



Florida Agency For Health Care Administration
Office of Medicaid Cost Reimbursement Planning and Analysis
2727 Mahan Drive - Mail Stop 21 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number 0279251-00
Date: 7/8/2010
Fiscal Year End: 06/30/2009
Audit Status: Unaudited [1]

Provider Type

CHD

Current Rate

124.23

New Rate

143.58

Effective Date

7/1/2010

Rate Type

Interim

 Total Interim

 Settlement Based on Cost

X

Prospective

X Total Prospective

 Prospective Adjusted For New Costs

BASIS

 Budget

X Unaudited Cost

 Desk Reviewed Cost

 Desk Audited Costs

 Field Audited Cost

Rydell Samuel, Administrator

Medicaid Cost Reimbursement Analysis

DISTRIBUTION:

Fiscal Agent
Contract Management
Cost Reimbursement
State Health Office

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Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number 0279251-01
Date: 7/8/2010
Fiscal Year End: 06/30/2009
Audit Status: Unaudited [1]

Provider Type

CHD

Current Rate

124.23

New Rate

143.58

Effective Date

7/1/2010

Rate Type

Interim

 Total Interim

 Settlement Based on Cost

X

Prospective

X Total Prospective

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

Provider Number 0279251-02
Date: 7/8/2010
Fiscal Year End: 06/30/2009
Audit Status: Unaudited [1]

Provider Type

CHD

Current Rate

124.23

New Rate

143.58

Effective Date

7/1/2010

Rate Type

Interim

 Total Interim

 Settlement Based on Cost

X

Prospective

X Total Prospective

 Prospective Adjusted For New Costs

BASIS

 Budget

X Unaudited Cost

 Desk Reviewed Cost

 Desk Audited Costs

 Field Audited Cost

Rydell Samuel, Administrator

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

Provider Number 0279251-03
Date: 7/8/2010
Fiscal Year End: 06/30/2009
Audit Status: Unaudited [1]

Provider Type

CHD

Current Rate

124.23

New Rate

143.58

Effective Date

7/1/2010

Rate Type

Interim

____ Total Interim

____ Settlement Based on Cost

X

Prospective

X

____ Total Prospective

____ Prospective Adjusted For New Costs

BASIS

____ Budget

X Unaudited Cost

____ Desk Reviewed Cost

____ Desk Audited Costs

____ Field Audited Cost

Rydell Samuel, Administrator

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

Provider Number 0279251-04
Date: 7/8/2010
Fiscal Year End: 06/30/2009
Audit Status: Unaudited [1]

Provider Type

CHD

Current Rate

124.23

New Rate

143.58

Effective Date

7/1/2010

Rate Type

Interim

 Total Interim

 Settlement Based on Cost

X

Prospective

X Total Prospective

 Prospective Adjusted For New Costs

BASIS

 Budget

X Unaudited Cost

 Desk Reviewed Cost

 Desk Audited Costs

 Field Audited Cost

Rydell Samuel, Administrator

Medicaid Cost Reimbursement Analysis

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Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number 0279251-12
Date: 7/8/2010
Fiscal Year End: 06/30/2009
Audit Status: Unaudited [1]

<u>Provider Type</u>	<u>Current Rate</u>	<u>New Rate</u>	<u>Effective Date</u>
<u>CHD</u>	<u>124.23</u>	<u>143.58</u>	<u>7/1/2010</u>

Rate Type

<u>Interim</u>	<u>X</u>	<u>Prospective</u>
<u> </u> Total Interim	<u> </u>	<u> </u> Total Prospective
<u> </u> Settlement Based on Cost	<u> </u>	<u> </u> Prospective Adjusted For New Costs

BASIS

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

Rydell Samuel, Administrator
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Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number 0279251-91
Date: 7/8/2010
Fiscal Year End: 06/30/2009
Audit Status: Unaudited [1]

Provider Type

CHD

Current Rate

124.23

New Rate

143.58

Effective Date

7/1/2010

Rate Type

Interim

 Total Interim

 Settlement Based on Cost

X

Prospective

X Total Prospective

 Prospective Adjusted For New Costs

BASIS

 Budget

X Unaudited Cost

 Desk Reviewed Cost

 Desk Audited Costs

 Field Audited Cost

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