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Departme	ent	Prov	ider Number: 0279536-0	00			
3441 SE Willoughby Blvd.			Date: 07/01/201	9			
Stuart, FL 34994-5060		Fiso	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		169.57	162.19	07/01/2019			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total I	nterim	X	Total Prospective				
Settler	ment Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted 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

Martin County Health Dep	artment			Provider Number: 0279536-11 Date: 07/01/2019					
3441 SE Willoughby Blvd.									
Stuart, FL 34994-5060				Fiscal Year End: 06/30/2018					
				Au	dit Status: Unaudite	d Cost			
Provider Type Curre				t Rate	Rate <u>New Rate</u> Effe				
<u>CHD</u>			169	.57	162.19	07/01/2019			
Rate Type									
<u>Interim</u>			Х	Prospective	2				
т	otal Interim			- X	Total Prospective				
Settlement Based on Cost					Prospective Adjus	sted For New Costs			
	BAS								
		Budget							
	X	Unaudited C							
		Desk Review							
		Desk Audite							
		Field Audite	d Cost						
DISTRIBUTION:				-	TR				
Fiscal Agent					M				
Contract Managemen			Ry	dell Samuel, Admini	strator				
Program Finance					edicaid Program Fina				
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Medicaid Reimbursement Rate Change Form for CHDs

Martin County H	lealth De	epartment				Prov	rider Number	: 0279536-	91		
3441 SE Willoug	ghby Blv	d.					Date	: 07/01/201	9		
Stuart, FL 3499	94-5060					Fiscal Year End: 06/30/2018					
							Audit Status	: Unaudited	d Cost		
Provider Type Curr				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date			
CHD			169.57		16	2.19	07/01/2019				
Rate Type											
<u>lı</u>	<u>nterim</u>				Х	Prospect	ive				
		Total Interim				- x	Total P	rospective			
Settlement Based on Cost				on Cost			Prospe	ective Adjus	sted For New Costs		
			BAS	SIS:							
				Budget							
			Х	- Unaudited	Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTION	<u>l:</u>						TR				
Fiscal Agen	nt						74				
Contract Ma	anageme	ent				Rydell Samuel, Administrator					
Program Fi	nance						Medicaid Pr	ogram Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe Count	ty Health [Department				Prov	/ider Number:	0279544-00)	
5100 College	Road						Date:	07/01/2019		
Key West, FL	33040					Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited C	Cost	
Provider Type Curre				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>			169.57		160	6.57	07/01/2019		
Rate Type										
	Interim				Х	Prospect	<u>tive</u>			
	-	Total Interim				- x	Total P	rospective		
Settlement Based on Cost						Prospe	ctive Adjuste	d For New Costs		
			BAS	<u>SIS:</u>						
				Budget						
			Х	- Unaudited	Cost					
				- Desk Revi	iewed Cost					
				- Desk Aud	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						74			
Contract I	Managem	ent				Rydell Samuel, Administrator				
Program	Finance						Medicaid Pro	ogram Financ	ce	

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department		Provider Number: 0279	9544-01			
5100 College Road		Date: 07/0	1/2019			
Key West, FL 33040		Fiscal Year End: 06/30/2018				
		Audit Status: Una	udited Cost			
Provider Type	Current Rate	New Rate	<u>Effective Date</u>			
CHD	169.57	166.57	07/01/2019			
Rate Type						
Interim	X <u>Pros</u>	<u>pective</u>				
Total Interim		X Total Prospe	ctive			
Settlement Based on Co	ost	Prospective	Adjusted For New Costs			
BASIS:						
Buc	dget					
XUna	audited Cost					
Des	sk Reviewed Cost					
Des	sk Audited Cost					
Fiel	ld Audited Cost					
DISTRIBUTION: Fiscal Agent		FF				
Contract Management		r Rydell Samuel, Ad	Iministrator			
Program Finance		Medicaid Program				

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe Count	ty Health [Department				Prov	ider Number:	0279544-03	3		
5100 College	Road						Date	07/01/2019			
Key West, FL	33040					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited 0	Cost		
Provider Type Curre				<u>Curren</u>	nt Rate New		Rate	Effective Date			
<u>CHD</u>				169.57		160	6.57	07/01/2019			
Rate Type											
	<u>Interim</u>				Х	Prospect	ive				
	-	Total Interim				- x	Total P	rospective			
Settlement Based on Cost				on Cost			Prospe	ctive Adjuste	ed For New Costs		
			BAS	SIS:							
				Budget							
			X	– Unaudited	d Cost						
				– Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						۲N				
Contract I	Managem	ent					Rydell Samu	uel, Administr	ator		
Program	Finance						Medicaid Pro	ogram Financ	ce		

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe Coun	ty Health [Department				Prov	ider Number:	0279544-04			
5100 College	Road						Date	07/01/2019			
Key West, FL	33040					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited C	Cost		
Provider T	<u>ype</u>				<u>Curren</u>	ent Rate <u>New Rate</u> Ef			Effective Date		
	CHD			169.57		160	6.57	07/01/2019			
Rate Type					X						
	Interim	Total Interim			X	-Prospect		roopootivo			
				a O a at				rospective			
Settlement Based on Cost			on Cost			Prospe	ctive Adjusted	d For New Costs			
			BAS	SIS:							
				Budget							
			X	- Unaudited	l Cost						
				- Desk Revi	iewed Cost						
				- Desk Aud	ited Cost						
				- Field Audi	ted Cost						
				-							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						M				
Contract	Managem	ent					Rydell Samu	iel, Administra	ator		
Program	Finance						Medicaid Pro	ogram Financ	e		

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health D	Department	Pro	vider Number: 0279544-	08			
5100 College Road			Date: 07/01/201	07/01/2019			
Key West, FL 33040		 Fis	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		169.57	166.57	07/01/2019			
Rate Type Interim		X <u>Prospec</u>	tive				
<u>interim</u>	Total Interim		Total Prospective				
	Settlement Based on Cost			sted For New Costs			
	BASIS: Budget X Unaudited Desk Revi Desk Audi Field Audi	iewed Cost ited Cost					
DISTRIBUTION: Fiscal Agent			FF				
Contract Manageme	ent		Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	ince			

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe Count	ty Health [Department				Prov	ider Number:	0279544-13	3	
5100 College	Road					Date: 07/01/201				
Key West, FL	33040					Fiscal Year End: 06/30/2018				
							Audit Status	Unaudited (Cost	
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
CHD				169.57		16	6.57	07/01/2019		
Rate Type										
	Interim				X	Prospect	<u>ive</u>			
	-	Total Interim				Х	Total P	rospective		
Settlement Based on Cost						Prospe	ctive Adjuste	ed For New Costs		
			BAS	SIS:						
				Budget						
			X	– Unaudited	l Cost					
				– Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ted Cost					
				_						
DISTRIBUTIO	<u>)N:</u>						TR			
Fiscal Age	ent						۲N			
Contract N	Managem	ent					Rydell Samu	uel, Administr	ator	
Program I	Finance						Medicaid Pro	ogram Finand	ce	

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department		Provid	ler Number:	0279544-30		
5100 College Road			Date:	07/01/2019		
Key West, FL 33040		Fiscal Year End: 06/30/2018				
		A	udit Status:	Unaudited Cos	st	
Provider Type	nt Rate	New	Rate	Effective Date		
CHD	16	9.57	166	5.57	07/01/2019	
Rate Type						
Interim	Х	Prospectiv	<u>/e</u>			
Total Interim		X	Total Pr	ospective		
Settlement Bas	sed on Cost		Prospe	ctive Adjusted I	For New Costs	
	BASIS:					
	Budget					
-	X Unaudited Cost					
-	Desk Reviewed Cos	st				
-	Desk Audited Cost					
-	Field Audited Cost					
DISTRIBUTION:			IK			
Fiscal Agent			PV			
Contract Management		F	Rydell Samu	el, Administrato	or	
Program Finance				gram Finance	_	

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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

Monroe Coun	ty Health [Department				Prov	ider Number:	0279544-91			
5100 College	Road						Date:	07/01/2019			
Key West, FL	33040					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited C	Unaudited Cost		
Provider Type Curre				<u>Curren</u>	ent Rate <u>New Rate</u>			Effective Date			
	<u>CHD</u>			169.57		160	6.57	07/01/2019			
Rate Type											
	<u>Interim</u>				Х	Prospect	ive				
	-	Total Interim				- x	Total P	rospective			
Settlement Based on C			on Cost			Prospe	ctive Adjuste	d For New Costs			
			BAS	SIS:							
				Budget							
			X	– Unaudited	d Cost						
				– Desk Revi	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ited Cost						
				_							
DISTRIBUTIC	<u>DN:</u>						TR				
Fiscal Ag	ent						7N				
Contract	Managem	ent					Rydell Samu	iel, Administra	ator		
Program	Finance						Medicaid Pro	ogram Financ	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

Monroe County Health Department					Prov	vider Number:	0279544-92		
5100 College	Road					Date: 07/01/201		07/01/2019	
Key West, FL	33040					Fiscal Year End: 06/30/2018			
							Audit Status:	Unaudited C	Cost
<u>Provider Tr</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	160	6.57	07/01/2019
Rate Type					X	_			
	<u>Interim</u>	Total Interim			X	_ <u>Prospect</u> X		rospective	
		- Settlement Ba		an Coot					d Far Naw Casta
			aseu	on Cost			Prospe	clive Adjuste	d For New Costs
			BAS	SIS:					
				Budget					
			X	- Unaudited	l Cost				
				- Desk Revi	iewed Cost				
				- Desk Aud	ited Cost				
				- Field Audi	ted Cost				
				_					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						rv,		
Contract	Managem	ent					Rydell Samu	uel, Administra	ator
Program	Finance						Medicaid Pro	ogram Financ	e

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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

Monroe County Health Department					Prov	ider Number:	0279544-93	;	
5100 College	Road					Date: 07/01/2019			
Key West, FL	33040					Fiscal Year End: 06/30/2018			
							Audit Status:	Unaudited C	Cost
<u>Provider Ty</u>	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	160	6.57	07/01/2019
Rate Type					X	_			
	Interim	Total Interim			X	-Prospect		roopootivo	
		-		O sat				rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	d For New Costs
			BAS	8IS:					
				Budget					
			X	- Unaudited	l Cost				
				- Desk Revi	iewed Cost				
				_ Desk Aud	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTIC	<u>DN:</u>						TR		
Fiscal Ag	ent						M		
Contract	Managem	ent					Rydell Samu	uel, Administra	ator
Program	Finance						Medicaid Pro	ogram Financ	xe

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department				Provider Number: 0279552-00			
P. O. Box 517				Date: 07/01/2019			
Fernandina Beach, F	L 32035-0517			Fiscal Year End: 06/30/2018			
				Αι	idit Status: U	naudited Cos	st
Provider Type			Current Ra	<u>nte</u>	<u>New Ra</u>	ate	Effective Date
CHD	<u>)</u>		127.57		125.8	4	07/01/2019
Rate Type							
Interi	<u>m</u>		X <u>Pr</u>	ospective	2		
	Total Interim			Х	Total Pros	pective	
	Settlement Bas	sed on Cost			Prospectiv	ve Adjusted F	For New Costs
	ļ	BASIS:					
		Budget					
	-	X Unaudited	d Cost				
	-	Desk Rev	iewed Cost				
	-	Desk Aud	ited Cost				
	-	Field Audi	ited Cost				
	-						
DISTRIBUTION:				~	TR		
Fiscal Agent					M		
Contract Manage	ement			Ry	/dell Samuel,	Administrato	or
Program Finance	e			M	edicaid Progra	am Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department			Provider Number: 0279552-01			
P. O. Box 517			Date: 07/01/2019			
Fernandina Beach, FL 32035-0517			Fiscal Y	'ear End: 06/30/2018	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type			t Rate	New Rate	Effective Date	
<u>CHD</u>	-	127.	.57	125.84	07/01/2019	
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	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	N		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department			Provider Number: 0279552-04			
P. O. Box 517			Date: 07/01/2019			
Fernandina Beach, FL 32035-0517	7		Fiscal Y	'ear End: 06/30/2018	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current	t Rate	New Rate	Effective Date	
CHD	_	127.	57	125.84	07/01/2019	
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 Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audite	ed Cost				
			-	IR		
DISTRIBUTION: Fiscal Agent			1	at the second se		
Contract Management			Rvc	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office						



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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department			Provider Number: 0279552-05			
P. O. Box 517			Date: 07/01/2019			
Fernandina Beach, FL 32035-051	7		Fiscal Y	ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD	-	127.	57	125.84	07/01/2019	
Rate Type						
Interim		Х	Prospective			
Total Inte	erim		Х	Total Prospective		
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1			
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department			Provider Number: 0279552-95			
P. O. Box 517			Date: 07/01/2019			
Fernandina Beach, FL 32035-0517	7		Fiscal Y	'ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current	t Rate	New Rate	Effective Date	
CHD	_	127.	57	125.84	07/01/2019	
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 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

Okaloosa County Health Departn	nent	Provi	der Number: 0279561-0	00		
221 Hospital Drive, N.E.			Date: 07/01/2019			
Ft. Walton Beach, FL 32548		Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		152.75	158.26	07/01/2019		
Rate Type						
Interim		X Prospecti	ive			
Total Int	erim	X	Total Prospective			
Settleme	ent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			[N			
Contract Management		-	Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health Depa	rtment	Prov	ider Number: 0279561-9	91		
221 Hospital Drive, N.E.			Date: 07/01/201	07/01/2019		
Ft. Walton Beach, FL 32548		Fise	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		152.75	158.26	07/01/2019		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total	Interim	X	Total Prospective			
Settlement Based on Cost			Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	d Cost				
	Desk Rev	viewed Cost				
	Desk Aud	lited Cost				
	Field Aud	ited Cost				
DISTRIBUTION:			TR			
Fiscal Agent			rv .			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Depa	Prov	ider Number: 0279579-0	00		
P.O. Box 18791728 N.W. 9th Ave	enue		Date: 07/01/201	: 07/01/2019	
Okeechobee , FL 34973-1879		Fiso	- Fiscal Year End: 06/30/2018		
				Cost	
Provider Type	Current Rate	New Rate	Effective Date		
CHD		147.33	131.18	07/01/2019	
Rate Type					
Interim		X Prospect	ive		
Total Int	terim	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			[N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee Cou	unty Health Departme	ent	Prov	Provider Number: 0279579-01			
P.O. Box 187917	28 N.W. 9th Avenue			Date: 07/01/2019			
Okeechobee , FL	34973-1879		Fise	Fiscal Year End: 06/30/2018			
				Audit Status: Unaudited	Cost		
Provider Type	<u>9</u>		Current Rate	New Rate	Effective Date		
CHD		147.33	131.18	07/01/2019			
Rate Type							
	terim		X Prospect	tive			
	Total Interim		X	Total Prospective			
Settlement Based on Cost			Prospective Adjus	ted For New Costs			
		BASIS:					
		Budget					
		X Unaudite	ed Cost				
		 Desk Re	viewed Cost				
		Desk Au	dited Cost				
		Field Aud	dited Cost				
DISTRIBUTION:				TR			
Fiscal Agent				(N			
Contract Mai	-			Rydell Samuel, Adminis			
Program Fina	ance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Departm	nent	Prov	Provider Number: 0279579-02			
P.O. Box 18791728 N.W. 9th Avenu	e		Date: 07/01/2019			
Okeechobee , FL 34973-1879		 Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		147.33	131.18	07/01/2019		
Rate Type						
<u>Interim</u>		X Prospect	<u>ive</u>			
Total Interi	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			۲۷ ا			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Departr	nent	Prov	Provider Number: 0279579-03				
P.O. Box 18791728 N.W. 9th Avenu	le		Date: 07/01/2019				
Okeechobee , FL 34973-1879		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	147.33	131.18	07/01/2019			
Rate Type							
<u>Interim</u>		X Prospect	<u>ive</u>				
Total Interi	m	X	Total Prospective				
Settlement	Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audit	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			(N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Depar	rtment	Provi	Provider Number: 0279579-04			
P.O. Box 18791728 N.W. 9th Aver	nue		Date: 07/01/201	07/01/2019		
Okeechobee , FL 34973-1879		Fisc	al Year End: 06/30/201	8		
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	147.33	131.18	07/01/2019		
Rate Type						
Interim		X Prospect	ive			
Total Inte	rim	x	Total Prospective			
Settlemen	nt 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			r N			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee	Okeechobee County Health Department					Provider Number: 0279579-30				
P.O. Box 1879	91728 N.V	V. 9th Avenue				Date: 07/01/2019				
Okeechobee,	, FL 3497	3-1879				Fisc	al Year End:	06/30/2018	8	
							Audit Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date	
	<u>CHD</u>				147	.33	131	.18	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospecti	ve			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ed For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						(N			
Contract	Managem	ent				_	Rydell Samu	el, Adminis	trator	
Program	Finance						Medicaid Pro	gram Finar	nce	

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Orange Count	Orange County Health Department					Provider Number: 0279587-00				
6101 Lake Elle	enor Drive						Date	07/01/2019		
Orlando, FL 3	32804					- Fiscal Year End: 06/30/2018				
							Audit Status	Unaudited (Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.57	16	6.57	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospect	<u>ive</u>			
	-	Total Interim				- x	Total P	rospective		
		Settlement B	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	Cost					
				_ Desk Rev	iewed Cost					
				_ Desk Aud	ited Cost					
				– Field Audi	ted Cost					
				_						
							F			
Fiscal Ag							/ •			
	Manageme 	ent						uel, Administr		
Program	⊢inance						wedicaid Pr	ogram Financ	ce	

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Medicaid Reimbursement Rate Change Form for CHDs

Orange County Health Department		Provide	Number: 0279587-	-01
6101 Lake Ellenor Drive			Date: 07/01/207	19
Orlando, FL 32804		Fiscal Year End: 06/30/2018		
		Au	dit Status: Unaudite	d Cost
Provider Type	Curren	t Rate	New Rate	Effective Date
CHD	169	.57	166.57	07/01/2019
Rate Type				
<u>Interim</u>	X	Prospective		
Total Interim		Χ	Total Prospective	
Settlement Based on	n Cost		Prospective Adjus	sted For New Costs
BASI	<u> S:</u>			
	Budget			
X	Unaudited Cost			
	Desk Reviewed Cost			
	Desk Audited Cost			
	Field Audited Cost			
DISTRIBUTION:		-	TR	
Fiscal Agent			PU ·	
Contract Management		ا ب.ب		
Program Finance			dell Samuel, Admini dicaid Program Fina	
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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Departme	ent	Prov	Provider Number: 0279595-00			
P. O. Box 4503091875 Boggy Cre	eek Road		Date: 07/01/201	: 07/01/2019		
Kissimmee, FL 34745-0309		Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	169.57	166.57	07/01/2019		
Rate Type						
Interim		X Prospect	ive			
Total Inte	erim	X	Total Prospective			
Settlement Based on Co			Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			/ N			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola Count	Osceola County Health Department					Provider Number: 0279595-30			
P. O. Box 4503	3091875 E	Boggy Creek F	Road			- Date:		: 07/01/2019	
Kissimmee, FL	. 34745-0	309				Fiscal Year End: 06/30/2018			
							Audit Status:	Unaudited C	ost
Provider Ty	pe				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	160	6.57	07/01/2019
Rate Type									
	<u>Interim</u>				Х	Prospect	tive		
		Total Interim				- x	Total P	rospective	
-		Settlement Ba	ased o	on Cost			Prospe	ctive Adjusted	d For New Costs
			BAS	SIS:					
			<u></u>	Budget					
			X	 Unaudited	l Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Audi	ited Cost				
				- Field Audi	ted Cost				
				-					
<u>DISTRIBUTIOI</u>	<u>N:</u>						TR		
Fiscal Age	ent						γv		
Contract N	lanageme	ent					Rydell Samu	iel, Administra	ator
Program F	inance						Medicaid Pro	ogram Financ	е

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Departme	ent	Provide	er Number: 0279595-9	92	
P. O. Box 4503091875 Boggy Cre	eek Road		Date: 07/01/201	9	
Kissimmee, FL 34745-0309		Fiscal Year End: 06/30/2018			
		Αι	udit Status: Unaudited	Cost	
Provider Type	Currer	nt Rate	New Rate	Effective Date	
<u>CHD</u>	169).57	166.57	07/01/2019	
Rate Type Interim	X	_ <u>Prospective</u>	<u>e</u>		
Total Inte	erim	Χ	Total Prospective		
Settleme	ent Based on Cost		Prospective Adjust	ted For New Costs	
	BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost	t			
DISTRIBUTION:			TR		
Fiscal Agent			M		
Contract Management		R	ydell Samuel, Adminis	trator	

Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Dep	Dsceola County Health Department				93	
P. O. Box 4503091875 Bogg	jy Creek Road			Date: 07/01/201	7/01/2019	
Kissimmee, FL 34745-0309	1		Fiscal Year End: 06/30/2018			
			Aud	dit Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD	-	169.	57	166.57	07/01/2019	
<u>Rate Type</u> Interim		х	Prospective			
Tot	tal Interim		X	Total Prospective		
Set	ttlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS: Budget X Unaudited Desk Revie Desk Audite Field Audite	ewed Cost ed Cost		_		
DISTRIBUTION:			-	TR		
Fiscal Agent			1	ev.		
Contract Management			Ryo	dell Samuel, Adminis	trator	

Medicaid Program Finance

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Program Finance



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Departmen	t	Provi	Provider Number: 0279617-00				
10841 Little Road			Date: 07/01/201	: 07/01/2019			
New Port Richey, FL 34654		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD	-	169.57	166.57	07/01/2019			
Rate Type							
<u>Interim</u> Total Int	orim	X Prospecti					
			Total Prospective				
	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			M				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Hea	Pasco County Health Department				Provider Number: 0279617-01			
10841 Little Road				Date: 07/01/2019				
New Port Richey, F	FL 34654			Fiscal Year End: 06/30/2018				
				Au	idit Status: Una	audited Cost	t	
Provider Type			<u>Curren</u>	t Rate	<u>New Ra</u>	te	Effective Date	
<u>CH</u>	ID		169.	.57	166.57	,	07/01/2019	
Rate Type			N/	- (1				
<u>Inte</u>	erim Total Interim		X	Prospective		o otiv o		
	Total Interim			X	Total Prosp			
	Settlement Ba	sed on Cost			Prospective	Adjusted F	or 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 Mana	agement			Ry	/dell Samuel, A	Administrato	r	
Program Finar	nce			M	edicaid Progra	m Finance	-	

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County	/ Health De	epartment			Prov	ider Number	: 0279617-9) 1
10841 Little R	Road					Date	07/01/2019	
New Port Rick	hey, FL 34	1654			Fiscal Year End: 06/30/2018			8
						Audit Status	: Unaudited	Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	<u> Rate</u>	Effective Date
	<u>CHD</u>			169	.57	16	6.57	07/01/2019
Rate Type								
	_ <u>Interim</u> _			X	_ <u>Prospect</u> _			
		Total Interim			Χ	Total F	rospective	
		Settlement Base	ed on Cost			Prospe	ective Adjus	ted For New Costs
		B	ASIS:					
			Budget					
			X Unaudite	d Cost				
		_	Desk Rev	viewed Cost				
			Desk Aud	dited Cost				
			Field Auc	lited Cost				
DISTRIBUTIO	<u>DN:</u>					TR		
Fiscal Ag	lent					M		
Contract	Manageme	ent				Rydell Samu	uel, Adminis	strator
Program	Finance					Medicaid Pr	ogram Finai	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department	Pasco County Health Department		ider Number: 0279617-9	92
10841 Little Road		Date: 07/01/2019		
New Port Richey, FL 34654	Fisc	cal Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	169.57	166.57	07/01/2019
Rate Type				
Interim		X Prospect	ive	
Total Interi	m	X	Total Prospective	
Settlement Based on Cost			Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revi	ewed Cost		
	Desk Audi	ted Cost		
	Field Audit	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Pinellas Coun	ty Health I	Department			Prov	ider Number:	0279625-00	l i i i i i i i i i i i i i i i i i i i
500 7th Avenue South			- Date:		e: 07/01/2019			
St. Petersburg, FL 33701		Fisc	al Year End:	06/30/2018				
						Audit Status:	Unaudited C	Cost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>			169	.57	160	6.57	07/01/2019
Rate Type								
	Interim			X	Prospect	<u>ive</u>		
	-	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				
		_						
DISTRIBUTIC	<u>DN:</u>					TR		
Fiscal Ag	ent					PV.		
Contract I	Managem	ent				Rydell Samu	iel, Administra	ator
Program	Finance					Medicaid Pro	ogram Financ	e

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Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County Health Department		Prov	vider Number: 0279625-9	91
500 7th Avenue South		Date: 07/01/2019		
St. Petersburg, FL 33701		Fise	cal Year End: 06/30/201	8
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		169.57	166.57	07/01/2019
Rate Type				
<u>Interim</u>		X Prospect	ive	
To	otal Interim	X	Total Prospective	
Se	ettlement Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	d Cost		
	Desk Rev	iewed Cost		
	Desk Aud	ited Cost		
	Field Audi	ited Cost		
DISTRIBUTION:			TR	
Fiscal Agent			(N	
Contract Management			Rydell Samuel, Adminis	trator
Program Finance			Medicaid Program Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	Provider Number: 0279633-00		
1290 Golfview Avenue, 4th Floor		Date: 07/01/201	07/01/2019		
Bartow, FL 33830-6740		Fise	cal Year End: 06/30/201	8	
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD		169.57	166.57	07/01/2019	
Rate Type					
Interim		X Prospect	ive		
Total Interim	ı	X	Total Prospective		
Settlement Based on Cost			Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	I Cost			
	 Desk Revi	iewed Cost			
	 Desk Audi	ited Cost			
	 Field Audi	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			M		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	ider Number: 0279633-0	01
1290 Golfview Avenue, 4th Floor		Date: 07/01/201)19	
Bartow, FL 33830-6740		Fisc	al Year End: 06/30/201	8
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	_	169.57	166.57	07/01/2019
Rate Type				
<u>Interim</u>		X Prospect	<u>ive</u>	
Total Interi	m	X	Total Prospective	
Settlement	Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	Cost		
	Desk Revie	wed Cost		
	Desk Audite	ed Cost		
	Field Audite	ed Cost		
DISTRIBUTION:			TR	
Fiscal Agent			/ N	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Final	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	ider Number: 0279633-0)2	
1290 Golfview Avenue, 4th Floor Bartow, FL 33830-6740			Date: 07/01/201	7/01/2019	
		Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.57	166.57	07/01/2019	
Rate Type					
<u>Interim</u>		X Prospect	<u>ive</u>		
Total Interi	m	X	Total Prospective		
Settlement	Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			<u> </u>		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	ider Number: 0279633-0)3	
1290 Golfview Avenue, 4th Floor Bartow, FL 33830-6740			Date: 07/01/201	/01/2019	
		Fiso	cal Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	_	169.57	166.57	07/01/2019	
Rate Type					
Interim		X Prospect	ive		
Total Inter	im	X	Total Prospective		
Settlement 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			ſN		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	Provider Number: 0279633-04		
1290 Golfview Avenue, 4th Floor Bartow, FL 33830-6740			Date: 07/01/201	ə: 07/01/2019	
		Fiso	cal Year End: 06/30/201	8	
			Audit Status: Unaudited	l Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.57	166.57	07/01/2019	
Rate Type					
<u>Interim</u>		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 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

Polk County Health Department		Prov	ider Number: 0279633-0	05	
1290 Golfview Avenue, 4th Floor Bartow, FL 33830-6740			Date: 07/01/201	07/01/2019	
		Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.57	166.57	07/01/2019	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total Interi	m	X	Total Prospective		
Settlement	Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			۲ ۷		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Provi	ider Number: 0279633-3	30	
1290 Golfview Avenue, 4th Floor Bartow, FL 33830-6740			Date: 07/01/201	1/2019	
		Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	_	169.57	166.57	07/01/2019	
Rate Type					
Interim		X Prospect	ive		
Total Inte	erim	X	Total Prospective		
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audite	ed Cost			
	Field Audite	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			<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

Polk County Health Department		Prov	ider Number: 0279633-9	90	
1290 Golfview Avenue, 4th Floor Bartow, FL 33830-6740			Date: 07/01/201)7/01/2019	
		Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	169.57	166.57	07/01/2019	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total Inter	im	X	Total Prospective		
Settlement	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			۲N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department		Prov	ider Number: 0279633-9	95	
1290 Golfview Avenue, 4th Floor Bartow, FL 33830-6740			Date: 07/01/201	07/01/2019	
		Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	169.57	166.57	07/01/2019	
Rate Type					
<u>Interim</u>		X Prospect	<u>ive</u>		
Total Inter	im	X	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			۲ ۷		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Putnam Count	Putnam County Health Department				Prov	vider Number:	0279641-00)	
2801 Kennedy	Street						Date:	07/01/2019	
Palatka, FL 32	2177					Fis	cal Year End:	06/30/2018	
							Audit Status:	Unaudited C	Cost
Provider Ty	vpe				Current	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169.	.57	16	6.57	07/01/2019
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	<u>SIS:</u>					
				Budget					
			Х	_ Unaudited	d Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Aud	ited Cost				
				- Field Audi	ited Cost				
				_					
DISTRIBUTIO	<u>N:</u>						TR		
Fiscal Age	ent						[N		
Contract N	/lanageme	ent					Rydell Samu	iel, Administr	ator
Program F	inance						Medicaid Pro	ogram Financ	ce

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Departmer	nt		Provider Numbe	r: 0279641-0)1		
2801 Kennedy Street			Date	e: 07/01/2019	7/01/2019		
Palatka, FL 32177			Fiscal Year End: 06/30/2018				
			Audit Status	s: Unaudited	Cost		
Provider Type	(Current Rate	<u>e</u> <u>Nev</u>	w Rate	Effective Date		
<u>CHD</u>		169.57	16	6.57	07/01/2019		
Rate Type							
<u>Interim</u>		X <u>Pros</u>	<u>pective</u>				
Total Inte	erim		X Total	Prospective			
Settleme	nt Based on Cost		Prosp	ective Adjust	ted For New Costs		
	BASIS:						
	Budget						
	X Unaudited Co	st					
	Desk Reviewe	ed Cost					
	Desk Audited	Cost					
	Field Audited	Cost					
DISTRIBUTION:			TR				
Fiscal Agent			1				
Contract Management				uel, Adminis			
Program Finance			Medicaid P	rogram Finar	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Departme	nt	Pro	vider Number: 0279641-	03			
2801 Kennedy Street			Date: 07/01/201	1/2019			
Palatka, FL 32177		Fis	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	_	169.57	166.57	07/01/2019			
Rate Type							
<u>Interim</u>		X <u>Prospec</u>	tive				
Total Inte	erim	X	Total Prospective				
Settleme	ent Based on Cost		Prospective Adjus	sted For New Costs			
	BASIS:						
	Budget						
	X Unaudited C	ost					
	Desk Review	ved Cost					
	Desk Audited	d Cost					
	Field Audited	d Cost					
DISTRIBUTION:			R				
Fiscal Agent			1				
Contract Management			Rydell Samuel, Adminis				
Program Finance			Medicaid Program Fina	ince			

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Departmen	t		Provider Number: 02796	341-04			
2801 Kennedy Street			Date: 07/01	//01/2019			
Palatka, FL 32177			Fiscal Year End: 06/30/2018				
			Audit Status: Unau	dited Cost			
Provider Type		Current Rate	e <u>New Rate</u>	Effective Date			
CHD	_	169.57	166.57	07/01/2019			
Rate Type							
<u>Interim</u>		X <u>Pros</u>	spective				
Total Inte	rim		X Total Prospec	tive			
Settlemen	nt Based on Cost		Prospective A	djusted 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			1				
Contract Management			Rydell Samuel, Adr				
Program Finance			Medicaid Program	r inance			

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Departmen	t		Provider	Number: 0279641-9	91		
2801 Kennedy Street				Date: 07/01/201	//01/2019		
Palatka, FL 32177			Fiscal Year End: 06/30/2018				
			Aud	dit Status: Unaudited	Cost		
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date		
CHD	_	169.5	7	166.57	07/01/2019		
Rate Type							
Interim		Х <u>і</u>	Prospective				
Total Inte	rim		Х	Total Prospective			
Settlemer	t Based on Cost	-		Prospective Adjust	ted For New Costs		
	BASIS:						
	Budget						
	X Unaudited C	ost					
	Desk Review	ved Cost					
	Desk Audited	d Cost					
	Field Audited	d Cost					
DISTRIBUTION:			-	R			
Fiscal Agent			1	8 7 9			
Contract Management				dell Samuel, Adminis			
Program Finance			Me	dicaid Program Finai	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County Health Depar	tment	Prov	ider Number: 0279650-	00
1955 US 1 South		Date: 07/01/201	9	
St. Augustine, FL 32086	Fisc	al Year End: 06/23/201	8	
			Audit Status: Unaudited	d Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		169.57	166.57	07/01/2019
Rate Type		X <u>Prospect</u>	ivo	
Total I	nterim		Total Prospective	
	ment Based on Cost			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			r v	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County Health Departm	ent	Prov	ider Number: 0279650-9	91	
1955 US 1 South			Date: 07/01/2019		
St. Augustine, FL 32086	Fiso	cal Year End: 06/23/201	8		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>		169.57	166.57	07/01/2019	
Rate Type					
Interim		X Prospect	ive		
Total Inte	erim	X	Total Prospective		
Settleme	ent Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audi	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			/ N		
Contract Management			Rydell Samuel, Adminis		
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cour	nty Health	Department					Provid	der Nu	umber:	0279668-0	0	
5150 NW Miln	er Drive								Date:	07/01/2019	9	
Port Saint Luc	ie, FL 349	963				Fiscal Year End: 06/30/2018						
							A	Audit \$	Status:	Unaudited	Cost	
Provider Ty	<u>/pe</u>				<u>Curre</u>	nt F	Rate		New	Rate	E	ffective Date
	<u>CHD</u>				169	9.57	7		166	5.57		07/01/2019
Rate Type	Interim				Х	Б	rospectiv	vo				
	- -	Total Interim				- <u>r</u>	X		Fotal Pr	ospective		
		- Settlement Bas	ed or	n Cost		_	χ.				ed For	New Costs
		-										
		<u>E</u>	BAS	<u>IS:</u>								
				Budget								
		_	Х	Unaudited	l Cost							
		_		Desk Revi	iewed Cos	st						
		_		Desk Audi	ited Cost							
		_		Field Audi	ted Cost							
		—										
DISTRIBUTIO	<u>)N:</u>							H	R			
Fiscal Age	ent							M				
Contract I	Managem	ent					F	Rydell	l Samu	el, Adminis	trator	
Program I	Finance						Ν	Medic	aid Pro	gram Finar	nce	

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departme	nt		Provider Number: 0279668-01 Date: 07/01/2019			
5150 NW Milner Drive						
Port Saint Lucie, FL 34963			Fiscal Y	ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current R</u>	ate	New Rate	Effective Date	
CHD		169.57		166.57	07/01/2019	
Rate Type						
Interim		X <u>Pr</u>	ospective			
Total Inte	rim		Х	Total Prospective		
Settlement Based on Cost				ted For New Costs		
				_		
	BASIS:					
	Budget					
	X Unaudited Co	ost				
	Desk Review	ed Cost				
	Desk Audited	l Cost				
	Field Audited	Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	N .		
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

St. Lucie County He	alth Department		I	Provider Number:	0279668-02		
5150 NW Milner Driv	ve			Date: 07/01/2019			
Port Saint Lucie, FL 34963				Fiscal Year End:	06/30/2018		
				Audit Status:	Unaudited Co	ost	
Provider Type			Current Rate	New	Rate	Effective Date	
<u>CHI</u>	<u>2</u>		169.57	166	6.57	07/01/2019	
Rate Type							
Inter	<u>im</u>		X <u>Pros</u> p	<u>bective</u>			
	Total Interim			X Total Pr	rospective		
	Settlement B	ased on Cost		Prospec	ctive Adjusted	For New Costs	
		BASIS:					
		Budget					
		X Unaudited	d Cost				
		Desk Rev	iewed Cost				
		Desk Aud	ited Cost				
		Field Audi	ited Cost				
DISTRIBUTION:				TR			
Fiscal Agent				PV			
Contract Manag	jement			Rydell Samu	el, Administra	tor	
Program Finance				Medicaid Program Finance			

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(No Change In Rate)



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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departm	Prov	ider Number: 0279668-0	03		
5150 NW Milner Drive			Date: 07/01/2019		
Port Saint Lucie, FL 34963	Fisc	cal Year End: 06/30/201	8		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	169.57	166.57	07/01/2019	
Rate Type					
Interim		X <u>Prospect</u>	ive		
Total In	terim	X	Total Prospective		
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			/ N		
Contract Management			Rydell Samuel, Adminis		
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departm	St. Lucie County Health Department)4	
5150 NW Milner Drive			Date: 07/01/2019		
Port Saint Lucie, FL 34963	Fisc	cal Year End: 06/30/201	8		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	169.57	166.57	07/01/2019	
Rate Type					
Interim		X Prospect	ive		
Total In	terim	X	Total Prospective		
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			R		
Fiscal Agent			/ N		
Contract Management			Rydell Samuel, Adminis		
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departmer	t. Lucie County Health Department			Provider Number: 0279668-05				
5150 NW Milner Drive			Date: 07/01/2019					
Port Saint Lucie, FL 34963			Fiscal Year End: 06/30/2018					
			Audit Status: Unaudited Cost					
Provider Type		Current Rate		New Rate	Effective Date			
CHD	_	169.57		166.57	07/01/2019			
Rate Type								
Interim		X <u>Pro</u>	<u>ospective</u>					
Total Inter	rim		Х	Total Prospective				
Settlemer	nt Based on Cost			Prospective Adjust	ted For New Costs			
				_				
	BASIS:							
	Budget							
	X Unaudited C	ost						
	Desk Review	ved Cost						
	Desk Audited	d Cost						
	Field Audited	d Cost						
DISTRIBUTION:			/	R				
Fiscal Agent			1	40				
Contract Management			Rydell Samuel, Administrator					
Program Finance				licaid Program Finar				
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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departmen	t. Lucie County Health Department			Provider Number: 0279668-11				
5150 NW Milner Drive			Date: 07/01/2019					
Port Saint Lucie, FL 34963			Fiscal Year End: 06/30/2018					
			Audit Status: Unaudited Cost					
Provider Type		Current Rate	New Rate	Effective Date				
CHD	_	169.57	166.57	07/01/2019				
Rate Type								
Interim		X <u>Pros</u> r	<u>pective</u>					
Total Inter	rim		X Total Prospective	9				
Settlemer	nt Based on Cost		Prospective Adju	sted For New Costs				
	BASIS:							
	Budget							
	X Unaudited Co	ost						
	Desk Review	ved Cost						
	Desk Audited	d Cost						
	Field Audited	l Cost						
DISTRIBUTION:			TR					
Fiscal Agent			M					
Contract Management			Rydell Samuel, Admin	istrator				
Program Finance			Medicaid Program Fin					
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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie Cou	St. Lucie County Health Department					Provider Number: 0279668-12				
5150 NW Milr	ner Drive						Date:	07/01/2019		
Port Saint Luc	cie, FL 34	963				Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited C	Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.57	160	6.57	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjusted	d For New Costs	
			BAS	SIS:						
				Budget						
			X	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						7N			
Contract	Managem	ent					Rydell Samu	iel, Administra	ator	
Program Finance				Medicaid Program Finance						

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Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Departm	nent	Prov	Provider Number: 0279668-30				
5150 NW Milner Drive			Date: 07/01/201	9			
Port Saint Lucie, FL 34963		Fiso	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		169.57	166.57	07/01/2019			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total In	terim	X	Total Prospective				
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	l Cost					
	Desk Revi	iewed Cost					
	Desk Audi	ited Cost					
	Field Audi	ted Cost					
DISTRIBUTION:			TR				
Fiscal Agent			ſN				
Contract Management	Contract Management			trator			
Program Finance			Medicaid Program Final	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County He	t. Lucie County Health Department				Provider Number: 0279668-91				
5150 NW Milner Dri	ve				Date:	07/01/2019			
Port Saint Lucie, FL	34963			Fiscal Year End: 06/30/2018					
				Au	idit Status:	Unaudited Co	st		
Provider Type			Current I	Rate	<u>New I</u>	Rate	Effective Date		
<u>CH</u>	<u>D</u>		169.5	7	166.	.57	07/01/2019		
Rate Type									
Inte			<u> </u>	Prospective					
	Total Interim			Х	Total Pro	ospective			
	Settlement B	ased on Cost	_		Prospec	tive Adjusted	For New Costs		
		BASIS:							
		Budget							
		X Unaudited	d Cost						
		Desk Rev	iewed Cost						
		Desk Aud	ited Cost						
		 Field Audi	ited Cost						
DISTRIBUTION:				-	TR				
Fiscal Agent					M				
Contract Manag	gement			Ry	/dell Samue	I, Administrate	or		
Program Finance				Medicaid Program Finance					

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa Count	anta Rosa County Health Department			Provid	er Number:	0279676-00		
P.O. Box 929					Date:	07/01/2019		
Milton, FL 32572-0)929			Fiscal Year End: 06/30/2018				
				A	udit Status:	Unaudited Co	ost	
Provider Type			<u>Curren</u>	t Rate	New	Rate	Effective Date	
<u>CH</u>	ID	-	100.	.95	150).91	07/01/2019	
Rate Type								
<u>Inte</u>	erim		X	Prospectiv	<u>'e</u>			
	Total Interim			Х	Total P	rospective		
	Settlement Base	d on Cost			Prospe	ctive Adjusted	For New Costs	
	B	ASIS:						
		Budget						
	>	Unaudited	Cost					
		Desk Revi	ewed Cost					
		Desk Audi	ted Cost					
	_	Field Audi	ted Cost					
DISTRIBUTION:				-	IK			
Fiscal Agent					M			
Contract Mana	agement			R	ydell Samu	iel, Administra	tor	
Program Finar	nce			N	ledicaid Pro	ogram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health	anta Rosa County Health Department			Provider Number: 0279676-01				
P.O. Box 929				Date: 07/01/201	9			
Milton, FL 32572-0929			Fiscal	Year End: 06/30/201	8			
			Au	udit Status: Unaudited	l Cost			
Provider Type		<u>Curre</u>	nt Rate	ate <u>New Rate</u> Effe				
<u>CHD</u>		10	0.95	150.91	07/01/2019			
Rate Type								
Interim		Х	Prospectiv	<u>e</u>				
т	otal Interim		X	Total Prospective				
s	Settlement Based on	n Cost		Prospective Adjus	ted For New Costs			
	<u>BASI</u>	<u>IS:</u>						
		Budget						
	X	Unaudited Cost						
		Desk Reviewed Cos	st					
		Desk Audited Cost						
		Field Audited Cost						
DISTRIBUTION:				TR				
Fiscal Agent				PU				
Contract Managemen	t		R	ydell Samuel, Adminis	strator			
Program Finance				edicaid Program Fina				
State Health Office								



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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Healt	anta Rosa County Health Department				Provider Number: 0279676-02				
P.O. Box 929				Date: 07/01/2019					
Milton, FL 32572-0929				Fiscal Year End: 06/30/2018					
					Audit Status:	Unaudited Co	ost		
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date		
<u>CHD</u>			100.	95	150).91	07/01/2019		
Rate Type									
<u>Interim</u>			х	Prospecti	ive				
	Total Interim			x	Total Pr	rospective			
	Settlement Based o	on Cost			Prospe	ctive Adjusted	For New Costs		
	BAS	SIS:							
		Budget							
	X	- Unaudited Co	ost						
		_ Desk Review	ved Cost						
		- Desk Audited	d Cost						
		- Field Audited	l Cost						
		-							
DISTRIBUTION:					TR				
Fiscal Agent					M				
Contract Managemer	nt				Rydell Samu	el, Administrat	or		
Program Finance				-	Medicaid Pro	gram Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Heal	anta Rosa County Health Department				Provider Number: 0279676-03				
P.O. Box 929				Date: 07/01/2019					
Milton, FL 32572-0929				Fiscal Year End: 06/30/2018					
					Audit Status:	Unaudited Co	ost		
Provider Type			<u>Current</u>	Rate	New	Rate	Effective Date		
<u>CHD</u>		_	100.	95	150	.91	07/01/2019		
Rate Type									
Interim			Х	Prospect	ive				
	Total Interim			x	Total Pr	ospective			
	Settlement Based o	on Cost			Prospec	ctive Adjusted	For New Costs		
	BAS	SIS:							
		Budget							
	X	– Unaudited (Cost						
		_ Desk Revie	wed Cost						
		_ Desk Audite	ed Cost						
		– Field Audite	ed Cost						
		_							
DISTRIBUTION:					TR				
Fiscal Agent					γv				
Contract Manageme	ent				Rydell Samu	el, Administrat	tor		
Program Finance					Medicaid Pro	gram Finance			

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa C	anta Rosa County Health Department					Provider Number: 0279676-04				
P.O. Box 929							Date:	07/01/2019)	
Milton, FL 32	572-0929					Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited	Cost	
Provider T	<u>ype</u>				Current	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				100.	.95	150	0.91	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospect	ive			
	-	Total Interim				x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjuste	ed For New Costs	
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				Budget						
			Х	- Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIC	<u>DN:</u>						TR			
Fiscal Ag	ent						۲N			
Contract	Managem	ent					Rydell Samu	iel, Administ	rator	
Program	Finance						Medicaid Pro	ogram Finan	ce	

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County He	anta Rosa County Health Department				Provider Number: 0279676-05			
P.O. Box 929					Date: 07/01/201	9		
Milton, FL 32572-0929)			Fiscal	Year End: 06/30/201	8		
				Au	dit Status: Unaudited	Cost		
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date		
<u>CHD</u>		-	100	.95	150.91	07/01/2019		
Rate Type								
Interim	L		Х	Prospective	2			
	Total Interim			- x	Total Prospective			
	Settlement Bas	sed on Cost			Prospective Adjus	ted For New Costs		
	_							
	<u>I</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	nent			Rv	dell Samuel, Adminis	strator		
Program Finance					edicaid Program Fina			
State Health Office	9							



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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Hea	anta Rosa County Health Department				Provider Number: 0279676-30			
P.O. Box 929					Date: 07/01/201	19		
Milton, FL 32572-0929				Fiscal	Year End: 06/30/201	18		
				Au	dit Status: Unaudited	d Cost		
Provider Type			<u>Curren</u>	it Rate	New Rate	Effective Date		
<u>CHD</u>		-	100	.95	150.91	07/01/2019		
Rate Type								
<u>Interim</u>			Х	Prospective				
	Total Interim			- x	Total Prospective			
	- Settlement Base	ed on Cost			Prospective Adjus	sted For New Costs		
	-							
	B	BASIS:						
		Budget						
		X Unaudited	Cost					
		Desk Revi	ewed Cost					
		Desk Audi	ted Cost					
	_	Field Audit	ted Cost					
DISTRIBUTION:				-	R			
Fiscal Agent					P()			
Contract Manageme	Contract Management			Ry	dell Samuel, Admini	strator		
Program Finance				Me	edicaid Program Fina	ance		
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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Depart	ment	Prov	ider Number: 0279676-	91			
P.O. Box 929			Date: 07/01/2019				
Milton, FL 32572-0929		Fiso	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	Cost			
<u>Provider Type</u>		Current Rate	New Rate	Effective Date			
CHD	-	100.95	150.91	07/01/2019			
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	Cost					
	Desk Revi	ewed Cost					
	Desk Audi	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			rv.				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota Cour	nty Health	Department				Provider Number: 0279684-00					
P. O. Box 265	8					Date: 07/01/2019					
Sarasota, FL	34230-26	58				Fiscal Year End: 06/30/2018					
						A	udit Status: Unau	dited Cost			
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New Rate	Effective Date			
	<u>CHD</u>				151	.12	148.19	07/01/2019			
Rate Type											
	Interim				X	Prospectiv					
		Total Interim				X	Total Prospec				
		Settlement Ba	ased o	on Cost			Prospective A	djusted For New Costs			
			BAS	<u>SIS:</u>							
				Budget							
			Х	Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				- Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				-							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						۲N				
Contract N	Managemo	ent				R	ydell Samuel, Adr	ministrator			
Program F	Program Finance					N	ledicaid Program	Finance			

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Medicaid Program Finance



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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health	Sarasota County Health Department					Provider Number: 0279684-91				
P. O. Box 2658					Date: 07/01/2019					
Sarasota, FL 34230-26	58				Fiscal Year End: 06/30/2018					
					Audit Status: Unaudited Cost					
Provider Type				<u>Curren</u>	t Rate	New	Rate	Effective Date		
<u>CHD</u>			-	151.	.12	148	8.19	07/01/2019		
Rate Type										
<u>Interim</u>				X	Prospective	<u>)</u>				
	Total Interim				X	Total P	rospective			
	_Settlement Ba _	sed on	Cost			Prospe	ctive Adjusted	d For New Costs		
		BASIS	<u>S:</u>							
		В	Budget							
	-	χι	Jnaudited	Cost						
	-	C	Desk Revi	ewed Cost						
	-	C	Desk Audi	ted Cost						
	-	F	ield Audit	ted Cost						
	-									
DISTRIBUTION:					-	TR				
Fiscal Agent					3	(N				
Contract Managem	ient				Ry	dell Samu	el, Administra	ator		
Program Finance					Me	edicaid Pro	gram Financ	e		

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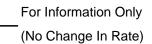


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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health I	Sarasota County Health Department					0279684-92		
P. O. Box 2658					Date:	07/01/2019		
Sarasota, FL 34230-265	8			Fiscal Year End: 06/30/2018				
				Audit Status: Unaudited Cost				
Provider Type			<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date	
<u>CHD</u>			151	.12	148	5.19	07/01/2019	
Rate Type								
<u>Interim</u>			X	Prospective				
	Total Interim			Χ	Total Pr –	ospective		
	Settlement Based	on Cost			Prospec	ctive Adjusted	For New Costs	
	BA	<u>SIS:</u>						
		Budget						
	X	_ Unaudited	Cost					
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DISTRIBUTION:				-	IR			
Fiscal Agent				1				
Contract Manageme	nt			Ryo	dell Samu	el, Administra	tor	
Program Finance		Me	dicaid Pro	gram Finance)			





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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota Cou	nty Health	Department				Provider Number: 0279684-93					
P. O. Box 265	58					Date: 07/01/2019					
Sarasota, FL	34230-26	58				Fiscal Year End: 06/30/2018					
						/	Audit Status:	Unaudited	Cost		
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				151	.12	148	3.19	07/01/2019		
Rate Type											
	Interim				X	Prospecti	ve				
		Total Interim				Х	Total P	rospective			
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjust	ted For New Costs		
			BAS	<u>81S:</u>							
				Budget							
			X	- Unaudited	Cost						
				- Desk Revi	ewed Cost						
				- Desk Audi	ted Cost						
				- Field Audi	ted Cost						
				-							
DISTRIBUTIC							TR				
Fiscal Ag	ent						/ N				
Contract	Managem	ent				<u> </u>	Rydell Samu	el, Adminis	trator		
Program	Finance					I	Medicaid Pro	ogram Finar	nce		

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Hea	alth Department			Provider Number: 0279692-00				
400 West Airport Bou	levard							
Sanford, FL 32773				Fiscal Year End: 06/30/2018				
				Ą	udit Status:	Unaudited Cos	st	
Provider Type Curr			Current	nt Rate New		Rate	Effective Date	
<u>CHD</u>			130.	22	166	.57	07/01/2019	
Rate Type								
Interi	<u>n</u>		Х	Prospectiv	<u>/e</u>			
	Total Interim			X	Total Pro	ospective		
	Settlement Bas	ed on Cost			Prospec	tive Adjusted I	For New Costs	
	<u>E</u>	BASIS:						
		Budget						
	_	X Unaudited	d Cost					
	_	Desk Rev	viewed Cost					
	_	Desk Aud	lited Cost					
	-	Field Aud	ited Cost					
	-							
DISTRIBUTION:				3	TR			
Fiscal Agent					7N			
Contract Manage		F	Rydell Samue	el, Administrato	or			
Program Finance		Ν	ledicaid Pro	gram Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Depar	tment	Provi	Provider Number: 0279692-30				
400 West Airport Boulevard			Date: 07/01/2019				
Sanford, FL 32773		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type	Current Rate	New Rate	Effective Date				
<u>CHD</u>	-	130.22	166.57	07/01/2019			
Rate Type							
Interim		X Prospect	ive				
Total I	Interim	X	Total Prospective				
Settle	ment Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	ewed Cost					
	Desk Audit	ted Cost					
	Field Audit	ed Cost					
DISTRIBUTION:			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

Seminole County He	alth Department			Provider Number: 0279692-90				
400 West Airport Bo	ulevard				Date:	07/01/2019		
Sanford, FL 32773				Fiscal Year End: 06/30/2018				
				A	udit Status:	Unaudited Co	ost	
Provider Type Cur			Current	ent Rate Nev		Rate	Effective Date	
CHE	<u>)</u>		130.	22	166	5.57	07/01/2019	
Rate Type								
Interi			X	Prospectiv				
	Total Interim			X	Total Pr	ospective		
	Settlement Base	d on Cost			Prospec	ctive Adjusted	For New Costs	
	<u>B</u>	ASIS:						
		Budget						
		X Unaudited	d Cost					
		Desk Rev	iewed Cost					
		 Desk Aud	ited Cost					
	_	 Field Audi	ited Cost					
DISTRIBUTION:					TR			
Fiscal Agent					M			
Contract Manag	ement			R	ydell Samu	el, Administra	tor	
Program Financ	e				-	gram Finance		

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health De	partment	Prov	Provider Number: 0279706-01				
P. O. Box 98			Date: 07/01/2019				
Bushnell, FL 33513		Fiso	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		155.79	141.52	07/01/2019			
Rate Type							
<u>Interim</u>		X Prospect	ive				
1	Total Interim	X	Total Prospective				
5	Settlement Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	d Cost					
	Desk Rev	iewed Cost					
	Desk Aud	ited Cost					
	Field Audi	ited Cost					
DISTRIBUTION:			TR				
Fiscal Agent			[N]				
Contract Managemen	nt		Rydell Samuel, Adminis	strator			
Program Finance			Medicaid Program Fina	nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter Count	Sumter County Health Department				Provider Number: 0279706-91				
P. O. Box 98						Date	07/01/2019	9	
Bushnell, FL	33513				Fiscal Year End: 06/30/2018				
						Audit Status	Unaudited	Cost	
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			155	.79	14	1.52	07/01/2019	
Rate Type	Interim			Х	Prospect	tivo			
	- -	Total Interim			- X		rospective		
		- Settlement Base	ed on Cost				•	ted For New Costs	
		-							
		B	ASIS:						
			Budget						
			X Unaudite	d Cost					
			Desk Rev	viewed Cost					
			Desk Aud	dited Cost					
			Field Auc	dited Cost					
DISTRIBUTIO	<u>DN:</u>					TR			
Fiscal Ag						M			
-	Managem	ent				Rydell Samu	iel, Adminis	trator	
Program	Finance					Medicaid Pro			

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health De	partment			Provider Number: 0279706-92				
P. O. Box 98					Date: 07/01/20	19		
Bushnell, FL 33513				Fiscal	Year End: 06/30/20	18		
				Audit Status: Unaudited Cost				
Provider Type			<u>Curren</u>	t Rate	Rate <u>New Rate</u> Eff			
CHD		-	155	.79	141.52	07/01/2019		
Rate Type								
<u>Interim</u>			Х	Prospectiv	<u>e</u>			
1	Total Interim			- x	Total Prospective	•		
	Settlement Based of	on Cost			Prospective Adju	sted For New Costs		
	BAS	<u>SIS:</u>						
		Budget						
	X	Unaudited	Cost					
		_ Desk Revie	ewed Cost					
		_ Desk Audit	ed Cost					
		_ Field Audite	ed Cost					
DISTRIBUTION:					TR			
Fiscal Agent					PI			
Contract Managemer	Contract Management			Rydell Samuel, Administrator				
Program Finance				M	edicaid Program Fina	ance		
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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County	/ Health D	epartment				Prov	/ider Number	: 0279722-	00	
1215 Peacocl	k Street						9			
Perry, FL 323	347					Fiscal Year End: 06/30/2018				
							d Cost			
Provider Type			<u>Curren</u>	Current Rate		<u>Rate</u>	Effective Date			
	<u>CHD</u>				116	.98	10	6.81	07/01/2019	
Rate Type										
	Interim				X	Prospect	<u>tive</u>			
		Total Interim				Χ	Total P	rospective		
		Settlement Ba	ased c	on Cost			Prospe	ective Adjus	sted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			X	_ Unaudited	d Cost					
				- Desk Revi	iewed Cost					
				_ Desk Aud	ited Cost					
				- Field Audi	ited Cost					
				_						
DISTRIBUTIO	<u>DN:</u>						TR			
Fiscal Ag	ent						M			
Contract	Managem	ent					Rydell Samu	uel, Adminis	strator	
Program Finance							Medicaid Pr	ogram Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department		Prov	ider Number: 0279722-0	01	
1215 Peacock Street			Date: 07/01/201	7/01/2019	
Perry, FL 32347	Fisc	cal Year End: 06/30/201	8		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
<u>CHD</u>	-	116.98	106.81	07/01/2019	
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 Revi	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			7N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Departm	ent	Prov	ider Number: 0279722-3	30
1215 Peacock Street			Date: 07/01/2019	
Perry, FL 32347	 Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		116.98	106.81	07/01/2019
Rate Type				
Interim		X Prospect		
	Interim	X	Total Prospective	
Settle	ment Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	l Cost		
	Desk Rev	iewed Cost		
	Desk Aud	ited Cost		
	Field Audi	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			PU	
Contract Management			Dydoll Comuci. Adminis	strotor
Program Finance			Rydell Samuel, Adminis Medicaid Program Fina	
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Medicaid Reimbursement Rate Change Form for CHDs

Union County H	lealth De	partment				Prov	/ider Number:	0279731-00)
495 East Main Street					Date:	07/01/2019			
Lake Butler, FL 32054				Fis	cal Year End:	06/30/2018			
							Audit Status:	Unaudited (Cost
Provider Ty	<u>pe</u>				Curren	nt Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	160	6.57	07/01/2019
Rate Type									
<u> </u>	<u>Interim</u>				X	_ <u>Prospec</u>			
_		Total Interim				X	Total P	rospective	
_		Settlement Ba	ised c	on Cost			Prospe	ctive Adjuste	d For New Costs
			BAS	<u>SIS:</u>					
				Budget					
			Х	- Unaudited	l Cost				
				- Desk Revi	iewed Cost	t			
				- Desk Aud	ited Cost				
				- Field Audi	ted Cost				
				-					
DISTRIBUTION	<u>N:</u>						TR		
Fiscal Age	nt						M		
Contract M	lanageme	ent					Rydell Samu	iel, Administr	ator
Program Fi	inance						Medicaid Pro	ogram Financ	ce

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Departmer	nt	Pr	Provider Number: 0279731-01			
495 East Main Street Lake Butler, FL 32054			Date: 07/01/2019			
			iscal Year End: 06/30/201	8		
			Audit Status: Unaudited	l Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	_	169.57	166.57	07/01/2019		
Rate Type						
Interim		X <u>Prospe</u>	ective			
Total Ir	nterim	x	Total Prospective			
Settlen	nent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited C	Cost				
	Desk Review	wed Cost				
	Desk Audite	d Cost				
	Field Audited	d Cost				
DISTRIBUTION:			-UF			
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

Union County Health Departmen	t	F	Provider Number: 0279731-03			
495 East Main Street Lake Butler, FL 32054			Date: 07/01/2019			
			Fiscal Year End: 06/30/201	18		
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	_	169.57	166.57	07/01/2019		
Rate Type						
Interim		X <u>Prosp</u>	ective			
Total In	terim		X Total Prospective			
Settlem	ent Based on Cost		Prospective Adjus	sted For New Costs		
	BASIS:					
	Budget					
	X Unaudited C	Cost				
	Desk Review	wed Cost				
	Desk Audite	d Cost				
	Field Audite	d Cost				
DISTRIBUTION:			- UF			
Fiscal Agent			[N			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina	ance		
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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Departme	ent	Prov	ider Number: 0279731-	04
495 East Main Street		Date: 07/01/201	9	
Lake Butler, FL 32054	Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	Cost
Provider Type		Current Rate	New Rate	Effective Date
CHD		169.57	166.57	07/01/2019
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	Cost		
	Desk Revi	ewed Cost		
	Desk Audi	ted Cost		
	Field Audi	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			M	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

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For Information Only

(No Change In Rate)



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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health De	epartment			Provider Number: 0279731-30			
495 East Main Street					9		
Lake Butler, FL 32054			Fiscal	Year End: 06/30/201	8		
				Au	dit Status: Unaudited	l Cost	
Provider Type			<u>Curren</u>	t Rate	New Rate	Effective Date	
<u>CHD</u>		-	169	.57	166.57	07/01/2019	
Rate Type							
<u>Interim</u>			Х	Prospective	<u>)</u>		
	Total Interim			- x	Total Prospective		
	Settlement Base	ed on Cost			Prospective Adjus	ted For New Costs	
	-						
	B	BASIS:					
	_	Budget					
		X Unaudited	Cost				
		Desk Revi	ewed Cost				
		Desk Audi	ted Cost				
	_	Field Audit	ted Cost				
DISTRIBUTION:				-	IK		
Fiscal Agent					r v		
Contract Managem	ent			Ry	dell Samuel, Adminis	strator	
Program Finance				Me	edicaid Program Fina	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Union County He	ealth De	partment				Prov	vider Number:	0279731-	91
495 East Main S	treet						Date	07/01/201	9
Lake Butler, FL 32054				Fis	cal Year End	06/30/201	8		
							Audit Status:	Unaudited	d Cost
Provider Typ	e				<u>Curren</u>	t Rate	New	Rate	Effective Date
<u>c</u>	<u>CHD</u>				169	.57	16	6.57	07/01/2019
Rate Type									
<u>Ir</u>	nterim				Х	Prospec	<u>tive</u>		
		Total Interim				- x	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs
			BAS	SIS:					
				Budget					
			Х	– Unaudited	Cost				
				_ Desk Revi	iewed Cost				
				_ Desk Aud	ited Cost				
				– Field Audi	ted Cost				
				_					
DISTRIBUTION:	<u>.</u>						TR		
Fiscal Agent	t						M		
Contract Ma	nageme	ent					Rydell Samu	iel, Adminis	strator
Program Fin	nance						Medicaid Pro	ogram Fina	ince

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department		Provider	Number: 0279749-0	00	
P. O. Box 9190			Date: 07/01/2019	01/2019	
Daytona Beach, FL 32120		Fiscal Y	'ear End: 06/30/2018	8	
		Aud	lit Status: Unaudited	Cost	
Provider Type	Current	Rate	New Rate	Effective Date	
CHD	169.5	57	166.57	07/01/2019	
Rate Type					
<u>Interim</u>	X	Prospective			
Total Interim	_	Х	Total Prospective		
Settlement Based on C	Cost		Prospective Adjust	ted For New Costs	
BASIS	<u>.</u>				
Bu	udget				
X Ur	naudited Cost				
De	esk Reviewed Cost				
De	esk Audited Cost				
 Fie	eld Audited Cost				
DISTRIBUTION:		-	TR		
Fiscal Agent		1	N		
Contract Management		Ryc	lell Samuel, Adminis	trator	
Program Finance			dicaid Program Finar		

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departr	ment		Provider Number: 0279749-15 Date: 07/01/2019			
P. O. Box 9190						
Daytona Beach, FL 32120			Fiscal Y	ear End: 06/30/2018	3	
			Aud	it Status: Unaudited	Cost	
Provider Type		Current Ra	te	New Rate	Effective Date	
CHD	-	169.57		166.57	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Pro</u>	spective			
Total	Interim		Х	Total Prospective		
Settle	ement Based on Cost			Prospective Adjust	ed For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audito	ed Cost				
			/	P		
DISTRIBUTION: Fiscal Agent			f	AT .		
Contract Management			Rvd	ell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
State Health Office				-		



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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departr	ment	I	Provider Number: 0279749-92 Date: 07/01/2019			
P. O. Box 9190						
Daytona Beach, FL 32120			Fiscal Year End: 06/30/20	18		
			Audit Status: Unaudite	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	169.57	166.57	07/01/2019		
Rate Type						
<u>Interim</u>		X <u>Pros</u> p	<u>pective</u>			
Total	Interim		X Total Prospective	1		
Settle	ement Based on Cost		Prospective Adjust	sted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audit	ed Cost				
			TR			
DISTRIBUTION: Fiscal Agent			R			
Contract Management			Rydell Samuel, Admini	strator		
Program Finance			Medicaid Program Fina			
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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Depa	artment		Provider Number: 0279749-93 Date: 07/01/2019			
P. O. Box 9190						
Daytona Beach, FL 32120			Fiscal Year E	nd: 06/30/2018	}	
			Audit Stat	us: Unaudited	Cost	
Provider Type		Current Rate	<u>e N</u>	ew Rate	Effective Date	
<u>CHD</u>	-	169.57		166.57	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>Pros</u>	pective			
To	tal Interim		X Tota	al Prospective		
Se	ettlement Based on Cost		Pros	spective Adjuste	ed For New Costs	
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			pr 1			
Contract Management			Rydell Sa	imuel, Administ	rator	
Program Finance			Medicaid	Program Finan	се	
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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Departmen	t		Provider Number: 0279749-97 Date: 07/01/2019			
P. O. Box 9190						
Daytona Beach, FL 32120			Fiscal Y	'ear End: 06/30/2018	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type	<u>C</u>	urren	t Rate	New Rate	Effective Date	
CHD		169	.57	166.57	07/01/2019	
Rate Type						
Interim		X	Prospective			
Total Inte	rim		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:			-	TR		
Fiscal Agent			1	av		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Departm	ent	Prov	Provider Number: 0279757-00			
48 Oak Street			Date: 07/01/201	e: 07/01/2019		
Crawfordville, FL 32327	Fisc	al Year End: 06/30/201	8			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	161.67	121.38	07/01/2019		
Rate Type						
Interim		X <u>Prospect</u>	ive			
Total In	terim	X	Total Prospective			
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ed Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			R			
Fiscal Agent			7 N			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance Medicaid Program Finance			nce			

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County	Health E	Department			Provider Number: 0279757-01			
48 Oak Street					Date: 07/01/2019)	
Crawfordville, FL 32327			Fisc	al Year End:	06/30/2018	3		
					/	Audit Status:	Unaudited	Cost
<u>Provider Typ</u>	<u>oe</u>			<u>Curren</u>	nt Rate	New	<u>Rate</u>	Effective Date
9	<u>CHD</u>			161	.67	121	.38	07/01/2019
Rate Type								
<u>l</u>	<u>nterim</u>			X	Prospecti			
_		Total Interim			X	Total P	rospective	
-		Settlement Base	d on Cost			Prospe	ctive Adjust	ed For New Costs
		B	ASIS:					
			Budget					
			K Unaudit	ed Cost				
			Desk Re	eviewed Cost				
			Desk Au	udited Cost				
			 Field Au	dited Cost				
DISTRIBUTION	<u>l:</u>					TR		
Fiscal Ager	nt					M		
Contract Ma	anageme	ent				Rydell Samu	el, Administ	rator
Program Fi	nance				-	Medicaid Pro		

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department			Provider Number: 0279757-02			
48 Oak Street			Date: 07/01/2019			
Crawfordville, FL 32327			Fiscal Y	'ear End: 06/30/201	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current	<u>Rate</u>	New Rate	Effective Date	
<u>CHD</u>	-	161.	67	121.38	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interi	m		Х	Total Prospective		
Settlement	Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	W		
Contract Management			Ryc	dell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department			Provider	Number: 0279757-0)3	
48 Oak Street			Date: 07/01/2019 Fiscal Year End: 06/30/2018			
Crawfordville, FL 32327						
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	-	161.	67	121.38	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interi	im		Х	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				
				7		
DISTRIBUTION:				la l		
Fiscal Agent			1	N		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Mee	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department			Provider Number: 0279757-04			
48 Oak Street			Date: 07/01/2019			
Crawfordville, FL 32327			Fiscal Y	'ear End: 06/30/201	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current	<u>Rate</u>	New Rate	Effective Date	
<u>CHD</u>	-	161.	67	121.38	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interi	m		Х	Total Prospective		
Settlement	Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	ey.		
Contract Management			Ryc	dell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department	Prov	vider Number: 0279757-	30
48 Oak Street		Date: 07/01/2019	
Crawfordville, FL 32327	Fis	cal Year End: 06/30/201	18
		Audit Status: Unaudited	d Cost
Provider Type	Current Rate	New Rate	Effective Date
CHD	161.67	121.38	07/01/2019
Rate Type	V Durana		
<u>Interim</u> Total Interim	X Prospect		
Settlement Based on Cost	^	Total Prospective	
Settlement Based on Cost			sted For New Costs
BASIS:			
Budget			
X Unaudite	ed Cost		
Desk Re	viewed Cost		
Desk Au	dited Cost		
Field Aud	dited Cost		
DISTRIBUTION: Fiscal Agent		T	
Contract Management		Rydell Samuel, Adminis	strator
Program Finance		Medicaid Program Fina	

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Depa	artment	Provi	Provider Number: 0279757-91			
48 Oak Street			Date: 07/01/2019			
Crawfordville, FL 32327		Fisc	al Year End: 06/30/201	8		
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>	-	161.67	121.38	07/01/2019		
Rate Type						
Interim		X Prospect				
Tota	al Interim	X	Total Prospective			
Set	ttlement 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			M			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Finar			

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department			Provider Number: 0279757-92			
48 Oak Street			Date: 07/01/2019			
Crawfordville, FL 32327			Fiscal Y	'ear End: 06/30/201	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
<u>CHD</u>	-	161.	67	121.38	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Interi	m		Х	Total Prospective		
Settlement	Based on Cost			Prospective Adjust	ted For New Costs	
				_		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ed Cost				
				-7		
DISTRIBUTION:				the second secon		
Fiscal Agent			1	N		
Contract Management			Ryc	lell Samuel, Adminis	trator	
Program Finance			Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Walton County Health Departmer	nt		Provider Number: 0279765-00 Date: 07/01/2019			
493 North 9th Street						
Defuniak Springs, FL 32433-9401			Fiscal Y	'ear End: 06/30/2018	8	
			Aud	lit Status: Unaudited	Cost	
Provider Type		Current R	ate	New Rate	Effective Date	
<u>CHD</u>	-	169.57		166.57	07/01/2019	
Rate Type						
<u>Interim</u>		X <u>P</u> I	ospective			
Total Int	erim		Х	Total Prospective		
Settleme	ent Based on Cost			Prospective Adjust	ted For New Costs	
	BASIS:					
	Budget	Onet				
	X Unaudited					
	Desk Revie					
	Desk Audit					
	Field Audite	ed Cost				
DISTRIBUTION:			-	R		
Fiscal Agent			1	N		
Contract Management				dell Samuel, Adminis		
Program Finance			Mee	dicaid Program Finar	nce	
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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: 07/01/2019			
Defuniak Springs, FL 32433-9401			Fiscal Y	ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD		169.	57	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inter	im		Х	Total Prospective		
Settlemen	t 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:			-	R		
Fiscal Agent			f	N.		
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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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: 07/01/2019			
Defuniak Springs, FL 32433-9401			Fiscal Y	ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type	<u>C</u>	Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>		169	.57	166.57	07/01/2019	
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 Cos					
	Desk Reviewe	ed Cost				
	Desk Audited	Cost				
	Field Audited 0	Cost				
DISTRIBUTION:			_	R		
Fiscal Agent			ľ	N		
Contract Management			Ryd	lell Samuel, Adminis	trator	
Program Finance				dicaid Program Finar		
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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Depa	rtment	Prov	Provider Number: 0279773-00		
1338 South Boulevard			Date: 07/01/201	: 07/01/2019	
Chipley, FL 32428		Fisc	- Fiscal Year End: 06/30/2018		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	_	145.26	148.83	07/01/2019	
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 Revie	wed Cost			
	Desk Audite	ed Cost			
	Field Audite	ed Cost			
DISTRIBUTION:			TR		
Fiscal Agent			/ N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Washington Cou	unty Hea	Ith Department				Prov	vider Number	: 0279773-	01
1338 South Bou	ulevard					- Date:		: 07/01/2019	
Chipley, FL 324	428					Fiscal Year End: 06/30/2018			8
							Audit Status	: Unaudited	d Cost
<u>Provider Typ</u>	<u>)e</u>				<u>Curren</u>	t Rate	New	<u> Rate</u>	Effective Date
<u>(</u>	<u>CHD</u>				145	.26	14	8.83	07/01/2019
Rate Type									
<u>l</u>	<u>nterim</u>				X	Prospec	<u>tive</u>		
		Total Interim				X	Total F	rospective	
_		Settlement Bas	sed o	n Cost			Prospe	ective Adjus	sted For New Costs
		_	BAS	<u>SIS:</u>					
				Budget					
		-	Х	- Unaudited	Cost				
		-		- Desk Revi	iewed Cost				
		-		- Desk Audi	ited Cost				
		-		- Field Audi	ted Cost				
		-		-					
DISTRIBUTION	<u>l:</u>						TR		
Fiscal Agen	nt						M		
Contract Ma	anageme	ent					Rydell Sam	uel, Adminis	strator
Program Fi	nance						Medicaid Pr		

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Medicaid Reimbursement Rate Change Form for CHDs

Washington Co	ounty Hea	Ith Department				Prov	/ider Number	: 0279773-	-04
1338 South Bo	ulevard					- Date:		: 07/01/2019	
Chipley, FL 32	428					Fiscal Year End: 06/30/2018			18
							Audit Status	: Unaudite	d Cost
Provider Ty	<u>pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				145	.26	14	8.83	07/01/2019
Rate Type									
<u> </u>	<u>Interim</u>				X	Prospec	<u>tive</u>		
_		Total Interim				Х	Total F	rospective	
_		Settlement Bas	sed o	n Cost			Prospe	ective Adjus	sted For New Costs
		ļ	BAS	<u>81S:</u>					
				Budget					
		-	Х	- Unaudited	l Cost				
		-		- Desk Revi	iewed Cost				
		-		- Desk Audi	ited Cost				
		-		- Field Audi	ted Cost				
		-		-					
DISTRIBUTION	<u>N:</u>						TR		
Fiscal Age	nt						M		
Contract M	lanageme	ent					Rydell Samu	uel, Admini	strator
Program F	inance						Medicaid Pr	ogram Fina	ance

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Depart	ment	Prov	vider Number: 0279773-			
1338 South Boulevard			Date: 07/01/201			
Chipley, FL 32428		Fis	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	145.26	148.83	07/01/2019		
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	Cost				
	Desk Revi	ewed Cost				
	Desk Audit	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			(N			
Contract Management			Rydell Samuel, Adminis	strator		
Program Finance			Medicaid Program Fina	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health De	epartment	Prov	ider Number: 0279773-	30	
1338 South Boulevard			Date: 07/01/201	: 07/01/2019	
Chipley, FL 32428		Fisc	al Year End: 06/30/201	8	
			Audit Status: Unaudited	d Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	-	145.26	148.83	07/01/2019	
Rate Type					
<u>Interim</u>		X Prospect	ive		
Total	Interim	Х	Total Prospective		
Settle	ement Based on Cost		Prospective Adjus	sted For New Costs	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audit	ted Cost			
DISTRIBUTION:			TR		
Fiscal Agent			TN .		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Fina	ince	

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Medicaid Reimbursement Rate Change Form for CHDs

Washington Co	ounty Hea	Ith Department				Prov	vider Number	: 0279773-	99
1338 South Bo	ulevard					- Date:		: 07/01/2019	
Chipley, FL 32	428					Fiscal Year End: 06/30/2018			8
							Audit Status	Unaudited	d Cost
Provider Ty	<u>pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				145	.26	14	8.83	07/01/2019
Rate Type									
<u> </u>	<u>Interim</u>				X	Prospec	<u>tive</u>		
_		Total Interim				Х	Total P	rospective	
_		Settlement Bas	sed o	n Cost			Prospe	ective Adjus	ted For New Costs
		<u> </u>	BAS	<u>SIS:</u>					
				Budget					
		-	Х	- Unaudited	l Cost				
		-		- Desk Revi	iewed Cost				
		-		- Desk Audi	ited Cost				
		-		- Field Audi	ted Cost				
		-		-					
DISTRIBUTION	<u>N:</u>						TR		
Fiscal Age	nt						M		
Contract M	lanageme	ent					Rydell Samu	uel, Adminis	strator
Program F	inance						Medicaid Pr		

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Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Department			Provider Number: 0290068-00			
597 West 11th Street				9		
Panama City, FL 32401-2330			Fiscal Year End: 06/30/2018			
			Aud	it Status: Unaudited	Cost	
Provider Type Cu			t Rate	New Rate	Effective Date	
CHD		96.4	43	166.57	07/01/2019	
Rate Type						
Interim		Х	Prospective			
Total Inter	im		X	Total Prospective		
Settlemen	t Based on Cost			Prospective Adjust	ted For New Costs	
	54010					
	BASIS:					
	Budget					
	X Unaudited Cos					
	Desk Reviewe					
	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	
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Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Department		Provider Number: 0290068-96			
597 West 11th Street			Date: 07/01/2019	7/01/2019	
Panama City, FL 32401-2330		Fiscal Year End: 06/30/2018			
		Aud	Cost		
Provider Type	Currer	nt Rate	New Rate	Effective Date	
CHD	96	.43	166.57	07/01/2019	
Rate Type					
Interim	Х	Prospective			
Total Inter	im	— x	Total Prospective		
Settlemen	t Based on Cost		Prospective Adjust	ted For New Costs	
			_		
	BASIS:				
	Budget				
	X Unaudited Cost				
	Desk Reviewed Cos	t			
	Desk Audited Cost				
	Field Audited Cost				
DISTRIBUTION:		-	R		
Fiscal Agent		1	el j		
Contract Management		Ryc	lell Samuel, Adminis	trator	
Program Finance		Med	dicaid Program Finar	nce	
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Medicaid Reimbursement Rate Change Form for CHDs

Lafayette County Health Departme	nt	Prov	ider Number: 0290343-0		
P.O. Box 1806			Date: 07/01/201		
Mayo, FL 32066		Fiso	Fiscal Year End: 06/30/2018		
			Audit Status: Unaudited	Cost	
Provider Type		Current Rate	New Rate	Effective Date	
CHD	_	169.57	131.82	07/01/2019	
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	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 Fina	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Lafayette County	Health Departm	ent		Provide	r Number: 02903	43-91	
P.O. Box 1806				Date:		: 07/01/2019	
Mayo, FL 32066				Fiscal Year End: 06/30/2018			
				Au	dit Status: Unaud	ited Cost	
Provider Type	2		<u>Current</u>	Rate	New Rate	Effective Date	
<u>C</u>	HD		169.5	57	131.82	07/01/2019	
Rate Type			X				
<u>In</u>	t <u>erim</u> Total Int	orim		Prospective X		ive.	
			-	Χ	Total Prospect		
	Settleme	ent Based on Cost	-		Prospective Ad	djusted For New Costs	
		BASIS:					
		Budget					
		X Unaudited	d Cost				
		Desk Rev	viewed Cost				
		Desk Auc	lited Cost				
		Field Aud	lited Cost				
DISTRIBUTION:				-	TR		
Fiscal Agent					M		
Contract Mar	nagement			Ry	dell Samuel, Adm	ninistrator	
Program Fina	ance				dicaid Program F		

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Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health D	epartment		Provider Number: 0290408-00			
801 S.W. Smith Street			- Date:		: 07/01/2019	
Madison, FL 32340			Fisc	al Year End:	06/30/2018	
			/	Audit Status:	Unaudited Cos	st
Provider Type		Curre	nt Rate	New	Rate	Effective Date
CHD		167	7.55	166	.57	07/01/2019
Rate Type						
<u>Interim</u>		Х	Prospecti	ve		
ı	Total Interim		X	Total Pr	ospective	
	Settlement Based or	n Cost		Prospec	tive Adjusted I	For New Costs
	BASI	<u>IS:</u>				
		Budget				
	X	Unaudited Cost				
		Desk Reviewed Cos	st			
		Desk Audited Cost				
		Field Audited Cost				
DISTRIBUTION:				TR		
Fiscal Agent				^N		
Contract Managemer	nt		_	Rydell Samue	el, Administrato	or
Program Finance			Ī	Medicaid Pro	gram 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				Date:	07/01/2019	
Madison, FL 32340			Fiscal Year End: 06/30/2018			
			Aud	dit Status:	Unaudited Cos	st
Provider Type		<u>Current R</u>	ate	New	Rate	Effective Date
<u>CHD</u>	-	167.55	j	166	.57	07/01/2019
Rate Type		× -				
<u>Interim</u>		<u> </u>	rospective		4'	
	al Interim		Х		ospective	
Sett	lement Based on Cost			Prospec —	tive Adjusted I	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	rv		
Contract Management			Ry	dell Samue	el, Administrato	or
Program Finance			Me	dicaid Pro	gram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Department		Provider	Number: 0290408-3	30	
801 S.W. Smith Street			Date: 07/01/2019	9	
Madison, FL 32340		Fiscal Year End: 06/30/2018			
		Aud	t Status: Unaudited	Cost	
Provider Type	Current R	Rate	New Rate	Effective Date	
CHD	167.5	5	166.57	07/01/2019	
Rate Type					
Interim	<u> </u>	rospective			
Total Interim	_	Х	Total Prospective		
Settlement Based on Co	ost		Prospective Adjust	ted For New Costs	
BASIS:					
Bud	lget				
X_Una	audited Cost				
Des	sk Reviewed Cost				
Des	sk Audited Cost				
Fiel	d Audited Cost				
DISTRIBUTION:			R		
Fiscal Agent		ľ	V		
Contract Management		Ryd	ell Samuel, Adminis	trator	
Program Finance			licaid Program Finar		

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Medicaid Reimbursement Rate Change Form for CHDs

Suwannee County Health	Suwannee County Health Department				00	
P. O. Box 6030		<u> </u>		Date: 07/01/201	9	
Live Oak, FL 32060		<u> </u>	Fiscal Year End: 06/30/2020			
			Audi	t Status: Unaudited	Cost	
Provider Type		Curren	t Rate	New Rate	Effective Date	
<u>CHD</u>		165	.18	135.74	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
То	otal Interim		- x	Total Prospective		
Settlement Based on Cost				Prospective Adjus	ted For New Costs	
	BASIS:					
		dget				
		audited Cost				
	De	sk Reviewed Cost				
	De	sk Audited Cost				
	 Fie	eld Audited Cost				
DISTRIBUTION:				R		
Fiscal Agent			ſ	V		
Contract Management			Ryd	ell Samuel, Adminis	strator	
Program Finance			Med	licaid Program Fina	nce	

State Health Office

For Information Only



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Suwannee Co	Suwannee County Health Department					ider Number:	0518328-9	91
P. O. Box 603	80					Date:	07/01/201	9
Live Oak, FL	32060				Fisc	al Year End:	06/30/202	0
						Audit Status:	Unaudited	l Cost
Provider Type Curre			<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>			165	.18	13	5.74	07/01/2019
Rate Type	<u>Interim</u>			Х	Prospect	ive		
	- -	Total Interim			- <u></u>		rospective	
		Settlement Base	d on Cost					ted For New Costs
		B	ASIS:					
			Budget					
		>	K Unaudited	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	lited Cost				
		_	Field Aud	ited Cost				
						F		
Fiscal Ag						1 •		
	Manageme	ent				Rydell Samu		
Program Finance						Medicaid Pro	gram rina	nce

For Information Only (No Change In Rate)



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Holmes County Health Departm	ent	Provi	der Number: 0519022-0	00
P. O. Box 337603 Scenic Circle			Date: 07/01/201	9
Bonifay, FL 32425		Fisc	al Year End: 06/30/201	8
			Audit Status: Unaudited	l Cost
<u>Provider Type</u>		Current Rate	New Rate	Effective Date
CHD		139.58	85.42	07/01/2019
Rate Type		X B (
<u>Interim</u> Total Ir	torim	X Prospecti		
		^	Total Prospective	ted For New Costs
Settien	nent Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	l Cost		
	Desk Revi	iewed Cost		
	Desk Audi	ited Cost		
	Field Audi	ted Cost		
DISTRIBUTION:			TR	
Fiscal Agent			rv,	
Contract Management		_	Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	nce

State Health Office



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	:	Provider Number: 0519022-15				
P. O. Box 337603 Scenic Circle		Date: 07/01/2019				
Bonifay, FL 32425		Fiscal Year End: 06/30/2018				
		Aud	lit Status: Unaudited	Cost		
Provider Type	Curren	t Rate	New Rate	Effective Date		
CHD	139	.58	85.42	07/01/2019		
Rate Type						
<u>Interim</u>	Х	Prospective				
Total Inter	im	- x	Total Prospective			
Settlemer	t Based on Cost		Prospective Adjust	ted For New Costs		
			_			
	BASIS:					
	Budget					
	X Unaudited Cost					
	Desk Reviewed Cost					
	Desk Audited Cost					
	Field Audited Cost					
DISTRIBUTION:		-	R			
Fiscal Agent		1	N			
Contract Management	Rydell Samuel, Administrator					
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

Holmes County Health Departm	ent	Provi	ider Number: 0519022-9	95			
P. O. Box 337603 Scenic Circle			Date: 07/01/201	: 07/01/2019			
Bonifay, FL 32425		Fisc	Fiscal Year End: 06/30/2018				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	_	139.58	85.42	07/01/2019			
Rate Type							
<u>Interim</u>		X Prospect	ive				
Total Ir	nterim	X	Total Prospective				
Settlement Based on Cost			Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	Cost					
	Desk Revie	wed Cost					
	Desk Audite	ed Cost					
	Field Audite	ed Cost					
DISTRIBUTION:			TR				
Fiscal Agent			۲N				
Contract Management			Rydell Samuel, Adminis	strator			
Program Finance		Medicaid Program Final	nce				

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Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Departme	nt	Prov	ider Number: 0519251-0	00	
2572 N. Courtenay Parkway			Date: 07/01/201	: 07/01/2019	
Merritt Island, FL 32953-4147		Fiso	Fiscal Year End: 06/30/2018		
			Audit Status: Unaudited	Cost	
Provider Type	Current Rate	New Rate	Effective Date		
CHD		169.57	162.71	07/01/2019	
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			N N		
Contract Management			Rydell Samuel, Adminis	strator	
Program Finance			Medicaid Program Final	nce	

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Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Brevard Coun	ty Heath Department			Provider Number: 0519251-01			
2572 N. Court	enay Parkway				Date: 07/01/201	9	
Merritt Island,	FL 32953-4147			Fiscal Year End: 06/30/2018			
				Auc	dit Status: Unaudited	Cost	
Provider Ty	<u>/pe</u>		Current F	Rate	New Rate	Effective Date	
	<u>CHD</u>		169.5	7	162.71	07/01/2019	
Rate Type							
	Interim		Х <u></u>	rospective			
	Total Inter	m		Х	Total Prospective		
Settlement Based on Cost		_	Prospective Adjusted For New C				
		BASIS:					
		Budget					
		X Unaudited	l Cost				
		Desk Revi	iewed Cost				
		Desk Audi	ited Cost				
		Field Audi	ted Cost				
DISTRIBUTIO	<u>N:</u>			-	TR		
Fiscal Age	ent			1			
Contract I	Vanagement			Ryo	dell Samuel, Adminis	trator	
Program I	Finance			Me	dicaid 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

Brevard County Heath Department						Prov	vider Number:	0519251-0)4
2572 N. Court	enay Park	way					Date	07/01/201	9
Merritt Island,	FL 32953	3-4147				Fiscal Year End: 06/30/2018			
							Audit Status:	Unaudited	Cost
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date
	<u>CHD</u>				169	.57	162	2.71	07/01/2019
Rate Type									
	<u>Interim</u>				Х	Prospec	<u>tive</u>		
		Total Interim				- x	Total P	rospective	
Settlement Based on Cost				Prospective Adjusted For New					
			BAS	SIS:					
				Budget					
			Х	_ Unaudited	d Cost				
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				_ Desk Aud	ited Cost				
				– Field Audi	ited Cost				
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DISTRIBUTIO	<u>N:</u>						TR		
Fiscal Age	ent						1 N		
Contract N	Contract Management					Rydell Samu	iel, Adminis	strator	
Program F	Finance						Medicaid Pro	ogram Finai	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department					Provide	er Number: (519251-05	
2572 N. Court	enay Parkwa	ıy				Date: 0	07/01/2019	
Merritt Island,	FL 32953-4	147			Fiscal Year End: 06/30/2018			
					Au	udit Status:	Jnaudited Co	st
Provider Ty	<u>vpe</u>			<u>Curren</u>	t Rate	<u>New F</u>	late	Effective Date
	<u>CHD</u>			169	.57	162.	71	07/01/2019
Rate Type								
	Interim			Х	Prospective	<u>e</u>		
	- Te	otal Interim			- x	Total Pro	spective	
Settlement Based on Cost					Prospect	ive Adjusted	For New Costs	
		В	ASIS:					
		—	Budget					
		_	X Unaudite	ed Cost				
		_	 Desk Re	eviewed Cost				
		_	Desk Au	udited Cost				
		_	Field Au	dited Cost				
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DISTRIBUTIO	<u>)N:</u>					TR		
Fiscal Age	ent					74		
Contract I	Management				R	ydell Samue	, Administrate	or
Program I	Finance				Μ	edicaid Prog	ram Finance	

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Departmen	t	Prov	ider Number: 0519251-§	91		
2572 N. Courtenay Parkway			Date: 07/01/201	9		
Merritt Island, FL 32953-4147		Fisc	Fiscal Year End: 06/30/2018			
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	169.57	162.71	07/01/2019		
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				
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	Field Audit	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			/ N			
Contract Management			Rydell Samuel, Adminis			
Program Finance			Medicaid Program Final	nce		

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department						Prov	ider Number	: 0519251-9	92	
2572 N. Court	enay Parkwa	ау				Date: 07/0			7/01/2019	
Merritt Island,	FL 32953-4	147				Fiscal Year End: 06/30/2018				
							Audit Status	: Unaudited	Cost	
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date	
	<u>CHD</u>				169	.57	16	2.71	07/01/2019	
Rate Type										
	Interim				Х	Prospect	<u>ive</u>			
	- т	otal Interim				- x	Total P	rospective		
Settlement Based on Cost				Prospective Adjusted For New Cos						
		ļ	BAS	<u>SIS:</u>						
				Budget						
		-	Х	Unaudited	l Cost					
		-		Desk Revi	iewed Cost					
		-		Desk Audi	ited Cost					
		-		- Field Audi	ted Cost					
		-		-						
DISTRIBUTIO	<u>DN:</u>						TR			
Fiscal Age	ent						$^{\prime}$			
	Managemen	t					Rydell Samu	uel, Adminis	strator	
Program I	Finance						Medicaid Pr	ogram Finai	nce	

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department				Provider Number: 0519251-93		
2572 N. Court	enay Parkway			Date: 07/01/2019 Fiscal Year End: 06/30/2018		
Merritt Island,	FL 32953-4147					
				Aud	dit Status: Unaudited	Cost
Provider Ty	<u>/pe</u>		Current F	Rate	New Rate	Effective Date
	<u>CHD</u>	-	169.57	7	162.71	07/01/2019
Rate Type						
	Interim		х <u>р</u>	rospective		
	Total Interi	m		Х	Total Prospective	
	Settlement	Based on Cost	_		Prospective Adjust	ted For New Costs
		BASIS:				
		Budget				
		X Unaudited	Cost			
		 Desk Revi	ewed Cost			
		Desk Audi	ted Cost			
		Field Audi	ted Cost			
DISTRIBUTIO	<u>N:</u>			-	TR	
Fiscal Age	ent			1		
Contract I	Vanagement			Ry	dell Samuel, Adminis	trator
Program Finance				Medicaid Program Finance		

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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

Palm Beach County Health Department			Provider Number: 0520331-00			
P. O. Box 29			Date: 07/01/2019			
West Palm Beach, FL 33402			Fiscal Y	'ear End: 06/30/2018	8	
			Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date	
CHD	_	169.	57	166.57	07/01/2019	
Rate Type						
<u>Interim</u>		Х	Prospective			
Total Inter	rim		Х	Total Prospective		
Settlemer	nt Based on Cost	-		Prospective Adjust	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			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

Palm Beach County Health Department			Provider Number: 0520331-09		
P. O. Box 29			Date: 07/01/2019		
West Palm Beach, FL 33402			Fiscal Y	'ear End: 06/30/2018	8
			Aud	it Status: Unaudited	Cost
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date
CHD	-	169.	57	166.57	07/01/2019
Rate Type					
<u>Interim</u>		Х	Prospective		
Total Inter	im		Х	Total Prospective	
Settlemen	t Based on Cost	sed on Cost		Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audit	ted Cost			
DISTRIBUTION:			-	R	
Fiscal Agent			ľ	u)	
Contract Management			Ryd	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

Palm Beach County Health Department			Provider Number: 0520331-45		
P. O. Box 29			Date: 07/01/2019		
West Palm Beach, FL 33402			Fiscal Y	ear End: 06/30/2018	8
		Aud	it Status: Unaudited	Cost	
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date
CHD	-	169.	57	166.57	07/01/2019
Rate Type					
Interim		Х	Prospective		
Total In	iterim		Х	Total Prospective	
Settlem	ent Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited				
		ewed Cost			
	Desk Audit				
	Field Audit	ted Cost			
DISTRIBUTION:			-	R	
Fiscal Agent			ľ	V	
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

Palm Beach County Health Depa	artment	Prov	Provider Number: 0520331-50			
P. O. Box 29			Date: 07/01/201)7/01/2019		
West Palm Beach, FL 33402		Fisc				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	169.57	166.57	07/01/2019		
Rate Type						
Interim		X Prospect	ive			
Total Ir	iterim	X	Total Prospective			
Settlem	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			rv,			
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

Palm Beach County Health Department			Provider Number: 0520331-89		
P. O. Box 29			Date: 07/01/2019		
West Palm Beach, FL 33402			Fiscal Y	'ear End: 06/30/2018	8
		Aud	it Status: Unaudited	Cost	
<u>Provider Type</u>		Current	Rate	New Rate	Effective Date
CHD	-	169.	57	166.57	07/01/2019
Rate Type					
Interim		Х	Prospective		
Total Inte	erim		Х	Total Prospective	
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			_	R	
Fiscal Agent			ľ	V	
Contract Management			Ryd	lell Samuel, Adminis	trator
Program Finance				dicaid Program Finar	
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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department			Provider Number: 0520331-95		
P. O. Box 29			Date: 07/01/2019		
West Palm Beach, FL 33402			Fiscal Y	'ear End: 06/30/2018	8
		Aud	it Status: Unaudited	Cost	
<u>Provider Type</u>		Current	t Rate	New Rate	Effective Date
CHD	-	169.	57	166.57	07/01/2019
Rate Type					
Interim		Х	Prospective		
Total Inte	erim		Х	Total Prospective	
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs
				_	
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revie	ewed Cost			
	Desk Audit	ted Cost			
	Field Audit	ed Cost			
DISTRIBUTION:			-	R	
Fiscal Agent			1	V	
Contract Management			Ryc	lell Samuel, Adminis	trator
Program Finance				dicaid Program Finar	
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Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Depa	Prov	Provider Number: 0520446-00				
514 East Grace Street			Date: 07/01/2019			
Punta Gorda, FL 33950		Fisc	Fiscal Year End: 06/30/2018			
		Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date		
CHD		106.17	105.36	07/01/2019		
Rate Type						
<u>Interim</u>		X Prospect	<u>ive</u>			
Total	Interim	X	Total Prospective			
Settle	ement Based on Cost		Prospective Adjusted For New Co			
	BASIS: Budget					
	X Unaudited	l Cost				
		iewed Cost				
	Desk Audi					
	Field Audi					
DISTRIBUTION:			TR			
Fiscal Agent			<u> </u>			
Contract Management			Rydell Samuel, Adminis	trator		
Program Finance			Medicaid Program Finance			

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department			Provider Number: 0520446-09		
514 East Grace Street			Date: 07/01/2019		
Punta Gorda, FL 33950			Fiscal Y	ear End: 06/30/2018	3
			Aud	it Status: Unaudited	Cost
Provider Type		Current R	<u>ate</u>	New Rate	Effective Date
<u>CHD</u>		106.17	,	105.36	07/01/2019
Rate Type					
<u>Interim</u>		Х <u>Р</u>	<u>rospective</u>		
To	otal Interim		Х	Total Prospective	
S	ettlement Based on Cost			Prospective Adjust	ed For New Costs
				-	
	BASIS:				
	Budget				
	X Unaudite	ed Cost			
	Desk Re	viewed Cost			
	Desk Au	dited Cost			
	Field Au	dited Cost			
DISTRIBUTION:			-	R	
Fiscal Agent			ť	N	
Contract Management	t		Ryd	ell Samuel, Administ	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

Charlotte County Health Department			Provider Number: 0520446-91			
514 East Grace Street			Date: 07/01/2019			
Punta Gorda, FL 33950		Fise	cal Year End: 06/30/201	8		
		Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date		
CHD	-	106.17	105.36	07/01/2019		
Rate Type						
<u>Interim</u>		X Prospect	ive			
Total In	terim	X	Total Prospective			
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revie	ewed Cost				
	Desk Audite	ed Cost				
	Field Audite	ed Cost				
DISTRIBUTION:			TR			
Fiscal Agent			M			
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

Hillsborough County Health Dep	Provi	Provider Number: 0557269-00				
1105 E. Kennedy Boulevard			Date: 07/01/2019			
Tampa, FL 33602		Fisc				
			Audit Status: Unaudited	Cost		
Provider Type		Current Rate	New Rate	Effective Date		
CHD		169.57	166.57	07/01/2019		
Rate Type						
Interim		X Prospect	ive			
Total I	nterim	X	Total Prospective			
Settler	nent Based on Cost		Prospective Adjus	ted For New Costs		
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audi	ted Cost				
DISTRIBUTION:			TR			
Fiscal Agent			[N			
Contract Management		_	Rydell Samuel, Adminis	strator		
Program Finance		Medicaid Program Finance				

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0557269-90		
ate: 07/01/2019		
nd: 06/30/2018		
tus: Unaudited Cost		
ew Rate Effective Date		
166.57 07/01/2019		
al Prospective		
spective Adjusted For New Costs		

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County H	ake County Health Department						Provid	der Nu	ımber:	0563234-00	
P. O. Box 1305	5421 Wes	t Main Street							Date:	07/01/2019	
Tavares, FL 32	2778-130	5					Fisca	al Yea	r End:	06/30/2018	
							A	Audit S	Status:	Unaudited C	Cost
Provider Ty	pe				<u>Curre</u>	nt l	<u>Rate</u>		<u>New</u>	<u>Rate</u>	Effective Date
	<u>CHD</u>				169.57			166	5.57	07/01/2019	
Rate Type											
	<u>Interim</u>				X	_ <u>F</u>	Prospectiv				
-		Total Interim				_	Х	Т	otal Pr	ospective	
-		Settlement Bas	sed o	n Cost		_		F	rospe	ctive Adjuste	d For New Costs
			BAS	SIS:							
				Budget							
		-	Х	Unaudited	Cost						
		-		Desk Revi	ewed Cos	st					
		-		- Desk Audi	ted Cost						
		-		- Field Audi	ted Cost						
		-		-							
DISTRIBUTIO	<u>N:</u>							H	Z		
Fiscal Age	ent							M			
Contract Management							F	Rydell	Samu	el, Administra	ator
Program Finance							Ν	Medica	aid Pro	gram Financ	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 Health Department			Provide	r Number: 0563234	-01
P. O. Box 1305421 West Main Street	t			Date: 07/01/20	19
Tavares, FL 32778-1305			Fiscal	Year End: 06/30/20	18
			Au	dit Status: Unaudite	d Cost
Provider Type		Current	Rate	New Rate	Effective Date
CHD	-	169.5	7	166.57	07/01/2019
Rate Type					
<u>Interim</u>		<u> </u>	Prospective		
Total Interin	n	_	Х	Total Prospective)
Settlement	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:			-	R	
Fiscal Agent			3	PV -	
Contract Management			Ry	dell Samuel, Admini	istrator
Program Finance			Me	edicaid Program Fina	ance

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Departr	ment		Provider	Number: 0563234-9	94
P. O. Box 1305421 West Ma	ain Street			Date: 07/01/201	9
Tavares, FL 32778-1305			Fiscal `	/ear End: 06/30/201	8
			Aud	dit Status: Unaudited	l Cost
Provider Type		<u>Current</u>	Rate	New Rate	Effective Date
<u>CHD</u>		169.	57	166.57	07/01/2019
Rate Type					
<u>Interim</u>		X	Prospective		
	tal Interim	-	Х	Total Prospective	
Se	ttlement Based on Cost	-		Prospective Adjus	ted For New Costs
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	 Field Audit	ted Cost			
DISTRIBUTION:			-	TR	
Fiscal Agent			1	rv.	
Contract Management			Rye	dell Samuel, Adminis	strator
Program Finance			Me	dicaid Program Fina	nce

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Co	unty Healtl	h Department				Prov	ider Number	0600181-00)		
1295 West Fa	airfield Driv	e					Date	07/01/2019			
Pensacola, Fl	_ 32501					Fiscal Year End: 06/30/2018					
							Audit Status	Unaudited C	Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>			156.89 1		16	6.57	07/01/2019			
Rate Type											
	<u>Interim</u>				Х	Prospect	ive				
	-	Total Interim				- x	Total P	rospective			
Settlement Based on				on Cost			Prospe	ctive Adjuste	d For New Costs		
			BAS	SIS:							
				Budget							
			X	_ Unaudited	Cost						
				_ Desk Rev	iewed Cost						
				_ Desk Aud	ited Cost						
				– Field Audi	ted Cost						
				_							
DISTRIBUTIO							TR				
Fiscal Ag							1				
Contract Management								uel, Administr			
Program	Finance						Medicaid Pr	ogram Financ	ce		

State Health Office



Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department						Prov	vider Number:	0600181-0	01		
1295 West Fai	irfield Driv	'e					Date:	07/01/201	9		
Pensacola, FL	. 32501					Fis	cal Year End:	06/30/201	8		
						Audit Status: Unaudited Cost					
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				156	.89	160	6.57	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospect	tive				
	•	Total Interim				- x	Total P	rospective			
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjus	ted For New Costs		
			BAS	SIS:							
				Budget							
			Х	- Unaudited	l Cost						
				- Desk Revi	iewed Cost						
				Desk Audi	ited Cost						
				Field Audi	ted Cost						
				-							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						M				
Contract Management							Rydell Samu	iel, Adminis	strator		
Program Finance							Medicaid Pro	ogram Fina	nce		

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(No Change In Rate)



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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						/ider Number	: 0600181-	03		
1295 West Fa	irfield Driv	e					Date	07/01/201	19		
Pensacola, FL	32501					Fis	cal Year End	: 06/30/201	18		
						Audit Status: Unaudited Cost					
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date		
	<u>CHD</u>				156	.89	16	6.57	07/01/2019		
Rate Type											
	Interim				Х	Prospec	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	sed c	on Cost			Prospe	ective Adjus	sted For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>)N:</u>						TR				
Fiscal Age	ent						M				
Contract Management							Rydell Samu	uel, Admini	strator		
Program Finance							Medicaid Pr	ogram Fina	ance		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						Provider Number: 0600181-04				
1295 West Fa	irfield Driv	e					Date	07/01/201	9		
Pensacola, FL	. 32501					Fis	cal Year End	06/30/201	8		
						Audit Status: Unaudited Cost					
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				156	.89	16	6.57	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospec	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	sed o	on Cost			Prospe	ctive Adjus	ted For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						M				
Contract Management							Rydell Samu	uel, Adminis	strator		
Program Finance							Medicaid Pro	ogram Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						/ider Number	: 0600181	-05		
1295 West Fa	irfield Driv	e					Date	: 07/01/20	19		
Pensacola, FL	. 32501					Fis	cal Year End	: 06/30/20	18		
						Audit Status: Unaudited Cost					
Provider Ty	<u>/pe</u>				<u>Curren</u>	it Rate	New	<u> Rate</u>	Effective Date		
	<u>CHD</u>				156	.89	16	6.57	07/01/2019		
Rate Type											
	Interim				X	- Prospec					
		Total Interim				X		rospective			
		Settlement Bas	ed o	n Cost			Prospe	ective Adju	sted For New Costs		
		<u>E</u>	BAS	<u>81S:</u>							
				Budget							
		-	Х	- Unaudited	l Cost						
		-		- Desk Revi	iewed Cost						
		-		- Desk Audi	ited Cost						
		_		- Field Audi	ted Cost						
		-		-							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						M				
Contract Management							Rydell Sam	uel, Admini	istrator		
Program Finance							Medicaid Pr	ogram Fina	ance		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						/ider Number	: 0600181-	07		
1295 West Fa	irfield Driv	e					Date	: 07/01/201	9		
Pensacola, FL	32501					Fis	cal Year End	: 06/30/201	8		
						Audit Status: Unaudited Cost					
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	New	<u> Rate</u>	Effective Date		
	<u>CHD</u>				156	.89	16	6.57	07/01/2019		
Rate Type											
	Interim				Х	Prospec	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	sed o	on Cost			Prospe	ective Adjus	sted For New Costs		
			BAS	SIS:							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>)N:</u>						TR				
Fiscal Age	ent						M				
Contract Management							Rydell Samu	uel, Adminis	strator		
Program Finance							Medicaid Pr	ogram Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						/ider Number	: 0600181-	·09		
1295 West Fa	irfield Driv	e					Date	07/01/202	19		
Pensacola, FL	. 32501					Fis	cal Year End	06/30/202	18		
						Audit Status: Unaudited Cost					
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	<u>v Rate</u>	Effective Date		
	<u>CHD</u>				156	.89	16	6.57	07/01/2019		
Rate Type											
	Interim				Х	Prospec	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	sed o	on Cost			Prospe	ective Adjus	sted For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						M				
Contract Management							Rydell Samu	uel, Admini	strator		
Program Finance							Medicaid Pr	ogram Fina	ance		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						Provider Number: 0600181-16				
1295 West Fa	irfield Driv	e					Date:	07/01/2019)		
Pensacola, FL	32501					Fis	cal Year End:	06/30/2018	3		
							Audit Status:	Unaudited	Cost		
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				156	.89	160	6.57	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospec	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjust	ed For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				-							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						γv				
Contract N	Managem	ent					Rydell Samu	iel, Administ	rator		
Program Finance							Medicaid Pro	ogram Finan	ice		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department						Prov	vider Number:	0600181-	20		
1295 West Fai	irfield Driv	e					Date:	07/01/201	9		
Pensacola, FL	32501					Fis	cal Year End:	06/30/201	8		
						Audit Status: Unaudited Cost					
Provider Ty	<u>vpe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
	<u>CHD</u>				156	.89	160	6.57	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospect	tive				
		Total Interim				- x	Total P	rospective			
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	sted For New Costs		
			BAS	SIS:							
				Budget							
			Х	- Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				_							
<u>DISTRIBUTIO</u>	<u>N:</u>						TR				
Fiscal Age	ent						M				
Contract Management							Rydell Samu	iel, Adminis	strator		
Program Finance							Medicaid Pro	ogram Fina	ince		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						Provider Number: 0600181-25				
1295 West Fa	irfield Driv	e					Date	07/01/2019			
Pensacola, FL	32501					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited (Cost		
Provider Ty	<u>ype</u>				Curren	t Rate	New	Rate	Effective Date		
CHD					156	.89	160	6.57	07/01/2019		
Rate Type	la é a nima				v	Ducouse	41				
	Interim	Total Interim			X	_ <u>Prospec</u> X		rospective			
		- Settlement Ba		n Cost		X		•	ed For New Costs		
			iseu c	in Cost			F105pe		eu foi mew Cosis		
			BAS	<u>SIS:</u>							
				Budget							
			Х	- Unaudited	l Cost						
				Desk Revi	iewed Cost						
				Desk Audi	ited Cost						
				Field Audi	ted Cost						
				-							
DISTRIBUTIC	<u>)N:</u>						TR				
Fiscal Age	ent						M				
Contract I	Managem	ent					Rydell Samu	iel, Administi	rator		
Program Finance							Medicaid Pro	ogram Finan	ce		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						Provider Number: 0600181-26				
1295 West Fa	irfield Driv	e					Date	07/01/201	19		
Pensacola, FL	32501					Fiscal Year End: 06/30/2018					
							Audit Status	: Unaudited	d Cost		
Provider Type Curr			<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date				
	<u>CHD</u>				156	.89	16	6.57	07/01/2019		
Rate Type											
	Interim				Х	Prospec	<u>tive</u>				
	-	Total Interim				- x	Total P	rospective			
		Settlement Ba	sed c	on Cost			Prospe	ective Adjus	sted For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTIC	<u>)N:</u>						TR				
Fiscal Age	ent						M				
Contract I	Managem	ent					Rydell Samu	uel, Admini	strator		
Program Finance							Medicaid Pr	ogram Fina	ance		

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						Provider Number: 0600181-29				
1295 West Fai	irfield Driv	e				Date: 07/01/2019					
Pensacola, FL	. 32501					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited	Cost		
Provider Type Cur			<u>Curren</u>	t Rate	New	Rate	Effective Date				
CHD					156	.89	160	6.57	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospect	<u>tive</u>				
	•	Total Interim				- x	Total P	rospective			
		Settlement Ba	ased c	on Cost			Prospe	ctive Adjus	ted For New Costs		
			BAS	SIS:							
				Budget							
			Х	- Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				-							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						M				
Contract N	Managemo	ent					Rydell Samu	iel, Adminis	strator		
Program Finance						Medicaid Program Finance					

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Office of Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						Provider Number: 0600181-31				
1295 West Fai	irfield Driv	e					Date:	07/01/201	7/01/2019		
Pensacola, FL	32501					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited	Cost		
Provider Type Cu			<u>Curren</u>	t Rate	New	Rate	Effective Date				
CHD					156	.89	160	6.57	07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospect	<u>tive</u>				
		Total Interim				- x	Total P	rospective			
		_ Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				-							
<u>DISTRIBUTIO</u>	<u>N:</u>						TR				
Fiscal Age	ent						M				
Contract N	/lanagem	ent					Rydell Samu	iel, Adminis	strator		
Program Finance						Medicaid Program Finance					

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	inty Healtl	h Department				Provider Number: 0600181-32				
1295 West Fai	irfield Driv	e					9			
Pensacola, FL	. 32501					Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited	Cost	
Provider Type Cur			<u>Curren</u>	t Rate	New	Rate	Effective Date			
CHD					156	.89	160	6.57	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospect	tive			
	•	Total Interim				- x	Total P	rospective		
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjus	ted For New Costs	
			BAS	SIS:						
				Budget						
			Х	- Unaudited	l Cost					
				- Desk Revi	iewed Cost					
				- Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
DISTRIBUTIO	<u>N:</u>						TR			
Fiscal Age	ent						M			
Contract N	Managem	ent					Rydell Samu	iel, Adminis	strator	
Program Finance						Medicaid Program Finance				

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						Provider Number: 0600181-33				
1295 West Fa	irfield Driv	e					Date	19			
Pensacola, FL	32501					Fiscal Year End: 06/30/2018					
							Audit Status	: Unaudited	d Cost		
Provider Type Curr			<u>Curren</u>	t Rate	New	<u>v Rate</u>	Effective Date				
	<u>CHD</u>				156	.89	16	6.57	07/01/2019		
Rate Type											
	Interim				X	Prospec	<u>tive</u>				
		Total Interim				X	Total P	rospective			
		Settlement Ba	ised c	on Cost			Prospe	ective Adjus	sted For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				_							
DISTRIBUTIC	<u>)N:</u>						TR				
Fiscal Age	ent						M				
Contract I	Managem	ent					Rydell Samu	uel, Admini	strator		
Program Finance						Medicaid Program Finance					

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia Cou	Escambia County Health Department						Provider Number: 0600181-91				
1295 West Fa	irfield Driv	'e					Date:	: 07/01/2019			
Pensacola, FL	32501					Fiscal Year End: 06/30/2018					
							Audit Status:	Unaudited	Cost		
Provider Ty	<u>/pe</u>				<u>Curren</u>	t Rate	New	Rate	Effective Date		
CHD					156	.89	166.57		07/01/2019		
Rate Type											
	<u>Interim</u>				Х	Prospec	<u>tive</u>				
	•	Total Interim				- x	Total P	rospective			
		Settlement Ba	ised c	on Cost			Prospe	ctive Adjuste	ed For New Costs		
			BAS	<u>SIS:</u>							
				Budget							
			Х	_ Unaudited	l Cost						
				_ Desk Revi	iewed Cost						
				_ Desk Audi	ited Cost						
				- Field Audi	ted Cost						
				-							
DISTRIBUTIO	<u>N:</u>						TR				
Fiscal Age	ent						γv				
Contract N	Managemo	ent					Rydell Samu	iel, Administ	rator		
Program Finance						Medicaid Program Finance					

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department						Provider Number: 0600181-92				
1295 West Fai	irfield Driv	e					9			
Pensacola, FL	32501					Fiscal Year End: 06/30/2018				
							Audit Status:	Unaudited	Cost	
Provider Type Cu			<u>Curren</u>	t Rate	New	Rate	Effective Date			
CHD					156	.89	16	6.57	07/01/2019	
Rate Type										
	<u>Interim</u>				Х	Prospect	<u>tive</u>			
		Total Interim				- x	Total P	rospective		
		Settlement Ba	ased o	on Cost			Prospe	ctive Adjus	ted For New Costs	
			BAS	<u>SIS:</u>						
				Budget						
			Х	_ Unaudited	l Cost					
				_ Desk Revi	iewed Cost					
				_ Desk Audi	ited Cost					
				- Field Audi	ted Cost					
				-						
<u>DISTRIBUTIO</u>	<u>N:</u>						TR			
Fiscal Age	ent						M			
Contract N	/lanagem	ent					Rydell Samu	iel, Adminis	strator	
Program Finance						Medicaid Program Finance				

For Information Only
(No Change In Rate)