

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### **Medicaid Reimbursement Rate Change Form for CHDs**

Alachua Cour	nty Health D	epartment			Pro	vider Number	: 0279111-0	00			
224 SE 24th S	Street730 N	.E. Waldo Ro	ad, Suite 500			Date	07/01/2020	0			
Gainesville, F	CHD					Fiscal Year End: 06/30/2019					
						Audit Status	Unaudited	Cost			
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date			
	CHD			166	.57	16	6.59	07/01/2020			
Rate Type				V	_						
	_	Total Interim		X	Prospec		roon ootii ro				
			and an Coat		X		rospective	tod For New Coats			
		Settlement Da	aseu on Cost				clive Aujusi	ted For New Costs			
			BASIS:								
			Budget								
			X Unaudite	ed Cost							
			—— Desk Re	viewed Cost							
			Desk Au	dited Cost							
			Field Aud	dited Cost							
DISTRIBUTIO	ON:					TR					
Fiscal Ag	jent					PV					
Contract	Managemer	nt				Rydell Samu	uel, Adminis	trator			
Program	Finance					Medicaid Pro	ogram Finar	nce			
State Hea	alth Office										
						For Info	ormation Or	nly			
						(No Ch	ange In Ra	te)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Alachua Coun	nty Health Department			Provider	Number: 0279111-	-91
224 SE 24th S	Street730 N.E. Waldo	Road, Suite 500			Date: 07/01/202	20
Gainesville, F	L 32641			Fiscal Y	ear End: 06/30/20	19
				Aud	it Status: Unaudite	d Cost
Provider Ty	<u>ype</u>		Curren	t Rate	New Rate	Effective Date
	<u>CHD</u>		166	.57	166.59	07/01/2020
Rate Type						
	<u>Interim</u>		X	<u>Prospective</u>		
	Total Interi	m		X	Total Prospective	<b>;</b>
	Settlement	Based on Cost			Prospective Adjust	sted For New Costs
DISTRIBUTIO Fiscal Ag Contract I Program State Hea	ent Management Finance	BASIS:  Budget  Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost	Ryc	lell Samuel, Admini	
					For Information C	
					(No Change In R	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Alachua Cour	r Type  CHD  pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewe					Pro	vider Number	: 0279111-	-93	
224 SE 24th S	Street730 N	N.E. Waldo Ro	ad, Suite	500			Date	: 07/01/202	20	
Gainesville, F	L 32641					Fi	scal Year End	: 06/30/20	19	
							Audit Status	Unaudite	d Cost	
Provider T	<u>ype</u>				Curren	t Rate	<u>Nev</u>	/ Rate	Effective Date	ž
	CHD			-	166	.57	16	6.59	07/01/2020	_
Rate Type	Interim				X	Prospec	etive			
	_	Total Interim				- X		Prospective	•	
		- Settlement Ba	ased on C	ost			Prospe	ective Adjus	sted For New Costs	
<b>DISTRIBUTIC</b> Fiscal Ag			X Ur De	dget audited sk Revi			F			
•	eni Manageme	⊇nt					Pudall Sam	ual Admini	introtor	
Program		J. 16					Rydell Same Medicaid Pr			
_	alth Office							<b>.</b>		
							For Inf	ormation C	Only	
							(No Cl	nange In Ra	ate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Baker County F	Health Departn	nent			Prov	ider Number	0279129-0	0	
480 West Lowd	der Street					Date	07/01/2020	)	
Macclenny, FL	32063				Fis	cal Year End	06/30/2019	9	
						Audit Status	Unaudited	Cost	
Provider Ty	<u>pe</u>			Curren	t Rate	New	Rate	Effective Dat	<u>e</u>
	<u>CHD</u>		_	145	.12	16	3.76	07/01/2020	
Rate Type									
<u> </u>	<u>Interim</u>			X	Prospect	<u>ive</u>			
_	Tota	l Interim			X	Total P	rospective		
_	Settl	ement Based on	Cost			Prospe	ctive Adjust	ed For New Costs	
DISTRIBUTION Fiscal Ager Contract M Program Fi State Healt	nt Ianagement inance		Budget Unaudited	ewed Cost ted Cost		Rydell Samu Medicaid Pro			
						For Info	ormation On	nly	
						(No Ch	ange In Rat	te)	



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Baker County	Health De	epartment			Prov	ider Number:	0279129-01	
480 West Lov	wder Street	t				Date:	07/01/2020	
Macclenny, F	L 32063				Fisc	cal Year End:	06/30/2019	
						Audit Status:	Unaudited (	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			145	.12	163	3.76	07/01/2020
Rate Type								
	<u>Interim</u>			X	<u>Prospect</u>	<u>ive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs
			BASIS:					
			Budget					
			X Unaudite	d Cost				
				viewed Cost				
				dited Cost				
				dited Cost				
DISTRIBUTIO	ON:					TH		
Fiscal Ag	jent					M		
Contract	Managemo	ent				Rydell Samu	iel, Administr	ator
Program	Finance					Medicaid Pro	ogram Financ	<del></del> ce
State Hea	alth Office							
						For Info	ormation Only	у
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Baker County	Health De	partment			Pro	vider Number	0279129-11	
480 West Lov	vder Street					Date	07/01/2020	
Macclenny, F	L 32063				Fis	scal Year End	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			145	.12	163	3.76	07/01/2020
Rate Type								
	<u>Interim</u>			X	<u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	jent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost dited Cost			uel, Administra ogram Financ	
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						(140 01	ange in rate	,



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Bradford Cou	nty Health	Department			Provide	r Number:	0279145-00	)		
1801 North Te	emple Ave	nue				Date:	07/01/2020			
Starke, FL 32	2091				Fiscal Year End: 06/30/2019					
					Αι	ıdit Status:	Unaudited (	Cost		
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date		
	<u>CHD</u>			166	.57	166	.59	07/01/2020		
Rate Type	<u>Interim</u>			Х	Prospective	<u> </u>				
		Total Interim			X	Total Pr	ospective			
		Settlement Ba	ased on Cost			Prospec	ctive Adjuste	ed For New Costs		
<b>DISTRIBUTIO</b> Fiscal Ag			Desk F	et lited Cost Reviewed Cost Audited Cost Audited Cost		R				
_	Managem	ent			R <sub>1</sub>	ı ıdell Samu	el, Administr	ator		
Program	_						gram Financ			
State Hea	alth Office									
						For Info	rmation Onl	у		
						— (No Cha	ange In Rate	e)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Bradford County Health Department		Provider N	umber: 0279145-04	4
1801 North Temple Avenue			Date: 07/01/2020	
Starke, FL 32091		Fiscal Ye	ar End: 06/30/2019	
		Audit	Status: Unaudited	Cost
Provider Type	Curren	t Rate	New Rate	Effective Date
CHD	166	.57	166.59	07/01/2020
Rate Type				
<u>Interim</u>	X	<u>Prospective</u>		
Total Interim		X	Total Prospective	
Settlement Based or	n Cost		Prospective Adjuste	ed For New Costs
DISTRIBUTION:  Fiscal Agent Contract Management Program Finance State Health Office	Budget Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost	Ryde	Il Samuel, Administ caid Program Finan	
			For Information Onl	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Bradford Cour	nty Health	Department				Pro	ovider Numbe	er: 0279145-	30
1801 North Te	emple Ave	nue					Dat	e: 07/01/202	20
Starke, FL 32	der Type Cu						scal Year En	d: 06/30/201	19
							Audit Statu	s: Unaudited	d Cost
Provider Ty	<u>/pe</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date
	<u>CHD</u>				166	.57	1	66.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	ctive		
	-	Total Interim				_ x	Total	Prospective	
		Settlement Ba	ased on (	Cost			Prosp	ective Adjus	sted For New Costs
DISTRIBUTIO	on:		X U D D	udget naudited esk Revi esk Audi			R		
Fiscal Age	ent						M		
Contract N	Manageme	ent					Rydell San	nuel, Adminis	strator
Program F							Medicaid F	rogram Fina	ince
State Hea	Ith Office								
							For Ir	nformation O	nly
								Change In Ra	-



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Bradford County Health	Department			Provider	Number:	0279145-91	
1801 North Temple Ave	enue				Date:	07/01/2020	
Starke, FL 32091				Fiscal \	ear End:	06/30/2019	
				Aud	lit Status:	Unaudited Co	ost
Provider Type			Curren	t Rate	<u>New</u>	Rate	Effective Date
<u>CHD</u>		-	166	.57	166	5.59	07/01/2020
Rate Type							
<u>Interim</u>			X	Prospective			
	Total Interim			X	_	rospective	
	Settlement Ba	sed on Cost			Prospe –	ctive Adjusted	For New Costs
DISTRIBUTION: Fiscal Agent Contract Managem Program Finance		BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audit	ewed Cost ted Cost			el, Administra ogram Finance	
State Health Office					For Info	ormation Only	
					(No Ch	ange In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Broward Cour	nty Health	Department				Pro	vider Number	: 0279161-0	00
780 SW 24th	Street						Date	: 07/01/202	20
ort Lauderda	ale, FL 333	315				Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider Ty	<u>ype</u>				Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD				128	.07	96	5.69	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>		
	_	Total Interim				×	Total P	rospective	
		Settlement Ba	ased on C	ost			Prospe	ective Adjus	sted For New Costs
DISTRIBUTIO			X Un De De	dget audited sk Revi sk Audi	Cost lewed Cost ited Cost ted Cost		R		
Fiscal Ag	ent						14		
	Manageme	ent					Rydell Samu		
Program							Medicaid Pr	ogram Fina	ince
State Hea	alth Office								
							For Inf	ormation O	nly
							—— (No Ch	nange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Broward County Health Department		Provider Numbe	r: 0279161-01	
780 SW 24th Street		Date	e: 07/01/2020	
Fort Lauderdale, FL 33315		Fiscal Year End	d: 06/30/2019	
		Audit Status	s: Unaudited Co	st
Provider Type	Curren	t Rate Nev	w Rate	Effective Date
CHD	128.	.07 9	6.69	07/01/2020
Rate Type				
<u>Interim</u>	X	Prospective		
Total Interim			Prospective	
Settlement Bas	sed on Cost	Prosp	ective Adjusted	For New Costs
	BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost	Rydell Sam	nuel, Administrate	<u>or</u>
State Health Office			-	
			nformation Only	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

roward County Health Department						Provider Number: 0279161-04				
780 SW 24th	Street						Date	07/01/202	20	
Fort Lauderda	ale, FL 333	315				Fi	scal Year End:	06/30/201	9	
							Audit Status:	Unaudited	l Cost	
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date	
	CHD				128	.07	96	.69	07/01/2020	
Rate Type	<u>Interim</u>				X	Prospec	ctive			
	_	Total Interim				×	Total P	rospective		
		Settlement Ba	ased on	Cost			Prospe	ctive Adjus	ted For New Costs	
DISTRIBUTIO			X (	Budget Jnaudited	iewed Cost ited Cost		R			
Fiscal Ag							/ 4			
	Manageme	ent					Rydell Samu			
Program	Finance alth Office						Medicaid Pro	ogram Fina	nce	
State Hea	aitti Ollice									
							For Info	ormation O	nly	
							(No Ch	ange In Ra	nte)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Broward County Health Department		Provider Number: 0279161-93					
780 SW 24th Street		Γ	Date: 07/01/2020				
Fort Lauderdale, FL 33315		Fiscal Year	End: 06/30/2019				
		Audit Sta	atus: Unaudited (	Cost			
Provider Type	<u>Curren</u>	t Rate !	New Rate	Effective Date			
<u>CHD</u>	128	.07	96.69	07/01/2020			
Rate Type	<b>V</b>	Dragnastiva					
Interim Total Interim	X	_ <u>Prospective</u> XTo	tal Prospective				
Settlement Bas	and on Cost		·	ed For New Costs			
——————————————————————————————————————	sed on Cost		Dapective Aujuste	ed I of New Costs			
DISTRIBUTION:  Fiscal Agent Contract Management Program Finance State Health Office	BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost	Rydell S	samuel, Administi d Program Finan				
			r Information Onl o Change In Rate				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Calhoun Cour	nty Health I	Department			Provider Number: 0279170-00				
19611 S.R. 20	) West					Date:	07/01/2020		
Blountstown, I	FL 32424				Fis	cal Year End:	06/30/2019		
						Audit Status:	Unaudited C	Cost	
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date	
	CHD			120	.36	160	6.59	07/01/2020	
Rate Type					_				
	<u>Interim</u>	<b>T</b>		X	_ <u>Prospec</u>				
		Total Interim			X		rospective	15 N O .	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs	
<b>DISTRIBUTIC</b> Fiscal Ag			Desk Au	ed Cost viewed Cost dited Cost dited Cost		R			
Contract I	Manageme	ent				Rydell Samu	iel, Administra	ator	
Program	Finance					Medicaid Pro	ogram Financ	e e	
State Hea	alth Office								
						For Info	ormation Only	,	
						(No Ch	ange In Rate	)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

alhoun County Health Department						Provider Number: 0279170-30					
19611 S.R. 20	West							Date:	07/01/2020	)	
Blountstown, F	L 32424						Fiscal Y	ear End:	06/30/2019	9	
							Aud	t Status:	Unaudited	Cost	
Provider Ty	<u>rpe</u>				Curren	t Rate		<u>New</u>	Rate	<u>Effe</u>	ctive Date
	<u>CHD</u>				120	.36		166	6.59	07/	01/2020
Rate Type	<u>Interim</u>				X	Prosp	<u>ective</u>				
	•	Total Interim				_	X	Total P	rospective		
•		Settlement Ba	ased on	Cost				- Prospe	ctive Adjust	ed For Ne	w Costs
DISTRIBUTIO			) X [	Budget Jnaudited	iewed Cost ited Cost			R			
Fiscal Age	ent						ľ	V			
Contract N	_	ent							el, Adminis		
Program F							Med	licaid Pro	ogram Finar	nce	
State Heal	Ith Office										
								For Info	ormation On	nly	
								- (No Ch	ange In Rat	te)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Calhoun Cour	nty Health	Department			Provider Number: 0279170-91				
19611 S.R. 20	0 West					Date	07/01/2020		
Blountstown,	FL 32424				Fis	scal Year End	06/30/2019		
						Audit Status:	Unaudited C	Cost	
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			120	.36	16	6.59	07/01/2020	
Rate Type				V	_				
	<u>Interim</u> -	Total lateria		X	_ <u>Prospec</u> -				
		Total Interim	and an Coat		X		rospective	d For Now Coats	
		Settlement Ba	ased on Cost			—— Prospe	ctive Adjuste	d For New Costs	
			BASIS:						
			Budget						
			X Unaudite						
				viewed Cost					
				dited Cost					
			—— Field Auc	lited Cost					
DISTRIBUTIO	ON:					at			
Fiscal Ag	ent					/ N			
	Manageme	ent					uel, Administr		
Program						Medicaid Pro	ogram Financ	ce	
State Hea	alth Office								
						For Info	ormation Only	y	
						— (No Ch	ange In Rate	e)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Citrus County I	Health Department			Provi	der Number:	0279196-0	0
3700 Sovereig	n Path				Date:	07/01/2020	)
_ecanto, FL 34	4461-8071			Fisc	al Year End:	06/30/2019	)
				,	Audit Status:	Unaudited	Cost
Provider Ty	<u>′pe</u>		<u>Curren</u>	t Rate	New	Rate	Effective Date
	CHD		166	.57	166	.59	07/01/2020
Rate Type	<u>Interim</u>		X	Prospecti	ve		
	Total Interin	n		X		ospective	
-	Settlement	Based on Cost		-	Prospec	tive Adjuste	ed For New Costs
DISTRIBUTIO	<u>N:</u>	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost		R		
Fiscal Age					PU		
Contract M Program F State Heal				_	Rydell Samue Medicaid Pro		
					For Info	rmation Onl	ly
				_	(No Cha	ange In Rate	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Citrus County	itrus County Health Department						Provider Number: 0279196-01					
3700 Soverei	gn Path							Date: 07/01/2020	)			
Lecanto, FL 3	34461-807	'1				F	iscal Y	ear End: 06/30/2019	)			
							Aud	it Status: Unaudited	Cost			
Provider T	ype				Curren	t Rate		New Rate	Effective Date			
	<u>CHD</u>				166	.57		166.59	07/01/2020			
Rate Type												
	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>					
		Total Interim				X		Total Prospective				
		Settlement Ba	ased on	Cost				Prospective Adjust	ed For New Costs			
			BASI	<u>S:</u>								
				Budget								
			<u>χ</u> ι	Jnaudited	l Cost							
				Desk Revi	iewed Cost							
				Desk Audi	ited Cost							
			<u> </u>	ield Audi	ted Cost							
DISTRIBUTIO	ON-						_	R				
Fiscal Ag							1	u)				
_	Managem	ent					Ryc	lell Samuel, Administ	trator			
Program	Finance							dicaid Program Finan				
State Hea	alth Office											
								For Information On	ıly			
								– (No Change In Rat	e)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Citrus County	itrus County Health Department					Provider Number: 0279196-02					
3700 Soverei	gn Path							Date: 07/01/2020	)		
Lecanto, FL 3	34461-807	'1				F	iscal Y	ear End: 06/30/2019	)		
							Aud	it Status: Unaudited	Cost		
Provider T	ype				Curren	t Rate		New Rate	Effective Date		
	<u>CHD</u>				166	.57		166.59	07/01/2020		
Rate Type											
	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>				
		Total Interim				X		Total Prospective			
		Settlement Ba	ased o	n Cost				Prospective Adjust	ed For New Costs		
			BAS	IS:							
				Budget							
			X	Unaudited	d Cost						
				Desk Rev	iewed Cost						
				Desk Aud	ited Cost						
				Field Audi	ited Cost						
DISTRIBUTIO	N.						_	R			
Fiscal Ag							1				
Contract	Managem	ent					Ryd	ell Samuel, Administ	rator		
Program	Finance						Med	dicaid Program Finan	ice		
State Hea	alth Office										
								For Information On	ly		
								– (No Change In Rat	e)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Citrus County	/ Health De	epartment			Provider Number: 0279196-91				
3700 Soverei	gn Path					Date	07/01/2020		
Lecanto, FL	34461-807	1			Fis	scal Year End	06/30/2019		
						Audit Status:	Unaudited C	ost	
<u>Provider T</u>	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			166	.57	16	6.59	07/01/2020	
Rate Type									
	Interim -			X	<u>Prospec</u>				
		Total Interim			X		rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs	
Program	gent Managem	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost lited Cost			uel, Administra ogram Financ		
						For Info	ormation Only	,	
							ange In Rate		
						(140 01		i	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Clay County F	ay County Health Department						Provider Number: 0279200-00				
P.O. Box 578							Date	: 07/01/202	20		
Green Cove S	Springs, FL	32043				Fi	scal Year End	: 06/30/201	19		
							Audit Status	: Unaudited	d Cost		
Provider T	<u>ype</u>				Curren	t Rate	<u>New</u>	/ Rate	Effective Date		
	CHD			_	166	.57	16	6.59	07/01/2020		
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>				
	_	Total Interim				_ x	Total F	rospective			
		Settlement Ba	ased on Cos	t			Prospe	ective Adjus	sted For New Costs		
DISTRIBUTIO Fiscal Ag			Desk	dited C Reviev Audite	Cost wed Cost ed Cost d Cost		F				
Fiscal Ag		ont					/ •				
Program	Manageme Finance	<b>∵</b> III					Rydell Samu Medicaid Pr				
_	alth Office						.viodiodia i i	ogram i ma			
							For Inf	ormation O	nly		
							(No Ch	nange In Ra	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

lay County Health Department						Provider Number: 0279200-01				
P.O. Box 578							Date	: 07/01/202	20	
Green Cove S	Springs, FL	32043				Fi	scal Year End	: 06/30/201	9	
							Audit Status	: Unaudited	l Cost	
Provider T	<u>ype</u>				Curren	t Rate	<u>New</u>	/ Rate	Effective Date	
	<u>CHD</u>				166	.57	16	6.59	07/01/2020	
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>			
	_	Total Interim				_ x	Total F	rospective		
		Settlement Ba	ased on	Cost			Prospe	ective Adjus	ted For New Costs	
<b>DISTRIBUTIC</b> Fiscal Ag Contract Program	ent Manageme	ent	X U	Budget Inaudited Desk Revi Desk Audi	I Cost iewed Cost ited Cost ted Cost		Rydell Same			
_	alth Office									
								ormation O	-	



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Clay County Health Depa	ırtment	Pi	Provider Number: 0279200-02					
P.O. Box 578			Date: 07/01/202	0				
Green Cove Springs, FL	32043	F	Fiscal Year End: 06/30/201	9				
			Audit Status: Unaudited Cost					
<u>Provider Type</u>		Current Rate	New Rate	Effective Date				
<u>CHD</u>		166.57	166.59	07/01/2020				
Rate Type								
<u>Interim</u>		X Prospe	<u>ective</u>					
	Total Interim	>	Total Prospective					
	Settlement Based on Cost		Prospective Adjus	ted For New Costs				
	BASIS:							
	Budget							
	X Unaudit	ted Cost						
	Desk Re	eviewed Cost						
	Desk Au	udited Cost						
	Field Au	udited Cost						
DISTRIBUTION:			R					
Fiscal Agent			PU					
Contract Managemer	nt		Rydell Samuel, Adminis	strator				
Program Finance			Medicaid Program Final					
State Health Office								
			For Information Or	nly				
			(No Change In Ra	te)				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Clay County H	Health Dep	artment				Pro	vider Number	: 0279200-0	03
P.O. Box 578							Date	: 07/01/202	20
Green Cove S	Springs, FL	32043				Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	l Cost
Provider T	уре				Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>		
	_	Total Interim				X	Total P	rospective	
		Settlement Ba	ased on C	Cost			Prospe	ective Adjus	ted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract Program	jent Manageme	ent	X UI De	udget naudited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost		Rydell Samu Medicaid Pr		
_	alth Office						iviedicald Pr	ogram Fina	HC <del>C</del>
Clate i lo	a.u. 011100								
							For Inf	ormation O	nly
							(No Ch	nange In Ra	ate)



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Clay County H	ounty Health Department ox 578					Prov	ider Number	: 0279200-0	04
P.O. Box 578							Date	07/01/202	0
Green Cove S	Springs, FL	32043				Fis	cal Year End	06/30/201	9
							Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>				Curren	nt Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>				166	5.57	160	6.59	07/01/2020
Rate Type									
	<u>Interim</u>				X	Prospec	<u>tive</u>		
		Total Interim				X	Total P	rospective	
		Settlement Ba	ased o	on Cost			Prospe	ective Adjust	ted For New Costs
			BAS	SIS:					
				Budget					
			X	_ Unaudited	d Cost				
				Desk Rev	iewed Cost	:			
				Desk Aud	ited Cost				
				– Field Audi –	ited Cost				
DISTRIBUTIO	ON:						R		
Fiscal Ag							PU		
_	Manageme	ent					Rydell Samu	uel. Adminis	strator
Program							Medicaid Pro		
State Hea	alth Office								
							For Info	ormation Or	nly
							(No Ch	ange In Ra	te)



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Clay County Healtl	h Department			Provider Number: 0279200-05					
P.O. Box 578					Date: 07/01/2020	0			
Green Cove Spring	gs, FL 32043			Fisca	al Year End: 06/30/2019	9			
				P	Audit Status: Unaudited	Cost			
<u>Provider Type</u>			<u>Current F</u>	<u>Rate</u>	New Rate	Effective Date			
<u>C</u>	<u>ID</u>		166.5	7	166.59	07/01/2020			
Rate Type									
Inte	<u>erim</u>		X_ <u>P</u>	rospectiv	<u>ve</u>				
	Total Interim			Χ	Total Prospective				
	Settlement Ba	ased on Cost	_		Prospective Adjust	ted For New Costs			
		BASIS:							
		Budget							
		X Unaudited	l Cost						
		Desk Rev	iewed Cost						
		Desk Aud	ited Cost						
		Field Audi	ted Cost						
DISTRIBUTION:					R				
Fiscal Agent					M				
Contract Mana	agement			F	Rydell Samuel, Adminis	trator			
Program Finar	nce			_	Medicaid Program Finar				
State Health C	Office								
					For Information Or	nly			
				_	—— (No Change In Rat	te)			



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Clay County Health Depa	rtment	Pro	Provider Number: 0279200-91					
P.O. Box 578			Date: 07/01/202	0				
Green Cove Springs, FL	32043	F	iscal Year End: 06/30/201	9				
			Audit Status: Unaudited	l Cost				
Provider Type		Current Rate	New Rate	Effective Date				
<u>CHD</u>		166.57	166.59	07/01/2020				
Rate Type								
<u>Interim</u>		X Prospe	<u>ctive</u>					
	Total Interim	X	Total Prospective					
	Settlement Based on Cost		Prospective Adjus	ted For New Costs				
	BASIS:							
	Budget							
	X Unaudi	ted Cost						
	Desk R	eviewed Cost						
	Desk A	udited Cost						
	Field A	udited Cost						
DISTRIBUTION:			R					
Fiscal Agent			PU					
Contract Managemer	nt		Rydell Samuel, Adminis	strator				
Program Finance			Medicaid Program Final					
State Health Office								
			For Information Or	nly				
			(No Change In Ra	ite)				



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Clay County F	County Health Department Box 578					Provi	der Numb	oer: 0279200-92	2
P.O. Box 578	Box 578 In Cove Springs, FL 32043						Da	ate: 07/01/2020	
Green Cove S	Springs, FL	32043				Fisc	al Year E	nd: 06/30/2019	
					_		Audit Stat	us: Unaudited	Cost
Provider T	<u>ype</u>				Curren	t Rate	New Rate Eff		Effective Date
	CHD				166	.57	1	166.59	07/01/2020
Rate Type									
	Interim				X	Prospecti	<u>ve</u>		
		Total Interim				X	Tota	I Prospective	
		Settlement Ba	ased o	n Cost			Pros	spective Adjuste	ed For New Costs
			BAS	IC.					
			DAS	Budget					
			X	Unaudited	l Coot				
					iewed Cost				
				Desk Aud					
				Field Audi	ted Cost				
DISTRIBUTIO	ON:						R		
Fiscal Ag							PU		
_	Managem	ent					Rvdell Sa	muel, Administ	rator
Program	_					-		Program Finan	
State Hea	alth Office								
							For	Information Onl	ly
						_		Change In Rate	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Collier County	y Health De	epartment			Pro	vider Number	: 0279218-00	
P.O. Box 429						Date	07/01/2020	
Naples, FL 3	4106-0429				Fis	scal Year End	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	16	6.59	07/01/2020
Rate Type								
	Interim_			X	Prospec	<u>tive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ective Adjuste	d For New Costs
Program	jent Manageme	ent	Desk Au	ed Cost eviewed Cost idited Cost dited Cost			uel, Administra ogram Financ	
Oldio 1160						For Inf	ormation Only	,
							nange In Rate	
						(INO CI	iaiiye ili Kale	1



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Collier County Health Department			Provider	Number: 027	9218-01	
P.O. Box 429				Date: 07/0	1/2020	
Naples, FL 34106-0429			Fiscal Y	ear End: 06/3	0/2019	
			Audi	t Status: Una	udited Cost	
<u>Provider Type</u>		Current	Rate	New Rate	<u>e E</u>	iffective Date
<u>CHD</u>	-	166.	57	166.59		07/01/2020
Rate Type						
<u>Interim</u>		X	<u>Prospective</u>			
Total Inter	rim		Х	Total Prospe	ective	
Settlemer	nt Based on Cost			Prospective	Adjusted For	New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost		ell Samuel, A icaid Progran		
State Health Office				-		
				For Informat	ion Only	
				_ (No Change	In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Collier County Health Department			Provider	Number: 0279218-1	1
P.O. Box 429				Date: 07/01/2020	)
Naples, FL 34106-0429			Fiscal Y	ear End: 06/30/2019	9
			Aud	it Status: Unaudited	Cost
Provider Type		Curren	t Rate	New Rate	Effective Date
<u>CHD</u>		166	.57	166.59	07/01/2020
Rate Type					
<u>Interim</u>		X	<u>Prospective</u>		
Total Inte	erim		Х	Total Prospective	
Settleme	nt Based on Cost			Prospective Adjust	ed For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	riewed Cost lited Cost	Ryc	ell Samuel, Administ	
				For Information On (No Change In Rat	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Collier County	Health De	epartment				Pro	vider Number	: 0279218-1	15
P.O. Box 429							Date	07/01/202	0
Naples, FL 34	4106-0429					Fi	scal Year End	06/30/201	9
							Audit Status	Unaudited	Cost
Provider Ty	<u>ype</u>				Curren	t Rate	New	Rate	Effective Date
	<u>CHD</u>				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	ctive		
	-	Total Interim				- X		rospective	
		- Settlement Ba	ased o	n Cost			Prospe	ective Adjust	ted For New Costs
<b>DISTRIBUTIO</b> Fiscal Age	ent		X	Budget Unaudited	iewed Cost ited Cost		R		
	Manageme 	ent					Rydell Samu		
Program I							Medicaid Pr	ogram Finaı	nce
State Hea	aith Office								
							For Inf	ormation Or	nly
							—— (No Ch	nange In Ra	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Collier County	Health De	epartment			Pro	vider Number:	0279218-30	
P.O. Box 429						Date	07/01/2020	
Naples, FL 34	1106-0429	)			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider Ty	<u>/pe</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type								
	<u>Interim</u>			X	<u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
<b>DISTRIBUTIO</b> Fiscal Age Contract N Program F State Hea	ent Manageme Finance	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost lited Cost			uel, Administra ogram Financ	
						For Info	ormation Only	/
							ange In Rate	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Collier County	Health De	epartment				Pro	ovider N	umber:	0279218-91		
P.O. Box 429					_			Date:	07/01/2020		
Naples, FL 34	4106-0429				_	Fi	scal Ye	ar End:	06/30/2019		
					_		Audit	Status:	Unaudited C	Cost	
Provider Ty	<u>ype</u>			<u>Curi</u>	<u>ren</u>	t Rate		New	Rate	Effective	<u>Date</u>
	CHD			1	66	.57		166	5.59	07/01/2	020
Rate Type											
	<u>Interim</u>				X	Prospec					
		Total Interim				X		Total Pi	rospective		
		Settlement Ba	ased on Cost					Prospe	ctive Adjuste	d For New Co	sts
DISTRIBUTIO Fiscal Age Contract I Program I State Hea	ent Manageme Finance	ent	Desk /		t				el, Administra ogram Financ		
2.3.2 . 100								For Info	ormation Only	/	
									ange In Rate		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Columbia County Health D	Pepartment	Pro	ovider Number: 0279226-	00				
217 North East Franklin St	reet		Date: 07/01/202	20				
Lake City, FL 32055		Fi	Fiscal Year End: 06/30/2019					
			Audit Status: Unaudited	d Cost				
Provider Type		Current Rate	New Rate	Effective Date				
<u>CHD</u>		166.57	166.59	07/01/2020				
Rate Type								
<u>Interim</u>		X <u>Prospec</u>	<u>ctive</u>					
Т	otal Interim	x	Total Prospective					
s	ettlement Based on Cost		Prospective Adjus	sted For New Costs				
<b>DISTRIBUTION:</b> Fiscal Agent Contract Management	Desk Aud	iewed Cost ited Cost	Rydell Samuel, Adminis					
Program Finance			Medicaid Program Fina	ance				
State Health Office								
			For Information O	only				
			(No Change In Ra	ate)				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Columbia Cou	unty Health	Department				Pro	ovider Number	: 0279226-0	09
217 North Eas	th East Franklin Street  y, FL 32055  er Type CHD  ype Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Co Field Audited Cost al Agent tract Management gram Finance					Date	: 07/01/202	0	
Lake City, FL	E Type Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost					Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	l Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total F	Prospective	
		Settlement Ba	ased or	n Cost			Prospe	ective Adjus	ted For New Costs
<b>DISTRIBUTIC</b> Fiscal Ag			X	Budget Unaudited Desk Rev Desk Aud	iewed Cost ited Cost		R		
_		ent					Rydell Sam	uel, Adminis	strator
	_						Medicaid Pr		
State Hea	alth Office								
							For Inf	formation O	nly
							(No Cl	hange In Ra	ite)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Columbia County Health Department			Provider I	Number: 027	9226-91	
217 North East Franklin Street	ch East Franklin Street  y, FL 32055  er Type CHD  ype Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Cost Field Audited Cost				1/2020	
Lake City, FL 32055	North East Franklin Street  City, FL 32055   Vider Type  CHD  Total Interim  Total Interim  Settlement Based on Cost  BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost  Field Audited Cost				30/2019	
		_	Audi	t Status: Una	udited Cos	t
Provider Type	<u>Curi</u>	rent Rate	2	New Rat	<u>e</u>	Effective Date
<u>CHD</u>	1	66.57		166.59		07/01/2020
Rate Type						
<u>Interim</u>		X Pros	pective			
Total Interim			X	Total Prospe	ective	
Settlement Bas	sed on Cost			Prospective -	Adjusted F	or New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office	Budget	t		ell Samuel, A icaid Progran		<u>r</u> _
2.4.6			_	For Information	-	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Columbia Cou	unty Health	Department				Pro	vider Number	: 0279226-9	92
217 North Eas	ch East Franklin Street  y, FL 32055  er Type  CHD  ype  Interim  Total Interim  Settlement Based on Cost  BASIS:  Budget  X Unaudited Cost  Desk Reviewed  Desk Audited Co  Field Audited Cost  BUTION:  al Agent  tract Management  gram Finance					Date	: 07/01/202	0	
Lake City, FL	CHD  Interim  Total Interim  Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost					Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	l Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>New</u>	<u>/ Rate</u>	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total F	Prospective	
		Settlement Ba	ased or	n Cost			Prospe	ective Adjus	ted For New Costs
<u>DISTRIBUTIC</u> Fiscal Ag			X	Budget Unaudited Desk Rev Desk Aud	iewed Cost ited Cost		R		
_		ent					Rydell Sami	uel. Adminis	strator
	_						Medicaid Pr		
State Hea	alth Office								
							For Inf	ormation O	nly
							(No Ch	nange In Ra	ite)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Dade County	Health De	partment				Pro	ovider Numb	er: 0279234-	00	
1350 N.W. 14	V. 14th Street  L 33125  Per Type CHD  //pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Co Field Audited Co Field Audited Cost  UTION: al Agent ract Management ram Finance					Da	te: 07/01/202	20		
Miami, FL 33	ider Type  CHD  Type Interim  Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost					Fiscal Year End: 06/30/2019				
							Audit Statu	ıs: Unaudite	d Cost	
Provider T	<u>ype</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date	
	CHD			-	166	.57	1	66.59	07/01/2020	
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>			
	_	Total Interim				X	Total	Prospective		
		Settlement Ba	ased on Co	st			Pros	pective Adjus	sted For New Costs	
DISTRIBUTIO Final As			X Una Des Des	audited sk Revi sk Audi	ewed Cost		F			
_							/ 4			
	_	ent						nuel, Admini		
_							iviedicald i	Program Fina	ance	
State Hea	aitii Oilice									
							For I	nformation O	nly	
							(No (	Change In Ra	ate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Dade County Health					Provider Number: 0279234-30					
1350 N.W. 14th Stre	V. 14th Street  L 33125  Per Type CHD  /pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Company Field Audited Cost Field Audited Cost UTION: Bal Agent				Date:	07/01/2020				
Miami, FL 33125			Fiscal Year End: 06/30/2019							
				Aud	dit Status:	Unaudited Co	ost			
Provider Type			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date			
CHE	<u>)</u>		166	.57	166	5.59	07/01/2020			
Rate Type										
Inter			X	Prospective						
				X	_	rospective				
	Settlement B	ased on Cost			Prospe	ctive Adjusted	I For New Costs			
DISTRIBUTION: Fiscal Agent Contract Manag Program Financ		X Unaudited Desk Revi	iewed Cost ited Cost	Rye		el, Administra ogram Finance				
State Health Off	ice									
					For Info	ormation Only				
					(No Ch	ange In Rate)				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Dade County	Health De	partment				Pro	ovider Numbe	r: 0279234-	91	
1350 N.W. 14	V. 14th Street L 33125  Per Type Cu CHD  /pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Co Field Audited Co UTION: al Agent tract Management						Date	e: 07/01/202	20	
Miami, FL 33	CHD CHD Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost Fiscal Agent Contract Management Program Finance					Fiscal Year End: 06/30/2019				
							Audit Status	: Unaudited	d Cost	
Provider T	уре				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date	
	CHD			-	166	.57	16	6.59	07/01/2020	
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>			
	_	Total Interim				X	Total	Prospective		
		Settlement Ba	ased on Cos	st			Prosp	ective Adjus	sted For New Costs	
<b>DISTRIBUTIO</b> Fiscal Ag			X Unated Desk	udited k Revi k Audi	ewed Cost ted Cost		R			
_		ant					f in		-11	
	=	Oiit						uel, Adminis		
_	alth Office							3. 3		
							For In	formation O	nly	
							(No C	hange In Ra	ate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

DeSoto Coun	ty Health D	Department			Pro	vider Number	: 0279242-00	
34 South Bald	Baldwin Avenue FL 33821  Pr Type Cu CHD  Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Cu Desk Audited Co Field Audited Co Field Audited Co					Date	07/01/2020	
Arcadia, FL 3	CHD  Interim  Total Interim  Settlement Based on Cost  BASIS:  Budget  X Unaudited Cost  Desk Reviewed 6  Desk Audited Co  Field Audited Co				Fis	scal Year End	06/30/2019	
						Audit Status	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			135	.66	122	2.60	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospec	<u>tive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Contract Program	jent Manageme Finance	ent	X Unaudited Desk Rev Desk Aud	viewed Cost dited Cost			uel, Administra ogram Financ	
2.3.5 . 100						Factor	amantica Oct	
							ormation Only	
						(No Ch	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

DeSoto Coun	ty Health D	Department			Pro	vider Number:	0279242-02	!
34 South Balo	Baldwin Avenue FL 33821  PET Type CHD  /pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Cost Field Audited Cost Field Audited Cost al Agent tract Management gram Finance					Date	07/01/2020	
Arcadia, FL 3	CHD  Type Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Co Field Audited Co				Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			135	.66	122	2.60	07/01/2020
Rate Type								
	<u>Interim</u>			X	_ <u>Prospec</u>			
		_			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
Contract Program	ent Manageme	ent	X Unaudite Desk Rev	viewed Cost dited Cost			uel, Administr	
						For Info	ormation Only	y
						—— (No Ch	ange In Rate	e)



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

DeSoto County Health Departmer	nt		Provider Number: 0279242-03					
34 South Baldwin Avenue				Date: 07/01/202	20			
Arcadia, FL 33821			Fiscal Year End: 06/30/2019					
			Α	udit Status: Unaudited	d Cost			
Provider Type		Current Ra	<u>te</u>	New Rate	Effective Date			
CHD		135.66		122.60	07/01/2020			
Rate Type								
<u>Interim</u>		X <u>Pro</u>	spectiv	<u>/e</u>				
Total Inte	erim		Χ	Total Prospective				
Settleme	ent Based on Cost			Prospective Adjus	sted For New Costs			
	BASIS:							
	Budget							
	X Unaudited	d Cost						
	Desk Rev	iewed Cost						
	Desk Aud	ited Cost						
	Field Audi	ited Cost						
DISTRIBUTION:				R				
Fiscal Agent				PU				
Contract Management			F	<b>,</b> Rydell Samuel, Adminis	strator			
Program Finance			_	Medicaid Program Fina				
State Health Office				C				
				For Information O	only			
			_	—— (No Change In Ra	ate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

DeSoto Coun	ty Health D	Department			Pro	vider Number	: 0279242-04	
34 South Balo	Baldwin Avenue FL 33821  Pr Type Cu CHD  Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Cu Desk Audited Co Field Audited Co Field Audited Co					Date	07/01/2020	
Arcadia, FL 3	CHD  Interim  Total Interim  Settlement Based on Cost  BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost				Fis	scal Year End	06/30/2019	
						Audit Status	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			135	.66	122	2.60	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospec	<u>ctive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Contract Program	jent Manageme Finance	ent	X Unaudited Desk Rev Desk Aud	viewed Cost dited Cost			uel, Administra ogram Financ	
						For Info	ormation Only	,
						(No Ch	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

DeSoto Coun	ty Health D	epartment			Pro	vider Number	0279242-11	
34 South Balo	Baldwin Avenue FL 33821  ET Type CHD  /pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Co Field Audited Co  UTION: al Agent tract Management					Date	07/01/2020	
Arcadia, FL 3	CHD  Interim  Total Interim  Settlement Based on Cost  BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost				Fis	scal Year End	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			135	.66	122	2.60	07/01/2020
Rate Type								
	Interim_			X	Prospec	<u>tive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
Contract Program	gent Manageme Finance	ent	Budget  X Unaudite  Desk Rev  Desk Auc	viewed Cost dited Cost			uel, Administra ogram Financ	
2.3.0 . 100						For Info	ormation Only	/
							ange In Rate	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

DeSoto County Health Depart	artment		Provider	Number: 0279242-3	30
34 South Baldwin Avenue				Date: 07/01/202	0
Arcadia, FL 33821			Fiscal Y	ear End: 06/30/201	9
			Aud	t Status: Unaudited	Cost
<u>Provider Type</u>		Curren	t Rate	New Rate	Effective Date
CHD	-	135	.66	122.60	07/01/2020
Rate Type					
<u>Interim</u>		X	<u>Prospective</u>		
To	tal Interim		X	Total Prospective	
Se	ettlement Based on Cost			Prospective Adjust	ted For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost		ell Samuel, Adminis licaid Program Final	
				For Information Or (No Change In Ra	-



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### **Medicaid Reimbursement Rate Change Form for CHDs**

DeSoto County H	ealth Department			Provider Number: 0279242-91				
34 South Baldwin	Avenue				Date: 07/01/2020	0		
Arcadia, FL 3382	<u>!</u> 1			Fisc	al Year End: 06/30/2019	9		
				ı	Audit Status: Unaudited	Cost		
Provider Type	<u>•</u>		Current	t Rate	New Rate	Effective Date		
<u>C</u>	<u>HD</u>		135.	66	122.60	07/01/2020		
Rate Type								
<u>Int</u>	<u>terim</u>		X	Prospecti	<u>ve</u>			
	Total Interim			X	Total Prospective			
	Settlement Ba	ased on Cost			Prospective Adjust	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		Desk Rev	iewed Cost					
		Desk Aud	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:					R			
Fiscal Agent					PU			
Contract Man	nagement				<b>,</b> Rydell Samuel, Adminis	trator		
Program Fina				_	Medicaid Program Finar			
State Health	Office				-			
					For Information Or	nly		
				_	(No Change In Ra	te)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Dixie County I	Health Dep	artment			Provider Number: 0279251-00					
149 NE 241S	Т					Date	07/01/2020			
Cross City, FL	32628				Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			124	.87	160	6.59	07/01/2020		
Rate Type										
	Interim			X	Prospec					
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs		
Program	ent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost dited Cost			uel, Administra ogram Financ			
2.3.0 1 100	011100					For Info	ormation Only	<i>l</i>		
						—— (No Ch	ange In Rate	)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Dixie County I	Health Dep	partment			Provid	er Number:	0279251-9	1
149 NE 241S	Т					Date:	07/01/2020	
Cross City, FL	32628				Fisca	l Year End:	06/30/2019	
					A	udit Status:	Unaudited (	Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	New	<u>Rate</u>	Effective Date
	<u>CHD</u>			124	.87	166	5.59	07/01/2020
Rate Type	<u>Interim</u>			X	Prospectiv	<u>re</u>		
	_	Total Interim			- X	Total Pr	ospective	
		- Settlement Ba	ased on Cost			Prospec	ctive Adjuste	ed For New Costs
			Desk A			W.		
DISTRIBUTIO						RT		
Fiscal Ag	eni Manageme	ent			D	vdell Samu	el, Administi	rator
Program	_	Sint					gram Finan	
_	alth Office						<b>J</b>	
						For Info	rmation Onl	ly
					_	— (No Cha	ange In Rate	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment			Provider Number: 0279269-00					
515 West Sixt	th Street					Date	07/01/2020			
Jacksonville, l	FL 32206				Fis	scal Year End	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			166	.57	16	6.59	07/01/2020		
Rate Type										
	Interim -			X	<u>Prospec</u>					
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ective Adjusted	d For New Costs		
Program	ent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost dited Cost			uel, Administra ogram Financ			
2 130-2 1 100						For Info	ormation Only	<i>'</i>		
						(No Ch	ange In Rate	)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pro	ovider Numbei	: 0279269-	01
515 West Sixt	th Street						Date	: 07/01/202	20
Jacksonville,	FL 32206					F	iscal Year End	1: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>		
		Total Interim				X	Total F	Prospective	
		Settlement Ba	ased on C	ost			Prospo	ective Adjus	sted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract Program	ent Manageme	ent	X Un De	dget audited sk Revi	I Cost iewed Cost ited Cost ted Cost		Rydell Sam Medicaid Pr		
_	alth Office						ivieuicaiu Pi	ogiani Filla	II IC <del>C</del>
2.2.2.100							_		
								formation O	
							(No Cl	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pro	vider Number	: 0279269-0	02
515 West Sixt	th Street						Date	: 07/01/202	20
Jacksonville, l	FL 32206					Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	l Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>New</u>	<u> Rate</u>	Effective Date
	<u>CHD</u>				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospec	<u>ctive</u>		
	- -	Total Interim				X	Total F	rospective	
		Settlement Ba	ased or	n Cost			Prospe	ective Adjus	ted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract	ent Manageme	ent		Budget Unaudited	iewed Cost ited Cost		Rydell Same Medicaid Pr		
_	alth Office						MEGICAIU PI	ogiaili Fiila	HOG
								ormation O	•



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pr	ovider Numbe	er: 0279269-	03
515 West Sixt	th Street						Dat	e: 07/01/202	20
Jacksonville,	FL 32206					F	iscal Year En	d: 06/30/201	19
							Audit Statu	s: Unaudited	d Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date
	<u>CHD</u>				166	.57	1	66.59	07/01/2020
Rate Type	Interim				X	Prospe	ctive		
		Total Interim				X	Total	Prospective	
		Settlement Ba	ased on Co	ost			Prosp	ective Adjus	sted For New Costs
Program	ent Manageme	ent	X Una Des	sk Audi	I Cost iewed Cost ited Cost ted Cost			nuel, Adminis Program Fina	
State Hea							For Ir	nformation O	nly
							(No C	Change In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment			Provider Number: 0279269-04					
515 West Sixt	th Street					Date	07/01/2020			
Jacksonville,	FL 32206				Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	ost		
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			166	.57	160	6.59	07/01/2020		
Rate Type										
	<u>Interim</u>			X	<u>Prospec</u>					
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs		
Program	ent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost dited Cost			ıel, Administra ogram Financo			
							ormation Only			
						(No Ch	ange In Rate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pro	ovider Numbe	r: 0279269-	05
515 West Sixt	th Street						Date	e: 07/01/202	20
Jacksonville,	FL 32206					Fi	scal Year End	d: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date
	<u>CHD</u>				166	.57	16	66.59	07/01/2020
Rate Type	Interim				X	Prospe	<u>ctive</u>		
		Total Interim				X	Total I	Prospective	
		Settlement Ba	ased on C	ost			Prosp	ective Adjus	sted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract		ent	X Ur De	udget naudited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost		Rydell Sam	uel, Adminis	strator
Program	_	J						rogram Fina	
_	alth Office							-	
							For In	formation O	nly
							(No C	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

<b>Duval County</b>	uval County Health Department						Provider Number: 0279269-11					
515 West Sixt	th Street							Date: 07/01/2020	)			
Jacksonville,	FL 32206					F	iscal Y	ear End: 06/30/2019	9			
							Aud	it Status: Unaudited	Cost			
Provider T	ype				Curren	t Rate		New Rate	Effective Date			
	<u>CHD</u>				166	.57		166.59	07/01/2020			
Rate Type												
	<u>Interim</u>				X	_ <u>Prospe</u>	<u>ctive</u>					
		Total Interim				X	•	Total Prospective				
		Settlement Ba	ased o	n Cost				Prospective Adjust	ed For New Costs			
			BAS	SIS:								
				 Budget								
			X	_ Unaudited	d Cost							
				- Desk Rev	iewed Cost							
				- Desk Aud	ited Cost							
				- Field Audi -	ited Cost							
DISTRIBUTIO	N.						_	$\mathbb{R}$				
Fiscal Ag							1					
Contract	Managem	ent					Ryc	lell Samuel, Administ	trator			
Program	Finance						Med	dicaid Program Finar	nce			
State Hea	alth Office											
								For Information On	nly			
								– (No Change In Rat	te)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pro	vider Number	: 0279269-4	43
515 West Sixt	th Street						Date	: 07/01/202	0
Jacksonville, l	FL 32206					Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	l Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>New</u>	<u>/ Rate</u>	Effective Date
	<u>CHD</u>				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospec	<u>ctive</u>		
	- -	Total Interim				X	Total F	rospective	
		Settlement Ba	ased or	n Cost			Prospe	ective Adjus	ted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract Program	ent Manageme	ent		Budget Unaudited	iewed Cost ited Cost		Rydell Same Medicaid Pr		
State Hea	alth Office								
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### **Medicaid Reimbursement Rate Change Form for CHDs**

<b>Duval County</b>	uval County Health Department						Provider Number: 0279269-45					
515 West Sixt	th Street							Date: 07/01/2020	)			
Jacksonville,	FL 32206					F	iscal Y	ear End: 06/30/2019	)			
							Aud	it Status: Unaudited	Cost			
Provider T	ype				Curren	t Rate		New Rate	Effective Date			
	<u>CHD</u>				166	.57		166.59	07/01/2020			
Rate Type												
	<u>Interim</u>				X	_ <u>Prospe</u>	<u>ctive</u>					
		Total Interim				X		Total Prospective				
		Settlement Ba	ased or	n Cost				Prospective Adjust	ed For New Costs			
			BAS	IS:								
				Budget								
				Unaudited	l Cost							
				Desk Revi	iewed Cost							
				Desk Aud	ited Cost							
				Field Audi	ted Cost							
DISTRIBUTIO	N.						_	TR.				
Fiscal Ag							1					
Contract	Manageme	ent					Ryd	ell Samuel, Administ	rator			
Program	Finance						Med	dicaid Program Finan	ice			
State Hea	alth Office											
								For Information On	ly			
								– (No Change In Rat	e)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment			Pro	vider Number:	0279269-46	
515 West Six	th Street					Date	07/01/2020	
Jacksonville,	FL 32206				Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
<u>Provider T</u>	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type								
	Interim			X	<u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	jent Manageme	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost dited Cost			uel, Administra ogram Financ	
						For Infe	ormation Only	,
							ange In Rate	
						(INO CI	iariye ili Kale	J



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pı	rovider	Number:	0279269-52	2	
515 West Sixt	th Street							Date:	07/01/2020		
Jacksonville,	FL 32206					F	iscal Y	ear End:	06/30/2019		
							Aud	t Status:	Unaudited (	Cost	
Provider T	уре				Curren	t Rate		<u>New</u>	<u>Rate</u>	Effective	) Date
	CHD			_	166	.57		166	5.59	07/01/2	2020
Rate Type											
	<u>Interim</u>				X	- <del></del>					
		Total Interim				>	<u> </u>	_	rospective		
		Settlement Ba	ased on Co	st				Prospe -	ctive Adjuste	ed For New Co	sts
DISTRIBUTIO Fiscal Ag Contract Program	jent Manageme	ent	Des	udited k Revi k Audi	Cost ewed Cost ted Cost red Cost				el, Administr ogram Financ		
State Hea	alth Office							_	ormation Onl ange In Rate		
								` -	5	,	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pro	vider Number	: 0279269-5	53
515 West Sixt	th Street						Date	07/01/2020	0
Jacksonville, I	FL 32206					Fi	scal Year End	06/30/2019	9
							Audit Status	Unaudited	Cost
Provider T	<u>ype</u>				Curren	t Rate	New	Rate	Effective Date
	CHD			,	166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospec	<u>ctive</u>		
		Total Interim		Coot		X		rospective	tod For New Coats
		Settlement Ba -	ased on (	Cost			—— Prospe	ective Adjust	ted For New Costs
	ent Manageme	ent	X U	udget naudited esk Revi	I Cost iewed Cost ited Cost ited Cost		Rydell Samu		
Program							Medicaid Pr	ogram Finar	nce
State Hea	alth Office								
							For Inf	ormation Or	nly
							— (No Ch	nange In Ra	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County F	Health De	partment				Prov	vider N	umber: (	0279269-89	9	
515 West Sixth	Street							Date:	07/01/2020		
Jacksonville, Fl	L 32206					Fis	scal Yea	ar End:	06/30/2019		
							Audit	Status: -	Unaudited (	Cost	
Provider Ty	<u>pe</u>				Curren	t Rate		New I	Rate	Effec	ctive Date
	CHD			_	166	.57		166.	.59	07/	01/2020
Rate Type											
	<u>Interim</u>				X	<u>Prospec</u>	<u>tive</u>				
_		Total Interim				X		Total Pro	ospective		
_		Settlement Ba	ased on Cost	•			I	Prospec	tive Adjuste	ed For Nev	v Costs
<b>DISTRIBUTION</b> Fiscal Age Contract M Program F State Heal	nt Ianageme inance	ent	Desk	dited ( Revie Audite	Cost wed Cost ed Cost ed Cost				el, Administi gram Finan		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment			Pro	vider Number:	0279269-91	
515 West Sixt	th Street					Date	07/01/2020	
Jacksonville,	FL 32206				Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type								
	Interim -			X	Prospec			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	ent Manageme	ent	Desk Au	ed Cost eviewed Cost dited Cost dited Cost			uel, Administra ogram Financ	
Olale Hea								
							ormation Only	
						(No Ch	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pro	ovider Numbe	r: 0279269-9	93
515 West Sixt	th Street						Date	e: 07/01/202	20
Jacksonville,	FL 32206					F	iscal Year End	1: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospe	<u>ctive</u>		
		Total Interim				X	Total F	Prospective	
		Settlement Ba	ased on C	ost			Prosp	ective Adjus	ted For New Costs
	ent Manageme	ent	X Un De	dget audited sk Revi	I Cost iewed Cost ited Cost ted Cost		Rydell Sam		
Program							Medicaid Pi	rogram Fina	nce
State Hea	alth Office								
							For In	formation O	nly
							— (No C	hange In Ra	nte)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Р	rovider l	Number:	0279269-9	95	
515 West Sixt	th Street							Date:	07/01/2020	0	
Jacksonville, I	FL 32206					I	Fiscal Ye	ear End:	06/30/2019	9	
							Audi	t Status:	Unaudited	Cost	
Provider T	<u>ype</u>				Curren	t Rate		New	Rate	Effe	ective Date
	CHD			-	166	.57		166	5.59	07	7/01/2020
Rate Type	Interim				X	Prospe	ective				
		Total Interim					X		rospective		
		Settlement Ba	ased on Cos	st				Prospe ·	ctive Adjust	ted For N	ew Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract		ent	Desl	udited k Revi k Audi	Cost ewed Cost ted Cost ted Cost		Ryde	ell Samu	el, Adminis	trator	
Program	_								gram Finar		
State Hea	alth Office										
								For Info	ormation Or	nly	
								No Ch	ange In Ra	te)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pro	vider Number	: 0279269-9	96
515 West Sixt	th Street						Date	: 07/01/202	0
Jacksonville,	FL 32206					Fi	scal Year End	: 06/30/201	9
							Audit Status	Unaudited	l Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	New	<u>/ Rate</u>	Effective Date
	<u>CHD</u>				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total F	Prospective	
		Settlement Ba	ased or	n Cost			Prospe	ective Adjus	ted For New Costs
<b>DISTRIBUTIC</b> Fiscal Ag Contract		ent		Budget Unaudited	iewed Cost ited Cost		Rvdell Sami	uel Adminis	strator
Program	=	ent					Rydell Sam Medicaid Pr		
_	alth Office						Wicaldala 1 1	ogram i ma	1100
							For Inf	ormation O	nly
							(No Cl	nange In Ra	ite)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County	Health De	partment				Pro	ovider Numbe	er: 0279269-	97
515 West Sixt	th Street						Dat	e: 07/01/202	20
Jacksonville, I	FL 32206					F	iscal Year En	d: 06/30/201	9
							Audit Statu	s: Unaudited	d Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date
	CHD				166	.57	1(	66.59	07/01/2020
Rate Type	<u>Interim</u>				Х	<u>Prospe</u>	<u>ctive</u>		
		Total Interim		\ <b>-</b>		X		Prospective	stad Fan Navy Caata
		Settlement Ba -	ased on C	ost			Prosp	ective Adjus	sted For New Costs
	ent Manageme	ent	X Ur De	udget naudited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost			nuel, Adminis	
Program							Medicaid P	rogram Fina	ince
State Hea	alth Office								
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County Health Departr	ment	Pro	vider Number: 0279269-9	98
515 West Sixth Street			Date: 07/01/202	0
Jacksonville, FL 32206		 Fis	scal Year End: 06/30/201	9
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	166.57	166.59	07/01/2020
Rate Type				
<u>Interim</u>		X <u>Prospec</u>	<u>tive</u>	
Tota	al Interim	X	Total Prospective	
Sett	tlement Based on Cost		Prospective Adjus	ted For New Costs
DISTRIBUTION: Fiscal Agent Contract Management	BASIS:  Budget  X Unaudited  Desk Reviet  Desk Audit  Field Audit	ewed Cost ted Cost	Rydell Samuel, Adminis	
Program Finance State Health Office			Medicaid Program Fina	nce
State Health Office				
			For Information Or	nly
			(No Change In Ra	ite)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler County	y Health D	epartment			Pro	vider Number:	0279285-00	
P. O. Box 847	7301 South	Lemon Street	:			Date:	07/01/2020	
Bunnell, FL 3	32110-0847	7			Fis	cal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			152	.32	144	4.31	07/01/2020
Rate Type								
	Interim			X	<u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
Program	ent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost dited Cost			ıel, Administra ogram Financ	
Oldio Hee						For Info	ormation Only	,
							ange In Rate	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	y Health D	epartment				Р	rovider	Number:	0279285-0	)1	
P. O. Box 847	7301 South	Lemon Street						Date:	07/01/2020	0	
Bunnell, FL 3	32110-0847	7					Fiscal Y	ear End:	06/30/2019	9	
							Audi	t Status:	Unaudited	Cost	
Provider T	уре				Curren	t Rate		New	Rate	<u>Eff</u>	ective Date
	CHD			•	152	.32		144	l.31		7/01/2020
Rate Type	Interim				X	<u>Prosp</u>	<u>ective</u>				
		Total Interim					X	Total P	rospective		
		Settlement Ba	ased on Co	ost				Prospe	ctive Adjust	ted For N	lew Costs
<b>DISTRIBUTIC</b> Fiscal Ag			X Una Dea	dget audited sk Revi sk Audi	I Cost iewed Cost ited Cost ted Cost			R			
•	Managem	ent					Rvd	ell Samu	el, Adminis	trator	
Program	_	- <del>-</del>							gram Finar		
_	alth Office										
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								No Ch	ange In Ra	te)	



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	y Health D	epartment				Р	rovider	Number:	0279285-0	)2	
P. O. Box 847	7301 South	Lemon Street						Date:	07/01/2020	0	
Bunnell, FL 3	32110-0847	7					Fiscal Y	ear End:	06/30/2019	9	
							Aud	it Status:	Unaudited	Cost	
Provider T	уре				Curren	t Rate		<u>New</u>	<u>Rate</u>	<u>Eff</u>	ective Date
	CHD			-	152	.32		144	l.31		7/01/2020
Rate Type	<u>Interim</u>				X	<u>Prosp</u>	<u>ective</u>				
	_	Total Interim				-	X	Total P	rospective		
		Settlement Ba	ased on Cos	st				- Prospe	ctive Adjust	ted For N	lew Costs
<b>DISTRIBUTIC</b> Fiscal Ag			Desi	udited k Revi k Audi	Cost ewed Cost ted Cost ted Cost		f	F			
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Program	Managemore Finance	EIIL							el, Adminis gram Finar		
_	alth Office						WIOC	iiouiu i IC	grain i mai		
							_	For Info	rmation Or	nly	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler County	/ Health Dep	partment					Provide	er Number:	0279285-	03		
P. O. Box 847	301 South L	emon Street						Date:	07/01/202	20		
Bunnell, FL 32	2110-0847						Fiscal	Year End:	06/30/201	19		
							Αι	udit Status:	Unaudited	d Cost		
Provider Ty	<u>/pe</u>				Curren	t Rate	!	New	Rate	<u>Ef</u>	ffective D	<u>ate</u>
	CHD			_	152	.32		144	1.31		07/01/202	20_
Rate Type	<u>Interim</u>				X	Pros	<u>pectiv</u>	<u>e</u>				
	1	Total Interim			-	_	Χ	Total P	rospective			
,		Settlement Ba	sed on Cos	st		1		— Prospe	ctive Adjus	sted For I	New Costs	í
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Fiscal Age								P)				
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								For Info	ormation O	nly		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	y Health D	epartment			Provider Number: 0279285-04					
P. O. Box 847	7301 South	Lemon Street	i			Date	07/01/2020			
Bunnell, FL 3	32110-084	7			Fis	scal Year End	06/30/2019			
						Audit Status	Unaudited C	Cost		
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			152	.32	14	4.31	07/01/2020		
Rate Type	Interim			X	Prospec	tivo				
	<u> </u>	Total Interim			_ <del>F103pec</del> X		rospective			
		Settlement Ba	ased on Cost				•	d For New Costs		
		-					<b>,</b>			
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DISTRIBUTIO	ON:					1				
Fiscal Ag	jent					M				
Contract	Managem	ent				Rydell Samu	uel, Administra	ator		
Program						Medicaid Pr	ogram Financ	e		
State Hea	alth Office									
						For Inf	ormation Only	/		
							ange In Rate			



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	ty Health D	epartment			Provider Number: 0279285-05					
P. O. Box 847	7301 South	Lemon Street	i			Date:	07/01/2020			
Bunnell, FL 3	32110-084	7			Fisc	cal Year End:	06/30/2019			
						Audit Status:	Unaudited (	Cost		
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			152	.32	144	4.31	07/01/2020		
Rate Type										
	<u>Interim</u>			X	Prospect	<u>ive</u>				
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		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs		
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			Budget							
			X Unaudited							
			Desk Rev	viewed Cost						
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DISTRIBUTIO	ON·					TR				
Fiscal Ag						PU				
Contract	Managem	ent				Rydell Samu	ıel, Administr	ator		
Program	Finance					Medicaid Pro				
State He	alth Office									
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	y Health D	epartment				Pro	ovider Numbe	r: 0279285-0	06
P. O. Box 847	7301 South	Lemon Street					Date	e: 07/01/202	20
Bunnell, FL 3	32110-0847	7				Fi	scal Year End	d: 06/30/201	9
							Audit Status	s: Unaudited	l Cost
Provider T	уре				<u>Curren</u>	t Rate	<u>Nev</u>	<u>w Rate</u>	Effective Date
	CHD				152	.32	14	14.31	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total	Prospective	
		Settlement Ba	ased on	Cost			Prosp	ective Adjus	ted For New Costs
DISTRIBUTIO			X (	Budget Unaudited	iewed Cost ited Cost		R		
Fiscal Ag							/ 2		
Contract Program	Manageme	ent						uel, Adminis rogram Fina	
_	alth Office						ivieultalu P	iogiaiii Fiila	IIC <del>C</del>
							For In	formation O	nly
							(No C	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	y Health D	epartment				Pro	vider Number	: 0279285-0	07
P. O. Box 847	7301 South	Lemon Street					Date	: 07/01/202	0
Bunnell, FL 3	32110-0847	7				Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	Cost
Provider T	уре				Curren	t Rate	<u>New</u>	/ Rate	Effective Date
	CHD				152	.32	14	4.31	07/01/2020
Rate Type	Interim				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total F	Prospective	
		Settlement Ba	ased on	Cost			Prospe	ective Adjus	ted For New Costs
DISTRIBUTIO Finant Ag				Budget Unaudited	iewed Cost ited Cost		R		
Fiscal Ag							14		
	Manageme	ent					Rydell Samu		
Program State Hea	alth Office						Medicaid Pr	ogram Final	rice
Olalo Hee									
							For Inf	ormation Or	nly
							(No Ch	nange In Ra	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	y Health D	epartment				Pro	ovider Numbe	r: 0279285-(	08
P. O. Box 847	7301 South	Lemon Street					Date	e: 07/01/202	20
Bunnell, FL 3	32110-0847	7				Fi	iscal Year End	d: 06/30/201	9
							Audit Status	s: Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>Nev</u>	v Rate	Effective Date
	CHD				152	.32	14	14.31	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>		
		Total Interim				X	Total	Prospective	
		Settlement Ba	ased on	Cost			Prosp	ective Adjus	sted For New Costs
DISTRIBUTIO Finant Are			X (	Budget Jnaudited	iewed Cost ited Cost		R		
Fiscal Ag							14		
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Program State Hea	Finance alth Office						iviedicald P	rogram Fina	nce
							For In	formation O	nly
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	y Health D	epartment			Provider Number: 0279285-09					
P. O. Box 847	7301 South	Lemon Street	i			Date	07/01/2020			
Bunnell, FL 3	32110-0847	7			Fis	scal Year End	06/30/2019			
						Audit Status	Unaudited C	Cost		
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			152	.32	14	4.31	07/01/2020		
Rate Type	Interim			X	Prospec	tivo				
	<u> </u>	Total Interim			_ <del>F10Spec</del> X		rospective			
		Settlement Ba	ased on Cost				•	d For New Costs		
		-								
			BASIS:							
			Budget							
			X Unaudited	d Cost						
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DISTRIBUTIO	<u> </u>					at				
Fiscal Ag	ent					/ \				
Contract	Managem	ent				Rydell Samu	uel, Administra	ator		
Program						Medicaid Pro	ogram Financ	ce		
State Hea	alth Office									
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Flagler Count	y Health D	epartment			Prov	vider Number:	0279285-3	0
P. O. Box 847	7301 South	Lemon Street				Date:	07/01/2020	)
Bunnell, FL 3	32110-0847	7			Fis	cal Year End:	06/30/2019	9
						Audit Status:	Unaudited	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			152	.32	144	4.31	07/01/2020
Rate Type	<u>Interim</u>			X	Prospec	<u>tive</u>		
	_	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs
DISTRIBUTIO	<u>ON:</u>		Desk Au	ed Cost eviewed Cost idited Cost dited Cost		R		
Fiscal Ag	jent					M		
Contract	Managem	ent				Rydell Samu	iel, Administ	trator
Program	Finance					Medicaid Pro	ogram Finar	nce
State Hea	alth Office							
						For Info	ormation On	ıly
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Franklin Cour	nty Health I	Department			Provider Number: 0279293-00				
139 12th Stre	et					Date	07/01/2020		
Apalachicola,	FL 32320	)			Fis	scal Year End	06/30/2019		
						Audit Status	Unaudited C	ost	
<u>Provider T</u>	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			166	.57	16	6.59	07/01/2020	
Rate Type									
	<u>Interim</u> -			X	Prospec				
		Total Interim	_		X		rospective		
		Settlement Ba	ased on Cost			Prospe	ective Adjusted	d For New Costs	
Program	gent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost dited Cost			uel, Administra ogram Financo		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Franklin Cour	nty Health I	Department			Provider Number: 0279293-01				
139 12th Stre	et					Date	07/01/2020		
Apalachicola,	FL 32320	)			Fis	scal Year End:	06/30/2019		
						Audit Status:	Unaudited C	ost	
<u>Provider T</u>	уре			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date	
	CHD			166	.57	160	6.59	07/01/2020	
Rate Type									
	_ <u>Interim</u> _			X	<u>Prospec</u>				
		Total Interim			X		rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs	
Program	gent Manageme	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost dited Cost			ıel, Administra ogram Financo		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

ranklin Cour	nty Health I	Department				Pro	vider Number	: 0279293-3	30
139 12th Stre	et						Date	: 07/01/202	20
Apalachicola,	FL 32320	)				Fis	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	l Cost
Provider T	уре				<u>Curren</u>	t Rate	<u>New</u>	/ Rate	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospec	tive		
	<u> </u>	Total Interim				_ <del>1103pec</del> X		Prospective	
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_	Managem	ent					Rydell Samı	uel. Adminis	strator
Program	_						Medicaid Pr		
State Hea	alth Office								
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Franklin County Health Depa	artment	Prov	vider Number: 0279293-	92				
139 12th Street			Date: 07/01/202	20				
Apalachicola, FL 32320		Fis	Fiscal Year End: 06/30/2019					
			Audit Status: Unaudited	d Cost				
Provider Type		Current Rate	New Rate	Effective Date				
<u>CHD</u>	-	166.57	166.59	07/01/2020				
Rate Type								
<u>Interim</u>		X Prospec	<u>tive</u>					
Tota	al Interim	x	Total Prospective					
Set	tlement Based on Cost		Prospective Adjus	sted For New Costs				
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost	Rydell Samuel, Adminis Medicaid Program Fina					
State Health Office			weulcaiu Filografii Filid	IIIO <del>G</del>				
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			For Information O	nly				
			(No Change In Ra	ate)				



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Franklin Coun	ranklin County Health Department					Provider Number: 0279293-93					
139 12th Stre	et						Date: 07/01/2020	0			
Apalachicola,	FL 32320	)				Fiscal	Year End: 06/30/2019	9			
						Αι	udit Status: Unaudited	Cost			
Provider T	ype				Curren	t Rate	New Rate	Effective Date			
	<u>CHD</u>			_	166	.57	166.59	07/01/2020			
Rate Type											
	<u>Interim</u>				X	Prospective	<u>e</u>				
	_	Total Interim				X	Total Prospective				
		Settlement Ba	ased on Co	st			Prospective Adjust	ted For New Costs			
			BASIS:								
			Bud	get							
			X Una	udited	Cost						
			Des	k Revi	ewed Cost						
			Des	k Audi	ted Cost						
			Field	d Audit	ted Cost						
DISTRIBUTIO	ON-					,	R				
Fiscal Ag							PU				
Contract	Managem	ent				R	ydell Samuel, Adminis	trator			
Program	Finance					M	edicaid Program Finar	nce			
State Hea	alth Office										
							For Information Or	nly			
							(No Change In Ra	te)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gadsden Cou	adsden County Health Department					Provider Number: 0279307-00				
P. O. Box 100	00					Date	07/01/2020			
Quincy, FL 3	2353-1000				Fiscal Year End: 06/30/2019					
						Audit Status:	Unaudited C	ost		
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			166	.57	10	5.88	07/01/2020		
Rate Type										
	Interim_			X	Prospec	<u>tive</u>				
		Total Interim			X	Total P	rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs		
Program	jent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost dited Cost			uel, Administra ogram Financ			
Oldio Flor						For Info	ormation Only	,		
							ange In Rate			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gadsden Cou	ınty Health	Department				Pro	ovider Numbe	r: 0279307-	01
P. O. Box 100	00						Date	: 07/01/202	20
Quincy, FL 3	2353-1000					Fi	scal Year End	l: 06/30/201	19
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date
	CHD			-	166	.57	10	5.88	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	ctive		
	_	Total Interim				X		Prospective	
		- Settlement Ba	ased on Cos	st			Prosp	ective Adjus	sted For New Costs
<u>DISTRIBUTIO</u> Fiscal Ag			Desk	udited Revi Audi	Cost ewed Cost ted Cost ted Cost		F		
_	jent Manageme	ont					D. Jell Com	-1 A .l ' - '	-11
Program	_	511L					Rydell Sam Medicaid Pi		
_	alth Office						1110010010111	- g. a	
							For In	formation O	nly
							(No C	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gadsden County Health Departmen		Provider Number: 0279307-02				
P. O. Box 1000				Date:	07/01/2020	
Quincy, FL 32353-1000			Fiscal Y	ear End:	06/30/2019	
			Aud	it Status:	Unaudited Co	ost
Provider Type		Curren	t Rate	New	<u>Rate</u>	Effective Date
<u>CHD</u>	-	166	.57	105	.88	07/01/2020
Rate Type						
<u> </u>		X	Prospective			
Total Interi			X	_	ospective	
Settlement	Based on Cost			Prospec -	tive Adjusted	For New Costs
DISTRIBUTION: Fiscal Agent Contract Management	BASIS:  Budget  Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost		lell Samue	el, Administra	tor
Program Finance					gram Finance	
State Health Office					-	
				For Info	rmation Only	
				– (No Cha	ange In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gadsden County Health Department		Provider Number: 0279307-04				
P. O. Box 1000				Date: 0	7/01/2020	
Quincy, FL 32353-1000			Fiscal Y	ear End: 0	06/30/2019	
			Audi	t Status: L	Jnaudited Co	st
Provider Type		Current	Rate	New F	<u>late</u>	Effective Date
<u>CHD</u>	_	166.5	<u> </u>	105.	88	07/01/2020
Rate Type						
<u>Interim</u>		X	<u>Prospective</u>			
Total Interir		_	Х	Total Pro -	•	
Settlement	Based on Cost	_		Prospect -	ive Adjusted	For New Costs
DISTRIBUTION: Fiscal Agent Contract Management	BASIS:  Budget  Unaudited Co  Desk Review  Desk Audited  Field Audited	ed Cost Cost	Ryde	<b>F</b>	, Administrat	or
Program Finance					ram Finance	
State Health Office			00			
				For Infor	mation Only	
				- (No Char	nge In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gadsden County Health Departme	ent		Provider Number: 0279307-12					
P. O. Box 1000				Date: 07/01/202	0			
Quincy, FL 32353-1000			Fiscal Year End: 06/30/2019					
			Aud	dit Status: Unaudited	Cost			
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date			
<u>CHD</u>		166	.57	105.88	07/01/2020			
Rate Type								
<u>Interim</u>		X	<u>Prospective</u>					
Total Inte	erim		X	Total Prospective				
Settleme	nt Based on Cost			Prospective Adjust	ted For New Costs			
	BASIS:							
	Budget							
	X Unaudited	d Cost						
		viewed Cost						
	Desk Aud	lited Cost						
	Field Aud	ited Cost						
DISTRIBUTION:				T				
Fiscal Agent			ĺ	eV.				
Contract Management			Ryo	dell Samuel, Adminis	trator			
Program Finance			Me	dicaid Program Finar	nce			
State Health Office								
				For Information Or	nly			
				_ (No Change In Ra	te)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gadsden County Health Department		Provider Number: 0279307-30					
P. O. Box 1000			Date: 07/01/2020				
Quincy, FL 32353-1000		Fiscal Year End: 06/30/2019					
		Audit S	Status: Unaudited	Cost			
Provider Type	Curren	<u>it Rate</u>	New Rate	Effective Date			
<u>CHD</u>	166	.57	105.88	07/01/2020			
Rate Type							
<u>Interim</u>	X	<u>Prospective</u>					
Total Interim		XT	otal Prospective				
Settlement Bas	ed on Cost	F	Prospective Adjuste	ed For New Costs			
DISTRIBUTION:  Fiscal Agent Contract Management Program Finance State Health Office	BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost	Rydell	Samuel, Administ				
			or Information Onl No Change In Rate	•			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gilchrist Coun	christ County Health Department					Provider Number: 0279315-00				
119 N.E. First	Street					Date:	07/01/2020			
Trenton, FL 3	32693-3459				Fiscal Year End: 06/30/2019					
					А	udit Status:	Unaudited C	ost		
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD		-	166	.57	160	6.59	07/01/2020		
Rate Type										
	<u>Interim</u>			X	Prospectiv	<u>′e</u>				
	Tota	l Interim			X	Total P	rospective			
	Sett	lement Based	on Cost			Prospe	ctive Adjusted	For New Costs		
DISTRIBUTIO Fiscal Age Contract I Program	ent Management Finance		BIS: Budget Unaudited Desk Revi Desk Audi Field Audi	ewed Cost ted Cost	<u>.</u>	-	uel, Administra ogram Finance			
					_		ormation Only			
						(No Ch	ange In Rate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gilchrist Coun	christ County Health Department					Provider Number: 0279315-91				
119 N.E. First	Street					Date:	07/01/2020			
Trenton, FL 3	32693-3459				Fiscal Year End: 06/30/2019					
					Αι	ıdit Status:	Unaudited C	ost		
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	<u>CHD</u>			166	.57	166	5.59	07/01/2020		
Rate Type										
	<u>Interim</u>			X	<u>Prospective</u>	<u>e</u>				
	T	otal Interim			X	Total P	rospective			
	S	ettlement Ba	ased on Cost			Prospe	ctive Adjusted	For New Costs		
DISTRIBUTIO Fiscal Ag Contract I Program State Hea	ent Management Finance	t	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost	<u>R</u>		el, Administra ogram Finance			
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						(No Ch	ange In Rate)	)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Glades County Health	Department			Provi	der Number:	0279323-0	0
P. O. Box 489					Date:	07/01/2020	)
Moore Haven, FL 3347	71			Fisc	al Year End:	06/30/2019	9
				,	Audit Status:	Unaudited	Cost
Provider Type			Curren	t Rate	<u>New</u>	Rate	Effective Date
<u>CHD</u>			166	.57	166	6.59	07/01/2020
Rate Type							
<u>Interim</u>			Х	<u>Prospecti</u>	<u>ve</u>		
	Total Interim			_ X	Total P	rospective	
	Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs
DISTRIBUTION: Fiscal Agent Contract Managent Program Finance State Health Office		BASIS:  Budget  Vinaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost ted Cost		Rydell Samu Medicaid Pro		
				_		ormation On	•
					(No Ch	ange In Rat	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Glades Count	ty Health D	epartment				Pro	vider Number	: 0279323-	30
P. O. Box 489	9						Date	: 07/01/202	20
Moore Haven	, FL 3347	1				Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>New</u>	/ Rate	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	ctive		
	_	Total Interim				- X		Prospective	
		- Settlement Ba	ased on Co	ost			Prospe	ective Adjus	sted For New Costs
<b>DISTRIBUTIC</b> Fiscal Ag			X Una Dea	dget audited sk Revi sk Audi	I Cost iewed Cost ited Cost ted Cost		R		
_	Manageme	ent					Rydell Samı	uel. Adminis	strator
Program	-						Medicaid Pr		
State Hea	alth Office								
							For Inf	ormation O	nly
							(No Ch	nange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Glades Count						Pr	ovider Num	ber: 0279323-	91
P. O. Box 489	)						D	ate: 07/01/202	20
Moore Haven	Er Type CHD  Type Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed G Desk Audited Co Field Audited Co					F	iscal Year E	End: 06/30/201	9
							Audit Sta	tus: Unaudited	d Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>N</u>	lew Rate	Effective Date
	CHD			-	166	.57		166.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	ective		
		Total Interim				×	Tot	al Prospective	
		Settlement Ba	ased on Co	st			Pro	spective Adjus	sted For New Costs
DISTRIBUTION Fiscal Ag	ent	ont.	X Una Des Des	udited k Revi k Audi	ewed Cost		R		
Contract Program	Manageme Finance	ent						amuel, Adminis I Program Fina	
_	alth Office						Medicalc	i i Togram i ma	
							For	Information O	nly
							(No	Change In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County H	Health Depart	ment			Prov	ider Number:	0279331-0	00
2475 Garrisor	n Avenue					Date	07/01/2020	0
Port St. Joe, F	CHD  /pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed ( Desk Audited Co Field Audited Co				Fisc	cal Year End:	06/30/2019	9
						Audit Status:	Unaudited	Cost
Provider T	<u>ype</u>			Curren	t Rate	New	Rate	Effective Date
	<u>CHD</u>			166	.57	160	6.59	07/01/2020
Rate Type	Interim			X	Prospect	ive		
	_	otal Interim			<u>- 1 103ресі</u> - -		rospective	
			sed on Cost				•	ed For New Costs
			Budget  X Unaudited  Desk Rev  Desk Aud	iewed Cost ited Cost				
Program	ent Management					Rydell Samu Medicaid Pro		
							ormation Or	
						(170 CI	iange in ital	· · · ·



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County H	lealth Depa	artment			Provide	er Number:	0279331-01	
2475 Garrison	Avenue					Date:	07/01/2020	
Port St. Joe, F	L 32456-	5265			Fiscal	Year End:	06/30/2019	
					Au	udit Status:	Unaudited C	ost
Provider Ty	<u>ype</u>			Curren	t Rate	New	<u>Rate</u>	Effective Date
	CHD			166	.57	166	5.59	07/01/2020
Rate Type								
	<u>Interim</u>			X	<u>Prospectiv</u>	<u>e</u>		
	_	Total Interim			X	Total Pr	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	For New Costs
<b>DISTRIBUTIC</b> Fiscal Ago Contract I	ent Manageme	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	riewed Cost lited Cost	<u>R</u>		el, Administra	
State Hea					_	For Info	ormation Only ange In Rate	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County F	ison Avenue					Pro	vider Number	: 0279331-0	03
2475 Garrisor	CHD  ype Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Composed Audited Composed Audited Composed Audited Cost Desk Audited Composed Audited Cost Desk Audited Composed Audited Cost Desk Audited Cost						Date	: 07/01/202	20
Port St. Joe, F						Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>New</u>	<u>/ Rate</u>	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	ctive		
	_	Total Interim				_ x	Total F	Prospective	
		Settlement Ba	ased on Co	ost			Prospe	ective Adjus	ted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag	ent		X Una Des	audited sk Revi sk Audi	ewed Cost		R		
	_	ent					Rydell Sam		
_							Medicaid Pr	ogram Fina	nce
State Hea	aith Office								
							For Inf	ormation O	nly
							(No Cl	nange In Ra	nte)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County H						Pro	vider Number	: 0279331-0	05
2475 Garrisor	ison Avenue be, FL 32456-5265  r Type  CHD  1						Date	07/01/202	0
Port St. Joe, F	CHD  /pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Co Field Audited Co					Fi	scal Year End	06/30/201	9
							Audit Status	Unaudited	Cost
Provider T	уре				Curren	t Rate	New	Rate	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total P	rospective	
		Settlement Ba	ased on	Cost			Prospe	ective Adjus	ted For New Costs
	ent Managem	ent	E	Budget Jnaudited Desk Revi Desk Aud	iewed Cost ited Cost		Rydell Samu		
Program State Hea	Finance alth Office						Medicaid Pr	ogram Finai	nce
State Hea									
							For Inf	ormation Or	nly
							(No Ch	nange In Ra	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County H	lealth Depa	artment			Provider Number: 0279331-07					
2475 Garrisor	n Avenue					Date	07/01/2020			
Port St. Joe, F	FL 32456-	5265			Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			166	.57	160	6.59	07/01/2020		
Rate Type										
	<u>Interim</u>			X	<u>Prospec</u>	<u>ctive</u>				
		Total Interim			X	Total P	rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs		
Program	ent Manageme	ent	Desk A				ıel, Administra ogram Financ			
						For Info	ormation Only	/		
						—— (No Ch	ange In Rate	)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County H	lealth Department			Provid	der Number: 027	9331-11	
2475 Garrisor	n Avenue				Date: 07/0	01/2020	
Port St. Joe, F	FL 32456-5265		Fisca	al Year End: 06/3	30/2019		
				A	Audit Status: Una	audited Cos	t
Provider T	<u>ype</u>		Current	: Rate	New Rat	<u>e</u>	Effective Date
	CHD		166.	57	166.59		07/01/2020
Rate Type	lutavius.		X	Dunnanti			
	_ <u>Interim</u> _ Total Inte	arim		Prospective X	<u>ve</u> Total Prosp	ective	
		nt Based on Cost					or New Costs
		ni Bassa sir Gost				, tajaotoa i	or rion dedic
		BASIS:					
		 Budget					
		X Unaudited	d Cost				
		Desk Rev	riewed Cost				
		Desk Aud	lited Cost				
		Field Aud	ited Cost				
					-00000-00000		
DISTRIBUTIO					dt.		
Fiscal Ag							
	Management			_	Rydell Samuel, A		<u>r</u>
Program State Hea				ľ	Medicaid Prograr	II FIIIAIIC <del>e</del>	
State Hea	aiti Ollice						
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County H						Pro	vider Number	: 0279331-1	19
2475 Garrisor	ison Avenue De, FL 32456-5265  Type CHD  De Interim Total Interim Settlement Based on Cost  BASIS: Budget						Date	07/01/202	0
Port St. Joe, F	CHD  /pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Co Field Audited Co					Fi	scal Year End	06/30/201	9
							Audit Status	: Unaudited	Cost
Provider T	уре				Curren	t Rate	New	Rate	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				Х	Prospec	<u>ctive</u>		
		_				X		rospective	
		Settlement Ba -	ased on C	ost			Prospe	ective Adjust	ted For New Costs
DISTRIBUTIO Fiscal Ag Contract	ent	ent	X Ur De	idget naudited esk Revi esk Audi	iewed Cost ited Cost		Rydell Sami	ual Adminis	trator
	_	<del>z</del> nt					Rydell Samu Medicaid Pr		
_	alth Office							- ga.	
							For Inf	ormation Or	nly
							(No Ch	nange In Ra	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County Health Department			Provider Number: 0279331-21					
2475 Garrison Avenue				Date: 07/01/2020	0			
Port St. Joe, FL 32456-5265			Fiscal Y	ear End: 06/30/2019	9			
			Aud	it Status: Unaudited	Cost			
<u>Provider Type</u>		Curren	t Rate	New Rate	Effective Date			
<u>CHD</u>	-	166	.57	166.59	07/01/2020			
Rate Type								
<u>Interim</u>		X	<u>Prospective</u>					
Total Inter	rim		X	Total Prospective				
Settlemen	t Based on Cost			Prospective Adjust	ted For New Costs			
DISTRIBUTION:  Fiscal Agent  Contract Management  Program Finance	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost		lell Samuel, Adminis dicaid Program Finar				
State Health Office				For Information Or (No Change In Ra	•			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Gulf County H						Pro	ovider Numbe	er: 0279331-	30
2475 Garrison	ison Avenue De, FL 32456-5265  Type CHD  De Interim Total Interim Settlement Based on Cost  BASIS:						Dat	e: 07/01/202	20
Port St. Joe, F	CHD  /pe Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Co Field Audited Co					Fi	iscal Year En	d: 06/30/201	19
							Audit Statu	us: Unaudited	d Cost
Provider Ty	<u>ype</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date
	CHD				166	.57	1	66.59	07/01/2020
Rate Type	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>		
		Total Interim				X	Total	Prospective	
		Settlement Ba	ased on (	Cost			Pros <sub>i</sub>	pective Adjus	sted For New Costs
DISTRIBUTIO Fiscal Age Contract I Program I	ent Manageme	ent	X U D D	udget naudited esk Revi esk Audi	iewed Cost ited Cost			nuel, Adminie Program Fina	
State Hea	alth Office								
								nformation O Change In Ra	-



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hamilton County Heal	th Department			Provide	Number:	0279340-00	
P. O. Box 267					Date:	07/01/2020	
Jasper, FL 32052				Fiscal `	Year End:	06/30/2019	
				Aud	dit Status:	Unaudited Co	ost
Provider Type			Curren	t Rate	New	<u>Rate</u>	Effective Date
CHD			165	.29	166	6.59	07/01/2020
Rate Type							
<u>Interir</u>	<u>n</u>		X	Prospective			
	Total Interim			X	Total P	rospective	
	Settlement Ba	ased on Cost			Prospe	ctive Adjusted	For New Costs
DISTRIBUTION: Fiscal Agent Contract Manage Program Finance		BASIS:  Budget  Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost	Ry		iel, Administra ogram Finance	
State Health Office	e						
					_	ormation Only	
					(No Ch	ange In Rate)	



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hamilton Cou						Pr	ovider N	umber:	0279340-25	5	
P. O. Box 267	7							Date:	07/01/2020		
Jasper, FL 32	Er Type CHD  YPE Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed of Desk Audited Cost Field Audited Cost					F	iscal Yea	ar End:	06/30/2019		
							Audit	Status:	Unaudited (	Cost	
Provider T	<u>ype</u>				Curren	t Rate		New	Rate	Effective	<u>Date</u>
	CHD				165	.29		166	.59	07/01/2	2020
Rate Type	<u>Interim</u>				X	Prospe	ective				
	_	Total Interim				_ X	(	Γotal Pr	ospective		
		Settlement Ba	ased on C	Cost			I	Prospec	tive Adjuste	ed For New Co	sts
DISTRIBUTIO			X UI	udget naudited esk Revi esk Audi	iewed Cost ited Cost		- K	R			
Fiscal Ag							/ \				
	Manageme	ent							el, Administr		
Program	Finance alth Office						iviedic	aid Pro	gram Finand	ce	
State Hea	aitti Office										
							I	For Info	rmation Onl	y	
								(No Cha	ange In Rate	e)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hamilton County Health Department		Provider Numb	er: 0279340-30	
P. O. Box 267		Da	ate: 07/01/2020	
Jasper, FL 32052		Fiscal Year E	nd: 06/30/2019	
		Audit Stat	us: Unaudited C	ost
Provider Type	Curren	<u>it Rate</u> No	ew Rate	Effective Date
<u>CHD</u>	165	.29	166.59	07/01/2020
Rate Type				
<u>Interim</u>	X	<u>Prospective</u>		
Total Interim		X Tota	I Prospective	
Settlement Based	on Cost	Pros	spective Adjusted	d For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	SIS:  Budget  Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost	Rydell Sa	muel, Administra Program Financ	
State Health Office			Information Only Change In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hamilton Cou	nty Health	Department				Pro	ovider Numbe	: 0279340-	91
P. O. Box 267	7						Date	e: 07/01/202	20
Jasper, FL 32	2052					Fi	scal Year End	l: 06/30/201	19
							Audit Status	: Unaudited	d Cost
Provider T	уре				<u>Curren</u>	t Rate	<u>Nev</u>	v Rate	Effective Date
	CHD				165	.29	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	ctive		
	_	Total Interim				- X	Total F	Prospective	
		- Settlement Ba	ased on	Cost			Prosp	ective Adjus	sted For New Costs
DISTRIBUTIO	OM:		X (	Budget Jnaudited	iewed Cost ited Cost		W.		
DISTRIBUTIO Fiscal Ag							P)		
_	Manageme	ent					Rydell Sam	uel. Adminis	strator
Program	=						Medicaid Pi		
State Hea	alth Office								
							For In	formation O	nly
							(No C	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hardee County	Health Departme	ent		Provid	der Number:	0279358-00	
115 K.D. Reve	ll Road				Date:	07/01/2020	
Wauchula, FL	33873			Fisca	al Year End:	06/30/2019	
				A	Audit Status:	Unaudited C	Cost
Provider Ty	<u>pe</u>		<u>Curren</u>	t Rate	New	Rate	Effective Date
	CHD		166	.57	166	.59	07/01/2020
Rate Type	<u>Interim</u>		X	Prospecti	ve		
	Total In	terim		- X		ospective	
-	Settlem	ent Based on Cost				•	d For New Costs
DISTRIBUTIOI	<u>N:</u>	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost dited Cost		R		
Fiscal Age					PU		
Contract M Program F State Heal				_	Rydell Samue Medicaid Pro		
					For Info	rmation Only	/
				_	(No Cha	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hardee Count	ty Health D	Department				Pr	ovider I	Number:	0279358-0	1	
115 K.D. Reve	ell Road							Date:	07/01/2020	)	
Wauchula, FL	. 33873					F	iscal Y	ear End:	06/30/2019	)	
							Audi	t Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>				Curren	t Rate		New	Rate	<u>Effe</u>	ctive Date
	<u>CHD</u>			_	166	.57		166	5.59	07	/01/2020
Rate Type											
	<u>Interim</u>				X						
		Total Interim				X		Total Pi	ospective		
		Settlement Ba	ased on Co	st				Prospe	ctive Adjust	ed For Ne	w Costs
<b>DISTRIBUTIC</b> Fiscal Age Contract I Program	ent Manageme	ent	Desi	udited k Revid k Audit	Cost ewed Cost ted Cost ed Cost				el, Administ gram Finar		
State Hea	alth Office							_	ormation On ange In Rat	-	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hardee County Health Department	artment		Provider	Number:	0279358-09	
115 K.D. Revell Road				Date:	07/01/2020	
Wauchula, FL 33873			Fiscal Y	ear End:	06/30/2019	
			Aud	it Status:	Unaudited Co	ost
Provider Type		Curren	t Rate	New I	Rate	Effective Date
CHD	-	166	.57	166.	.59	07/01/2020
Rate Type						
<u>Interim</u>		X	<u>Prospective</u>			
To	otal Interim		X	Total Pro	ospective	
Se	ettlement Based on Cost			Prospec	tive Adjusted	For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost			el, Administrat gram Finance	
State Health Office			_	_	rmation Only	
				(INO OHA	ingo in itale)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hardee Coun	ty Health D	Department				Pro	vider Number	: 0279358-3	30
115 K.D. Rev	ell Road						Date	: 07/01/202	0
Wauchula, FL	33873					Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	l Cost
Provider T	уре				Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>		
	_	Total Interim				X	Total P	rospective	
		Settlement Ba	ased or	n Cost			Prospe	ective Adjus	ted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag	jent	ent.		Budget Unaudited	iewed Cost ited Cost		A Pudall Sami	uol. Adminis	atro to r
	Manageme	ent					Rydell Samu		
Program State Hea	Finance alth Office						Medicaid Pr	ogram Fina	nce
State Hea	aitii Oilice								
							For Inf	ormation O	nly
							(No Ch	nange In Ra	ite)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hendry County Health De	epartment			Provi	der Number:	0279366-0	0
P. O. Box 70					Date:	07/01/2020	)
_aBelle, FL 33975				Fisc	al Year End:	06/30/2019	)
					Audit Status:	Unaudited	Cost
Provider Type			Curren	t Rate	<u>New</u>	Rate	Effective Date
<u>CHD</u>			166	.57	160	6.59	07/01/2020
Rate Type							
<u>Interim</u>			Х	Prospecti	ve		
	Total Interim			X	Total P	rospective	
	Settlement Based	d on Cost			Prospe	ctive Adjuste	ed For New Costs
DISTRIBUTION: Fiscal Agent Contract Manageme Program Finance		ASIS:  Budget  Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost		Rydell Samu Medicaid Pro		
State Health Office					For Info	ormation On	lv
				_		ange In Rat	
					1110 (71)	anuc 111 1/41	E1



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hendry Count	ty Health D	epartment			Provid	er Number:	0279366-30	)
P. O. Box 70						Date:	07/01/2020	
_aBelle, FL 3	3975				Fisca	l Year End:	06/30/2019	
					А	udit Status:	Unaudited (	Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	166	5.59	07/01/2020
Rate Type	<u>Interim</u>			X	Prospectiv	' <u>e</u>		
		Total Interim			X	Total Pr	rospective	
		Settlement Ba	ased on Cost			Prospec	ctive Adjuste	ed For New Costs
DISTRIBUTION Fiscal Ag	ent	ont.	Desk Au	ed Cost eviewed Cost udited Cost udited Cost		The same of the sa		
Contract l	Manageme	ent					el, Administr gram Finand	
_	alth Office				IV	icultalu PIC	yranı Financ	<del></del>
						For Info	rmation Onl	y
					_	(No Ch	ange In Rate	<del>e</del> )



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hendry Count	ty Health D	epartment				Pro	ovider Numbe	r: 0279366-	92
P. O. Box 70							Date	e: 07/01/202	20
_aBelle, FL 3	33975					F	iscal Year En	d: 06/30/201	19
							Audit Statu	s: Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>Ne</u>	w Rate	Effective Date
	<u>CHD</u>				166	.57	16	66.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>		
		Total Interim				X		Prospective	
		Settlement Ba	ased on	Cost			Prosp	ective Adjus	sted For New Costs
	ent Manageme	ent	) X [	Budget Jnaudited	iewed Cost ited Cost			nuel, Admini	
Program State Hea	alth Office						iviedicald P	rogram Fina	ance
0.0.01100									
							For Ir	formation O	only
							(No C	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hernando Cour	nty Health D	epartment					Provide	r Number:	0279374	-00		
300 S. Main St.								Date:	07/01/202	20		_
Brooksville, FL	34601						Fiscal	Year End:	06/30/20	19		
							Au	dit Status:	Unaudite	d Cost		
Provider Ty	<u>pe</u>				Curren	t Rate		<u>New</u>	Rate	<u>E</u> :	ffective Dat	<u>te</u>
	<u>CHD</u>				139	.95		166	6.59		07/01/2020	)
Rate Type	<u>Interim</u>				X	<u>Pros</u> į	pective	<u>!</u>				
	To	otal Interim				_	Χ	Total P	rospective	<b>:</b>		
_	Se	ettlement Ba	sed on (	Cost				Prospe	ctive Adju	sted For	New Costs	
DISTRIBUTION	<u>N:</u>		X U	udget naudited esk Revi esk Audi	Cost fewed Cost ited Cost ted Cost			R				
Fiscal Age	nt							PU				
Contract M Program F State Heal									iel, Admini ogram Fina			
								For Info	ormation C	Only		
								— (No Ch	ange In R	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hernando County Hea	alth Department			Prov	ider Number:	0279374-91	
300 S. Main St.					Date:	07/01/2020	
Brooksville, FL 34601				Fisc	cal Year End:	06/30/2019	
					Audit Status:	Unaudited C	Cost
Provider Type			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
CHD			139	.95	166	5.59	07/01/2020
Rate Type							
Interin	<u>n</u>		X	Prospect	<u>ive</u>		
	Total Interim			X	Total Pı	rospective	
	Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
DISTRIBUTION: Fiscal Agent Contract Managel Program Finance State Health Office		BASIS:  Budget  Vinaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost		Rydell Samu Medicaid Pro		
				-		ormation Only ange In Rate	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hernando Coเ	unty Health	n Department				Pr	rovider N	umber:	0279374-9	2	
300 S. Main S	it.							Date:	07/01/2020	)	
Brooksville, FL	34601					F	Fiscal Ye	ar End:	06/30/2019	)	
							Audit	Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>				Curren	t Rate		New	<u>Rate</u>	<u>Eff</u>	ective Date
	CHD				139	.95		166	5.59	07	7/01/2020
Rate Type											
	<u>Interim</u>				X	Prospe					
		Total Interim				X			ospective		
		Settlement Ba	ased on	Cost				Prospe	ctive Adjust	ed For N	ew Costs
<b>DISTRIBUTIO</b> Fiscal Age Contract N Program F State Hea	ent Manageme Finance	ent	X (	Budget Unaudited	iewed Cost ited Cost				el, Administ gram Finan		
									rmation On ange In Rat	•	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Highlands Co	unty Healt	h Department			Pro	vider Number	: 0279382-00	
7205 South G	George Bou	ılevard				Date	07/01/2020	
Sebring, FL 3	33872				Fis	scal Year End	06/30/2019	
						Audit Status	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			127	.71	13	5.85	07/01/2020
Rate Type	Intorim			X	Drocnoo	ativo.		
	Interim -	Total Interim			_ <u>Prospec</u> X		rospective	
		Settlement B	ased on Cost				•	d For New Costs
		-	acca cii 666t				ouvo majaoto	a 1 01 110W 00010
			BASIS:					
			Budget					
			X Unaudite	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	dited Cost				
			Field Aud	dited Cost				
DISTRIBUTIO	ON:					THE		
Fiscal Ag	ent					M		
Contract	Managem	ent				Rydell Samu	uel, Administra	ator
Program	Finance						ogram Financ	
State Hea	alth Office							
						For Info	ormation Only	<i>!</i>
							ange In Rate	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Highlands Cou	unty Health	Department			Provide	er Number:	0279382-91	
7205 South G	eorge Boul	evard				Date:	07/01/2020	
Sebring, FL 3	33872				Fiscal	Year End:	06/30/2019	
					Au	udit Status:	Unaudited C	ost
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			127	.71	135	5.85	07/01/2020
Rate Type								
	<u>Interim</u>			X	<u>Prospectiv</u>	<u>e</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	For New Costs
DISTRIBUTIO Fiscal Ago Contract I Program	ent Manageme	nt	Desk Au	ed Cost eviewed Cost dited Cost dited Cost	<u>R</u>		el, Administra ogram Finance	
State Hea	alth Office						ormation Only ange In Rate)	
						`	<u> </u>	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

ndian River County Health Depart	ment		Provider	Number:	0279412-00	
1900 27th Street				Date:	07/01/2020	
Vero Beach, FL 32960			Fiscal \	ear End:	06/30/2019	
			Auc	it Status:	Unaudited Co	ost
Provider Type		Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
<u>CHD</u>	-	148	.06	147	.15	07/01/2020
Rate Type						
<u>Interim</u>		X	<u>Prospective</u>			
Total Inte	rim		X	Total Pro	ospective	
Settlemen	nt Based on Cost			Prospec	tive Adjusted	For New Costs
DISTRIBUTION: Fiscal Agent Contract Management	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost			el, Administra	
Program Finance State Health Office			Me	dicaid Prog	gram Finance	9
State Health Office						
				For Info	rmation Only	
				– (No Cha	ange In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Indian River C	County Hea	alth Departmer	t		Prov	vider Number:	0279412-0	)1
1900 27th Stre	eet					Date:	07/01/2020	0
Vero Beach, F	L 32960				Fis	cal Year End:	06/30/2019	9
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	<u>CHD</u>			148	.06	147	7.15	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospec	<u>tive</u>		
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs
DISTRIBUTIO Fiscal Ago Contract I Program I State Hea	ent Managemo Finance	ent	Desk R Desk A	ted Cost eviewed Cost udited Cost udited Cost		Rydell Samu Medicaid Pro		
							ormation Or ange In Rat	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

ndian River C	County Heal	th Departmen	nt		Pro	vider Number	: 0279412-02	2
1900 27th Str	eet					Date	07/01/2020	
Vero Beach, F	FL 32960				Fi	scal Year End	06/30/2019	
						Audit Status	Unaudited (	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			148	.06	14	7.15	07/01/2020
Rate Type								
	Interim -			X	Prospec			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ective Adjuste	ed For New Costs
DISTRIBUTIO Fiscal Ag Contract Program	jent Manageme	nt	Desk Au	ed Cost eviewed Cost idited Cost dited Cost			uel, Administr ogram Financ	
State Hea	alth Office					For Inf	ormation Only	v
							nange In Rate	-
						(	95	,



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### **Medicaid Reimbursement Rate Change Form for CHDs**

ndian River C	ounty Health Depa	rtment		Provi	der Number: 0279412-	03
1900 27th Stre	eet				Date: 07/01/202	20
Vero Beach, F	L 32960			Fisc	al Year End: 06/30/20	19
					Audit Status: Unaudited	d Cost
Provider Ty	<u>ype</u>		Curren	t Rate	New Rate	Effective Date
	<u>CHD</u>		148	.06	147.15	07/01/2020
Rate Type						
	Interim -		X	Prospecti		
	Total Int			X	Total Prospective	
	Settleme	ent Based on Cost			Prospective Adjus	sted For New Costs
DISTRIBUTIO Fiscal Age Contract N	ent Management	Desk Au	ed Cost eviewed Cost dited Cost dited Cost		Rydell Samuel, Admini Medicaid Program Fina	
State Hea						
					For Information C	nly
				_	(No Change In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Indian River County Health Department		Provider Nur	nber: 0279412-0	4
1900 27th Street		I	Date: 07/01/2020	
Vero Beach, FL 32960		Fiscal Year	End: 06/30/2019	
		Audit St	atus: Unaudited	Cost
Provider Type	Current	Rate	New Rate	Effective Date
<u>CHD</u>	148.	06	147.15	07/01/2020
Rate Type				
<u>Interim</u>	X	<u>Prospective</u>		
Total Interim		X To	tal Prospective	
Settlement Based on	Cost	Pr	ospective Adjuste	ed For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	S: Budget Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost		Samuel, Administ d Program Finan	
State Health Office			or Information Onlo	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Indian River County Health Dep	artment		Provide	r Number: 0	279412-05	
1900 27th Street				Date: 0	7/01/2020	
Vero Beach, FL 32960			Fiscal	Year End: 0	6/30/2019	
			Au	dit Status: L	Inaudited Co	st
Provider Type		Curren	t Rate	New R	<u>ate</u>	Effective Date
CHD		148	.06	147.	15	07/01/2020
Rate Type Interim		X	Prospective			
Total I	nterim		<u>- 1103ресшче</u> - Х	Total Pro	spective	
	nent Based on Cost			_	•	For New Costs
				_	,	
DISTRIBUTION:  Fiscal Agent  Contract Management  Program Finance  State Health Office	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost	Ry		, Administrat ram Finance	<u>or</u>
Ciato Ficaliti Cinoc				_	mation Only	
				(No Char	nge In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Indian River Coun	nty Heal	lth Departmen	ıt			Pro	vider N	umber:	0279412-3	0	
1900 27th Street								Date:	07/01/2020	)	
Vero Beach, FL 3	32960					Fis	scal Ye	ar End:	06/30/2019	)	
							Audit	Status:	Unaudited	Cost	
Provider Type	<u>)</u>				Curren	t Rate		New	Rate	<u>Effe</u>	ctive Date
<u>C</u> l	<u>HD</u>				148	.06		147	'.15	07/	/01/2020
Rate Type											
<u>Int</u>	<u>terim</u>				X	<u>Prospec</u>	<u>tive</u>				
		Total Interim				X		Total Pr	ospective		
		Settlement Ba	ased or	n Cost				Prospec	ctive Adjuste	ed For Ne	w Costs
DISTRIBUTION: Fiscal Agent Contract Man Program Fina State Health	ance	nt		Budget Unaudited	iewed Cost ited Cost				el, Administ gram Finan		
									rmation On ange In Rat	-	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Indian River C	ounty Hea	alth Departmer	t		Prov	vider Number:	0279412-9	1
1900 27th Stre	eet					Date:	07/01/2020	)
Vero Beach, F	L 32960				Fis	cal Year End:	06/30/2019	)
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			148	.06	147	7.15	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospec	<u>tive</u>		
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs
DISTRIBUTIO Fiscal Age Contract N Program N State Hea	ent Managemo Finance	ent	Desk R Desk A	ted Cost eviewed Cost udited Cost udited Cost		Rydell Samu Medicaid Pro		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Indian River C	County Hea	alth Departmen	nt			Pro	ovider Numbe	r: 0279412-	92
1900 27th Str	eet						Date	e: 07/01/202	20
Vero Beach, F	L 32960					Fi	iscal Year End	d: 06/30/201	19
							Audit Status	s: Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>Nev</u>	v Rate	Effective Date
	<u>CHD</u>				148	.06	14	7.15	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>		
		Total Interim				X	Total	Prospective	
		Settlement Ba	ased on	Cost			Prosp	ective Adjus	sted For New Costs
<b>DISTRIBUTIC</b> Fiscal Ag Contract		ent	X U	udget Inaudited Jesk Revi Jesk Audi	I Cost iewed Cost ited Cost ited Cost		Rydell Sam	uual Admini	etrator
Contract Program	_	ent						uel, Adminis	
_	alth Office						Wouldard F	rogiani i ille	
								formation O	-



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### **Medicaid Reimbursement Rate Change Form for CHDs**

ndian River C	County Heal	lth Departmen	nt		Provid	er Number:	0279412-96	
1900 27th Stre	eet					Date:	07/01/2020	
Vero Beach, F	FL 32960				Fisca	l Year End:	06/30/2019	
					А	udit Status:	Unaudited C	ost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			148	.06	147	7.15	07/01/2020
Rate Type								
	<u>Interim</u>			X	<u>Prospectiv</u>	<u>⁄e</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	For New Costs
DISTRIBUTIO Fiscal Ago Contract I Program I State Hea	ent Manageme Finance	nt	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost	<u>F</u>	-	el, Administra ogram Finance	
					_		ormation Only	
						(No Ch	ange In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson Cour	nty Health I	Department			Provider Number: 0279421-00				
P. O. Box 310	)					Date:	07/01/2020		
Marianna, FL	32447				Fis	scal Year End:	06/30/2019		
						Audit Status:	Unaudited C	Cost	
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			166	.57	159	9.23	07/01/2020	
Rate Type	Interim			X	Prospec	tive			
	_	Total Interim			- X		rospective		
		- Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs	
DISTRIBUTIO	<u>ON:</u>		Desk Aud	d Cost viewed Cost dited Cost dited Cost		R			
Fiscal Ag						PU			
Contract	Manageme	ent				Rydell Samu	ıel, Administra	ator	
Program	Finance						ogram Financ		
State Hea	alth Office								
						For Info	ormation Only	/	
						— (No Ch	ange In Rate	)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson Count	ty Health I	Department				Pro	ovider Numb	er: 0279421-	01
P. O. Box 310							Da	te: 07/01/202	20
Marianna, FL	32447					F	iscal Year Er	nd: 06/30/201	19
							Audit Statu	us: Unaudited	d Cost
<u>Provider Ty</u>	<u>pe</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date
	<u>CHD</u>				166	.57	1	59.23	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>		
		Total Interim				X	Total	Prospective	
•		Settlement Ba	ased o	n Cost			Pros	pective Adjus	sted For New Costs
<u>DISTRIBUTIO</u>			X	Budget Unaudited	iewed Cost ited Cost		T		
Fiscal Age							LA		
Contract N	_	ent						nuel, Adminis	
Program F							Medicaid I	Program Fina	ince
State Heal	Ith Office								
							For I	nformation O	nly
							(No (	Change In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson Cour	nty Health [	Department			Provid	er Number:	0279421-02	
P. O. Box 310	)					Date:	07/01/2020	
Marianna, FL	32447				Fisca	l Year End:	06/30/2019	
					A	udit Status:	Unaudited C	ost
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			166	.57	159	9.23	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospectiv	<u>′e</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
DISTRIBUTIO Fiscal Ag Contract I Program State Hea	ent Manageme Finance	ent	BASIS:  Budget  Unaudited  Desk Rev  Desk Aud  Field Audi	riewed Cost lited Cost	<u>.</u>		uel, Administra ogram Financ	
					_		ormation Only ange In Rate)	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson Coun	ckson County Health Department						Provider Number: 0279421-03				
P. O. Box 310								Date:	07/01/2020		
Marianna, FL	32447						Fiscal Y	ear End:	06/30/2019		
							Aud	it Status:	Unaudited (	Cost	
Provider Ty	<u>ype</u>				Curren	t Rate		<u>New</u>	<u>Rate</u>	Effective D	)ate
	CHD			_	166	.57		159	0.23	07/01/20	20
Rate Type	Interim				X	Prosp	ective				
	•	Total Interim				_	X	Total P	rospective		
		Settlement Ba	ased on Cos	st				_	•	ed For New Costs	S
DISTRIBUTIO			Desk	udited Revie Audit	Cost ewed Cost ted Cost ed Cost		-	F			
Fiscal Age	ent						7	V			
	Manageme 	ent							el, Administr		
Program I							Med	licaid Pro	gram Finan	ce	
State Hea	alth Office										
								For Info	rmation Onl	у	
								- (No Ch	ange In Rate	e)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson Count	ty Health D	epartment				Р	Provider N	lumber:	0279421-04	4	
P. O. Box 310								Date:	07/01/2020		
Marianna, FL	32447						Fiscal Ye	ar End:	06/30/2019		
							Audit	Status:	Unaudited	Cost	
Provider Ty	<u>pe</u>				Curren	t Rate		New	Rate	Effective	<u>Date</u>
	CHD				166	.57		159	0.23	07/01/2	020
Rate Type	<u>Interim</u>				X	<u>Prosp</u>	<u>ective</u>				
		Total Interim					X	Total P	rospective		
		Settlement Ba	ased or	Cost				Prospe	ctive Adjuste	ed For New Cos	sts
DISTRIBUTIOI	<u>N:</u>			Budget Unaudited	iewed Cost ited Cost			R			
Fiscal Age	ent						19	1			
Contract M	_	nt							el, Administ		
Program F							Medi	caid Pro	gram Finan	ce	
State Heal	Ith Office										
								For Info	ormation Onl	ly	
								(No Ch	ange In Rate	e)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson Cour	nty Health	Department			Provi	der Number:	0279421-13	3
P. O. Box 310	)					Date:	07/01/2020	
Marianna, FL	32447				Fisc	al Year End:	06/30/2019	
						Audit Status:	Unaudited (	Cost
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			166	.57	159	9.23	07/01/2020
Rate Type	<u>Interim</u>			X	Prospecti	ive		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs
	ent Manageme	ent	Desk Au	d Cost viewed Cost dited Cost dited Cost		Rydell Samu		
Program	Finance				-	Medicaid Pro		
State Hea	alth Office							
						For Info	ormation Onl	у
					-	(No Ch	ange In Rate	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson Count	ty Health [	Department				Pr	ovider Numl	ber: 0279421-	14
P. O. Box 310							D	ate: 07/01/202	20
Marianna, FL	32447					F	iscal Year E	nd: 06/30/201	19
							Audit Sta	tus: Unaudited	d Cost
Provider Ty	<u>pe</u>				Curren	t Rate	<u>N</u>	ew Rate	Effective Date
	<u>CHD</u>				166	.57	_	159.23	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>		
		Total Interim				- x	Tota	al Prospective	
_		Settlement Ba	ased on	Cost			Pro	spective Adjus	sted For New Costs
DISTRIBUTIO				Budget Unaudited	iewed Cost ited Cost		T		
Fiscal Age	ent						PU		
Contract M	_	ent						amuel, Adminis	
Program F							Medicaid	Program Fina	ince
State Heal	Ith Office								
							For	Information O	nly
							(No	Change In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson County Health Departme	ent		Provider Number: 0279421-30				
P. O. Box 310				Date:	07/01/2020		
Marianna, FL 32447			Fiscal	Year End:	06/30/2019		
			Au	dit Status:	Unaudited Co	ost	
Provider Type		Curren	t Rate	New	Rate	Effective Date	
<u>CHD</u>		166	.57	159	.23	07/01/2020	
Rate Type Interim		X	Prospective				
Total Int	erim		- X		ospective		
	ent Based on Cost			_	·	For New Costs	
	one Bassa on Soci				nivo majaotoe	. 1 01 110W 000t0	
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost			el, Administra gram Finance		
State Fredhill Silver				For Info	rmation Only		
				(No Cha	ange In Rate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jackson Cour	nty Health I	Department				Pr	ovider Numbe	er: 0279421-	-91
P. O. Box 310	)						Dat	e: 07/01/202	20
Marianna, FL	32447					F	iscal Year En	d: 06/30/20	19
							Audit Statu	s: Unaudite	d Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date
	CHD				166	.57	1	59.23	07/01/2020
Rate Type	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>		
	_	Total Interim				_ X	Total	Prospective	
		Settlement Ba	ased on C	ost			Prosp	pective Adjus	sted For New Costs
<b>DISTRIBUTIC</b> Fiscal Ag			X Un De	dget audited sk Revi sk Audi	Cost fewed Cost ited Cost ted Cost		R		
Contract	Manageme	ent					Rydell San	nuel, Admini	strator
Program	Finance							Program Fina	
State Hea	alth Office								
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							(No 0	Change In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jefferson Cou	unty Health	Department			Provider Number: 0279439-00				
1255 W. Was	hington Str	reet				Date	07/01/2020		
Monticello, FL	32344				Fis	scal Year End:	06/30/2019		
						Audit Status:	Unaudited C	ost	
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			166	.57	160	0.57	07/01/2020	
Rate Type									
	Interim -			X	Prospec				
		Total Interim			X		rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs	
Program	jent Manageme	ent	BASIS:  Budget  Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ		
2.3.0 . 100						For Info	ormation Only	,	
							ange In Rate		
						(INO Ch	ianye in Kale	J	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jefferson Cou	unty Health	Department			Provider Number: 0279439-04				
1255 W. Was	hington Str	reet				Date	07/01/2020		
Monticello, FL	32344				Fis	scal Year End:	06/30/2019		
						Audit Status:	Unaudited C	ost	
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			166	.57	160	0.57	07/01/2020	
Rate Type									
	<u>Interim</u>			X	<u>Prospec</u>				
		Total Interim			X		rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs	
Program	jent Manageme	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ		
Glate Hea									
							ormation Only		
						(No Ch	ange In Rate	)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Jefferson County Health Department		Provider Number: 0279439-30					
1255 W. Washington Street		Date	e: 07/01/2020				
Monticello, FL 32344		Fiscal Year End	d: 06/30/2019				
		Audit Status	: Unaudited Co	st			
Provider Type	Current I	Rate Nev	v Rate	Effective Date			
CHD	166.5	7 16	60.57	07/01/2020			
Rate Type							
<u>Interim</u>	X_ <u>F</u>	<u>Prospective</u>					
Total Interim	_		Prospective				
Settlement Based on C	Cost _	Prosp	ective Adjusted	For New Costs			
X UI De	udget naudited Cost esk Reviewed Cost esk Audited Cost eld Audited Cost		uel, Administrat rogram Finance	<u>or</u>			
			formation Only hange In Rate)				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Lee County H	lealth Depa	artment				Pro	vider Number	: 0279463-	00
3920 Michiga	n Avenue						Date	: 07/01/202	20
Fort Myers, F	L 33916					Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>New</u>	<u> Rate</u>	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total F	rospective	
		Settlement Ba	ased on C	ost			Prospe	ective Adjus	sted For New Costs
<u>DISTRIBUTIO</u> Fiscal Ag			X Ur De	idget iaudited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost		R		
_	Manageme	ent					Rydell Samı	uel. Adminis	strator
Program	_						Medicaid Pr		
State Hea	alth Office								
							For Inf	ormation O	nly
							— (No Ch	nange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Lee County H	ealth Depa	artment				Pro	ovider Num	ber: 0279463-	01
3920 Michigar	n Avenue						D	ate: 07/01/202	20
Fort Myers, Fl	_ 33916					Fi	iscal Year E	End: 06/30/201	19
							Audit Sta	tus: Unaudited	d Cost
Provider Ty	<u>ype</u>				Curren	t Rate	<u>N</u>	lew Rate	Effective Date
	CHD			-	166	.57		166.59	07/01/2020
Rate Type									
	<u>Interim</u>				X	Prospe			
		Total Interim				X		al Prospective	
		Settlement Ba	ased on C	ost			——— Pro	spective Adjus	sted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ago Contract I Program I State Hea	ent Manageme Finance	ent	X Ur De	idget naudited esk Revi esk Audi	Cost ewed Cost ited Cost ted Cost			amuel, Adminis I Program Fina	
								Information O Change In Ra	•



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### **Medicaid Reimbursement Rate Change Form for CHDs**

_ee County Hea	alth Depart	tment				F	Provide	Number:	0279463	-04		
3920 Michigan	Avenue							Date:	07/01/20	20		
ort Myers, FL	33916						Fiscal `	ear End:	06/30/20	19		
							Aud	dit Status:	Unaudite	ed Cost		
Provider Ty <sub>l</sub>	<u>oe</u>				Curren	t Rate		<u>New</u>	Rate	<u>E</u>	Effective I	<u>Date</u>
<u>!</u>	<u>CHD</u>				166	.57		160	6.59		07/01/20	20
Rate Type I	nterim				X	Prosp	ective					
		Total Interim					Χ		rospective	)		
_		Settlement Ba	ased on	Cost				– Prospe	ctive Adju	sted For	New Cost	:S
DISTRIBUTION	<u>l:</u>		) X	Budget Jnaudited	iewed Cost ited Cost			R				
Fiscal Ager							1	ell				
Contract Ma Program Fi State Healt	nance	nt							el, Admin ogram Fina			
								For Info	ormation C	Only		
								– (No Ch	ange In R	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

_eon County I	Health Dep	artment				Р	Provider N	lumber:	0279471-	00		
2965 Municipa	al Way							Date:	07/01/202	20		-
Tallahassee, F	FL 32304						Fiscal Ye	ar End:	06/30/201	19		
							Audit	Status:	Unaudited	d Cost		_
Provider Ty	<u>ype</u>				Curren	t Rate		<u>New</u>	<u>Rate</u>	<u>E</u> 1	ffective Date	<u> </u>
	CHD				159	.06		118	3.82		07/01/2020	_
Rate Type	Intorim				X	Prospe	octivo					
	<u>Interim</u> -	Total Interim				_	X	Total P	rospective			
		Settlement Ba	ased on	Cost					•	sted For	New Costs	
									,			
			BASI	<u>S:</u>								
				Budget								
				Unaudited	l Cost							
				Desk Revi	iewed Cost							
				Desk Aud	ited Cost							
				Field Audi	ted Cost							
DISTRIBUTIO	N·							R				
Fiscal Age							p	1				
Contract I	Manageme	nt					Ryde	ell Samu	el, Adminis	strator		
Program I	Finance						Medi	caid Pro	gram Fina	ince		
State Hea	alth Office											
								For Info	ormation O	nly		
								(No Ch	ange In Ra	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Leon County	Health Dep	partment			Pro	vider Number:	0279471-91	
2965 Municip	al Way					Date	07/01/2020	
Tallahassee,	FL 32304				Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			159	.06	118	3.82	07/01/2020
Rate Type				V	_			
	Interim -	Total Interim		X	_ <u>Prospec</u> -		roopootivo	
		Total Interim	and an Coat		X		rospective	d Far New Casts
	-	Settlement Ba -	ased on Cost			——— Prospe	ctive Adjusted	d For New Costs
Program	ent Manageme	ent	Desk Au	ed Cost viewed Cost dited Cost dited Cost			ıel, Administra ogram Financo	
2.3.0	<b>.</b>					Ear Infe	ormation Only	
							ange In Rate)	
						(NO Ch	ange in Rate)	1



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### **Medicaid Reimbursement Rate Change Form for CHDs**

_evy County H	Health Dep	artment				Pro	ovider Numbe	er: 0279480-	00
P. O. Box 406	66 South M	lain Street					Dat	e: 07/01/202	20
Bronson, FL	32621					Fi	scal Year En	d: 06/30/201	19
							Audit Statu	s: Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>Ne</u>	w Rate	Effective Date
	<u>CHD</u>				166	.57	1	66.59	07/01/2020
Rate Type	Interim				X	Prospec	ctive		
		Total Interim				X	Total	Prospective	
		Settlement Ba	ased on C	ost			Prosp	ective Adjus	sted For New Costs
DISTRIBUTIO Fiscal Ag Contract I Program	ent Manageme	ent	X Ur De	idget audited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost			nuel, Adminis Program Fina	
_	alth Office						Modicaid	rogiani i illa	
								nformation O Change In Ra	-



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Levy County Health Department		Prov	vider Number: 0279480-9	91
P. O. Box 4066 South Main Street			Date: 07/01/202	0
Bronson, FL 32621		Fis	cal Year End: 06/30/201	9
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		166.57	166.59	07/01/2020
Rate Type				
<u>Interim</u>		X Prospect	<u>tive</u>	
Total Inte	rim	X	Total Prospective	
Settlemen	nt Based on Cost		Prospective Adjus	ted For New Costs
	BASIS:			
	Budget			
	X Unaudited	d Cost		
	Desk Rev	riewed Cost		
	Desk Aud	lited Cost		
	Field Aud	ited Cost		
DISTRIBUTION:			T	
Fiscal Agent			PU	
Contract Management			Rydell Samuel, Adminis	strator
Program Finance			Medicaid Program Fina	
State Health Office			-	
			For Information O	nly
			(No Change In Ra	te)



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

_iberty Count	y Health D	epartment			Pro	vider Number	0279498-00	
P. O. Box 489	9247 N. Ce	entral Street				Date	07/01/2020	
Bristol, FL 32	2321				Fis	scal Year End	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			144	.88	160	6.59	07/01/2020
Rate Type				V	_			
	<u>Interim</u> -	Tatal Intovino		X	Prospec			
		Total Interim	and an Coat		X		rospective	d For New Cooks
		Settlement Ba -	ased on Cost			——— Prospe	ctive Adjusted	d For New Costs
			BASIS:					
			Budget					
			X Unaudited	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	lited Cost				
			Field Aud	lited Cost				
DISTRIBUTIO	NI:					- IR		
Fiscal Ag						g) ·		
_	Manageme	ent				Rvdell Samu	ıel, Administra	ator
Program	_						ogram Financ	
State Hea	alth Office							
						For Info	ormation Only	,
						—— (No Ch	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

_iberty County Health	Department			Provi	ider Number:	0279498-08	
P. O. Box 489247 N. (	Central Street				Date:	07/01/2020	
Bristol, FL 32321				Fisc	al Year End:	06/30/2019	
					Audit Status:	Unaudited C	Cost
Provider Type			Curren	t Rate	<u>New</u>	Rate	Effective Date
CHD		-	144	.88	166	5.59	07/01/2020
Rate Type							
<u>Interin</u>	<u>n</u>		X	Prospect	<u>ive</u>		
	Total Interim			X	Total P	rospective	
	Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
DISTRIBUTION: Fiscal Agent Contract Manage Program Finance State Health Office		BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audit	ewed Cost ted Cost		Rydell Samu Medicaid Pro		
				-		ormation Only ange In Rate	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

_iberty County	/ Health D	epartment			Prov	rider Number:	0279498-1	0
P. O. Box 489	247 N. Ce	ntral Street				Date:	07/01/2020	)
Bristol, FL 32	321				Fis	cal Year End:	06/30/2019	)
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			Curren	nt Rate	<u>New</u>	Rate	Effective Date
	CHD			144	.88	166	6.59	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospect	<u>tive</u>		
	_	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs
DISTRIBUTIO Fiscal Age Contract N Program N State Hea	ent Manageme Finance	ent	BASIS:  Budget  Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost		Rydell Samu Medicaid Pro		
							ormation On ange In Rat	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Liberty County	y Health De	partment				Р	rovider N	lumber:	0279498-	14		
P. O. Box 489	9247 N. Cer	ntral Street						Date:	07/01/202	20		
Bristol, FL 32	2321					F	Fiscal Ye	ar End:	06/30/201	19		
							Audit	Status:	Unaudited	d Cost		
Provider T	<u>ype</u>			<u>Cu</u>	<u>rren</u>	t Rate		New	<u>Rate</u>	<u>E</u>	ffective Da	<u>te</u>
	<u>CHD</u>			-	144	.88		166	5.59		07/01/2020	)
Rate Type	<u>Interim</u>			_	X	Prospe	<u>ective</u>					
		Total Interim				>	X	Total Pi	ospective			
		Settlement Ba	sed on Cost	t				Prospe	ctive Adjus	sted For	New Costs	
<b>DISTRIBUTIO</b> Fiscal Ag Contract		nt	Desk Desk	et dited Cost Reviewed ( Audited Co Audited Co	st		Ryde	<b>F</b>	el, Admini	strator		
Program	_								gram Fina			
_	alth Office											
								For Info	rmation O	nly		
								(No Ch	ange In Ra	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Liberty County	y Health De	epartment					Provider	Number:	0279498-3	30	
P. O. Box 489	9247 N. Ce	ntral Street						Date:	07/01/2020	0	
Bristol, FL 32	2321						Fiscal Y	ear End:	06/30/2019	9	
							Aud	it Status:	Unaudited	Cost	
Provider T	<u>ype</u>				Curren	t Rate		New	Rate	Effe	ective Date
	CHD				144	.88		166	5.59	07	/01/2020
Rate Type	<u>Interim</u>				X	<u>Pros</u>	<u>pective</u>				
		Total Interim					X	Total P	rospective		
		Settlement Ba	ased on C	ost				Prospe	ctive Adjust	ted For Ne	w Costs
<b>DISTRIBUTIC</b> Fiscal Ag			X Ur De	idget naudited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost		-	F			
_	Manageme	ent					Rvd	ell Samu	el, Adminis	trator	
Program	_								gram Finar		
State Hea	alth Office										
								For Info	ormation Or	nly	
								(No Ch	ange In Ra	te)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

_iberty County	y Health De	partment			Provider Number: 0279498-91					
P. O. Box 489	247 N. Cen	tral Street				Date:	07/01/2020	)		
Bristol, FL 32	2321				Fisc	al Year End:	06/30/2019	)		
						Audit Status:	Unaudited	Cost		
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			144.	.88	166	5.59	07/01/2020		
Rate Type	<u>Interim</u>			X	Prospecti	i <u>ve</u>				
	- 	Total Interim			X	Total P	rospective			
	;	Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs		
<b>DISTRIBUTIC</b> Fiscal Ag	ent		Desk F	et lited Cost Reviewed Cost Audited Cost Audited Cost		R				
	Managemer 	nt			-	Rydell Samu				
Program						Medicaid Pro	ogram Finan	ce		
State Hea	alth Office									
						For Info	ormation On	ly		
					_	(No Ch	ange In Rat	e)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Manatee Cou	nty Health	Department			Provider Number: 0279510-00					
410 Six Aveni	ue East					Date:	07/01/202	0		
Bradenton, FL	34208				Fisc	cal Year End:	06/30/201	9		
						Audit Status:	Unaudited	Cost		
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			117	.92	95	.90	07/01/2020		
Rate Type	<u>Interim</u>			X	Prospect	<u>ive</u>				
		Total Interim			Х		rospective	to I Fan No. Ocata		
		Settlement Ba -	ased on Cost			—— Prospe	ctive Adjus	ted For New Costs		
DISTRIBUTIO Fiscal Ag Contract		ent	Desk A			Rydell Samu	ıel. Adminis	strator		
Program	_	J. 14				Medicaid Pro				
_	alth Office						-			
						For Info	ormation Or	nly		
					•	(No Ch	ange In Ra	te)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Manatee County Health Department		Provider Number: 0279510-01					
410 Six Avenue East			Date: 07/01/2020				
Bradenton, FL 34208		Fiscal Ye	ar End: 06/30/2019				
		Audit	Status: Unaudited (	Cost			
Provider Type	Curren	t Rate	New Rate	Effective Date			
<u>CHD</u>	117	.92	95.90	07/01/2020			
Rate Type							
<u>Interim</u>	X	<u>Prospective</u>					
Total Interim			Total Prospective				
Settlement Ba	sed on Cost		Prospective Adjuste	d For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost	Ryde	Il Samuel, Administr				
State Health Office			For Information Onl				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Manatee County Health Depa	rtment		Provider Number: 0279510-30					
410 Six Avenue East				Date: 07/01/2	020			
Bradenton, FL 34208			Fiscal Y	ear End: 06/30/2	019			
			Aud	it Status: Unaudit	ed Cost			
Provider Type		Curren	t Rate	New Rate	Effective Date			
CHD	-	117.	.92	95.90	07/01/2020			
Rate Type		V						
<u>Interim</u>	Llata das	X	<u>Prospective</u>	Tatal Dagger action				
	I Interim		X	Total Prospectiv				
Settle	ement Based on Cost			Prospective Adj -	usted For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  Unaudited  Desk Revie  Desk Audit  Field Audite	ewed Cost ed Cost		lell Samuel, Admi dicaid Program Fil				
State Health Office								
				For Information	Only			
				– (No Change In∃	Rate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Manatee County Health Department		Provider Number: 0279510-91					
410 Six Avenue East			Date: 07/01/2020				
Bradenton, FL 34208		Fiscal Yea	ar End: 06/30/2019				
		Audit	Status: Unaudited C	Cost			
Provider Type	Currer	nt Rate	New Rate	Effective Date			
<u>CHD</u>	117	<u>.92                                    </u>	95.90	07/01/2020			
Rate Type							
<u>Interim</u>	X	Prospective					
Total Interim		X	Total Prospective				
Settlement Bas	ed on Cost		Prospective Adjuste	d For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost	Rydel	I Samuel, Administr				
State Health Office			For Information Only (No Change In Rate				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Marion County	on County Health Department					Provider Number: 0279528-00					
1801 S.E. 32r	nd Avenuel	P. O. Box 2408	3			Date:	07/01/2020				
Ocala, FL 34	478-2408				Fis	cal Year End:	06/30/2019				
						Audit Status:	Unaudited C	Cost			
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date			
	CHD			166	.57	160	6.59	07/01/2020			
Rate Type	<u>Interim</u>			X	Prospec	<u>tive</u>					
	_	Total Interim			_ X	Total P	rospective				
		- Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs			
			Desk Au	ed Cost eviewed Cost idited Cost dited Cost		-IR					
DISTRIBUTIO						R					
Fiscal Ag	jent Manageme	ant				f in	al Administra	-1			
Program	_	5111					iel, Administra ogram Financ				
•	alth Office					Modicald I II					
						For Info	ormation Only	/			
						(No Ch	ange In Rate	)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Marion Count	ion County Health Department						Provider Number: 0279528-01					
1801 S.E. 32r	nd AvenueF	. O. Box 2408	3				Date	e: 07/01/202	20			
Ocala, FL 34	478-2408					F	iscal Year End	d: 06/30/201	9			
							Audit Status	: Unaudited	d Cost			
Provider T	<u>ype</u>				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date			
	<u>CHD</u>				166	.57	16	6.59	07/01/2020			
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>					
		Total Interim				X	Total F	Prospective				
		Settlement Ba	ased on	Cost			Prosp	ective Adjus	sted For New Costs			
<u>DISTRIBUTIO</u> Fiscal Ag Contract		nt	X U	Budget Inaudited Desk Revi Desk Audi	I Cost iewed Cost ited Cost ted Cost		Rydell Sam	uel, Adminis	strator			
Program	_						Medicaid Pi					
State Hea	alth Office											
							For In	formation O	nly			
							(No C	hange In Ra	ate)			



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Marion County	on County Health Department				Provider Number: 0279528-02					
1801 S.E. 32r	nd AvenueP. O. Box	2408			Date: 07/01/2	2020				
Ocala, FL 34	478-2408			Fiscal Year End: 06/30/2019						
					Audit Status: Unaud	ited Cost				
Provider T	<u>ype</u>		Curren	t Rate	New Rate	Effective Date				
	<u>CHD</u>		166	.57	166.59	07/01/2020				
Rate Type										
	Interim -		X	Prospect						
	Total Inte			X	Total Prospecti					
	Settleme	nt Based on Cost			Prospective Ac	djusted For New Costs				
DISTRIBUTIO Fiscal Ag Contract Program	ent Management	Desk Au	d Cost viewed Cost dited Cost dited Cost		Rydell Samuel, Adm Medicaid Program F					
_	alth Office				3					
					For Information	n Only				
				_	(No Change In	Rate)				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Marion County	ion County Health Department						Provider Number: 0279528-04					
1801 S.E. 32r	nd AvenueF	P. O. Box 2408	3				Date	07/01/202	20			
Ocala, FL 34	478-2408					Fiscal Year End: 06/30/2019						
							Audit Status	Unaudited	l Cost			
Provider T	<u>ype</u>				Curren	t Rate	New	Rate	Effective Date			
	CHD				166	.57	16	6.59	07/01/2020			
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>					
		Total Interim				X	Total P	rospective				
		Settlement Ba	ased on	Cost			Prospe	ective Adjus	ted For New Costs			
<b>DISTRIBUTIO</b> Fiscal Ag Contract		nt		Budget Jnaudited	iewed Cost ited Cost		Rydell Samu	uel, Adminis	strator			
Program	Finance						Medicaid Pr					
State Hea	alth Office											
							For Inf	ormation O	nly			
							— (No Ch	nange In Ra	nte)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Marion County	y Health Departmei	nt		Provider Number: 0279528-05				
1801 S.E. 32r	nd AvenueP. O. Box	x 2408			Date: 0	7/01/2020		
Ocala, FL 34	478-2408			Fisca	l Year End: 0	6/30/2019		
				Δ	udit Status: L	Inaudited Co	ost	
Provider T	<u>ype</u>		Current F	Rate	New R	ate	Effective Date	
	CHD		166.5	7	166.	59	07/01/2020	
Rate Type	last outine		V <b>.</b>		_			
	_ <u>Interim</u> _ Total Inf	torim	X_ <u>P</u>	rospectiv X	<u>/e</u> Total Pro	enoctivo.		
		ent Based on Cost	_			•	For New Costs	
		ent based on cost	_			ve Aujusteu	TOTACW COSIS	
		BASIS:						
		Budget						
		X Unaudited	d Cost					
		Desk Rev	iewed Cost					
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DISTRIBUTIO					At .			
Fiscal Ag	ent Management			-	\	A . l ' . ' . t		
Program				_	Rydell Samuel Medicaid Prog			
State Hea				•,	nodiodia i rog		,	
					For Inforr	nation Only		
					(No Char	ige In Rate)		



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Marion County Health Department	on County Health Department					Provider Number: 0279528-12					
1801 S.E. 32nd AvenueP. O. Box 2	408			Date:	07/01/2020						
Ocala, FL 34478-2408			Fiscal	Year End:	06/30/2019						
			Αι	udit Status:	Unaudited C	Cost					
Provider Type		Curren	t Rate	New	<u>Rate</u>	Effective Date					
<u>CHD</u>	-	166	.57	166	5.59	07/01/2020					
Rate Type											
Interim		X	Prospective								
Total Interi			X		ospective						
Settlement	Based on Cost			Prospec —	ctive Adjusted	d For New Costs					
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost	<u>R</u>		el, Administra gram Financ						
State Health Office			IVI	Calcala i 10	grann i manc						
2.3.10											
				For Info	rmation Only	′					
				(No Cha	ange In Rate	)					



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Marion County	y Health Department		Provider Number: 0279528-30					
1801 S.E. 32n	nd AvenueP. O. Box 240	)8			Date:	07/01/2020		
Ocala, FL 344	478-2408			Fiscal \	ear End:	06/30/2019		
				Auc	lit Status:    -	Unaudited Co	ost	
Provider Ty	<u>ype</u>		Curren	t Rate	New I	Rate	Effective Date	
	CHD		166	.57	166.	.59	07/01/2020	
Rate Type								
	Interim -		X	<u>Prospective</u>				
	Total Interim	l		X	Total Pro	ospective		
	Settlement E	Based on Cost			Prospec	tive Adjusted	For New Costs	
DISTRIBUTIO Fiscal Age Contract I Program	ent Management Finance	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost	Ryc		el, Administra gram Finance		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Marion County	arion County Health Department						Provider Number: 0279528-91				
1801 S.E. 32r	nd Avenuel	P. O. Box 2408	3					Date:	07/01/202	.0	
Ocala, FL 34	478-2408					]	Fiscal Ye	ar End:	06/30/201	9	
							Audit	Status:	Unaudited	Cost	
Provider T	<u>ype</u>				Curren	t Rate		<u>New</u>	<u>Rate</u>	<u>Ef</u>	fective Date
	CHD				166	.57		166	5.59	0	7/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ective</u>				
		Total Interim					X	Total P	rospective		
		Settlement Ba	ased on Co	ost				Prospe	ctive Adjus	ted For N	New Costs
DISTRIBUTIO Fiscal Ag Contract Program	ent Manageme	ent	X Una	dget audited sk Revi sk Audi	I Cost iewed Cost ited Cost ted Cost				el, Adminis gram Fina		
State Hea	alth Office										
								For Info	ormation O	nly	
								(No Ch	ange In Ra	ite)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Martin County	y Health Departme	ent		Provider Number: 0279536-00					
3441 SE Willo	oughby Blvd.				Date: 0	7/01/2020			
Stuart, FL 34	994-5060			Fiscal Year End: 06/30/2019					
				A	Audit Status: U	Inaudited Co	st		
Provider T	<u>ype</u>		<u>Curren</u>	t Rate	New R	<u>late</u>	Effective Date		
	<u>CHD</u>		162	.19	166.	59	07/01/2020		
Rate Type									
	<u>Interim</u> –		X	Prospecti					
		nterim		X	Total Pro	·			
	Settle	ment Based on Cost			Prospect	ive Adjusted	For New Costs		
DISTRIBUTIO Fiscal Ag Contract Program	jent Management	Desk Au	ed Cost eviewed Cost udited Cost udited Cost	_	Rydell Samuel Medicaid Prog				
_	alth Office				_				
				_		mation Only			
					(No Char	nge In Rate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Martin County Health Departr	nent		Provider Number: 0279536-11					
3441 SE Willoughby Blvd.				Date:	07/01/2020			
Stuart, FL 34994-5060			Fiscal Y	ear End:	06/30/2019			
			Audi	t Status:	Unaudited Co	st		
Provider Type		Curren	t Rate	New	<u>Rate</u>	Effective Date		
<u>CHD</u>	-	162.	.19	166	.59	07/01/2020		
Rate Type								
<u>Interim</u>		X	<u>Prospective</u>					
Tota	al Interim		X	Total Pr -	rospective			
Sett	lement Based on Cost			Prospect	ctive Adjusted	For New Costs		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office	BASIS:  Budget  Unaudited  Desk Revie  Desk Audit  Field Audite	ewed Cost ed Cost			el, Administrat gram Finance			
State Health Office				_	ormation Only			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Martin County	Health Department			Provi	der Number:	0279536-91	1
3441 SE Willo	oughby Blvd.				Date:	07/01/2020	
Stuart, FL 349	994-5060			Fisc	al Year End:	06/30/2019	
				,	Audit Status:	Unaudited (	Cost
Provider Ty	<u>ype</u>		Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD		162	.19	166	5.59	07/01/2020
Rate Type							
	<u>Interim</u> -		X	Prospecti			
	Total Interir			X		ospective	
	Settlement	Based on Cost			Prospecture Prospe	ctive Adjuste	ed For New Costs
DISTRIBUTIO Fiscal Age Contract I Program I State Hea	ent Management Finance	BASIS:  Budget  Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost	_	Rydell Samu Medicaid Pro		
					For Info	rmation Onl	у
				_	(No Ch	ange In Rate	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe Coun	ty Health D	Department			Provid	der Number:	0279544-0	0		
5100 College	Road					Date:	07/01/2020	)		
Key West, FL	33040				Fiscal Year End: 06/30/2019					
					ı	Audit Status:	Unaudited	Cost		
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			166	.57	166	5.59	07/01/2020		
Rate Type	<u>Interim</u>			X	Prospecti	<u>ve</u>				
		Total Interim			X	Total P	rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs		
<b>DISTRIBUTIC</b> Fiscal Ag	ent		Desk R	ted Cost eviewed Cost udited Cost udited Cost		R				
	Manageme	ent			_	Rydell Samu				
Program					ı	Medicaid Pro	ogram Finan	ice		
State Hea	alth Office									
						For Info	ormation On	ly		
					_	(No Ch	ange In Rat	e)		



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe County	onroe County Health Department						Provider Number: 0279544-01				
5100 College F	Road						Date	9: 07/01/202	0		
Key West, FL	33040					Fiscal Year End: 06/30/2019					
							Audit Status	: Unaudited	l Cost		
<u>Provider Ty</u>	<u>rpe</u>				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date		
	<u>CHD</u>				166	.57	16	6.59	07/01/2020		
Rate Type	<u>Interim</u>				X	<u>Prospe</u>	ctive				
		Total Interim				- · x		Prospective			
		- Settlement Ba	ased or	n Cost			Prosp	ective Adjus	ted For New Costs		
<b>DISTRIBUTIO</b> Fiscal Age	ent			Budget Unaudited	iewed Cost ited Cost		R				
Contract N	Manageme	ent					Rydell Sam	uel, Adminis	strator		
Program F							Medicaid P	rogram Fina	nce		
State Hea	Ith Office										
							For In	formation O	nly		
							(No C	hange In Ra	ite)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe Coun	ty Health D	epartment				Р	Provider N	Number:	0279544-	-03		
5100 College	Road							Date:	07/01/202	20		
Key West, FL	33040						Fiscal Ye	ear End:	06/30/20	19		
							Audit	Status:	Unaudite	d Cost		
Provider Ty	<u>ype</u>				Curren	t Rate		New Rate Effecti			ffective Da	<u>te</u>
	<u>CHD</u>				166	.57		166	5.59		07/01/2020	<u>)                                    </u>
Rate Type	<u>Interim</u>				X	Prospe	ective					
	<u> </u>	Total Interim				_ `	X	Total P	rospective			
		Settlement Ba	ased on	Cost				ı	•		New Costs	
			<b>BASIS</b>	<u>3:</u>								
			Е	Budget								
			<u> </u>	Jnaudited	l Cost							
				esk Revi	iewed Cost							
				esk Audi	ited Cost							
			<u> </u>	ield Audi	ted Cost							
DISTRIBUTIO	ON:							ア				
Fiscal Ag							P	4				
Contract I	Manageme	ent					Ryde	ell Samu	el, Admini	strator		
Program	Finance								gram Fina			
State Hea	alth Office											
								For Info	ormation C	nly		
								(No Ch	ange In Ra	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe Count	ty Health [	Department				Pro	ovider Numbe	r: 0279544-	-04		
5100 College	Road						Dat	e: 07/01/202	20		
Key West, FL	33040					Fiscal Year End: 06/30/2019					
							Audit Statu	s: Unaudited	d Cost		
Provider Ty	<u>/pe</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date	<u>5</u>	
	CHD			-	166	.57	10	66.59	07/01/2020	_	
Rate Type											
	<u>Interim</u>				X	Prospe					
		Total Interim				X		Prospective			
		Settlement Ba	ased on (	Cost			Prosp	ective Adjus	sted For New Costs		
DISTRIBUTIO Fiscal Age Contract N Program I State Hea	ent Manageme Finance	ent	X U	udget naudited esk Revi esk Audi	Cost lewed Cost ited Cost ted Cost			nuel, Admini rogram Fina			
								nformation O	•		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe Coun	ty Health D	Department			Provider Number: 0279544-08					
5100 College	Road					Date:	07/01/2020			
Key West, FL	33040				Fiscal Year End: 06/30/2019					
						Audit Status:	Unaudited Co	ost		
Provider T	<u>уре</u>			<u>Curren</u>	t Rate	New Rate		Effective Date		
	CHD			166	.57	160	6.59	07/01/2020		
Rate Type	Interim			X	Prospec	tive				
		Total Interim			- X		rospective			
	-	- Settlement Ba	ased on Cost				-	For New Costs		
<b>DISTRIBUTIO</b> Fiscal Ag			BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost		F				
_	Manageme	ent				Pydoll Samu	ual Administra	ator		
Program		····					iel, Administra ogram Finance			
_	alth Office									
						For Info	ormation Only			
						(No Ch	ange In Rate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe Coun	onroe County Health Department						Provider Number: 0279544-13					
5100 College	Road							Date:	07/01/2020	)		
Key West, FL	33040					Fiscal Year End: 06/30/2019						
							Aud	it Status:	Unaudited	Cost		
Provider Ty	<u>ype</u>				Curren	t Rate		<u>New</u>	<u>Rate</u>	Effec	tive Date	
	CHD			-	166	.57		166	5.59	07/0	01/2020	
Rate Type												
	<u>Interim</u>				X	<u>Prosp</u>	<u>ective</u>					
		Total Interim					Χ	Total P	ospective			
		Settlement Ba	ased on C	ost				Prospe	ctive Adjust	ed For New	/ Costs	
Program	ent Managemo Finance	ent	X Un De	idget iaudited esk Revi esk Audi	Cost ewed Cost ted Cost ted Cost				el, Administ ogram Finan			
State Hea	alth Office							_	ormation On ange In Rat	-		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe County Health Department		Provider Number: 0279544-30					
5100 College Road			Date: 07/01/2020				
Key West, FL 33040		Fiscal Year End: 06/30/2019					
		Audi	t Status: Unaudited (	Cost			
Provider Type	<u>Currer</u>	nt Rate	New Rate	Effective Date			
<u>CHD</u>	166	5.57	166.59	07/01/2020			
Rate Type							
<u>Interim</u>	X	Prospective					
Total Interim		X	Total Prospective				
Settlement Ba	ased on Cost		Prospective Adjuste	ed For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost	Ryde	ell Samuel, Administricaid Program Finan				
State Health Office			For Information Onl (No Change In Rate				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe Coun	onroe County Health Department						Provider Number: 0279544-91				
5100 College	Road						Da	te: 07/01/202	20		
Key West, FL	33040					Fiscal Year End: 06/30/2019					
							Audit Stat	us: Unaudited	d Cost		
Provider T	<u>ype</u>				Curren	t Rate	<u>Ne</u>	ew Rate	Effective Date		
	CHD				166	.57	1	66.59	07/01/2020		
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>				
	_	Total Interim				_ x	Tota	I Prospective			
		Settlement Ba	ased on (	Cost			Pros	pective Adjus	sted For New Costs		
<b>DISTRIBUTIC</b> Fiscal Ag	ent		X U	udget naudited esk Revi esk Audi	I Cost iewed Cost ited Cost ited Cost		R				
Contract	Manageme	ent					Rydell Sa	muel, Adminis	strator		
Program							Medicaid	Program Fina	ance		
State Hea	alth Office										
							For	nformation O	nly		
							(No	Change In Ra	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe Coun	ty Health [	Department				F	Provider	Number:	0279544-9	2	
5100 College	Road							Date:	07/01/2020	)	
Key West, FL	33040						Fiscal Y	ear End:	06/30/2019	)	
							Aud	it Status:	Unaudited	Cost	
Provider T	уре				Curren	t Rate		<u>New</u>	Rate	Effective	<u>Date</u>
	CHD				166	.57		166	5.59	07/01/20	020
Rate Type											
	<u>Interim</u>				X	<u>Prosp</u>	<u>ective</u>				
		Total Interim					Χ	Total P	rospective		
		Settlement Ba	ased on (	Cost				Prospe	ctive Adjust	ed For New Cos	ts
			BASIS	<u>:</u> udget							
				naudited	Cost						
					ewed Cost						
			D	esk Audi	ted Cost						
			Fi	eld Audi	ted Cost						
DISTRIBUTIO	ON:							R			
Fiscal Ag							1	40			
Contract	Managem	ent					Ryc	lell Samu	el, Administ	rator	
Program	Finance						Med	dicaid Pro	gram Finan	ce	
State Hea	alth Office										
								For Info	ormation On	ly	
								No Ch	ange In Rat	e)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Monroe County Health Department			Provider	Number: 0279544-9	3
5100 College Road				Date: 07/01/2020	)
Key West, FL 33040			Fiscal Y	ear End: 06/30/2019	9
			Aud	lit Status: Unaudited	Cost
Provider Type		Curren	t Rate	New Rate	Effective Date
<u>CHD</u>		166	.57	166.59	07/01/2020
Rate Type					
<u>Interim</u>		X	Prospective		
Total Inter			X	Total Prospective	
Settlemen	t Based on Cost			Prospective Adjust	ed For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost	Ryc	dell Samuel, Administ dicaid Program Finar	
State Health Office			_	For Information On  (No Change In Rat	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Nassau Coun	ity Health D	Department			Pro	vider Number:	0279552-00	)
P. O. Box 517	7					Date	07/01/2020	
ernandina B	each, FL 3	32035-0517			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			125	.84	97	.95	07/01/2020
Rate Type	Interim			X	Prospec	tive		
		Total Interim			- X		rospective	
		- Settlement Ba	ased on Cost				-	d For New Costs
		-						
			BASIS:					
			Budget					
			X Unaudited	d Cost				
			Desk Rev	riewed Cost				
			Desk Aud	lited Cost				
			Field Aud	ited Cost				
DISTRIBUTIO	ON.					- IK		
Fiscal Ag						PU		
_	Manageme	ent				Rydell Samu	ıel, Administr	ator
Program	Finance						ogram Financ	
State Hea	alth Office							
						For Info	ormation Only	У
						— (No Ch	ange In Rate	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Nassau Coun	ty Health D	Department			Prov	ider Number:	0279552-0	1
P. O. Box 517	7					Date:	07/01/2020	)
ernandina B	each, FL 3	32035-0517			Fisc	al Year End:	06/30/2019	9
						Audit Status:	Unaudited	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			125	.84	97	.95	07/01/2020
Rate Type	<u>Interim</u>			X	Prospect	iv <u>e</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract		ent	Desk Au	ed Cost eviewed Cost udited Cost udited Cost		Rydell Samu	el, Adminis	trator
Program	_					Medicaid Pro		
State Hea	alth Office							
						For Info	ormation On	nly
					-	—— (No Ch	ange In Rat	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Nassau Coun	ty Health D	epartment				Р	rovider Numl	oer: 0279552	-04
P. O. Box 517	7						Da	ate: 07/01/20	20
ernandina B	each, FL 3	2035-0517				I	Fiscal Year E	nd: 06/30/20	19
							Audit Sta	tus: Unaudite	d Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>N</u>	ew Rate	Effective Date
	<u>CHD</u>				125	.84		97.95	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ective</u>		
		Total Interim					X Tota	al Prospective	•
		Settlement Ba	ased on C	ost			Pro	spective Adju	sted For New Costs
	ent Manageme	nt	X Un De	dget audited sk Revi	I Cost iewed Cost ited Cost ted Cost			amuel, Admini	
Program State Hea	Finance alth Office						iviedicaid	Program Fina	ance
Olalo Hea									
							For	Information C	Only
							(No	Change In R	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Nassau County	y Health De	epartment				F	Provider N	lumber:	0279552-0	)5		
P. O. Box 517								Date:	07/01/202	0		
ernandina Be	each, FL 32	2035-0517					Fiscal Ye	ear End:	06/30/201	9		
							Audit	Status:	Unaudited	Cost		
Provider Ty	<u>/pe</u>				Curren	t Rate		New	Rate	<u>Ef</u>	fective Da	<u>ıte</u>
	CHD				125	.84		97	.95		7/01/2020	0
Rate Type	<u>Interim</u>				X	Prosp	<u>ective</u>					
-		Γotal Interim Settlement Ba	sed on C	ost			X		rospective ctive Adjus	ted For N	New Costs	
DISTRIBUTIO Fiscal Age Contract M Program F	ent Managemer	nt	X Un De De	dget audited sk Revi sk Audi	I Cost iewed Cost ited Cost ted Cost				el, Adminis ogram Finai			
State Heal								For Info	ormation Or	nly		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Nassau County I	Health Departm	ent		Provide	r Number:	0279552-95	
P. O. Box 517					Date:	07/01/2020	
ernandina Bead	ch, FL 32035-0	517		Fiscal	Year End:	06/30/2019	
				Au	dit Status:	Unaudited Co	st
Provider Typ	<u>e</u>		Current	: Rate	New	Rate	Effective Date
<u>C</u>	CHD		125.	84	97.	95	07/01/2020
Rate Type <u>In</u>	nterim		X	Prospective	<u>)</u>		
	Total I	nterim		X	Total Pr	ospective	
	Settler	nent Based on Cost			Prospec	ctive Adjusted	For New Costs
<b>DISTRIBUTION:</b> Fiscal Agent		BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost		R		
Contract Ma				Ry	dell Samue	el, Administrat	or
Program Fin						gram Finance	<del>_</del>
State Health	Office						
					For Info	rmation Only	
					— (No Cha	ange In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Okaloosa Cou	unty Health	n Department			Provider Number: 0279561-00					
221 Hospital I	Drive, N.E.					Date	07/01/2020			
t. Walton Be	ach, FL 3	2548			Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			158	.26	16	5.33	07/01/2020		
Rate Type	Interim			X	Prospec	tivo				
	_ <u>iiiteiiiii</u>	Total Interim			_ <del>F10Spec</del> X		rospective			
		Settlement Ba	ased on Cost				•	d For New Costs		
		-								
			BASIS:							
			Budget							
			X Unaudite	ed Cost						
			—— Desk Re	viewed Cost						
			—— Desk Au	dited Cost						
			Field Au	dited Cost						
DISTRIBUTIO	ON:					TR				
Fiscal Ag	jent					PU				
Contract	Manageme	ent				Rydell Samu	uel, Administra	ator		
Program	Finance						ogram Financ			
State Hea	alth Office									
						For Info	ormation Only	,		
						(No Ch	ange In Rate	)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Okaloosa Cou	unty Health	n Department			Provider Number: 0279561-91					
221 Hospital I	Drive, N.E.					Date	07/01/2020			
Ft. Walton Be	ach, FL 3	2548			Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	ost		
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			158	.26	16	5.33	07/01/2020		
Rate Type										
	<u>Interim</u> -	<b>.</b>		X	_ <u>Prospec</u>					
		Total Interim			X		rospective	15 N 0 1		
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs		
Program	ent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost dited Cost			ıel, Administra ogram Financo			
						For Info	ormation Only			
						— (No Ch	ange In Rate)	1		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Okeechobee	County He	alth Departme	nt		Provider Number: 0279579-00					
P.O. Box 187	91728 N.V	V. 9th Avenue				Date	07/01/2020			
Okeechobee	, FL 3497	3-1879			Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			131	.18	154	4.03	07/01/2020		
Rate Type				V	_					
	Interim -	Total Interim		X	_ <u>Prospec</u> X		rospective			
		Settlement Ba	acad on Cast				•	d For Now Costs		
		- Semement D	ased on Cost				ctive Adjuste	d For New Costs		
			BASIS:							
			Budget							
			X Unaudite	d Cost						
			Desk Rev	iewed Cost						
			Desk Aud	dited Cost						
			Field Aud	lited Cost						
DISTRIBUTIO	<u> </u>					JK.				
Fiscal Ag	ent					M				
Contract	Managem	ent				Rydell Samu	iel, Administra	ator		
Program	Finance					Medicaid Pro	ogram Financ	ee		
State Hea	alth Office									
						For Info	ormation Only	/		
						—— (No Ch	ange In Rate	)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Okeechobee	County He	alth Departme	nt		Provider Number: 0279579-01					
P.O. Box 187	91728 N.V	V. 9th Avenue				Date:	07/01/2020			
Okeechobee	, FL 3497	3-1879			Fisc	al Year End:	06/30/2019			
					,	Audit Status:	Unaudited (	Cost		
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date		
	CHD			131	.18	154	1.03	07/01/2020		
Rate Type	Interim			X	Prospecti	<u>ve</u>				
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs		
DISTRIBUTIO Fiscal Ag Contract Program	jent Managem	ent	Desk A			Rydell Samu Medicaid Pro				
_	alth Office						-			
					_		ormation Onl ange In Rate			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Okeechobee (	County He	alth Departme	nt		Prov	rider Number:	0279579-0	2
P.O. Box 1879	91728 N.W	/. 9th Avenue				Date:	07/01/2020	)
Okeechobee,	FL 34973	3-1879			Fis	cal Year End:	06/30/2019	)
						Audit Status:	Unaudited	Cost
Provider Ty	<u>/pe</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			131	.18	154	4.03	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospect	<u>iive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs
DISTRIBUTIO Fiscal Age Contract N Program F State Hea	ent Manageme Finance	ent	BASIS:  Budget  Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost ted Cost		Rydell Samu Medicaid Pro		
State Hea							ormation On	
						(No Ch	ange In Rate	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Okeechobee (	keechobee County Health Department						Provider Number: 0279579-03					
P.O. Box 1879	91728 N.W	/. 9th Avenue						Date:	07/01/2020	)		
Okeechobee ,	, FL 34973	3-1879					Fiscal Yea	ar End:	06/30/2019	)		
							Audit	Status:	Unaudited	Cost		
Provider T	уре				Curren	t Rate		New	Rate	Effecti	ive Date	
	CHD				131	.18	_	154	.03	07/0	1/2020	
Rate Type	Interim				X	Prospe	<u>ective</u>					
		Total Interim					X	Total Pr	ospective			
		Settlement Ba	ased on C	ost			!	Prospec	ctive Adjuste	ed For New	Costs	
<b>DISTRIBUTIO</b> Fiscal Ag Contract		ent	X Un De	dget audited sk Revi sk Audi	I Cost iewed Cost ited Cost ted Cost		Rydel	<b>K</b> I Samue	el, Administ	rator		
Program	_								gram Finan			
_	alth Office											
							ı	For Info	rmation On	ly		
								(No Cha	ange In Rate	e)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Okeechobee C	County Hea	alth Departme	nt		Provider Number: 0279579-04				
P.O. Box 1879	91728 N.W	. 9th Avenue				Date:	07/01/2020		
Okeechobee ,	FL 34973	-1879			Fis	cal Year End:	06/30/2019		
						Audit Status:	Unaudited (	Cost	
Provider Ty	<u>/pe</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			131	.18	154	4.03	07/01/2020	
Rate Type									
	<u>Interim</u>			X	Prospect	<u>ive</u>			
_	•	Total Interim			X	Total P	rospective		
•		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs	
DISTRIBUTIO Fiscal Age Contract N Program F State Hea	ent Manageme Finance	nt	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost		Rydell Samu Medicaid Pro			
State 11ea	iiiii Oilice					E. J. C			
							ormation Onl		
						(No Ch	ange In Rate	e)	



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Okeechobee	County He	alth Departme	nt		Provider Number: 0279579-30					
P.O. Box 187	91728 N.W	/. 9th Avenue				Date:	07/01/2020			
Okeechobee	, FL 34973	3-1879			Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			131	.18	154	4.03	07/01/2020		
Rate Type				V	_					
	<u>Interim</u> -	T. (-11.6.2.)		X	Prospec					
		Total Interim			X		rospective	J.F. N. O. de		
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs		
			BASIS:							
			Budget	t						
			X Unaud	ited Cost						
			Desk F	Reviewed Cost						
			Desk A	udited Cost						
			Field A	udited Cost						
DISTRIBUTIO	ON:					THE				
Fiscal Ag						PU				
_	Manageme	ent				Rydell Samu	ıel, Administr	ator		
Program	Finance						ogram Financ			
State Hea	alth Office									
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						(No Ch	ange In Rate	e)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Orange Count	y Health D	Department			Provider Number: 0279587-00				
6101 Lake Elle	enor Drive					Date:	07/01/2020	)	
Orlando, FL 3	32804				Fis	cal Year End:	06/30/2019	)	
						Audit Status:	Unaudited	Cost	
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	<u>CHD</u>			166	.57	166	5.59	07/01/2020	
Rate Type									
	Interim			X	Prospect	<u>:ive</u>			
		Total Interim			X	Total P	ospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs	
<b>DISTRIBUTIO</b> Fiscal Age Contract M Program F State Hea	ent Manageme Finance	ent	Desk Au	d Cost viewed Cost dited Cost dited Cost		Rydell Samu Medicaid Pro			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Orange Coun	ty Health D	Department			Provider Number: 0279587-01				
6101 Lake Ell	lenor Drive					Date	07/01/2020		
Orlando, FL	32804				Fis	scal Year End:	06/30/2019		
						Audit Status:	Unaudited C	ost	
Provider T	уре			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date	
	CHD			166	.57	160	6.59	07/01/2020	
Rate Type									
	Interim -			X	Prospec				
		Total Interim			X		rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs	
Program	jent Manageme	ent	Desk Au	ed Cost eviewed Cost dited Cost dited Cost			uel, Administra ogram Financ		
State Hea	aiiii Oilice					For Infe	ormation Only	,	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Osceola Cour	sceola County Health Department						Provider Number: 0279595-00					
P. O. Box 450	3091875 E	Boggy Creek R	oad				Dat	e: 07/01/202	20			
Kissimmee, F	L 34745-0	309				F	iscal Year En	d: 06/30/201	19			
							Audit Statu	s: Unaudited	d Cost			
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>Ne</u>	w Rate	Effective Date			
	CHD				166	.57	1(	66.59	07/01/2020			
Rate Type	Interim				X	Prospe	<u>ctive</u>					
		Total Interim				X	Total	Prospective				
		Settlement Ba	ased on	Cost			Prosp	ective Adjus	sted For New Costs			
<u>DISTRIBUTIC</u> Fiscal Ag			X (	Budget Jnaudited	iewed Cost ited Cost		R					
•	Manageme	ent					Rvdell San	nuel, Adminis	strator			
Program	_							rogram Fina				
State Hea	alth Office											
							For Ir	nformation O	nly			
							(No C	hange In Ra	ate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Osceola Cour	sceola County Health Department						Provider Number: 0279595-30					
P. O. Box 450	3091875 E	Boggy Creek R	oad				Date	: 07/01/202	0			
Kissimmee, F	L 34745-0	309				Fis	scal Year End	: 06/30/201	9			
							Audit Status	Unaudited	l Cost			
Provider T	<u>ype</u>				Curren	t Rate	<u>New</u>	<u>/ Rate</u>	Effective Date			
	CHD				166	.57	16	6.59	07/01/2020			
Rate Type	<u>Interim</u>				X	Prospec	<u>stive</u>					
		Total Interim				X	Total F	Prospective				
		Settlement Ba	ased on (	Cost			Prospe	ective Adjus	ted For New Costs			
DISTRIBUTIO Fiscal Ag Contract I Program	ent Manageme	ent	X U	udget naudited esk Revi	I Cost iewed Cost ited Cost ited Cost		Rydell Same Medicaid Pr					
_	alth Office						iviculcalu PI	ogiani Filla	IIO <del>C</del>			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Osceola Cour	sceola County Health Department						Provider Number: 0279595-92				
P. O. Box 450	3091875 B	Boggy Creek R	oad				Da	te: 07/01/202	20		
Kissimmee, F	L 34745-0	309				F	iscal Year Er	nd: 06/30/201	19		
							Audit Statu	us: Unaudited	d Cost		
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>Ne</u>	w Rate	Effective Date		
	<u>CHD</u>				166	.57	1	66.59	07/01/2020		
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>				
		Total Interim				X	Total	Prospective			
		Settlement Ba	ased or	n Cost			Pros	pective Adjus	sted For New Costs		
<u>DISTRIBUTIO</u> Fiscal Ag				Budget Unaudited	iewed Cost ited Cost		R				
•	Manageme	ent					Rydell Sar	nuel, Admini	strator		
Program	_							Program Fina			
State Hea	alth Office										
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### **Medicaid Reimbursement Rate Change Form for CHDs**

		Provid	er Number:	0279595-93	
oad			Date:	07/01/2020	
		Fisca	l Year End:	06/30/2019	
		Α	udit Status:	Unaudited Co	ost
	Current	t Rate	New	<u>Rate</u>	Effective Date
_	166.	.57	166	5.59	07/01/2020
	X	Prospectiv	<u>'e</u>		
		X	Total Pr	ospective	
ased on Cost			Prospec	ctive Adjusted	For New Costs
Desk Revie	wed Cost ed Cost		F		
		R	ydell Samu	el, Administrat	or
		N	ledicaid Pro	gram Finance	
			For Info	rmation Only	
		_	(No Cha	ange In Rate)	
	BASIS: Budget X Unaudited ( Desk Revie	Current  166.  X  ased on Cost  BASIS:  Budget	Current Rate  166.57  X Prospective X  ased on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost	Date: Fiscal Year End: Audit Status:  Current Rate 166.57 166   X Prospective X Total Prospective Prospective X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost Field Audited Cost Field From Prospective For Info	Fiscal Year End: 06/30/2019 Audit Status: Unaudited Co  Current Rate New Rate 166.57 166.59   X Prospective X Total Prospective Adjusted  BASIS: Budget X Unaudited Cost Desk Reviewed Cost Desk Audited Cost Desk Audited Cost



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Pasco County Health D	epartment			Provider Number: 0279617-00					
10841 Little Road					Date:	07/01/2020			
New Port Richey, FL 3	4654			Fisca	al Year End:	06/30/2019			
				A	udit Status:	Unaudited Co	ost		
Provider Type			Current R	<u>Rate</u>	<u>New</u>	Rate	Effective Date		
CHD		-	166.57	7	166	5.59	07/01/2020		
Rate Type									
<u>Interim</u>			X_ <u>P</u>	rospectiv	<u>/e</u>				
_	Total Interim			Χ	Total Pi	rospective			
	Settlement Ba	sed on Cost			Prospe	ctive Adjusted	For New Costs		
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Tiato Fioatai Offico					For Info	ormation Only			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Pasco County	sco County Health Department						Provider Number: 0279617-01				
10841 Little R	load						Date	: 07/01/202	20		
New Port Rich	ney, FL 34	1654				Fi	scal Year End	1: 06/30/201	9		
							Audit Status	: Unaudited	d Cost		
Provider T	<u>ype</u>				Curren	t Rate	<u>New</u>	v Rate	Effective Date		
	CHD				166	.57	16	6.59	07/01/2020		
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>				
	_	Total Interim				- X	Total F	Prospective			
		- Settlement Ba	ased on	Cost			Prospe	ective Adjus	sted For New Costs		
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	Manageme	ent					Rydell Sam				
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State Hea	alth Office										
							For Inf	formation O	nly		
							(No Cl	hange In Ra	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Pasco County	sco County Health Department						Provider Number: 0279617-91					
10841 Little R	Road						Date	e: 07/01/202	20			
New Port Rich	hey, FL 34	654				Fi	scal Year End	d: 06/30/201	19			
							Audit Status	s: Unaudited	d Cost			
Provider T	уре			<u>C</u>	urren	t Rate	<u>Nev</u>	<u>v Rate</u>	Effective Date			
	<u>CHD</u>				166	.57	16	66.59	07/01/2020			
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>					
	_	Total Interim				_ x	Total	Prospective				
		Settlement Ba	ased on Cos	t			Prosp	ective Adjus	sted For New Costs			
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Program	_							rogram Fina				
_	alth Office							-				
							For In	formation O	enly			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Pasco County	/ Health Dep	artment				Pro	ovider Numbe	er: 0279617-	-92
10841 Little R	Road						Dat	e: 07/01/202	20
New Port Rich	hey, FL 346	54				F	iscal Year En	d: 06/30/20	19
							Audit Statu	s: Unaudite	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>Ne</u>	w Rate	Effective Date
	<u>CHD</u>				166	.57	1	66.59	07/01/2020
Rate Type	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>		
		Total Interim				X	Total	Prospective	
		Settlement Ba	sed on C	ost			Prosp	pective Adjus	sted For New Costs
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State Hea	alth Office								
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Pinellas Coun	ty Health Departme	nt		Provid	der Number:	0279625-00	
500 7th Avenu	ue South				Date:	07/01/2020	
St. Petersburg	g, FL 33701			Fisca	al Year End:	06/30/2019	
				A	Audit Status:	Unaudited C	Cost
Provider Ty	<u>ype</u>		<u>Curren</u>	t Rate	New I	Rate	Effective Date
	CHD		166	.57	166.	.59	07/01/2020
Rate Type	<u>Interim</u>		X	<u>Prospecti</u>	<u>ve</u>		
	- Total Inte	erim		X		ospective	
	Settleme	ent Based on Cost			Prospec	tive Adjuste	d For New Costs
DISTRIBUTIO	<b>NAI</b> -	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost		- IR		
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Contract I Program State Hea				_	Rydell Samue Medicaid Prog		
				_		mation Only	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Pinellas Coun	nty Health [	Department				Pro	ovider Numbe	r: 0279625-	91
500 7th Aven	ue South						Date	e: 07/01/202	20
St. Petersburg	g, FL 3370	)1				F	iscal Year End	d: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date
	CHD			•	166	.57	16	66.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>		
	_	Total Interim				X	Total I	Prospective	
		Settlement Ba	ased on Co	st			Prosp	ective Adjus	sted For New Costs
<u>DISTRIBUTIO</u> Fiscal Ag			Des Des	udited k Revi k Audi	Cost lewed Cost ited Cost ted Cost		R		
_	ent Manageme	ant .					Dudoll Com	اما ۸ ماساماد	atrotor
Program	=	Oilt						uel, Adminis rogram Fina	
_	alth Office							<b>J</b>	
							For In	formation O	nly
							(No C	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County H	ealth Department		Pro	vider Number: 0279633-	00
1290 Golfview	Avenue, 4th Floor			Date: 07/01/202	20
Bartow, FL 33	8830-6740		 Fis	scal Year End: 06/30/201	9
				Audit Status: Unaudited	d Cost
Provider Ty	<u>/pe</u>		Current Rate	New Rate	Effective Date
	CHD		166.57	166.59	07/01/2020
Rate Type					
	<u>Interim</u>		X Prospec	<u>tive</u>	
	Total In	terim	X	Total Prospective	
	Settlem	ent Based on Cost		Prospective Adjus	sted For New Costs
Program F	ent Management Finance	BASIS:  Budget  Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost	Rydell Samuel, Adminis Medicaid Program Fina	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County F	Health Dep	artment				Pro	ovider Numbe	r: 0279633-	01
1290 Golfview	v Avenue,	4th Floor					Date	e: 07/01/202	20
Bartow, FL 3	3830-6740	)				F	iscal Year End	d: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	<u>Prospe</u>	otivo		
	<u> </u>	Total Interim				_ <del>F105pe</del> X		Prospective	
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Program							Medicaid P	rogram Fina	ince
State Hea	alth Office								
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County F	Health Dep	artment			Prov	vider Number:	0279633-0	2
1290 Golfviev	v Avenue,	4th Floor				Date:	07/01/2020	)
Bartow, FL 3	3830-6740				Fis	cal Year End:	06/30/2019	)
						Audit Status:	Unaudited	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	166	5.59	07/01/2020
Rate Type	Interim			Х	Prospect	tive		
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		- Settlement Ba	ased on Cost			—— Prospe	ctive Adjuste	ed For New Costs
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_	alth Office					Wouldar 1	ygiaili i illali	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County F	Health Dep	artment			Pro	vider Number:	0279633-03	
1290 Golfview	v Avenue,	4th Floor				Date:	07/01/2020	
Bartow, FL 3	3830-6740				Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type								
	<u>Interim</u>			X	_ <u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	jent Manageme	ent	BASIS:  Budget  Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ	
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						— (No Ch	ange In Rate)	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County H	Health Dep	artment			Provider Number: 0279633-04					
1290 Golfviev	v Avenue,	4th Floor				Date:	07/01/2020			
Bartow, FL 3	3830-6740	)			Fis	cal Year End:	06/30/2019			
						Audit Status:	Unaudited C	ost		
Provider T	уре			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date		
	CHD			166	.57	160	6.59	07/01/2020		
Rate Type				V	_					
	Interim -	Total Interim		X	<u>Prospec</u> X		roopoetivo			
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	jent Manageme	ent	BASIS:  Budget  Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost			iel, Administra			
Program State He	Finance alth Office					iviedicald Pro	ogram Finance	₽		
Giale i le										
						For Info	ormation Only			
						(No Ch	ange In Rate)	)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County F	Health Dep	artment			Prov	vider Number:	0279633-0	5
1290 Golfviev	v Avenue,	4th Floor				Date:	07/01/2020	)
Bartow, FL 3	3830-6740				Fis	cal Year End:	06/30/2019	)
						Audit Status:	Unaudited	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			166	.57	166	5.59	07/01/2020
Rate Type	Interim			X	Prospec	tive		
	_	Total Interim			X		rospective	
		- Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs
<u>DISTRIBUTIO</u> Fiscal Ag			Desk I	et dited Cost Reviewed Cost Audited Cost Audited Cost		R		
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Program	_	J. 16				Rydell Samu Medicaid Pro		
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						(No Ch	ange In Rat	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County F	Health Dep	artment			Provider Number: 0279633-30					
1290 Golfview	v Avenue,	4th Floor				Date	07/01/2020			
Bartow, FL 3	3830-6740	)			Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	ost		
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			166	.57	160	6.59	07/01/2020		
Rate Type										
	<u>Interim</u> -			X	Prospec					
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs		
Program	ent Managem	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost dited Cost			uel, Administra ogram Financ			
						For Info	ormation Only	,		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County I	Health Dep	artment			Pro	vider Number:	0279633-90	
1290 Golfviev	w Avenue,	4th Floor				Date	07/01/2020	
Bartow, FL 3	3830-6740	)			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
<u>Provider T</u>	уре			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type				V	_			
	<u>Interim</u> -	Tatal Intonian		X	Prospec			
		Total Interim	and an Coat		X		rospective	d Far Naw Casts
		Settlement Ba	ased on Cost			——— Prospe	ctive Adjusted	d For New Costs
Program	gent Manageme	ent	BASIS:  Budget  Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost			uel, Administra ogram Finance	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Polk County F	Health Depa	artment				Р	rovider N	lumber:	0279633-9	95	
1290 Golfviev	w Avenue, 4	th Floor						Date:	07/01/202	20	
Bartow, FL 3	3830-6740					!	Fiscal Ye	ear End:	06/30/201	9	
							Audit	Status:	Unaudited	d Cost	
Provider T	уре				Curren	t Rate		New	<u>Rate</u>	<u>Ef</u>	fective Date
	<u>CHD</u>			-	166	.57		166	5.59		7/01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ective</u>				
		Total Interim					X	Total P	rospective		
		Settlement Ba	ased on Co	st				Prospe	ctive Adjus	ted For N	New Costs
	gent Manageme	nt	Des	audited sk Revi sk Audi	Cost lewed Cost ited Cost ted Cost				el, Adminis		
Program							Medi	caid Pro	gram Fina	nce	
State Hea	alth Office										
								For Info	ormation O	nly	
								(No Ch	ange In Ra	ite)	



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Putnam Coun	ty Health D	epartment				Pro	ovider Numb	er: 0279641-	-00
2801 Kennedy	y Street						Da	te: 07/01/202	20
Palatka, FL 3	32177					F	iscal Year Er	d: 06/30/20	19
							Audit Statu	ıs: Unaudite	d Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	<u>Ne</u>	w Rate	Effective Date
	<u>CHD</u>				166	.57	1	66.59	07/01/2020
Rate Type	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>		
		Total Interim				X	Total	Prospective	
		Settlement Ba	ased on	Cost			Pros	pective Adjus	sted For New Costs
DISTRIBUTIO Fiscal Ag Contract I Program	ent Manageme	ent		Budget Unaudited	iewed Cost ited Cost			nuel, Admini Program Fina	
_	alth Office							_	
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Putnam County Health Department		Provider Number: 0279641-01					
2801 Kennedy Street			Date: 07/01/2020				
Palatka, FL 32177		Fiscal Year	End: 06/30/2019				
		Audit S	tatus: Unaudited	Cost			
Provider Type	<u>Curren</u>	t Rate	New Rate	Effective Date			
<u>CHD</u>	166	.57	166.59	07/01/2020			
Rate Type	X	Dragnativa					
Interim Total Interim		_ <u>Prospective</u> X	otal Prospective				
Settlement Ba	seed on Cost		•	ed For New Costs			
	ised on Cost		rospective Adjusti	ed I of New Costs			
DISTRIBUTION:  Fiscal Agent  Contract Management  Program Finance  State Health Office	BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost	Rydell	Samuel, Administ				
			or Information On To Change In Rate				



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Putnam Coun	nty Health De <sub>l</sub>	partment			Provider Number: 0279641-03					
2801 Kenned	y Street					Date	07/01/2020			
Palatka, FL 3	32177				Fi	scal Year End	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date		
	<u>CHD</u>			166	.57	16	6.59	07/01/2020		
Rate Type										
	<u>Interim</u>			X	Prospec					
		otal Interim			X		rospective			
	s	ettlement Ba	sed on Cost			Prospe	ctive Adjuste	d For New Costs		
DISTRIBUTIO Fiscal Ag Contract Program	jent Management		BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administr			
State Hea	alth Office						ormation Only			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Putnam County Health Department		Provider Number: 0279641-04					
2801 Kennedy Street		Date	e: 07/01/2020				
Palatka, FL 32177		Fiscal Year End	d: 06/30/2019				
		Audit Status	Unaudited Co	ost			
Provider Type	<u>Curren</u>	t Rate Nev	v Rate	Effective Date			
<u>CHD</u>	166.	.5716	66.59	07/01/2020			
Rate Type Interim	X	Prospective					
Total Interim		_	Prospective				
Settlement Ba	ased on Cost		•	For New Costs			
<del></del>			,				
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office	BASIS:  Budget  X Unaudited Cost  Desk Reviewed Cost  Desk Audited Cost  Field Audited Cost	Rydell Sam	uel, Administrat rogram Finance				
			formation Only hange In Rate)				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Putnam Coun	ty Health Departme	ent		Provid	ler Number: (	0279641-91	
2801 Kennedy	y Street				Date: 0	07/01/2020	
Palatka, FL 3	2177			Fisca	al Year End: (	06/30/2019	
				A	udit Status: \	Unaudited C	Cost
Provider T	<u>ype</u>		Current	Rate	New I	Rate	Effective Date
	CHD		166.5	57	166.	59	07/01/2020
Rate Type	Intorim		Х	Drooposti			
	_ <u>Interim</u> _ Total Int	terim		Prospectiv X		spective	
		ent Based on Cost	-			•	d For New Costs
		om Bassa on Gost	-			aro majaoto	
		BASIS:					
		Budget					
		X Unaudited	d Cost				
		Desk Rev	riewed Cost				
		Desk Aud	lited Cost				
		Field Aud	ited Cost				
DISTRIBUTIO	NAI.				T.		
DISTRIBUTIO Fiscal Ag					M)		
Contract	Management			F	Rydell Samue	l, Administra	ator
Program	Finance			N	/ledicaid Prog	gram Financ	e
State Hea	alth Office						
					For Infor	mation Only	/
					(No Cha	nge In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Johns Cou	unty Health	Department			Provider Number: 0279650-00					
1955 US 1 Sc	outh					Date	07/01/2020			
St. Augustine	, FL 32086	6			Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	уре			Curren	t Rate	New Rate		Effective Date		
	CHD			166	.57	160	6.59	07/01/2020		
Rate Type										
	Interim -			X	_ <u>Prospec</u>					
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs		
Program	jent Manageme Finance	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ			
State Hea	alth Office									
							ormation Only			
						(No Ch	ange In Rate	)		



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Johns County Health Departme	nt		Provider Number: 0279650-91					
1955 US 1 South				Date: 0	7/01/2020			
St. Augustine, FL 32086			Fiscal	Year End: 0	5/30/2019			
			Αι	dit Status: U	naudited Co	ost		
Provider Type		Curren	t Rate	New R	ate	Effective Date		
<u>CHD</u>		166	.57	166.5	<b>.</b>	07/01/2020		
Rate Type								
<u>Interim</u>		X	Prospective					
Total Inter			X	Total Pros	•			
Settlemen	t Based on Cost			Prospecti	ve Adjusted	For New Costs		
<b>DISTRIBUTION:</b> Fiscal Agent Contract Management	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost	<u>R</u> y	vdell Samuel,				
Program Finance				edicaid Progr				
State Health Office								
				For Inforn	nation Only			
				— (No Chan	ge In Rate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie Cou	nty Health	Department			Provider Number: 0279668-00					
5150 NW Milr	ner Drive					Date	07/01/2020			
Port Saint Luc	cie, FL 349	963			Fis	scal Year End:	06/30/2019			
						Audit Status:	Unaudited C	Cost		
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			166	.57	160	6.59	07/01/2020		
Rate Type										
	Interim -			X	Prospec					
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs		
Program	jent Manageme	ent	Desk Au	d Cost viewed Cost dited Cost dited Cost			uel, Administra ogram Financ			
	011100					For Info	ormation Only	1		
							ange In Rate			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie County Health D	Department	Pro	Provider Number: 0279668-01					
5150 NW Milner Drive			Date: 07/01/202	20				
Port Saint Lucie, FL 3496	63	 Fis	scal Year End: 06/30/201	9				
			Audit Status: Unaudited	l Cost				
Provider Type		Current Rate	New Rate	Effective Date				
CHD		166.57	166.59	07/01/2020				
Rate Type								
<u>Interim</u>		X <u>Prospec</u>	<u>tive</u>					
-	Total Interim	X	<b>Total Prospective</b>					
	Settlement Based on Cost		Prospective Adjus	ted For New Costs				
<u>DISTRIBUTION:</u> Fiscal Agent Contract Managemer	Desk Aud	d Cost viewed Cost dited Cost dited Cost	Rydell Samuel, Adminis	strator				
Program Finance			Medicaid Program Fina	nce				
State Health Office								
			For Information O	nly				
			(No Change In Ra	ate)				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie Cou	nty Health	Department				Provider Number: 0279668-02					
5150 NW Milr	ner Drive						D	ate: 07/01/202	20		
Port Saint Luc	cie, FL 349	963				F	iscal Year E	nd: 06/30/201	9		
							Audit Sta	tus: Unaudited	d Cost		
Provider T	<u>ype</u>				Curren	t Rate	<u>N</u>	lew Rate	Effective Date		
	CHD			-	166	.57		166.59	07/01/2020		
Rate Type	<u>Interim</u>				X	Prospe	ective				
		Total Interim				×	Tota	al Prospective			
		Settlement Ba	sed on Cos	st			Pro	spective Adjus	sted For New Costs		
<b>DISTRIBUTIO</b> Fiscal Ag Contract		ent	Desk	udited Revi Audi	Cost ewed Cost ted Cost ted Cost		Rydell Si	amuel, Adminis	strator		
Program	_	J. 1.						Program Fina			
_	alth Office							-			
							For	Information O	nly		
							(No	Change In Ra	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie Cou	nty Health	Department				Provider Number: 0279668-03					
5150 NW Milr	ner Drive						Date	: 07/01/202	0		
Port Saint Luc	cie, FL 349	963				Fi	scal Year End	: 06/30/201	9		
							Audit Status	: Unaudited	l Cost		
Provider T	<u>ype</u>				Curren	t Rate	New	<u>/ Rate</u>	Effective Date		
	<u>CHD</u>				166	.57	16	6.59	07/01/2020		
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>				
		Total Interim				X	Total F	rospective			
		Settlement Ba	ased on	Cost			Prospe	ective Adjus	ted For New Costs		
<b>DISTRIBUTIC</b> Fiscal Ag Contract		ent		Budget Inaudited Desk Revi Desk Audi	I Cost iewed Cost ited Cost ted Cost		Rvdell Sami	uel Adminis	strator		
Program	_	<del>2</del> II(					Rydell Same Medicaid Pr				
_	alth Office						Modiodid 1 1	ogidin i ma	1100		
							For Inf	ormation O	nly		
							(No Ch	nange In Ra	ite)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie Cou	nty Health	Department				Provider Number: 0279668-04					
5150 NW Milr	ner Drive						Date	e: 07/01/202	20		
Port Saint Luc	cie, FL 349	963				Fi	scal Year End	d: 06/30/201	19		
							Audit Status	: Unaudited	d Cost		
Provider T	уре				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date		
	CHD				166	.57	16	6.59	07/01/2020		
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>				
		Total Interim				X	Total I	Prospective			
		Settlement Ba	ased on Co	st			Prosp	ective Adjus	sted For New Costs		
<b>DISTRIBUTIO</b> Fiscal Ag	ent		Des	audited sk Revi sk Audi	I Cost iewed Cost ited Cost ted Cost		R				
	Manageme	ent					Rydell Sam				
Program State Hea	Finance alth Office						Medicaid P	rogram Fina	ance		
State Hea	aitii Oilice										
							For In	formation O	nly		
							— (No C	hange In Ra	ate)		



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie County Health Dep	partment		Provid	er Number:	0279668-05	
5150 NW Milner Drive				Date:	07/01/2020	
Port Saint Lucie, FL 34963			Fisca	l Year End:	06/30/2019	
			А	udit Status:	Unaudited C	ost
Provider Type		Current R	<u>late</u>	<u>New l</u>	Rate	Effective Date
<u>CHD</u>		166.57	<b>7</b>	166	.59	07/01/2020
Rate Type						
<u>Interim</u>		X_ <u>P</u>	rospectiv	<u>'e</u>		
Tot	tal Interim		Χ	Total Pro	ospective	
Sei	ttlement Based on Cost			Prospec	tive Adjusted	d For New Costs
	BASIS:					
	Budget					
	X Unaudited	Cost				
	Desk Revi	ewed Cost				
	Desk Audi	ted Cost				
	Field Audit	ted Cost				
DISTRIBUTION:			1.4	TH		
Fiscal Agent				M		
Contract Management			F	ydell Samue	el, Administra	ator
Program Finance			N	ledicaid Pro	gram Financ	<u>—</u> е
State Health Office						
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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie Cou	Lucie County Health Department					Provider Number: 0279668-11					
5150 NW Milr	ner Drive							Date: 07/01/202	0		
Port Saint Luc	cie, FL 349	963				F	iscal Y	ear End: 06/30/201	9		
							Aud	it Status: Unaudited	Cost		
Provider T	<u>ype</u>				Curren	t Rate		New Rate	Effective Date		
	CHD				166	.57	_	166.59	07/01/2020		
Rate Type											
	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>				
		Total Interim				X		Total Prospective			
		Settlement Ba	ased on	Cost				Prospective Adjust	ted For New Costs		
			BASI	S:							
				— Budget							
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				Desk Revi	iewed Cost						
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DISTRIBUTIO	ON-						_	R			
Fiscal Ag							P	40			
_	Manageme	ent					Ryd	ell Samuel, Adminis	trator		
Program	Finance							licaid Program Finar			
State Hea	alth Office										
								For Information Or	nly		
								– (No Change In Ra	te)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie Cou	nty Health	Department				Р	rovider N	lumber:	0279668-1	2	
5150 NW Milr	ner Drive							Date:	07/01/2020	0	
Port Saint Luc	cie, FL 349	963				İ	Fiscal Ye	ar End:	06/30/2019	9	
							Audit	Status:	Unaudited	Cost	
Provider T	уре				Curren	t Rate		New	<u>Rate</u>	Effe	ective Date
	CHD				166	.57		166	5.59	07	//01/2020
Rate Type	<u>Interim</u>				X	Prospe	<u>ective</u>				
		Total Interim					X	Total P	ospective		
		Settlement Ba	ased on C	ost				Prospe	ctive Adjust	ted For Ne	w Costs
	jent Manageme	ent	X Un De	dget audited sk Revi	I Cost iewed Cost ited Cost ted Cost				el, Adminis		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie Cou	. Lucie County Health Department					Provider Number: 0279668-30					
5150 NW Milr	ner Drive					Date: 07/01/2020	0				
Port Saint Luc	cie, FL 349	963			Fisc	al Year End: 06/30/2019	9				
					,	Audit Status: Unaudited	Cost				
Provider T	ype			Curren	t Rate	New Rate	Effective Date				
	<u>CHD</u>			166	.57	166.59	07/01/2020				
Rate Type											
	<u>Interim</u>			X	Prospecti	<u>ve</u>					
		Total Interim			X	Total Prospective					
		Settlement Ba	ased on Cost			Prospective Adjust	ted For New Costs				
			BASIS:								
			Budget	t							
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DISTRIBUTIO	ON.					- IR					
Fiscal Ag						P)					
Contract	Managem	ent				Rydell Samuel, Adminis	trator				
Program	Finance				Ī	Medicaid Program Finar	nce				
State Hea	alth Office										
						For Information Or	nly				
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### **Medicaid Reimbursement Rate Change Form for CHDs**

St. Lucie Cou	nty Health	Department			Pro	vider Number:	0279668-9	1
5150 NW Milr	ner Drive					Date:	07/01/2020	)
Port Saint Luc	cie, FL 349	963			Fis	scal Year End:	06/30/2019	9
						Audit Status:	Unaudited	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			166	.57	166	6.59	07/01/2020
Rate Type	<u>Interim</u>			X	Prospec	<u>tive</u>		
	_	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs
<b>DISTRIBUTIC</b> Fiscal Ag Contract		ent	Desk Au	ed Cost eviewed Cost udited Cost udited Cost		Rydell Samu	rel, Adminis	trator
Program	_	O. I.C				Medicaid Pro		
_	alth Office							
						For Info	ormation On	ıly
						(No Ch	ange In Rat	re)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Santa Rosa C	nta Rosa County Health Department					vider Number:	0279676-00	
P.O. Box 929						Date	07/01/2020	
Milton, FL 32	572-0929				Fis	cal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			150	.91	147	7.82	07/01/2020
Rate Type								
	<u>Interim</u>			X	<u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
Program	ent Manageme	ent	Desk Aud	d Cost viewed Cost dited Cost lited Cost			uel, Administra ogram Financ	
						For Info	ormation Only	<i>!</i>
						(No Ch	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Santa Rosa County Health D	Department		Provider Number: 0279676-01					
P.O. Box 929				Date: 0	7/01/2020			
Milton, FL 32572-0929			Fiscal Y	ear End: 0	6/30/2019			
			Aud	it Status: L	Inaudited Cos	st		
Provider Type		Curren	t Rate	New R	ate	Effective Date		
<u>CHD</u>	_	150.	.91	147.8	32	07/01/2020		
Rate Type								
<u>Interim</u>		X	<u>Prospective</u>					
Tota	al Interim		X	Total Pro	spective			
Set	tlement Based on Cost			Prospecti	ve Adjusted I	For New Costs		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited of Desk Reviet  Desk Audite  Field Audite	ewed Cost ed Cost			, Administrato	<u>or</u>		
State Health Office				_	mation Only			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Santa Rosa C	County Hea	ılth Departmen	t		Provi	der Number:	0279676-0	2
P.O. Box 929						Date:	07/01/2020	)
Milton, FL 32	572-0929				Fisc	al Year End:	06/30/2019	9
					,	Audit Status:	Unaudited	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			150	.91	147	7.82	07/01/2020
Rate Type	<u>Interim</u>			X	Prospecti	v <u>e</u>		
	_	Total Interim			X		rospective	
		- Settlement Ba	ased on Cost			 Prospe	ctive Adjust	ed For New Costs
DISTRIBUTIO	OM:		Desk A			- IR		
DISTRIBUTIO Fiscal Ag						R		
_	Manageme	ent			I	າ Rydell Samu	el Administ	trator
Program	_				_	Medicaid Pro		
_	alth Office							
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Santa Rosa C	nta Rosa County Health Department					vider Number:	0279676-03	<b>;</b>
P.O. Box 929						Date	07/01/2020	
Milton, FL 32	2572-0929				Fis	cal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			150	.91	147	7.82	07/01/2020
Rate Type	Intorim			Х	Drosnoo	tivo		
	Interim -	Total Interim			_ <u>Prospec</u> X		rospective	
		Settlement Ba	ased on Cost				-	d For New Costs
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			Budget					
			X Unaudite	d Cost				
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			Desk Aug	dited Cost				
			Field Aud	lited Cost				
DISTRIBUTIO	ON:					TR		
Fiscal Ag	jent					PV		
_	Manageme	ent				Rydell Samu	ıel, Administra	ator
Program	Finance						ogram Financ	
State Hea	alth Office							
						For Info	ormation Only	y
						(No Ch	ange In Rate	e)



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Santa Rosa C	nta Rosa County Health Department					vider Number:	0279676-04	
P.O. Box 929						Date:	07/01/2020	
Milton, FL 32	2572-0929				Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			150	.91	147	7.82	07/01/2020
Rate Type				V	_			
	Interim -	Total Interim		X	_ <u>Prospec</u> -		roopootivo	
		Total Interim	and an Cast		X		rospective	d For New Costs
		Settlement Ba	ased on Cost			—— Prospe	ctive Adjuste	d For New Costs
			BASIS:					
			Budget					
			X Unaudite	d Cost				
				iewed Cost				
				dited Cost				
			Field Aud					
DISTRIBUTIO	ON:					R		
Fiscal Ag						PU		
_	Manageme	ent				Rvdell Samı	ıel, Administra	ator
Program	_						ogram Financ	
_	alth Office							
						For Info	ormation Only	/
						(No Ch	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Santa Rosa C	County Hea	ılth Departmen	t			Pro	ovider Numbe	er: 0279676-	05
P.O. Box 929							Dat	e: 07/01/202	20
Milton, FL 32	572-0929					Fi	scal Year En	d: 06/30/201	19
							Audit Statu	s: Unaudited	d Cost
Provider Ty	ype				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date
	<u>CHD</u>			_	150	.91	1	47.82	07/01/2020
Rate Type	<u>Interim</u>				Х	Prospe	<u>ctive</u>		
	_	Total Interim				X	Total	Prospective	
		Settlement Ba	ased on Cos	t			Pros	pective Adjus	sted For New Costs
DISTRIBUTIO			Desk	dited ( Revie Audite	Cost ewed Cost ed Cost ed Cost		F		
Fiscal Ag							M		
	Manageme	ent						nuel, Adminis	
Program							Medicaid F	Program Fina	ince
State Hea	alth Office								
							For I	nformation O	nly
							(No (	Change In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Santa Rosa C	nta Rosa County Health Department					vider Number:	0279676-30	
P.O. Box 929						Date	07/01/2020	
Milton, FL 32	2572-0929				Fis	cal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			150	.91	147	7.82	07/01/2020
Rate Type								
	Interim -			X	Prospect			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	jent Manageme	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost dited Cost			uel, Administra ogram Financ	
- 1,500						For Info	ormation Only	<i>'</i>
							ange In Rate	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Santa Rosa C	County Hea	ılth Departmen	t		Prov	ider Number:	0279676-9	1
P.O. Box 929						Date:	07/01/2020	
Milton, FL 32	572-0929				Fisc	cal Year End:	06/30/2019	
						Audit Status:	Unaudited	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			150	.91	147	7.82	07/01/2020
Rate Type	<u>Interim</u>			X	Prospect	<u>ive</u>		
	_	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs
DISTRIBUTIO Final Ar			Desk Aud	d Cost viewed Cost dited Cost dited Cost		T.		
Fiscal Ag						/ "		
	Manageme	ent				Rydell Samu		
Program State Hea	alth Office					Medicaid Pro	ogram rinan	c <del>e</del>
					-		ormation On	
						(INO CII	ange In Rate	<del>5</del> )



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Sarasota Coun	ty Health Department			Provid	ler Number:	0279684-00	
P. O. Box 2658	3				Date:	07/01/2020	
Sarasota, FL 3	34230-2658			Fisca	al Year End:	06/30/2019	
				Δ	udit Status:	Unaudited C	ost
Provider Ty	<u>pe</u>		Curren	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>		148	.19	161	.01	07/01/2020
Rate Type	<u>Interim</u>		X	Prospectiv	<b>/</b> A		
	Total Interim			<u>ттозресич</u> - -		ospective	
_		ased on Cost				•	d For New Costs
DISTRIBUTION	<u>N:</u>	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost		T.		
Fiscal Age	nt				PU		
Contract M Program F State Heal				_		el, Administra gram Financo	
					For Info	rmation Only	
				_	(No Cha	ange In Rate)	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Sarasota Cou	ınty Health	Department			Pro	vider Number:	0279684-91	
P. O. Box 265	58					Date:	07/01/2020	
Sarasota, FL	34230-26	58			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited Co	ost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			148	.19	16^	1.01	07/01/2020
Rate Type	Interim			X	Prospec	tive		
		Total Interim			- X		rospective	
	-	- Settlement Ba	ased on Cost				·	For New Costs
<b>DISTRIBUTIC</b> Fiscal Ag				viewed Cost dited Cost		R		
_	Manageme	ent ent				Pudall Samu	ual Administra	tor
Program	_	J. I.C.					iel, Administra ogram Finance	
	alth Office					2 3 2 3 2	. 3	-
						For Info	ormation Only	
						— (No Ch	ange In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Sarasota County Health Department						Pr	rovider Nu	ımber:	0279684-92		
P. O. Box 265	58							Date:	07/01/2020		
Sarasota, FL	34230-265	58				F	Fiscal Yea	r End:	06/30/2019		
							Audit S	Status:	Unaudited C	Cost	
Provider T	<u>ype</u>				Curren	t Rate		<u>New</u>	Rate	Effective Da	<u>te</u>
	CHD				148	.19	_	161	.01	07/01/2020	<u>)                                    </u>
Rate Type	Interim				X	Prospe	ective				
		Total Interim				×	<b>С</b>	otal Pro	ospective		
		Settlement Ba	ased on	Cost			F	Prospec	tive Adjuste	d For New Costs	
<u>DISTRIBUTIC</u> Fiscal Ag				Budget Inaudited Desk Revi	iewed Cost ited Cost		THE STATE OF THE S	Z.			
_	eni Manageme	ent					Pydoll	Samue	al Administr	otor	
Program	_								el, Administra gram Financ		
_	alth Office							·	-		
							F	or Info	rmation Only	/	
							(	No Cha	ange In Rate	)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Sarasota Cou	nty Health	Department			Prov	vider Number:	0279684-93	
P. O. Box 265	58					Date:	07/01/2020	
Sarasota, FL	34230-265	58			Fis	cal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			148	.19	16	1.01	07/01/2020
Rate Type	Interim			X	Prospec	tive		
	-	Total Interim			- <u>ттоороо</u> Х		rospective	
		Settlement Ba	ased on Cost				•	d For New Costs
DISTRIBUTIO			Desk A			F		
Fiscal Ag						/ N		
	Manageme	ent					iel, Administra	
Program						Medicaid Pro	ogram Finance	Э
State Hea	alth Office							
						For Info	ormation Only	
						—— (No Ch	ange In Rate)	1



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Seminole Co	unty Health	n Department			Provider Number: 0279692-00				
400 West Airp	port Boulev	/ard				Date	07/01/2020		
Sanford, FL	32773				Fis	scal Year End	06/30/2019		
						Audit Status	Unaudited C	ost	
<u>Provider T</u>	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			166	.57	16	6.59	07/01/2020	
Rate Type									
	_ <u>Interim</u>			X	Prospec	<u>tive</u>			
		Total Interim			X	Total P	rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs	
Program	gent Managem	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ		
							ormation Only		
						(No Ch	ange In Rate	)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Seminole Cou	unty Health	Department			Provider Number: 0279692-30				
400 West Airp	oort Boulev	/ard				Date:	07/01/2020	)	
Sanford, FL 3	32773				Fis	scal Year End:	06/30/2019	9	
						Audit Status:	Unaudited	Cost	
Provider T	уре			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date	
	CHD			166	.57	166	6.59	07/01/2020	
Rate Type	<u>Interim</u>			X	Prospec	<u>tive</u>			
	_	Total Interim			X		rospective		
		- Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs	
DISTRIBUTIO			Desk Au	ed Cost eviewed Cost udited Cost udited Cost		R			
Fiscal Ag									
Program	Manageme Finance	HIIL				Rydell Samu Medicaid Pro			
_	alth Office					Modicala	ygram i mar		
						For Info	ormation On	ıly	
						(No Ch	ange In Rat	re)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Seminole Cou	unty Health	Department			Provider Number: 0279692-90				
400 West Airp	oort Boulev	ard				Date	07/01/2020		
Sanford, FL	32773				Fis	cal Year End:	06/30/2019		
						Audit Status:	Unaudited C	Cost	
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			166	.57	160	6.59	07/01/2020	
Rate Type									
	<u>Interim</u>			X	<u>Prospec</u>	<u>tive</u>			
		Total Interim			X	Total P	rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs	
Program	jent Manageme	ent	Desk Au	ed Cost eviewed Cost udited Cost udited Cost			uel, Administra ogram Financ		
Cidio 1 lec						For Info	ormation Only	ı	
							ange In Rate		
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Sumter Count	ty Health D	Department			Provider Number: 0279706-01				
P. O. Box 98						Date:	07/01/2020	)	
Bushnell, FL	33513				Fis	scal Year End:	06/30/2019	9	
						Audit Status:	Unaudited	Cost	
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			141	.52	143	3.23	07/01/2020	
Rate Type	<u>Interim</u>			Х	Prospec	<u>:tive</u>			
	_	Total Interim			X	Total P	rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs	
			Desk R Desk A	ted Cost eviewed Cost udited Cost udited Cost					
<b>DISTRIBUTIO</b> Fiscal Ag						A			
Contract	Manageme	ent				Rydell Samu	iel, Administ	trator	
Program	Finance					Medicaid Pro	ogram Finar	nce	
State Hea	alth Office								
						For Info	ormation On	ıly	
						(No Ch	ange In Rat	e)	



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

umter County Health Department						F	Provider	Number:	0279706-9	1	
P. O. Box 98								Date:	07/01/2020		
Bushnell, FL	33513						Fiscal Y	ear End:	06/30/2019		
							Aud	t Status:	Unaudited (	Cost	
Provider Ty	<u>ype</u>				Curren	t Rate		New	Rate	<u>Effecti</u>	ve Date
	CHD			-	141	.52		143	3.23	07/01	/2020
Rate Type											
	<u>Interim</u>				X	<u>Prosp</u>	<u>ective</u>				
		otal Interim					X	Total P	rospective		
	s	ettlement Ba	sed on C	ost				Prospe -	ctive Adjuste	ed For New (	Costs
	ent Management		X Un De	dget audited sk Revi	Cost ewed Cost ted Cost ted Cost				el, Administi		
Program I							Med	licaid Pro	gram Finan	ce	
State Hea	alth Office										
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								No Ch	ange In Rate	e)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Sumter County Health Department						Р	rovider N	lumber:	0279706-92	2
P. O. Box 98								Date:	07/01/2020	
Bushnell, FL	33513					F	Fiscal Ye	ar End:	06/30/2019	
							Audit	Status:	Unaudited (	Cost
Provider Ty	<u>ype</u>				Curren	t Rate		New	Rate	Effective Date
	<u>CHD</u>				141	.52	_	143	3.23	07/01/2020
Rate Type	Interim				X	Prospe	<u>ective</u>			
		Total Interim				>	Χ	Total Pi	rospective	
		Settlement Ba	ased on	Cost				Prospe	ctive Adjuste	ed For New Costs
DISTRIBUTIO	DN:		) X [	Budget Jnaudited	iewed Cost ited Cost			R		
Fiscal Ag	ent						M	1		
	Manageme	ent							el, Administr	
Program							Medi	caid Pro	gram Finan	ce
State Hea	alth Office									
								For Info	rmation Onl	у
								(No Ch	ange In Rate	<del>)</del> )



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Taylor County			Provide	Number:	0279722-	00						
1215 Peacock	Street							Date:	07/01/202	20		_
Perry, FL 323	347						Fiscal `	ear End:	06/30/201	19		
							Aud	dit Status:	Unaudited	d Cost		_
Provider Ty	<u>ype</u>				Curren	t Rate		<u>New</u>	Rate	<u>Ef</u>	ffective Date	3
	<u>CHD</u>				106	.81		93	.41		07/01/2020	_
Rate Type					V	_						
	Interim -	Total Interim			X	<u>Pros</u> p	oective		roon ootii ro			
		Total Interim - Settlement Ba	acad on	Coot			Х	_	rospective		New Costs	
		-	25 <b>c</b> u 011	Cosi				— —	ctive Aujus	sieu i oi i	New Costs	
			BASI	S:								
				<del></del> Budget								
				Jnaudited	d Cost							
				Desk Revi	iewed Cost							
				Desk Audi	ited Cost							
				Field Audi	ted Cost							
DISTRIBUTIO	ON:						_	IR				
Fiscal Age	ent						ı					
Contract I	Manageme	ent					Ry	dell Samu	el, Admini	strator		
Program I	Finance						Me	dicaid Pro	gram Fina	ance		
State Hea	alth Office											
								For Info	ormation O	nly		
								– (No Ch	ange In Ra	ate)		



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Taylor County	Health Depa	artment			Prov	ider Number	0279722-0	1
1215 Peacock	Street					Date	07/01/2020	
Perry, FL 323	347				Fis	cal Year End	06/30/2019	
						Audit Status	Unaudited	Cost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			106	.81	93	3.41	07/01/2020
Rate Type								
	<u>Interim</u>			X	_	<u>tive</u>		
	T	otal Interim			X	Total P	rospective	
	S	ettlement Ba	sed on Cost			Prospe	ective Adjuste	ed For New Costs
DISTRIBUTIO Fiscal Ago Contract I Program I	ent Management		Desk Au	ed Cost eviewed Cost udited Cost udited Cost		Rydell Samu Medicaid Pro		
State Hea	alth Office					For Inf	ormation Onl	у
						(No Ch	ange In Rate	e)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Taylor County	Health De	partment			Provide	er Number:	0279722-30	
1215 Peacock	Street					Date:	07/01/2020	
Perry, FL 323	347				Fiscal	Year End:	06/30/2019	
					Αι	udit Status:	Unaudited C	ost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			106	.81	93	.41	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospective	<u>e</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
DISTRIBUTIO Fiscal Age Contract I Program	ent Manageme Finance	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost dited Cost	<u>R</u>		el, Administra ogram Financ	
						For Info	ormation Only	,
						(No Ch	ange In Rate)	)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Jnion County	Health De	partment			Provid	der Number:	0279731-0	0
495 East Mair	n Street					Date:	07/01/2020	)
_ake Butler, F	L 32054				Fisca	al Year End:	06/30/2019	)
					A	Audit Status:	Unaudited	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			166	.57	166	5.59	07/01/2020
Rate Type	<u>Interim</u>			X	Prospecti	<u>ve</u>		
		Total Interim			X	Total Pi	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ed For New Costs
<u>DISTRIBUTIO</u> Fiscal Ag Contract		ent	Desk A		ŗ	Rydell Samu	el, Administ	trator
Program	_				_	Medicaid Pro		
State Hea	alth Office							
						For Info	rmation On	ıly
					_	(No Ch	ange In Rat	re)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Union County	Health De	epartment				Pro	vider Number	: 0279731-0	01
495 East Mair	n Street						Date	: 07/01/202	20
Lake Butler, F	FL 32054					Fi	scal Year End	: 06/30/201	9
							Audit Status	: Unaudited	d Cost
Provider T	уре				Curren	t Rate	<u>New</u>	<u>/ Rate</u>	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	Interim				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total F	Prospective	
		Settlement Ba	ased on Co	ost			Prospe	ective Adjus	sted For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract		ent	X Una Dea	dget audited sk Revi sk Audi	I Cost iewed Cost ited Cost ted Cost		Rydell Sami	uel, Adminis	strator
Program	Finance						Medicaid Pr		
State Hea	alth Office								
							For Inf	ormation O	nly
							(No Ch	nange In Ra	ate)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Union County Health Depa	artment	Pro	vider Number: 0279731-	03
495 East Main Street			Date: 07/01/202	20
Lake Butler, FL 32054		 Fis	scal Year End: 06/30/201	19
			Audit Status: Unaudited	d Cost
<u>Provider Type</u>		Current Rate	New Rate	Effective Date
<u>CHD</u>		166.57	166.59	07/01/2020
Rate Type				
<u>Interim</u>		X <u>Prospec</u>	<u>etive</u>	
	Total Interim	x	Total Prospective	
s	Settlement Based on Cost		Prospective Adjus	sted For New Costs
<b>DISTRIBUTION:</b> Fiscal Agent Contract Managemen	Desk Aud	riewed Cost lited Cost	Rydell Samuel, Adminis	
Program Finance			Medicaid Program Fina	ance
State Health Office				
			For Information O	nly
			(No Change In Ra	ate)



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Union County H	ealth Department			Provid	der Number: 0279731-0	)4
495 East Main S	Street				Date: 07/01/2020	0
Lake Butler, FL	32054			Fisca	al Year End: 06/30/2019	9
				A	Audit Status: Unaudited	Cost
Provider Typ	<u>)e</u>		Current R	ate	New Rate	Effective Date
<u>(</u>	CHD		166.57	<u>,                                      </u>	166.59	07/01/2020
Rate Type						
<u>lı</u>	<u>nterim</u>		X <u>P</u> i	rospecti	<u>ve</u>	
_	Total Interi	n		Х	Total Prospective	
_	Settlement	Based on Cost	_		Prospective Adjust	ted For New Costs
		BASIS:				
		Budget				
		X Unaudited	d Cost			
		Desk Rev	iewed Cost			
		Desk Aud	ited Cost			
		Field Aud	ited Cost			
DISTRIBUTION	<u>:</u>				R	
Fiscal Agen	nt				M	
Contract Ma	anagement			F	Rydell Samuel, Adminis	trator
Program Fi	nance			_	Medicaid Program Finar	
State Healtl	h Office					
					For Information Or	nly
				_	—— (No Change In Ra	te)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Union County	Health De	epartment			Pro	vider Number:	0279731-30	)
495 East Mair	n Street					Date:	07/01/2020	
Lake Butler, F	L 32054				Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited 0	Cost
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type	Interim			X	Prospec	tivo		
	<u> </u>	Total Interim			_ <del>FTOSPEC</del> X		rospective	
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			Field A	udited Cost				
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Fiscal Ag	ent					M		
Contract	Manageme	ent				Rydell Samu	el, Administr	ator
Program	Finance					Medicaid Pro	ogram Financ	<del></del> ce
State Hea	alth Office							
						For Info	ormation Only	y
						(No Ch	ange In Rate	e)



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Union County Health D	Department			Provi	der Number:	0279731-9	1
495 East Main Street					Date:	07/01/2020	)
Lake Butler, FL 32054	ļ			Fisc	al Year End:	06/30/2019	9
				,	Audit Status:	Unaudited	Cost
Provider Type			Curren	t Rate	New	<u>Rate</u>	Effective Date
CHD			166	.57	166	5.59	07/01/2020
Rate Type							
<u>Interim</u>	<u>1</u>		X	Prospecti	<u>ve</u>		
	Total Interim			_ X	Total Pr	ospective	
	Settlement Ba	ased on Cost			Prospec	ctive Adjust	ed For New Costs
		BASIS:					
		Budget					
		X Unaudited	Cost				
		Desk Revi	ewed Cost				
		Desk Audi	ted Cost				
		Field Audi	ted Cost				
DISTRIBUTION:					R		
Fiscal Agent					PU		
Contract Manager	nent				Rydell Samu	el. Administ	trator
Program Finance				_	Medicaid Pro		
State Health Office	е						
					For Info	rmation On	ıly
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## **Medicaid Reimbursement Rate Change Form for CHDs**

√olusia Count	y Health Depa	artment			Prov	rider Number:	0279749-0	00
P. O. Box 919	00					Date	07/01/2020	0
Daytona Beac	ch, FL 32120				Fis	cal Year End:	06/30/2019	9
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			166	.57	159	9.76	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospect	<u>ive</u>		
	To	tal Interim			X	Total P	rospective	
	Se	ttlement Based	d on Cost			Prospe	ctive Adjust	ed For New Costs
Program I	ent Management Finance		ASIS:  Budget  Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost		Rydell Samu Medicaid Pro		
State Hea	aitri Oilice							
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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Volusia County	Health Department			Provider Number: 0279749-15						
P. O. Box 9190					Date: 07/01/2020	0				
Daytona Beach,	, FL 32120			Fisca	al Year End: 06/30/2019	9				
				P	Audit Status: Unaudited	Cost				
Provider Typ	<u>)e</u>		Current F	<u>Rate</u>	New Rate	Effective Date				
<u>(</u>	<u>CHD</u>		166.5	7	159.76	07/01/2020				
Rate Type										
<u>l</u>	<u>nterim</u>		X_ <u>F</u>	rospectiv	<u>ve</u>					
_	Total Interim			Χ	Total Prospective					
_	Settlement B	ased on Cost	_		Prospective Adjust	ted For New Costs				
		BASIS:								
		Budget								
		X Unaudited	d Cost							
		Desk Rev	iewed Cost							
		Desk Aud	ited Cost							
		Field Aud	ited Cost							
DISTRIBUTION	<u>l:</u>				R					
Fiscal Agen	nt				M					
Contract Ma	anagement			F	Rydell Samuel, Adminis	trator				
Program Fi	nance			_	Medicaid Program Finar					
State Healtl	h Office									
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Volusia Count	y Health D	Department			Pro	vider Number:	0279749-92	2
P. O. Box 919	0					Date	07/01/2020	
Daytona Beac	h, FL 321	20			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited 0	Cost
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	159	9.76	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospec			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Volusia Count	a County Health Department  Box 9190					Pro	ovider	Number: 0279749-9	3
P. O. Box 919	90							Date: 07/01/2020	)
Daytona Bead	h, FL 321	20				F	iscal Y	ear End: 06/30/2019	)
							Aud	it Status: Unaudited	Cost
Provider T	ype				Curren	t Rate		New Rate	Effective Date
	CHD				166	.57		159.76	07/01/2020
Rate Type									
	<u>Interim</u>				X	<u>Prospe</u>	<u>ctive</u>		
		Total Interim				X		Total Prospective	
		Settlement Ba	ased o	n Cost				Prospective Adjust	ed For New Costs
			BAS	IS:					
				Budget					
			X	Unaudited	l Cost				
				Desk Revi	iewed Cost				
				Desk Aud	ited Cost				
				Field Audi	ted Cost				
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_	Manageme	ent					Rvd	lell Samuel, Administ	trator
Program	Finance							dicaid Program Finan	
State Hea	alth Office								
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## **Medicaid Reimbursement Rate Change Form for CHDs**

√olusia Coun	ty Health D	epartment			Pro	vider Number:	0279749-97	
P. O. Box 919	90					Date	07/01/2020	
Daytona Bead	ch, FL 321	20			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	159	9.76	07/01/2020
Rate Type								
	<u>Interim</u> -			X	_ <u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ective Adjusted	d For New Costs
Program	jent Manageme	ent	Desk Au	ed Cost viewed Cost dited Cost dited Cost			uel, Administra ogram Financ	
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Wakulla County Health Depa	rtment	Pro	vider Number: 0279757-0	00
48 Oak Street			Date: 07/01/202	0
Crawfordville, FL 32327		 Fis	scal Year End: 06/30/201	9
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	121.38	117.51	07/01/2020
Rate Type				
<u>Interim</u>		X <u>Prospec</u>	<u>ctive</u>	
Tota	al Interim	X	Total Prospective	
Sett	tlement Based on Cost	-	Prospective Adjus	ted For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost	Rydell Samuel, Adminis Medicaid Program Fina	
State Health Office			modicale i rogiam i ma	1100
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			For Information O	•
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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Wakulla County I	Health Department			Provid	ler Number: 0279757-0	)1
48 Oak Street					Date: 07/01/2020	0
Crawfordville, FL	ovider Type CHD  Ite Type Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cos Desk Reviewed Desk Audited Cos Field Audited Cos Fiscal Agent Contract Management Program Finance				al Year End: 06/30/2019	9
				Δ	udit Status: Unaudited	Cost
Provider Type	<u>e</u>		Current F	<u>Rate</u>	New Rate	Effective Date
<u>C</u>	:HD		121.38	3	117.51	07/01/2020
Rate Type						
<u>ln</u>	<u>terim</u>		X_ <u>P</u>	rospectiv	<u>/e</u>	
	Total Interim			X	Total Prospective	
_	Settlement B	ased on Cost			Prospective Adjust	ted For New Costs
		BASIS:				
		Budget				
		X Unaudited	d Cost			
		Desk Rev	iewed Cost			
		Desk Aud	ited Cost			
		Field Audi	ted Cost			
DISTRIBUTION:					R	
					PU	
_				F	Rydell Samuel, Adminis	trator
Program Fina	ance				Medicaid Program Finar	
State Health	Office					
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Nakulla Cour	nty Health [	Department			Pro	vider Number:	0279757-02	
48 Oak Stree	t					Date	07/01/2020	
Crawfordville,	vider Type CHD  e Type Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewed Desk Audited Field Audited					scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			121	.38	117	7.51	07/01/2020
Rate Type								
	Interim			X	Prospec			
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Wakulla Cour	nty Health I	Department			Pro	vider Number:	0279757-03	
48 Oak Street	t					Date:	07/01/2020	
Crawfordville,	, FL 32327	7			Fis	cal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			121	.38	117	7.51	07/01/2020
Rate Type					_			
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		Total Interim			X		rospective	LEVAN OVE
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Wakulla Cour	nty Health I	Department			Pro	vider Number:	0279757-04	
48 Oak Stree	t					Date	07/01/2020	
Crawfordville,	, FL 32327	7			Fi	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
<u>Provider T</u>	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			121	.38	117	7.51	07/01/2020
Rate Type								
	<u>Interim</u> -			X	Prospec			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	gent Manageme	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ	
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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Wakulla County Health Depa	artment		Provider Number: 0279757-30						
48 Oak Street				Date:	07/01/2020				
Crawfordville, FL 32327			Fiscal Year End: 06/30/2019						
			Α	udit Status:	Unaudited C	Cost			
Provider Type		Curren	t Rate	<u>New</u>	Rate	Effective Date			
<u>CHD</u>	-	121	.38	117	.51	07/01/2020			
Rate Type									
<u>Interim</u>		X	Prospectiv	<u>/e</u>					
Tot	al Interim		X	Total Pr	ospective				
Set	tlement Based on Cost			Prospec	ctive Adjuste	d For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost			el, Administra gram Financ				
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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Wakulla Cour	nty Health	Department			Prov	ider Number:	0279757-91				
48 Oak Stree	t					Date:	07/01/2020				
Crawfordville,	, FL 32327	7			Fiscal Year End: 06/30/2019						
						Audit Status:	Unaudited C	Cost			
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date			
	<u>CHD</u>			121	.38	117	7.51	07/01/2020			
Rate Type											
	<u>Interim</u>			X	<u>Prospect</u>	<u>ive</u>					
		Total Interim			X	Total P	rospective				
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs			
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			BASIS:								
			Budget								
			X Unaudited								
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			Desk Aud	lited Cost							
			Field Aud	lited Cost							
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Program	_						ogram Financ				
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Wakulla Cour	lla County Health Department						rovider N	lumber:	0279757-9	2	
48 Oak Street	t							Date:	07/01/2020	)	
Crawfordville,	ider Type CHD  Type Interim Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Cost Desk Reviewe Desk Audited Field Audited of					I	Fiscal Ye	ar End:	06/30/2019	)	
							Audit	Status:	Unaudited	Cost	
Provider T	уре				Curren	t Rate		New	Rate	Effectiv	<u>/e Date</u>
	<u>CHD</u>				121	.38		117	.51	07/01	/2020
Rate Type	Interim				X	Prospe	ective				
		Total Interim						Total Pr	ospective		
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Fiscal Ag	ent						1	4			
Contract	Managem	ent					Ryde	ell Samue	el, Administ	trator	
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State Hea	alth Office										
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Washington C	hington County Health Department						rovide	· Number:	0279773	-00		
1338 South Bo	oulevard							Date:	07/01/20	20		
Chipley, FL 3	South Boulevard ey, FL 32428  rider Type  CHD  Type Interim  Total Interim Settlement Based on Cost  BASIS: Budget X Unaudited Co Desk Review Desk Audited Field Audited					I	Fiscal `	Year End:	06/30/20	19		
					_		Aud	dit Status:	Unaudite	ed Cost		
Provider Ty	<u>ype</u>			<u>Cur</u>	ren	t Rate		New Rate		ļ	Effective Date	
	<u>CHD</u>			1	148	.83		162	2.38		07/01/20	)20
Rate Type						_						
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		- Settlement Da	ased on Cost					– Prospe	ctive Adju	istea Fo	r New Cost	เร
			BASIS:									
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DISTRIBUTIO	ON:						_	K				
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Contract I	Managem	ent					Ry	dell Samu	el, Admin	istrator		
Program I	Finance						Me	dicaid Pro	gram Fin	ance		
State Hea	alth Office											
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Washington County Health Departr	nent		Provider Number: 0279773-01					
1338 South Boulevard				Date: 0	7/01/2020			
Chipley, FL 32428			Fiscal Y	ear End: 0	6/30/2019			
			Audi	t Status: U	naudited Co	st		
Provider Type		Current	: Rate	New R	<u>ate</u>	Effective Date		
<u>CHD</u>	_	148.	83	162.3	<u>88                                   </u>	07/01/2020		
Rate Type								
<u>Interim</u>		X	<u>Prospective</u>					
Total Inter			X	Total Pros	•			
Settlemen	t Based on Cost			Prospecti	ve Adjusted	For New Costs		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited C  Desk Review  Desk Audite  Field Audite	wed Cost			Administrate	<u>or</u>		
State Health Office				· ·				
				For Inforn	nation Only			
				(No Chan	ge In Rate)			



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Washington Co	ngton County Health Department						Provider	Number:	0279773-0	)4	
1338 South Bo	ulevard							Date:	07/01/2020	0	
Chipley, FL 32	2428						Fiscal Y	ear End:	06/30/2019	9	
							Aud	t Status:	Unaudited	Cost	
Provider Ty	<u>pe</u>				Curren	t Rate		New	Rate	<u>Effe</u>	ective Date
	CHD				148	.83		162	2.38	07	/01/2020
Rate Type	<u>Interim</u>				X	<u>Prosp</u>	<u>ective</u>				
		Total Interim				_	Χ	Total P	rospective		
-		Settlement Ba	ased or	n Cost				Prospe	ctive Adjust	ted For Ne	w Costs
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Fiscal Age	ent						Γ	V			
Contract M	_	ent							el, Adminis		
Program F							Med	licaid Pro	ogram Finar	nce	
State Heal	Ith Office										
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								- (No Ch	ange In Ra	te)	



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Washington C	shington County Health Department					er Number:	0279773-12	
1338 South B	oulevard					Date:	07/01/2020	
Chipley, FL 3	2428				Fisca	l Year End:	06/30/2019	
					А	udit Status:	Unaudited C	ost
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			148	.83	162	2.38	07/01/2020
Rate Type								
	<u>Interim</u>			Х	Prospectiv	<u>′e</u>		
	_	Total Interim			_ X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
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							ormation Only	
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Washington C	hington County Health Department  South Boulevard					vider Number	: 0279773-30	
1338 South B	Soulevard					Date	07/01/2020	
Chipley, FL 3	32428				Fis	scal Year End	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			148	.83	162	2.38	07/01/2020
Rate Type								
	Interim -			X	Prospec			
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		Settlement Ba	ased on Cost			Prospe	ective Adjuste	d For New Costs
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Washington County Health Department		Provider Number: 0279773-99					
1338 South Boulevard		Date:	07/01/2020				
Chipley, FL 32428		Fiscal Year End:	06/30/2019				
		Audit Status:	Unaudited Cost				
Provider Type	Current Ra	<u>te</u> <u>New</u>	Rate	Effective Date			
<u>CHD</u>	148.83	162	2.38	07/01/2020			
Rate Type							
<u>Interim</u>	X Pro	<u>ospective</u>					
Total Interim		X Total P	rospective				
Settlement Based on C	ost	Prospe	ctive Adjusted Fo	or New Costs			
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State Health Office			ormation Only ange In Rate)				



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Bay County H	County Health Department West 11th Street					vider Number:	0290068-00	
597 West 11tl	h Street					Date:	07/01/2020	
Panama City,	FL 32401	I-2330			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	166	6.59	07/01/2020
Rate Type	Intorim			X	Prospos	tivo		
	Interim -	Total Interim			_ <u>Prospec</u> X		rospective	
		Settlement Ba	ased on Cost				•	d For New Costs
		-						
			BASIS:					
			Budget					
			X Unaudite	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	dited Cost				
			Field Aud	lited Cost				
						50000000000000000000000000000000000000		
DISTRIBUTIO	<u> </u>					JK.		
Fiscal Ag	jent					M		
Contract	Managemo	ent				Rydell Samu	iel, Administra	ator
Program	Finance					Medicaid Pro	ogram Financ	e
State Hea	alth Office							
						For Info	ormation Only	<i>I</i>
							ange In Rate	



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Bay County H	County Health Department West 11th Street					vider Number:	0290068-96	
597 West 11tl	h Street					Date:	07/01/2020	
Panama City,	FL 32401	-2330			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type								
	<u>Interim</u> -	<b>.</b>		X	_ <u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
Program	ent Managem	ent	Desk Au	ed Cost eviewed Cost idited Cost dited Cost			iel, Administra ogram Financ	
						For Info	ormation Only	<i>(</i>
						—— (No Ch	ange In Rate	)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

_afayette Cou	ette County Health Department Box 1806					Pr	ovider Num	ber: 0290343-	00
P.O. Box 180	6						D	ate: 07/01/202	20
Mayo, FL 320	066					F	iscal Year E	nd: 06/30/201	19
							Audit Sta	tus: Unaudited	d Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>N</u>	lew Rate	Effective Date
	<u>CHD</u>				131	.82		166.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	ective		
	_	Total Interim				_ X	( Tot	al Prospective	
		Settlement Ba	ased on C	Cost			Pro	spective Adjus	sted For New Costs
DISTRIBUTIO	<u>ON:</u>		X Ur	udget naudited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost		THE STATE OF THE S		
Fiscal Ag							PU		
_	Manageme	ent					Rydell S	amuel, Adminis	strator
Program	Finance							Program Fina	
State Hea	alth Office								
							For	Information O	nly
							(No	Change In Ra	ate)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

_afayette Cou	yette County Health Department  Box 1806					er Number:	0290343-91	
P.O. Box 180	6					Date:	07/01/2020	
Mayo, FL 320	066				Fisca	l Year End:	06/30/2019	
					А	udit Status:	Unaudited C	ost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			131	.82	166	5.59	07/01/2020
Rate Type								
	<u>Interim</u>			X	<u>Prospectiv</u>	<u>′e</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	ent Manageme	nt		viewed Cost dited Cost	<u>F</u>		iel, Administra ogram Financi	
						For Info	ormation Only	,
						No Ch	ange In Rate)	)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Madison Cou	ison County Health Department					vider Number:	0290408-00	
801 S.W. Smi	ith Street					Date:	07/01/2020	
Madison, FL	32340				Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type				V	_			
	<u>Interim</u> -	Tatal latawa		X	<u>Prospec</u>			
		Total Interim			X		rospective	LEVAN OVE
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	ent Manageme	ent	Desk Au	ed Cost eviewed Cost udited Cost udited Cost			uel, Administra ogram Financ	
						For Info	ormation Only	,
						(No Ch	ange In Rate	)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Madison Cour	ison County Health Department					vider Number	0290408-01	
301 S.W. Smi	ith Street					Date	07/01/2020	
Madison, FL	32340				Fis	scal Year End	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	16	6.59	07/01/2020
Rate Type								
	Interim -			X	Prospec			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
Program	ent Manageme	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost lited Cost			uel, Administra ogram Financ	
State Hea						For Info	ormation Only	,
						— (No Ch	ange In Rate	)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Madison Cour	ison County Health Department				Pro	vider Number	: 0290408-30	
301 S.W. Smi	ith Street					Date	07/01/2020	
Madison, FL	32340				Fis	scal Year End	06/30/2019	
						Audit Status	Unaudited C	Cost
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	16	6.59	07/01/2020
Rate Type								
	Interim			X	Prospec			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs
Program	ent Manageme Finance	ent	Desk Au	d Cost viewed Cost dited Cost dited Cost			uel, Administra ogram Financ	
State Hea	alth Office							
						For Info	ormation Only	/
						(No Ch	ange In Rate	)



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Suwannee Co	nnee County Health Department  Box 6030					Pr	rovider N	umber: (	0518328-00	)	
P. O. Box 603	30							Date:	07/01/2020		
_ive Oak, FL	32060					F	iscal Yea	ar End:	06/30/2019		
							Audit	Status: -	Unaudited (	Cost	
Provider T	<u>ype</u>				Curren	t Rate		New I	Rate	Effective Da	<u>ate</u>
	CHD			_	135	.74		151.	.22	07/01/202	0
Rate Type	<u>Interim</u>				X	Prospe	ective				
		Total Interim				×	· -	Total Pro	ospective		
		Settlement Ba	sed on Cos	st				Prospec	tive Adjuste	ed For New Costs	
DISTRIBUTIO	<u>ON:</u>		Desk	udited « Revi « Audi	Cost ewed Cost ted Cost ted Cost			R			
Fiscal Ag	ent						M				
	Manageme	ent							el, Administr		
Program							Medic	aid Prog	gram Finand	ce	
State Hea	alth Office										
								For Infor	rmation Only	y	
								(No Cha	inge In Rate	e)	



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## **Medicaid Reimbursement Rate Change Form for CHDs**

Suwannee County Health Depa	artment		Provider Number: 0518328-91				
P. O. Box 6030				Date: 07/01/20	020		
Live Oak, FL 32060			Fiscal Y	ear End: 06/30/20	019		
			Aud	it Status: Unaudit	ed Cost		
Provider Type		Curren	t Rate	New Rate	Effective Date		
<u>CHD</u>	-	135.	.74	151.22	07/01/2020		
Rate Type							
<u>Interim</u>		X	Prospective				
Total	Interim		X	Total Prospectiv	e		
Settle	ment Based on Cost			Prospective Adj	usted For New Costs		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost		ell Samuel, Admin dicaid Program Fir			
State Health Office			_	For Information	•		
				(No Change In F	≺ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Holmes Coun	ty Health D	Department				Р	rovider l	Number:	0519022-	-00		
P. O. Box 337	'603 Sceni	c Circle						Date:	07/01/202	20		
Bonifay, FL 3	2425					F	Fiscal Y	ear End:	06/30/20	19		
							Audi	t Status:	Unaudite	d Cost		
Provider Ty	<u>ype</u>				Curren	t Rate		New	Rate	<u>E</u> :	ffective Da	<u>te</u>
	<u>CHD</u>			-	85.	42		126	5.89		07/01/2020	<u>)                                    </u>
Rate Type	<u>Interim</u>				X	Prospe	ective					
		Total Interim				>	Κ	Total P	rospective			
		Settlement Ba	ased on Co	st				Prospe	ctive Adjus	sted For	New Costs	
DISTRIBUTIO	DN:		Des	audited sk Revi sk Audi	Cost ewed Cost ted Cost ted Cost			ア				
Fiscal Ag							P	V				
Contract I	Manageme	ent					Ryd	ell Samu	el, Admini	strator		
Program	Finance						Med	icaid Pro	gram Fina	ance		
State Hea	alth Office											
								For Info	ormation C	nly		
								- (No Ch	ange In Ra	ate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Holmes County Health Department			Provider	Number: 05190	)22-15	
P. O. Box 337603 Scenic Circle				Date: 07/01	/2020	
Bonifay, FL 32425			Fiscal Y	ear End: 06/30	/2019	
			Aud	it Status: Unau	dited Cost	
Provider Type		Curren	t Rate	New Rate	Effective Da	<u>ate</u>
<u>CHD</u>	_	85.	42	126.89	07/01/202	0
Rate Type						
<u>Interim</u>		X	Prospective			
Total Interir			X	Total Prospec		
Settlement	Based on Cost			Prospective A  -	djusted For New Costs	
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  Unaudited ( Desk Revie)  Desk Audite  Field Audite	ewed Cost ed Cost		ell Samuel, Adr dicaid Program		
State Health Office				For Information	on Only	
				– (No Change I	•	
				`	,	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Holmes County Health Departmen	t		Provider	Number: 0519022-9	95
P. O. Box 337603 Scenic Circle				Date: 07/01/2020	0
Bonifay, FL 32425			Fiscal Y	ear End: 06/30/2019	9
			Aud	it Status: Unaudited	Cost
Provider Type		Curren	t Rate	New Rate	Effective Date
<u>CHD</u>		85.	42	126.89	07/01/2020
Rate Type					
<u>Interim</u>		X	<u>Prospective</u>		
Total Inte	rim		X	Total Prospective	
Settlemer	nt Based on Cost		-	Prospective Adjust	ted For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost	Ryd	ell Samuel, Adminis dicaid Program Finar	
				For Information Or (No Change In Ra	_



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Brevard County Heath Department			Provider	Number:	0519251-00	
2572 N. Courtenay Parkway				Date:	07/01/2020	
Merritt Island, FL 32953-4147			Fiscal Y	ear End:	06/30/2019	
			Aud	it Status: -	Unaudited Co	ost
Provider Type		Curren	t Rate	<u>New</u>	Rate	Effective Date
<u>CHD</u>		162	.71	166	.59	07/01/2020
Rate Type						
<u>Interim</u>		X	Prospective			
Total Inter	rim		X	Total Pro	ospective	
Settlemen	nt Based on Cost			Prospec	tive Adjusted	For New Costs
DISTRIBUTION:  Fiscal Agent  Contract Management	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost			el, Administra	
Program Finance			Med	dicaid Pro	gram Finance	9
State Health Office						
				For Info	rmation Only	
				– (No Cha	ange In Rate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Brevard Cour	nty Heath D	Department			Pro	vider Number	: 0519251-01	
2572 N. Cour	tenay Park	way				Date	07/01/2020	
Merritt Island,	, FL 32953	3-4147			Fis	scal Year End	06/30/2019	
						Audit Status	Unaudited C	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			162	.71	16	6.59	07/01/2020
Rate Type								
	_ <u>Interim</u>			X	<u>Prospec</u>			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ective Adjuste	d For New Costs
Program	gent Managem	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ	
						For Inf	ormation Only	/
						(No Ch	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Brevard Cour	nty Heath D	Department			Pro	vider Number	: 0519251-04	
2572 N. Cour	tenay Park	way				Date	07/01/2020	
Merritt Island	, FL 32953	3-4147			Fis	scal Year End	06/30/2019	
						Audit Status	Unaudited C	Cost
<u>Provider T</u>	уре			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			162	.71	16	6.59	07/01/2020
Rate Type								
	_ <u>Interim</u> _			X	Prospec			
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ective Adjusted	d For New Costs
Program	gent Managem	ent	BASIS:  Budget  Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ	
							ormation Only	
						(No Ch	nange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Brevard Coun	nty Heath D	epartment				Pro	ovider Number	: 0519251-0	05
2572 N. Court	tenay Park	way					Date	: 07/01/202	20
Merritt Island,	Type Interim Total Interim Settlement Based on Cost  BASIS: Budget					Fi	scal Year End	: 06/30/201	9
							Audit Status	Unaudited	d Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>Nev</u>	<u>/ Rate</u>	Effective Date
	CHD				162	.71	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>		
	_	Total Interim				_ x	Total F	Prospective	
		Settlement Ba	ased on C	ost			Prospe	ective Adjus	sted For New Costs
DISTRIBUTIO			X Un De	dget audited sk Revi sk Audi	I Cost iewed Cost ited Cost ted Cost		R		
Fiscal Ag		- m t					/ 4		
Program	Manageme	ent					Rydell Sam Medicaid Pr		
_	alth Office						IVIGUICAIU FI	ogram i ma	
							For Inf	ormation O	nly
							(No Cl	nange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Brevard Coun	nty Heath D	Department				Pro	vider Number	: 0519251-9	91
2572 N. Cour	tenay Park	way					Date	07/01/202	20
Merritt Island,	Type Interim Total Interim Settlement Based on Cost  BASIS:					Fi	scal Year End	06/30/201	9
							Audit Status	Unaudited	l Cost
Provider T	уре				Curren	t Rate	New	Rate	Effective Date
	<u>CHD</u>				162	.71	16	6.59	07/01/2020
Rate Type	lu to uluo				V	D	45		
	<u>interim</u> -	Total Interim			X	<u>Prospec</u> X		rospective	
		_	acad an	Cost		^		•	ted For New Costs
	-	-	2300 011	0031				olive Aujus	ilea i oi ivew oosis
			BASI	S:					
				Budget					
				Unaudited	l Cost				
				Desk Rev	iewed Cost				
				Desk Aud	ited Cost				
				Field Audi	ted Cost				
DISTRIBUTIO	ON:						TH		
Fiscal Ag	ent						M		
Contract	Managem	ent					Rydell Samu	uel, Adminis	strator
Program	Finance						Medicaid Pr	ogram Fina	nce
State Hea	alth Office								
							For Inf	ormation O	nly
							(No Ch	ange In Ra	nte)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Brevard Cour	nty Heath D	Department			Pro	vider Number	: 0519251-92	
2572 N. Cour	tenay Park	way				Date	07/01/2020	
Merritt Island	, FL 32953	3-4147			Fis	scal Year End	06/30/2019	
						Audit Status	Unaudited C	Cost
<u>Provider T</u>	ype			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			162	.71	16	6.59	07/01/2020
Rate Type								
	<u>Interim</u>			X	Prospec	<u>tive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ective Adjuste	d For New Costs
Program	gent Managem	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Financ	
							ormation Only	
						(No Ch	nange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Brevard County Heath Departme	ent	Prov	vider Number: 0519251-9	93
2572 N. Courtenay Parkway			Date: 07/01/202	20
Merritt Island, FL 32953-4147		 Fis	cal Year End: 06/30/201	9
			Audit Status: Unaudited	l Cost
Provider Type		Current Rate	New Rate	Effective Date
<u>CHD</u>		162.71	166.59	07/01/2020
Rate Type				
<u>Interim</u>		X Prospect	<u>tive</u>	
Total In	terim	X	<b>Total Prospective</b>	
Settlem	nent Based on Cost		Prospective Adjus	ted For New Costs
DISTRIBUTION: Fiscal Agent Contract Management	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost	Rydell Samuel, Adminis	
Program Finance			Medicaid Program Fina	nce
State Health Office				
			For Information Or	nly
			—— (No Change In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Palm Beach County Hea	alth Departmen	t		Provi	der Number:	0520331-00	)
P. O. Box 29					Date:	07/01/2020	
West Palm Beach, FL 3	33402			Fisc	al Year End:	06/30/2019	
				,	Audit Status:	Unaudited (	Cost
Provider Type			Curren	t Rate	<u>New</u>	Rate	Effective Date
<u>CHD</u>			166	.57	166	5.59	07/01/2020
Rate Type							
<u>Interim</u>			X	<u>Prospecti</u>	<u>ve</u>		
	Total Interim			_ X	Total P	rospective	
	Settlement Ba	sed on Cost			Prospe	ctive Adjuste	ed For New Costs
DISTRIBUTION: Fiscal Agent Contract Management Program Finance State Health Office		BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost ted Cost	<u>.</u>		el, Administr ogram Finand	
State Floatian Silice				_		ormation Onl	
					(No Ch	ange In Rate	<del>?</del> )



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Palm Beach C	County Hea	alth Departmer	nt		Pro	vider Number:	0520331-09	
P. O. Box 29						Date:	07/01/2020	
West Palm Be	each, FL 3	33402			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	ost
Provider T	уре			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type	Interim			X	Prospec	etive		
	<u> </u>	Total Interim			_ <del>1103pec</del> X		rospective	
		- Settlement Ba	ased on Cost				•	d For New Costs
		-					ŕ	
			BASIS:					
			Budget					
			X Unaudite	d Cost				
			Desk Rev	viewed Cost				
			Desk Aud	lited Cost				
			Field Aud	lited Cost				
						4000		
DISTRIBUTIO	ON:					THE STATE OF THE S		
Fiscal Ag	ent					PV		
Contract	Managem	ent				Rydell Samu	iel, Administra	ator
Program	Finance					Medicaid Pro	ogram Financ	e
State Hea	alth Office							
						For Info	ormation Only	,
						—— (No Ch	ange In Rate)	)



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Palm Beach County He	m Beach County Health Department  D. Box 29				der Number: 0520331-4	<b>1</b> 5
P. O. Box 29					Date: 07/01/2020	0
West Palm Beach, FL	33402			Fisca	al Year End: 06/30/2019	9
				A	Audit Status: Unaudited	Cost
Provider Type			Current	Rate	New Rate	Effective Date
<u>CHD</u>			166.	57	166.59	07/01/2020
Rate Type						
<u>Interim</u>			X	<u>Prospective</u>	<u>/e</u>	
	Total Interim			Χ	Total Prospective	
	Settlement Ba	sed on Cost	-		Prospective Adjust	ted For New Costs
		BASIS:				
		Budget				
	•	X Unaudited	l Cost			
	•	Desk Rev	iewed Cost			
	-	Desk Aud	ited Cost			
		Field Audi	ted Cost			
DISTRIBUTION:				8	R	
Fiscal Agent					PU	
Contract Managem	nent			F	Rydell Samuel, Adminis	trator
Program Finance				_	Medicaid Program Finar	
State Health Office						
					For Information Or	nly
				_	—— (No Change In Ra	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Palm Beach C	County Hea	alth Departmen	nt			Pro	vider Number	: 0520331-	50
P. O. Box 29							Date	: 07/01/202	20
West Palm Be	each, FL 3	33402				Fi	scal Year End	: 06/30/201	9
							Audit Status	Unaudited	l Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>New</u>	<u>/ Rate</u>	Effective Date
	CHD				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	ctive		
	_	Total Interim				- X		Prospective	
	-	- Settlement Ba	ased or	n Cost		r	Prospe	ective Adjus	ted For New Costs
DISTRIBUTIO				Budget Unaudited	iewed Cost ited Cost		R		
Fiscal Ag							LA		
	Manageme	ent					Rydell Sam		
Program							Medicaid Pr	ogram Fina	nce
State Hea	alth Office								
							For Inf	ormation O	nly
							(No Cl	nange In Ra	ite)



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Palm Beach Cou	m Beach County Health Department  D. Box 29				der Number: 0520331-8	39
P. O. Box 29					Date: 07/01/2020	0
West Palm Bead	ch, FL 33402			Fisca	al Year End: 06/30/2019	9
				A	udit Status: Unaudited	Cost
Provider Typ	<u>oe</u>		Current F	Rate	New Rate	Effective Date
<u>(</u>	<u>CHD</u>		166.57	7	166.59	07/01/2020
Rate Type						
<u>li</u>	<u>nterim</u>		X_ <u>P</u>	rospectiv	<u>/e</u>	
_	Total Interim			X	Total Prospective	
_	Settlement B	ased on Cost			Prospective Adjust	ted For New Costs
		BASIS:				
		Budget				
		X Unaudited	d Cost			
		Desk Rev	iewed Cost			
		Desk Aud	ited Cost			
		Field Audi	ted Cost			
<u>DISTRIBUTION</u>	<u>:</u>				R	
Fiscal Agen	t				M	
Contract Ma	anagement			F	Rydell Samuel, Adminis	trator
Program Fir	nance			_	Medicaid Program Finar	
State Health	h Office					
					For Information Or	nly
				_	—— (No Change In Rat	te)



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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Palm Beach Cou	m Beach County Health Department  D. Box 29				der Number: 0520331-9	95
P. O. Box 29					Date: 07/01/2020	0
West Palm Bead	ch, FL 33402			Fisca	al Year End: 06/30/2019	9
				P	Audit Status: Unaudited	Cost
Provider Typ	<u>oe</u>		Current F	<u>Rate</u>	New Rate	Effective Date
<u>(</u>	<u>CHD</u>		166.57	7	166.59	07/01/2020
Rate Type						
<u>li</u>	<u>nterim</u>		X_ <u>P</u>	rospectiv	<u>ve</u>	
_	Total Interim			Χ	Total Prospective	
_	Settlement Ba	ased on Cost			Prospective Adjust	ted For New Costs
		BASIS:				
		Budget				
		X Unaudited	d Cost			
		Desk Rev	iewed Cost			
		Desk Aud	ited Cost			
		Field Audi	ted Cost			
<u>DISTRIBUTION</u>	<u>.</u>				R	
Fiscal Agen	t				M	
Contract Ma	anagement			F	Rydell Samuel, Adminis	trator
Program Fir	nance			_	Medicaid Program Finar	
State Health	n Office					
					For Information Or	nly
				_	(No Change In Ra	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Charlotte Cou	ınty Health	Department			Pro	vider Number:	0520446-00	
514 East Gra	ce Street					Date:	07/01/2020	
Punta Gorda,	FL 33950	)			Fis	scal Year End:	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			105	.36	98	.93	07/01/2020
Rate Type				V	_			
	<u>Interim</u> -	Total lateria		X	Prospec			
		Total Interim	and an Coat		X		rospective	d For New Costs
		Settlement Ba	ased on Cost				ctive Adjusted	d For New Costs
			BASIS:					
			Budget					
			X Unaudite	d Cost				
				iewed Cost				
				dited Cost				
			Field Aud					
DISTRIBUTIO	ON:					THE		
Fiscal Ag						PU		
_	Manageme	ent				Rvdell Samı	iel, Administra	ator
Program	_						ogram Financ	
_	alth Office							
						For Info	ormation Only	,
						(No Ch	ange In Rate	)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Charlotte Cou	nty Health	Department				Pr	ovider Numbe	r: 0520446-	09
514 East Grad	e Street						Dat	e: 07/01/202	20
Punta Gorda,	FL 33950					F	iscal Year En	d: 06/30/201	19
							Audit Statu	s: Unaudited	d Cost
Provider Ty	<u>ype</u>				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date
	CHD			-	105	.36	9	8.93	07/01/2020
Rate Type	Interim				X	Prospe	<u>ctive</u>		
		Total Interim Settlement Ba	seed on Co	et		X		Prospective	sted For New Costs
Program I	ent Manageme Finance	ent	Des Des	udited k Revi k Audi	Cost ewed Cost ited Cost ted Cost			nuel, Admini Program Fina	
State Hea	aith Office							nformation C	-



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Charlotte County Health Department		Provider	Number: 0520446-9	91
514 East Grace Street		•	Date: 07/01/202	0
Punta Gorda, FL 33950		Fiscal `	Year End: 06/30/201	9
		Aud	dit Status: Unaudited	l Cost
Provider Type	Curre	ent Rate	New Rate	Effective Date
<u>CHD</u>	10	<b>05.36</b>	98.93	07/01/2020
Rate Type				
<u>Interim</u>	X			
Total Interin		X	Total Prospective	
Settlement I	Based on Cost		Prospective Adjus	ted For New Costs
<u>DISTRIBUTION:</u> Fiscal Agent Contract Management	BASIS:  Budget  X Unaudited Cost  Desk Reviewed Co  Desk Audited Cost  Field Audited Cost		dell Samuel, Adminis	strator
Program Finance			dell Samuel, Adminis dicaid Program Fina	
State Health Office		ivie	ulcalu Frogram Filla	iio <del>c</del>
			For Information O	nly
			— (No Change In Ra	ite)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hillsborough (	County Hea	alth Departme	nt		Pro	vider Number	: 0557269-00	
1105 E. Kenn	edy Boule	vard				Date	07/01/2020	
Tampa, FL 3	3602				Fis	scal Year End	06/30/2019	
						Audit Status:	Unaudited C	Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			166	.57	16	6.59	07/01/2020
Rate Type								
	Interim_			X	Prospec	<u>tive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjusted	d For New Costs
Program	gent Manageme	ent		viewed Cost dited Cost			uel, Administra ogram Financ	
							ormation Only	
						(No Ch	ange In Rate	)



Office of Medicaid Program Finance

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### **Medicaid Reimbursement Rate Change Form for CHDs**

Hillsborough (	County He	alth Departmer	nt			Pro	ovider Numbe	r: 0557269-	90
1105 E. Kenne	edy Boule	vard					Date	e: 07/01/202	20
Tampa, FL 33	3602					Fi	scal Year End	d: 06/30/201	19
							Audit Statu	s: Unaudited	d Cost
Provider Ty	<u>ype</u>				<u>Curren</u>	t Rate	<u>Nev</u>	w Rate	Effective Date
	<u>CHD</u>				166	.57	16	66.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospe	ctive		
	-	Total Interim				_ X	Total	Prospective	
		- Settlement Ba	ased on	Cost			Prosp	ective Adjus	sted For New Costs
<u>DISTRIBUTIO</u>			X	Budget Unaudited	iewed Cost ited Cost		R		
Fiscal Age							14		
	Manageme	ent						nuel, Adminis	
Program I							iviedicaid P	rogram Fina	ince
State Hea	aith Office								
							For In	formation O	nly
							(No C	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

_ake County I	Health Dep	artment				Pro	vider Number	r: 0563234-	00
P. O. Box 130	)5421 West	Main Street					Date	e: 07/01/202	20
Tavares, FL 3	32778-1305	5				Fi	scal Year End	l: 06/30/201	19
							Audit Status	: Unaudited	d Cost
Provider T	<u>ype</u>				Curren	t Rate	<u>Nev</u>	v Rate	Effective Date
	<u>CHD</u>				166	.57	16	6.59	07/01/2020
Rate Type	<u>Interim</u>				X	Prospec	<u>ctive</u>		
		Total Interim				X	Total F	Prospective	
		Settlement Ba	ased on C	Cost			Prospe	ective Adjus	sted For New Costs
<b>DISTRIBUTIC</b> Fiscal Ag			X UI	udget naudited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost		R		
•	jent Manageme	ınt					Dudall Cam	ual Admini	otrotor
Program	_	111					Rydell Sam Medicaid Pr		
_	alth Office							<b>3</b>	
							For Inf	formation O	only
							(No Cl	hange In Ra	ate)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Lake County	Health Dep	partment			Prov	vider Number:	0563234-0	1
P. O. Box 130	)5421 Wes	t Main Street				Date:	07/01/2020	
Tavares, FL	32778-130	5			Fis	cal Year End:	06/30/2019	
						Audit Status:	Unaudited	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
	CHD			166	.57	166	5.59	07/01/2020
Rate Type	<u>Interim</u>			X	Prospec	<u>tive</u>		
	_	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag Contract		ent	Desk Au	ed Cost viewed Cost dited Cost dited Cost		Rydell Samu	el, Administ	rator_
Program	-					Medicaid Pro		
State Hea	alth Office							
						For Info	ormation Onl	ly
						(No Ch	ange In Rate	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

_ake County F	Health Dep	partment			Prov	ider Number:	0563234-9	94
P. O. Box 130	5421 Wes	t Main Street				Date	07/01/202	0
Tavares, FL 3	32778-130	5			Fisc	cal Year End:	06/30/201	9
						Audit Status:	Unaudited	Cost
Provider Ty	<u>/pe</u>			Curren	t Rate	New	Rate	Effective Date
	CHD			166	.57	160	6.59	07/01/2020
Rate Type	<u>Interim</u>			X	Prospect	<u>ive</u>		
	-	Total Interim			- X		rospective	
		- Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs
DISTRIBUTIO	N:		Desk Au	ed Cost eviewed Cost udited Cost udited Cost				
Fiscal Age						PU		
Contract N Program F State Hea	Manageme Finance	ent				Rydell Samu Medicaid Pro		
						For Info	ormation Or	nly
					-	(No Ch	ange In Ra	te)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia Co	cambia County Health Department					Provider Number: 0600181-00				
1295 West Fa	airfield Driv	е					Dat	e: 07/01/202	20	
Pensacola, Fl	L 32501					Fi	scal Year En	d: 06/30/201	19	
							Audit Statu	s: Unaudited	d Cost	
Provider T	уре				Curren	t Rate	<u>Ne</u>	w Rate	Effective Date	
	CHD			_	166	.57	1	66.59	07/01/2020	
Rate Type	<u>Interim</u>				X	<u>Prospec</u>	<u>ctive</u>			
		Total Interim				X		Prospective		
		Settlement Ba -	ased on Cos	st			Prosp	pective Adjus	sted For New Costs	
<b>DISTRIBUTIC</b> Fiscal Ag Contract		ent	Desk	udited Revi	Cost ewed Cost ted Cost red Cost		Rydell San	ouel Admini	strator	
Program	_	<del>2</del> II(						nuel, Admini Program Fina		
_	alth Office							g		
							For Ir	nformation O	nly	
							(No C	Change In Ra	ate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Departn	nent		Provider Number: 0600181-01					
1295 West Fairfield Drive				Date: 07/01/202	0			
Pensacola, FL 32501			Fiscal \	ear End: 06/30/201	9			
			Auc	lit Status: Unaudited	l Cost			
Provider Type		Curren	t Rate	New Rate	Effective Date			
CHD		166	.57	166.59	07/01/2020			
Rate Type								
<u>Interim</u>		X	<u>Prospective</u>					
Total Into	erim		X	Total Prospective				
Settleme	ent Based on Cost			Prospective Adjus	ted For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost	Ryc	dell Samuel, Adminis dicaid Program Fina				
State Health Office				For Information On	•			
				(No Change In Ra	ite)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia Co	unty Health	n Department				Provider Number: 0600181-03				
1295 West Fa	airfield Driv	е					Da	te: 07/01/202	20	
Pensacola, Fl	L 32501					F	iscal Year E	nd: 06/30/201	9	
							Audit Stat	us: Unaudited	d Cost	
Provider T	уре				Curren	t Rate	<u>Ne</u>	ew Rate	Effective Date	
	CHD			-	166	.57	1	66.59	07/01/2020	
Rate Type	<u>Interim</u>				X	Prospe	<u>ctive</u>			
	_	Total Interim				X	Tota	I Prospective		
		Settlement Ba	ased on Cos	st			Pros	pective Adjus	sted For New Costs	
<u>DISTRIBUTIO</u> Fiscal Ag			Desi	udited Revi Audi	Cost lewed Cost ited Cost ted Cost		R			
_	jeni Manageme	ant .					Pudall Ca	mual Adminis	atrotor	
Program	-	Ont						muel, Adminis Program Fina		
_	alth Office							. 9		
							For	nformation O	nly	
							(No	Change In Ra	ate)	



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Departme	ent		Provider Number: 0600181-04					
1295 West Fairfield Drive				Date: 07/01/202	0			
Pensacola, FL 32501			Fiscal \	ear End: 06/30/201	9			
			Auc	it Status: Unaudited	Cost			
Provider Type		Curren	t Rate	New Rate	Effective Date			
<u>CHD</u>		166	.57	166.59	07/01/2020			
Rate Type								
<u>Interim</u>		X	<u>Prospective</u>					
Total Inte	rim		X	Total Prospective				
Settlemer	nt Based on Cost		-	Prospective Adjus	ted For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost	Ryc	lell Samuel, Adminis dicaid Program Final				
State Health Office				For Information Or – (No Change In Ra	•			
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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Department		Provider Number: 0600181-05					
1295 West Fairfield Drive			Date: 07/01/2020				
Pensacola, FL 32501		Fiscal Ye	ar End: 06/30/2019				
		Audit	Status: Unaudited	Cost			
<u>Provider Type</u>	<u>Curren</u>	t Rate	New Rate	Effective Date			
<u>CHD</u>	166	.57	166.59	07/01/2020			
Rate Type							
<u>Interim</u>	X	<u>Prospective</u>					
Total Interim		X	Total Prospective				
Settlement Based on	Cost		Prospective Adjuste	ed For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	S: Budget Unaudited Cost Desk Reviewed Cost Desk Audited Cost Field Audited Cost		Il Samuel, Administ caid Program Finan				
State Health Office			For Information Onl				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia Cou	cambia County Health Department				Provider Number: 0600181-07				
1295 West Fa	irfield Drive				Date: 07/01/202	20			
Pensacola, FL	32501			Fiscal Y	ear End: 06/30/20	19			
				Aud	it Status: Unaudite	d Cost			
Provider Ty	<u>ype</u>		Curren	t Rate	New Rate	Effective Date			
	CHD		166	.57	166.59	07/01/2020			
Rate Type									
	<u>Interim</u>		X	<b>Prospective</b>					
	Total Int	erim		X	Total Prospective				
	Settleme	ent Based on Cost			Prospective Adjus	sted For New Costs			
DISTRIBUTIO Fiscal Ag Contract I Program State Hea	ent Management Finance	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost	Ryc	lell Samuel, Admini dicaid Program Fina				
State Floor	AIG. 511100				For Information C	-			
					(No Change In Ra	ate)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia Cou	cambia County Health Department				Provider Number: 0600181-09				
1295 West Fa	irfield Driv	е				Date	07/01/2020		
Pensacola, FL	32501				Fis	scal Year End	06/30/2019		
						Audit Status	Unaudited C	ost	
Provider Ty	<u>/pe</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			166	.57	16	6.59	07/01/2020	
Rate Type									
	<u>Interim</u>	<b>.</b>		X	_ <u>Prospec</u>				
		Total Interim			X		rospective	15 N 0 1	
		Settlement Ba	ased on Cost			Prospe	ective Adjusted	d For New Costs	
DISTRIBUTIO Fiscal Age Contract N Program I State Hea	ent Managemo Finance	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	viewed Cost dited Cost			uel, Administra ogram Finance		
						For Info	ormation Only		
							nange In Rate)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Departmer	nt		Provider Number: 0600181-16					
1295 West Fairfield Drive				Date: 07/01/20	020			
Pensacola, FL 32501			Fiscal Y	ear End: 06/30/20	019			
			Aud	it Status: Unaudit	ed Cost			
Provider Type		Curren	t Rate	New Rate	Effective Date			
CHD	_	166	.57	166.59	07/01/2020			
Rate Type								
<u>Interim</u>		X	Prospective					
Total Interi	m		X	Total Prospectiv	e			
Settlement	Based on Cost			Prospective Adj	usted For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited ( Desk Revie)  Desk Audite  Field Audite	ewed Cost ed Cost		lell Samuel, Admindicaid Program Fir				
State Health Office				For Information (No Change In F	•			
				\	/			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Departme	ent		Provider Number: 0600181-20					
1295 West Fairfield Drive				Date: 07/01/202	0			
Pensacola, FL 32501			Fiscal Y	ear End: 06/30/201	9			
			Aud	it Status: Unaudited	Cost			
Provider Type		Curren	t Rate	New Rate	Effective Date			
<u>CHD</u>	-	166.	.57	166.59	07/01/2020			
Rate Type								
<u>Interim</u>		X	Prospective					
Total Inte	rim		X	Total Prospective				
Settlemer	nt Based on Cost			Prospective Adjus	ted For New Costs			
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ed Cost		lell Samuel, Adminis dicaid Program Final				
State Health Office				For Information Or	•			
				(No Change In Ra	te)			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia Cou	scambia County Health Department					Pı	rovider N	lumber:	0600181-	25		
1295 West Fa	irfield Driv	е						Date:	07/01/202	20		
Pensacola, FL	32501					F	iscal Ye	ar End:	06/30/201	19		
							Audit	Status:	Unaudited	d Cost		
Provider Ty	<u>ype</u>				Curren	t Rate		New	<u>Rate</u>	<u>E</u>	ffective	<u>Date</u>
	CHD			_	166	.57		166	5.59		07/01/20	<b>)20</b>
Rate Type												
	<u>Interim</u>				X	Prospe	<u>ective</u>					
		Total Interim				>	<u> </u>	Total Pr	ospective			
		Settlement Ba	ased on Cost	t				Prospec	ctive Adjus	sted For	New Cos	ts
<b>DISTRIBUTIO</b> Fiscal Ago Contract I Program State Hea	ent Manageme Finance	ent	Desk	dited ( Revie Audite	Cost ewed Cost ed Cost ed Cost				el, Admini gram Fina			
									rmation C	-		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia Co	cambia County Health Department				Provider Number: 0600181-26				
1295 West Fa	airfield Driv	е				Date	07/01/2020		
Pensacola, F	L 32501				Fis	scal Year End	06/30/2019		
						Audit Status	Unaudited C	ost	
<u>Provider T</u>	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date	
	<u>CHD</u>			166	.57	16	6.59	07/01/2020	
Rate Type									
	_ <u>Interim</u> _			X	_ <u>Prospec</u>				
		Total Interim			X		rospective		
		Settlement Ba	ased on Cost			Prospe	ective Adjusted	d For New Costs	
Program	gent Manageme	ent	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost			uel, Administra ogram Finance		
						For Info	ormation Only		
							ange In Rate)		
						11.10			



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Department		Provider Number: 0600181-29					
1295 West Fairfield Drive		Date: 07/01/2	020				
Pensacola, FL 32501		Fiscal Year End: 06/30/2	019				
		Audit Status: Unaudit	ted Cost				
<u>Provider Type</u>	Current Rate	New Rate	Effective Date				
<u>CHD</u>	166.57	166.59	07/01/2020				
Rate Type							
<u>Interim</u>	X Pros	<u>pective</u>					
Total Interim		X Total Prospectiv	/e				
Settlement Based on Co		Prospective Adj	justed For New Costs				
Des Des Des Des Fiel  DISTRIBUTION:  Fiscal Agent Contract Management Program Finance	dget audited Cost sk Reviewed Cost sk Audited Cost Id Audited Cost	Rydell Samuel, Admi Medicaid Program Fil					
State Health Office		For Information (No Change In	-				



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Department			Provider Number: 0600181-31				
1295 West Fairfield Drive			Date: 07/01/202	07/01/2020			
Pensacola, FL 32501			Fiscal \	9			
			Auc	lit Status: Unaudited	Cost		
Provider Type		Curren	t Rate	New Rate	Effective Date		
<u>CHD</u>		166	.57	166.59	07/01/2020		
Rate Type							
<u>Interim</u>		X	Prospective				
Total Int	erim		X	Total Prospective			
Settleme	ent Based on Cost		-	Prospective Adjus	ted For New Costs		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost	Ryc	dell Samuel, Adminis dicaid Program Final			
State Health Office				For Information O	•		
				(No Change In Ra	te)		



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Department			Provider Number: 0600181-32				
1295 West Fairfield Drive			Date: 07/01/2020	07/01/2020			
Pensacola, FL 32501			Fiscal \	9			
			Auc	lit Status: Unaudited	Cost		
Provider Type		Curren	t Rate	New Rate	Effective Date		
<u>CHD</u>		166	.57	166.59	07/01/2020		
Rate Type							
<u>Interim</u>		X	<u>Prospective</u>				
Total Inte	rim		X	Total Prospective			
Settlemer	nt Based on Cost		-	Prospective Adjust	ted For New Costs		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audit	ewed Cost	Ryc	dell Samuel, Adminis dicaid Program Finar			
State Health Office			_	For Information Or (No Change In Ra	•		
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#### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Department  1295 West Fairfield Drive					Provider Number: 0600181-33				
						Date	07/01/2020		
Pensacola, FL 32501				Fiscal Year End: 06/30/2019					
						A	Audit Status	: Unaudited	Cost
Provider T	<u>ype</u>				<u>Curren</u>	t Rate	<u>Nev</u>	v Rate	Effective Date
	<u>CHD</u>				166	.57	16	66.59	07/01/2020
Rate Type									
	<u>Interim</u>				X	Prospectiv	<u>ve</u>		
		Total Interim				X	Total I	Prospective	
		Settlement Ba	ased on	Cost			Prosp	ective Adjust	ed For New Costs
			BASI	<u>S:</u>					
			E	Budget					
			<u>X</u> (	Jnaudited	l Cost				
				Desk Revi	iewed Cost				
				Desk Audi	ited Cost				
			F	Field Audi	ted Cost				
							TR		
DISTRIBUTION Fiscal Ag							PI		
Contract	Manageme	ent				F	Rydell Sam	uel, Administ	trator
Program	Finance					_		rogram Finan	
State Hea	alth Office								
							For In	formation On	ly
						_	(No C	hange In Rat	e)



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### **Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Department			Provider Number: 0600181-91				
1295 West Fairfield Drive			Date: 07/01/202	07/01/2020			
Pensacola, FL 32501			Fiscal Y	9			
			Aud	it Status: Unaudited	Cost		
Provider Type		<u>Curren</u>	t Rate	New Rate	Effective Date		
<u>CHD</u>		166	.57	166.59	07/01/2020		
Rate Type							
<u>Interim</u>		X	<u>Prospective</u>				
Total Int	terim		X	Total Prospective			
Settleme	ent Based on Cost			Prospective Adjust	ted For New Costs		
DISTRIBUTION: Fiscal Agent Contract Management Program Finance	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost		lell Samuel, Adminis dicaid Program Finar			
State Health Office				For Information Or	•		
				(No Change In Ra	te)		



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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: Fiscal Year End:		07/01/2020		
					06/30/2019		
			Aud	it Status:	Unaudited Co	ost	
Provider Type		Curren	t Rate	New	<u>Rate</u>	Effective Date	
CHD	-	166	.57	166	.59	07/01/2020	
Rate Type							
<u>Interim</u>		X	Prospective	T ( 15			
Total Inter			X	_	ospective	- N 0 .	
Settlemen ———	t Based on Cost			Prospec -	tive Adjusted	For New Costs	
DISTRIBUTION: Fiscal Agent Contract Management	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost			el, Administra		
Program Finance			Med	dicaid Pro	gram Finance	•	
State Health Office							
				For Info	rmation Only		
				– (No Cha	ange In Rate)		