Florida Agency For Health Care Admininstration

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Alachua County Health Department
224 SE 24th Street730 N.E. Waldo Road, Suite 500
Gainesville, FL 32641

Provider Number: 0279111-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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State Health Office

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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

Alachua County Health Department
224 SE 24th Street730 N.E. Waldo Road, Suite 500
Gainesville, FL 32641

Provider Number: 0279111-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Alachua County Health Department
224 SE 24th Street730 N.E. Waldo Road, Suite 500
Gainesville, FL 32641

Provider Number: 0279111-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Florida Agency For Health Care Admininstration

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Baker County Health Department
480 West Lowder Street
Macclenny, FL 32063

Provider Number: 0279129-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	145.12	163.76	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Baker County Health Department
480 West Lowder Street
Macclenny, FL 32063

Provider Number: 0279129-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	145.12	163.76	07/01/2020

Rate Type

	Interim	X	**Prospective**
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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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

Baker County Health Department
480 West Lowder Street
Macclenny, FL 32063

Provider Number: 0279129-11
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	145.12	163.76	07/01/2020

Rate Type

	Interim	X	**Prospective**
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Florida Agency For Health Care Admininstration

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Department
1801 North Temple Avenue
Starke, FL 32091

Provider Number: 0279145-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Department
1801 North Temple Avenue
Starke, FL 32091

Provider Number: 0279145-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Department
1801 North Temple Avenue
Starke, FL 32091

Provider Number: 0279145-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Bradford County Health Department
1801 North Temple Avenue
Starke, FL 32091

Provider Number: 0279145-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Department
780 SW 24th Street
Fort Lauderdale, FL 33315

Provider Number: 0279161-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	128.07	96.69	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Department
780 SW 24th Street
Fort Lauderdale, FL 33315

Provider Number: 0279161-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	128.07	96.69	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Department
780 SW 24th Street
Fort Lauderdale, FL 33315

Provider Number: 0279161-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	128.07	96.69	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

Broward County Health Department
780 SW 24th Street
Fort Lauderdale, FL 33315

Provider Number: 0279161-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	128.07	96.69	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Calhoun County Health Department
19611 S.R. 20 West
Blountstown, FL 32424

Provider Number: 0279170-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	120.36	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun County Health Department
19611 S.R. 20 West
Blountstown, FL 32424

Provider Number: 0279170-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	120.36	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Calhoun County Health Department
19611 S.R. 20 West
Blountstown, FL 32424

Provider Number: 0279170-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	120.36	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department
3700 Sovereign Path
Lecanto, FL 34461-8071

Provider Number: 0279196-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department
3700 Sovereign Path
Lecanto, FL 34461-8071

Provider Number: 0279196-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department
3700 Sovereign Path
Lecanto, FL 34461-8071

Provider Number: 0279196-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Citrus County Health Department
3700 Sovereign Path
Lecanto, FL 34461-8071

Provider Number: 0279196-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department
P.O. Box 578
Green Cove Springs, FL 32043

Provider Number: 0279200-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Florida Agency For Health Care Admininstration

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department
P.O. Box 578
Green Cove Springs, FL 32043

Provider Number: 0279200-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

Fiscal Agent
Contract Management
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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department
P.O. Box 578
Green Cove Springs, FL 32043

Provider Number: 0279200-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department
P.O. Box 578
Green Cove Springs, FL 32043

Provider Number: 0279200-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department
P.O. Box 578
Green Cove Springs, FL 32043

Provider Number: 0279200-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department
P.O. Box 578
Green Cove Springs, FL 32043

Provider Number: 0279200-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department
P.O. Box 578
Green Cove Springs, FL 32043

Provider Number: 0279200-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Clay County Health Department
P.O. Box 578
Green Cove Springs, FL 32043

Provider Number: 0279200-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department
P.O. Box 429
Naples, FL 34106-0429

Provider Number: 0279218-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department
P.O. Box 429
Naples, FL 34106-0429

Provider Number: 0279218-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department
P.O. Box 429
Naples, FL 34106-0429

Provider Number: 0279218-11
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department
P.O. Box 429
Naples, FL 34106-0429

Provider Number: 0279218-15
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department
P.O. Box 429
Naples, FL 34106-0429

Provider Number: 0279218-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Collier County Health Department
P.O. Box 429
Naples, FL 34106-0429

Provider Number: 0279218-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Department
217 North East Franklin Street
Lake City, FL 32055

Provider Number: 0279226-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Department
217 North East Franklin Street
Lake City, FL 32055

Provider Number: 0279226-09
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Department
217 North East Franklin Street
Lake City, FL 32055

Provider Number: 0279226-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Columbia County Health Department
217 North East Franklin Street
Lake City, FL 32055

Provider Number: 0279226-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Department
1350 N.W. 14th Street
Miami, FL 33125

Provider Number: 0279234-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Department
1350 N.W. 14th Street
Miami, FL 33125

Provider Number: 0279234-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Dade County Health Department
1350 N.W. 14th Street
Miami, FL 33125

Provider Number: 0279234-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department
34 South Baldwin Avenue
Arcadia, FL 33821

Provider Number: 0279242-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.66	122.60	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department
34 South Baldwin Avenue
Arcadia, FL 33821

Provider Number: 0279242-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.66	122.60	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department
34 South Baldwin Avenue
Arcadia, FL 33821

Provider Number: 0279242-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.66	122.60	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department
34 South Baldwin Avenue
Arcadia, FL 33821

Provider Number: 0279242-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.66	122.60	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department
34 South Baldwin Avenue
Arcadia, FL 33821

Provider Number: 0279242-11
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.66	122.60	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department
34 South Baldwin Avenue
Arcadia, FL 33821

Provider Number: 0279242-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.66	122.60	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

DeSoto County Health Department
34 South Baldwin Avenue
Arcadia, FL 33821

Provider Number: 0279242-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.66	122.60	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Dixie County Health Department
149 NE 241ST
Cross City, FL 32628

Provider Number: 0279251-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	124.87	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Dixie County Health Department
149 NE 241ST
Cross City, FL 32628

Provider Number: 0279251-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	124.87	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-11
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-43
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-45
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-46
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-52
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-53
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-89
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-95
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-96
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-97
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Provider Number: 0279269-98
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-06
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-07
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-08
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-09
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

Provider Number: 0279285-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	152.32	144.31	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Department
139 12th Street
Apalachicola, FL 32320

Provider Number: 0279293-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Franklin County Health Department
139 12th Street
Apalachicola, FL 32320

Provider Number: 0279293-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Franklin County Health Department
139 12th Street
Apalachicola, FL 32320

Provider Number: 0279293-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Franklin County Health Department
139 12th Street
Apalachicola, FL 32320

Provider Number: 0279293-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Franklin County Health Department
139 12th Street
Apalachicola, FL 32320

Provider Number: 0279293-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department
P. O. Box 1000
Quincy, FL 32353-1000

Provider Number: 0279307-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	105.88	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department
P. O. Box 1000
Quincy, FL 32353-1000

Provider Number: 0279307-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	105.88	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department
P. O. Box 1000
Quincy, FL 32353-1000

Provider Number: 0279307-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	105.88	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department
P. O. Box 1000
Quincy, FL 32353-1000

Provider Number: 0279307-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	105.88	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department
P. O. Box 1000
Quincy, FL 32353-1000

Provider Number: 0279307-12
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	105.88	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gadsden County Health Department
P. O. Box 1000
Quincy, FL 32353-1000

Provider Number: 0279307-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	105.88	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Department
119 N.E. First Street
Trenton, FL 32693-3459

Provider Number: 0279315-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Gilchrist County Health Department
119 N.E. First Street
Trenton, FL 32693-3459

Provider Number: 0279315-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Department
P. O. Box 489
Moore Haven, FL 33471

Provider Number: 0279323-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Department
P. O. Box 489
Moore Haven, FL 33471

Provider Number: 0279323-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Glades County Health Department
P. O. Box 489
Moore Haven, FL 33471

Provider Number: 0279323-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-07
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-11
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-19
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-21
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

Provider Number: 0279331-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department
P. O. Box 267
Jasper, FL 32052

Provider Number: 0279340-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	165.29	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department
P. O. Box 267
Jasper, FL 32052

Provider Number: 0279340-25
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	165.29	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department
P. O. Box 267
Jasper, FL 32052

Provider Number: 0279340-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	165.29	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department
P. O. Box 267
Jasper, FL 32052

Provider Number: 0279340-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	165.29	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Department
115 K.D. Revell Road
Wauchula, FL 33873

Provider Number: 0279358-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Department
115 K.D. Revell Road
Wauchula, FL 33873

Provider Number: 0279358-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Department
115 K.D. Revell Road
Wauchula, FL 33873

Provider Number: 0279358-09
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hardee County Health Department
115 K.D. Revell Road
Wauchula, FL 33873

Provider Number: 0279358-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Department
P. O. Box 70
LaBelle, FL 33975

Provider Number: 0279366-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Department
P. O. Box 70
LaBelle, FL 33975

Provider Number: 0279366-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Department
P. O. Box 70
LaBelle, FL 33975

Provider Number: 0279366-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Health Department
300 S. Main St.
Brooksville, FL 34601

Provider Number: 0279374-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	139.95	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Health Department
300 S. Main St.
Brooksville, FL 34601

Provider Number: 0279374-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	139.95	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Hernando County Health Department
300 S. Main St.
Brooksville, FL 34601

Provider Number: 0279374-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	139.95	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Highlands County Health Department
7205 South George Boulevard
Sebring, FL 33872

Provider Number: 0279382-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	127.71	135.85	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Highlands County Health Department
7205 South George Boulevard
Sebring, FL 33872

Provider Number: 0279382-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	127.71	135.85	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

Provider Number: 0279412-96
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.06	147.15	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-13
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-14
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Provider Number: 0279421-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Department
1255 W. Washington Street
Monticello, FL 32344

Provider Number: 0279439-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	160.57	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Department
1255 W. Washington Street
Monticello, FL 32344

Provider Number: 0279439-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	160.57	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Jefferson County Health Department
1255 W. Washington Street
Monticello, FL 32344

Provider Number: 0279439-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	160.57	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

Lee County Health Department
3920 Michigan Avenue
Fort Myers, FL 33916

Provider Number: 0279463-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Lee County Health Department
3920 Michigan Avenue
Fort Myers, FL 33916

Provider Number: 0279463-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Lee County Health Department
3920 Michigan Avenue
Fort Myers, FL 33916

Provider Number: 0279463-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Department
2965 Municipal Way
Tallahassee, FL 32304

Provider Number: 0279471-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	159.06	118.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Department
2965 Municipal Way
Tallahassee, FL 32304

Provider Number: 0279471-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	159.06	118.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Levy County Health Department
P. O. Box 4066 South Main Street
Bronson, FL 32621

Provider Number: 0279480-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Levy County Health Department
P. O. Box 4066 South Main Street
Bronson, FL 32621

Provider Number: 0279480-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department
P. O. Box 489247 N. Central Street
Bristol, FL 32321

Provider Number: 0279498-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	144.88	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department
P. O. Box 489247 N. Central Street
Bristol, FL 32321

Provider Number: 0279498-08
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	144.88	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department
P. O. Box 489247 N. Central Street
Bristol, FL 32321

Provider Number: 0279498-10
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	144.88	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department
P. O. Box 489247 N. Central Street
Bristol, FL 32321

Provider Number: 0279498-14
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	144.88	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Liberty County Health Department
P. O. Box 489247 N. Central Street
Bristol, FL 32321

Provider Number: 0279498-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	144.88	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Liberty County Health Department
P. O. Box 489247 N. Central Street
Bristol, FL 32321

Provider Number: 0279498-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	144.88	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County Health Department
410 Six Avenue East
Bradenton, FL 34208

Provider Number: 0279510-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	117.92	95.90	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County Health Department
410 Six Avenue East
Bradenton, FL 34208

Provider Number: 0279510-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	117.92	95.90	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County Health Department
410 Six Avenue East
Bradenton, FL 34208

Provider Number: 0279510-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	117.92	95.90	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Manatee County Health Department
410 Six Avenue East
Bradenton, FL 34208

Provider Number: 0279510-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	117.92	95.90	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd AvenueP. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd AvenueP. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd AvenueP. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd AvenueP. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd AvenueP. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd AvenueP. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-12
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd AvenueP. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd AvenueP. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Department
3441 SE Willoughby Blvd.
Stuart, FL 34994-5060

Provider Number: 0279536-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.19	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Department
3441 SE Willoughby Blvd.
Stuart, FL 34994-5060

Provider Number: 0279536-11
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.19	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Department
3441 SE Willoughby Blvd.
Stuart, FL 34994-5060

Provider Number: 0279536-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.19	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-08
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-13
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department
P. O. Box 517
Fernandina Beach, FL 32035-0517

Provider Number: 0279552-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	125.84	97.95	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department
P. O. Box 517
Fernandina Beach, FL 32035-0517

Provider Number: 0279552-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	125.84	97.95	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department
P. O. Box 517
Fernandina Beach, FL 32035-0517

Provider Number: 0279552-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	125.84	97.95	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Nassau County Health Department
P. O. Box 517
Fernandina Beach, FL 32035-0517

Provider Number: 0279552-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	125.84	97.95	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department
P. O. Box 517
Fernandina Beach, FL 32035-0517

Provider Number: 0279552-95
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	125.84	97.95	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health Department
221 Hospital Drive, N.E.
Ft. Walton Beach, FL 32548

Provider Number: 0279561-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	158.26	165.33	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Okaloosa County Health Department
221 Hospital Drive, N.E.
Ft. Walton Beach, FL 32548

Provider Number: 0279561-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	158.26	165.33	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department
P.O. Box 18791728 N.W. 9th Avenue
Okeechobee , FL 34973-1879

Provider Number: 0279579-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	131.18	154.03	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department
P.O. Box 18791728 N.W. 9th Avenue
Okeechobee , FL 34973-1879

Provider Number: 0279579-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	131.18	154.03	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department
P.O. Box 18791728 N.W. 9th Avenue
Okeechobee , FL 34973-1879

Provider Number: 0279579-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	131.18	154.03	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department
P.O. Box 18791728 N.W. 9th Avenue
Okeechobee , FL 34973-1879

Provider Number: 0279579-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	131.18	154.03	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department
P.O. Box 18791728 N.W. 9th Avenue
Okeechobee , FL 34973-1879

Provider Number: 0279579-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	131.18	154.03	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department
P.O. Box 18791728 N.W. 9th Avenue
Okeechobee , FL 34973-1879

Provider Number: 0279579-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	131.18	154.03	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Orange County Health Department
6101 Lake Ellenor Drive
Orlando, FL 32804

Provider Number: 0279587-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Orange County Health Department
6101 Lake Ellenor Drive
Orlando, FL 32804

Provider Number: 0279587-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Department
P. O. Box 4503091875 Boggy Creek Road
Kissimmee, FL 34745-0309

Provider Number: 0279595-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Department
P. O. Box 4503091875 Boggy Creek Road
Kissimmee, FL 34745-0309

Provider Number: 0279595-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Department
P. O. Box 4503091875 Boggy Creek Road
Kissimmee, FL 34745-0309

Provider Number: 0279595-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Department
P. O. Box 4503091875 Boggy Creek Road
Kissimmee, FL 34745-0309

Provider Number: 0279595-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department
10841 Little Road
New Port Richey, FL 34654

Provider Number: 0279617-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department
10841 Little Road
New Port Richey, FL 34654

Provider Number: 0279617-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department
10841 Little Road
New Port Richey, FL 34654

Provider Number: 0279617-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Pasco County Health Department
10841 Little Road
New Port Richey, FL 34654

Provider Number: 0279617-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County Health Department
500 7th Avenue South
St. Petersburg, FL 33701

Provider Number: 0279625-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County Health Department
500 7th Avenue South
St. Petersburg, FL 33701

Provider Number: 0279625-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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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

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-90
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-95
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL 32177

Provider Number: 0279641-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL 32177

Provider Number: 0279641-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL 32177

Provider Number: 0279641-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL 32177

Provider Number: 0279641-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL 32177

Provider Number: 0279641-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County Health Department
1955 US 1 South
St. Augustine, FL 32086

Provider Number: 0279650-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County Health Department
1955 US 1 South
St. Augustine, FL 32086

Provider Number: 0279650-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-11
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-12
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	150.91	147.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	150.91	147.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	150.91	147.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	150.91	147.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	150.91	147.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	150.91	147.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	150.91	147.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
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Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	150.91	147.82	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Department
P. O. Box 2658
Sarasota, FL 34230-2658

Provider Number: 0279684-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.19	161.01	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Department
P. O. Box 2658
Sarasota, FL 34230-2658

Provider Number: 0279684-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.19	161.01	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

Fiscal Agent
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Program Finance
State Health Office

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2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Department
P. O. Box 2658
Sarasota, FL 34230-2658

Provider Number: 0279684-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.19	161.01	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Department
P. O. Box 2658
Sarasota, FL 34230-2658

Provider Number: 0279684-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.19	161.01	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Department
400 West Airport Boulevard
Sanford, FL 32773

Provider Number: 0279692-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Department
400 West Airport Boulevard
Sanford, FL 32773

Provider Number: 0279692-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Department
400 West Airport Boulevard
Sanford, FL 32773

Provider Number: 0279692-90
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health Department
P. O. Box 98
Bushnell, FL 33513

Provider Number: 0279706-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	141.52	143.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health Department
P. O. Box 98
Bushnell, FL 33513

Provider Number: 0279706-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	141.52	143.23	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health Department
P. O. Box 98
Bushnell, FL 33513

Provider Number: 0279706-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	141.52	143.23	07/01/2020

Rate Type

	Interim	X	**Prospective**
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department
1215 Peacock Street
Perry, FL 32347

Provider Number: 0279722-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	106.81	93.41	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

	Budget
X	Unaudited Cost
	Desk Reviewed Cost
	Desk Audited Cost
	Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department
1215 Peacock Street
Perry, FL 32347

Provider Number: 0279722-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	106.81	93.41	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department
1215 Peacock Street
Perry, FL 32347

Provider Number: 0279722-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	106.81	93.41	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department
495 East Main Street
Lake Butler, FL 32054

Provider Number: 0279731-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department
495 East Main Street
Lake Butler, FL 32054

Provider Number: 0279731-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department
495 East Main Street
Lake Butler, FL 32054

Provider Number: 0279731-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department
495 East Main Street
Lake Butler, FL 32054

Provider Number: 0279731-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department
495 East Main Street
Lake Butler, FL 32054

Provider Number: 0279731-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department
495 East Main Street
Lake Butler, FL 32054

Provider Number: 0279731-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department
P. O. Box 9190
Daytona Beach, FL 32120

Provider Number: 0279749-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.76	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department
P. O. Box 9190
Daytona Beach, FL 32120

Provider Number: 0279749-15
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.76	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department
P. O. Box 9190
Daytona Beach, FL 32120

Provider Number: 0279749-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.76	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department
P. O. Box 9190
Daytona Beach, FL 32120

Provider Number: 0279749-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.76	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department
P. O. Box 9190
Daytona Beach, FL 32120

Provider Number: 0279749-97
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	159.76	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	121.38	117.51	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	121.38	117.51	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	121.38	117.51	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	121.38	117.51	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	121.38	117.51	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	121.38	117.51	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	121.38	117.51	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	121.38	117.51	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.83	162.38	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.83	162.38	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.83	162.38	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-12
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.83	162.38	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.83	162.38	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-99
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	148.83	162.38	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Department
597 West 11th Street
Panama City, FL 32401-2330

Provider Number: 0290068-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Department
597 West 11th Street
Panama City, FL 32401-2330

Provider Number: 0290068-96
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Lafayette County Health Department
P.O. Box 1806
Mayo, FL 32066

Provider Number: 0290343-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	131.82	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Lafayette County Health Department
P.O. Box 1806
Mayo, FL 32066

Provider Number: 0290343-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	131.82	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Department
801 S.W. Smith Street
Madison, FL 32340

Provider Number: 0290408-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Department
801 S.W. Smith Street
Madison, FL 32340

Provider Number: 0290408-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Department
801 S.W. Smith Street
Madison, FL 32340

Provider Number: 0290408-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Suwannee County Health Department
P. O. Box 6030
Live Oak, FL 32060

Provider Number: 0518328-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.74	151.22	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Suwannee County Health Department
P. O. Box 6030
Live Oak, FL 32060

Provider Number: 0518328-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	135.74	151.22	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Holmes County Health Department
P. O. Box 337603 Scenic Circle
Bonifay, FL 32425

Provider Number: 0519022-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	85.42	126.89	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Holmes County Health Department
P. O. Box 337603 Scenic Circle
Bonifay, FL 32425

Provider Number: 0519022-15
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	85.42	126.89	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Holmes County Health Department
P. O. Box 337603 Scenic Circle
Bonifay, FL 32425

Provider Number: 0519022-95
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	85.42	126.89	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.71	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.71	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.71	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.71	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.71	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.71	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	162.71	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402

Provider Number: 0520331-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402

Provider Number: 0520331-09
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402

Provider Number: 0520331-45
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402

Provider Number: 0520331-50
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402

Provider Number: 0520331-89
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402

Provider Number: 0520331-95
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department
514 East Grace Street
Punta Gorda, FL 33950

Provider Number: 0520446-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	105.36	98.93	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department
514 East Grace Street
Punta Gorda, FL 33950

Provider Number: 0520446-09
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	105.36	98.93	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department
514 East Grace Street
Punta Gorda, FL 33950

Provider Number: 0520446-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	105.36	98.93	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Hillsborough County Health Department
1105 E. Kennedy Boulevard
Tampa, FL 33602

Provider Number: 0557269-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Hillsborough County Health Department
1105 E. Kennedy Boulevard
Tampa, FL 33602

Provider Number: 0557269-90
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Department
P. O. Box 1305421 West Main Street
Tavares, FL 32778-1305

Provider Number: 0563234-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Department
P. O. Box 1305421 West Main Street
Tavares, FL 32778-1305

Provider Number: 0563234-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Department
P. O. Box 1305421 West Main Street
Tavares, FL 32778-1305

Provider Number: 0563234-94
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-07
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-09
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-16
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-20
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-25
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-26
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-29
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-31
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

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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

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-32
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-33
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

Provider Type	Current Rate	New Rate	Effective Date
CHD	166.57	166.59	07/01/2020

Rate Type

	Interim	X	Prospective
	Total Interim	X	Total Prospective
	Settlement Based on Cost		Prospective Adjusted For New Costs

BASIS:

- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

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