Medicaid Reimbursement Rate Change Form for CHDs

Alachua County Health Department  
224 SE 24th Street  730 N.E. Waldo Road, Suite 500  
Gainesville, FL 32641

Provider Number: 0279111-00  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Provider Number:** 0279111-91  
**Date:** 07/01/2020

**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

**For Information Only**

- **Rydell Samuel, Administrator**
  - Medicaid Program Finance
  - (No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
  - Total Interim
- Prospective
  - Total Prospective
  - Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance
For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>145.12</td>
<td>163.76</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>X Prospective</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>Total Interim</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost: X
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>145.12</td>
<td>163.76</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Prospective</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

DISTRIBUTION:

Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Baker County Health Department
480 West Lowder Street
Macclenny, FL 32063

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>145.12</td>
<td>163.76</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
  - Total Interim
- Settlement Based on Cost
- Prospective
  - Total Prospective
  - Prospective Adjusted For New Costs

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>X</th>
<th>Total Interim</th>
<th>X</th>
<th>Total Prospective</th>
<th>Prospectively Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
  - Desk Reviewed Cost
  - Desk Audited Cost
  - Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Ry dell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

Total Interim
Settlement Based on Cost

Total Prospective
Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308  

Medicaid Reimbursement Rate Change Form for CHDs  

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- X Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost  

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office  

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)  

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>128.07</td>
<td>96.69</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydel Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>128.07</td>
<td>96.69</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
  - Total Interim
  - Settlement Based on Cost
- Prospective
  - Total Prospective
  - Prospective Adjusted For New Costs

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>128.07</td>
<td>96.69</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td>x Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- x Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydel Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM
Batch ID: G2HR9
Broward County Health Department
780 SW 24th Street
Fort Lauderdale, FL 33315

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>128.07</td>
<td>96.69</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X Total Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>X Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X Total Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prospectively Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>120.36</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
  - Total Interim
  - Settlement Based on Cost

- Prospective
  - Total Prospective
  - Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>120.36</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Calhoun County Health Department
19611 S.R. 20 West
Blountstown, FL 32424

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>120.36</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

DISTRIBUTION:
Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>TOTAL INTERIM</th>
<th>TOTAL PROSPECTIVE</th>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

**For Information Only**

(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th></th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- **X** Prospective

BASIS:
- Budget
- **X** Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISTRIBUTION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Agent</td>
</tr>
<tr>
<td>Contract Management</td>
</tr>
<tr>
<td>Program Finance</td>
</tr>
<tr>
<td>State Health Office</td>
</tr>
</tbody>
</table>

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number: 0279200-04  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

### Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td>Prospective</td>
</tr>
</tbody>
</table>

### BASIS:

<table>
<thead>
<tr>
<th>Budget</th>
<th>Unaudited Cost</th>
<th>Desk Reviewed Cost</th>
<th>Desk Audited Cost</th>
<th>Field Audited Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Interim Total</th>
<th>Prospective Total</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basis</td>
<td>Budget</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Desk Reviewed Cost</td>
<td>Desk Reviewed Cost</td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Desk Audited Cost</td>
<td>Desk Audited Cost</td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Field Audited Cost</td>
<td>Field Audited Cost</td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost (X)
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
  - Desk Reviewed Cost
  - Desk Audited Cost
  - Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office
- Rydell Samuel, Administrator
  - Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydel Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance
For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim: Total Interim
- Prospective: Total Prospective

**BASIS:**
- Budget
- **X** Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>X</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
- Prospective

Total Interim
Settlement Based on Cost

Total Prospective
Prospective Adjusted For New Costs

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0279226-00  
Date: 07/01/2020

Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- **X** Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

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

### Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

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

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Unaudited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk Audited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field Audited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:
Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- X Prospective

<table>
<thead>
<tr>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**  
- Interim  
- Prospective

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

**BASIS:**  
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
DeSoto County Health Department
34 South Baldwin Avenue
Arcadia, FL 33821

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.66</td>
<td>122.60</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Admininstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.66</td>
<td>122.60</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>Total Prospective</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

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

### Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

### Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Number: 0279242-03</th>
<th>Date: 07/01/2020</th>
<th>Fiscal Year End: 06/30/2019</th>
<th>Audit Status: Unaudited Cost</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.66</td>
<td>122.60</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td>Total Prospective</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

### BASIS:
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

### DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.66</td>
<td>122.60</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.66</td>
<td>122.60</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

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

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

DISTRIBUTION:  
Fiscal Agent  
Contract Management  
Program Finance  
State Health Office  
Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.66</td>
<td>122.60</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Total Interim</th>
<th>Prospective</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.66</td>
<td>122.60</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Ryde1l Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>124.87</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>124.87</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost X
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

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

**Florida Agency For Health Care Administration**
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- Prospective

**BASIS:**

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

**DISTRIBUTION:**

Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

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

Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th></th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospectively Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

**DISTRIBUTION:**

<table>
<thead>
<tr>
<th>Fiscal Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Management</td>
</tr>
<tr>
<td>Program Finance</td>
</tr>
<tr>
<td>State Health Office</td>
</tr>
</tbody>
</table>

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- [ ] Budget
- [x] Unaudited Cost
- [ ] Desk Reviewed Cost
- [ ] Desk Audited Cost
- [ ] Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Number: 0279269-05</th>
<th>Date: 07/01/2020</th>
<th>Fiscal Year End: 06/30/2019</th>
<th>Audit Status: Unaudited Cost</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - [X] Unaudited Cost
  - [ ] Desk Reviewed Cost
  - [ ] Desk Audited Cost
  - [ ] Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- **Prospective**

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

- [ ] Budget  
- [x] Unaudited Cost  
- [ ] Desk Reviewed Cost  
- [ ] Desk Audited Cost  
- [ ] Field Audited Cost

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

---

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
## Medicaid Reimbursement Rate Change Form for CHDs

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

**Florida Agency For Health Care Administration**  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308  

---

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**  
- Interim  
- **Prospective**

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

**BASIS:**  
- Budget  
- √ Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

### Duval County Health Department

<table>
<thead>
<tr>
<th>Provider Number: 0279269-52</th>
<th>Date: 07/01/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year End: 06/30/2019</td>
<td>Audit Status: Unaudited Cost</td>
</tr>
</tbody>
</table>

### Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number: 0279269-53

Date: 07/01/2020

Fiscal Year End: 06/30/2019

Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

Total Interim
Settlement Based on Cost

Total Prospective
Prospective Adjusted For New Costs

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Duval County Health Department
515 West Sixth Street
Jacksonville, FL 32206

Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Provider Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X Interim</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X Settlement Based on Cost</td>
</tr>
<tr>
<td>Total Interim</td>
<td>Total Interim</td>
</tr>
<tr>
<td>Total Prospective</td>
<td>Total Prospective</td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

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

### Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospectives</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### BASIS:

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

---

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Duval County Health Department

515 West Sixth Street
Jacksonville, FL  32206

Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospectively Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**
- **Interim**
  - Total Interim
  - Settlement Based on Cost
- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**
- Budget
  - Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance  
For Information Only  
(No Change In Rate)
Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL  32110-0847

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim  
- Prospective  

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Settlement Based on Cost

Prospective Adjusted For New Costs

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type  
Interim X Prospective  
Total Interim  
Settlement Based on Cost  

Prospective Adjusted For New Costs

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

DISTRIBUTION:  
Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)

Printed:  7/1/2020 11:47 AM  
Batch ID:G2HR9
Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

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

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

Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

BASIS:

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

DISTRIBUTION:

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospectively Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
<th>Budget</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISTRIBUTION:</th>
<th>Fiscal Agent</th>
<th>Contract Management</th>
<th>Program Finance</th>
<th>State Health Office</th>
</tr>
</thead>
</table>

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Flagler County Health Department  
P. O. Box 847301 South Lemon Street  
Bunnell, FL 32110-0847  

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

(No Change In Rate)
Flagler County Health Department
P. O. Box 847301 South Lemon Street
Bunnell, FL 32110-0847

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
- Prospective

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM
Batch ID: G2HR9
**Medicaid Reimbursement Rate Change Form for CHDs**

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>152.32</td>
<td>144.31</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

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

Provider Number: 0279293-01  
Date: 07/01/2020

Fiscal Year End: 06/30/2019

Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

For Information Only  
(No Change In Rate)

Rydell Samuel, Administrator  
Medicaid Program Finance
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:

- Budget
- Unaudited Cost [X]
- Desk Reviewed Cost

Distribution:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
  - Desk Reviewed Cost
  - Desk Audited Cost
  - Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>105.88</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- Prospective

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

**For Information Only**

(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Number: 0279307-01</th>
<th>Date: 07/01/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year End: 06/30/2019</td>
<td>Audit Status: Unaudited Cost</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>105.88</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distribution:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Agent</td>
</tr>
<tr>
<td>Contract Management</td>
</tr>
<tr>
<td>Program Finance</td>
</tr>
<tr>
<td>State Health Office</td>
</tr>
</tbody>
</table>

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>105.88</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>105.88</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>105.88</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

<table>
<thead>
<tr>
<th>Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>x Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>105.88</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

Settlement Based on Cost

Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td>X Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Total Interim</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Total Prospective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- [x] Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  
For Information Only  
(No Change In Rate)
Glades County Health Department
P. O. Box 489
Moore Haven, FL 33471

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

### Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Settlement Based on Cost</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Glades County Health Department

Provider Number: 0279323-91

Date: 07/01/2020

Fiscal Year End: 06/30/2019

Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Gulf County Health Department  
2475 Garrison Avenue  
Port St. Joe, FL 32456-5265

Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

<table>
<thead>
<tr>
<th></th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X Total Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>X Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X Total Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL 32456-5265

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydeel Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Gulf County Health Department
2475 Garrison Avenue
Port St. Joe, FL  32456-5265

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
<tr>
<td>Prospetive</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance
For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Rate</th>
<th>Settlement Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>Settlement Based on Cost</td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td>Total Prospective</td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

**Rydell Samuel, Administrator**  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>165.29</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Hamilton County Health Department

Provider Number: 0279340-25

P. O. Box 267

Date: 07/01/2020

Jasper, FL 32052

Fiscal Year End: 06/30/2019

Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>165.29</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>x Total Interim</td>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>x Total Prospective</td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Hamilton County Health Department
P. O. Box 267
Jasper, FL  32052

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>165.29</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
- Prospective

Total Interim
Settlement Based on Cost

Prospective Adjusted For New Costs

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Hamilton County Health Department  
P. O. Box 267  
Jasper, FL 32052

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>165.29</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROSPECTIVE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
- X Prospective

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>x Interim</th>
<th>x Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settlement Based on Cost</td>
<td>x</td>
<td>x</td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- x Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only (No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- **Prospective**

Total Interim

Total Prospective

Settlement Based on Cost

Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Settlement Based on Cost
Prospective Adjusted For New Costs

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Hendry County Health Department

Provider Number: 0279366-00
P. O. Box 70
LaBelle, FL  33975

Date: 07/01/2020

Fiscal Year End: 06/30/2019

Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
  - Total Interim
  - Settlement Based on Cost

- Prospective
  - Total Prospective
  - Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

For Information Only
(No Change In Rate)

Rydell Samuel, Administrator
Medicaid Program Finance
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospsective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>139.95</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>139.95</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>139.95</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>Total Prospective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Highlands County Health Department  
7205 South George Boulevard  
Sebring, FL 33872  

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>127.71</td>
<td>135.85</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prosp</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Settlement</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- X Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office  

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>127.71</td>
<td>135.85</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number: 0279412-01  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- Prospective

**BASIS:**

- Budget
- X Unaudited Cost

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only

(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Settlement Based on Cost</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Rate</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Rate</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective Date</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost X
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospect Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydel Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

### Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM
Batch ID: G2HR9
Indian River County Health Department
1900 27th Street
Vero Beach, FL 32960

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>X Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISTRIBUTION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Agent</td>
</tr>
<tr>
<td>Contract Management</td>
</tr>
<tr>
<td>Program Finance</td>
</tr>
<tr>
<td>State Health Office</td>
</tr>
</tbody>
</table>

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

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

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

### Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.06</td>
<td>147.15</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- **Prospective**

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Signed by:

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**: Total Interim
- **Prospective**: Total Prospective, Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Jackson County Health Department
P. O. Box 310
Marianna, FL  32447

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>XXX</td>
<td>X</td>
<td>XXX</td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X Prospective</td>
</tr>
<tr>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Florida Agency For Health Care Admininstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

**Medicaid Reimbursement Rate Change Form for CHDs**

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Jackson County Health Department  
P. O. Box 310  
Marianna, FL  32447

Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type  
Interim  
Prospective

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

DISTRIBUTION:  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Jackson County Health Department  
P. O. Box 310  
Marianna, FL 32447  

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>X  Unaudited Cost</td>
</tr>
<tr>
<td>X  Total Interim</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>X  Settlement Based on Cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td></td>
<td>Field Audited Cost</td>
</tr>
<tr>
<td>Prospective</td>
<td>X  Total Prospective</td>
</tr>
<tr>
<td>X  Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

Rydell Samuel, Administrator  
Medicaid Program Finance  

**DISTRIBUTION:**

Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

For Information Only  
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Jackson County Health Department
P. O. Box 310
Marianna, FL 32447

Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Settlement Based on Cost
Prospective Adjusted For New Costs

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>160.57</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

#### Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

#### BASIS:

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

#### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>160.57</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- Unaudited Cost (X)  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office  

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>160.57</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**
- **Interim**: Total Interim
- **Prospective**: Total Prospective
- **Settlement Based on Cost**: Prospective Adjusted For New Costs

**BASIS:**
- **Budget**
- **X** Unaudited Cost
- **Desk Reviewed Cost**
- **Desk Audited Cost**
- **Field Audited Cost**

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Department  
2965 Municipal Way  
Tallahassee, FL 32304  

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>159.06</td>
<td>118.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td>x</td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>x</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- X Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Leon County Health Department
2965 Municipal Way
Tallahassee, FL 32304

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>159.06</td>
<td>118.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Propective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X Prospectively Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number: 0279480-91  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th></th>
<th>Interim</th>
<th>Prospctive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

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

Provider Number: 0279498-00  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

---

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>144.88</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>X Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

---

**BASIS:**

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

---

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydel Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>144.88</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

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

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>144.88</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>144.88</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**
- Interim
- Proposed

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

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>144.88</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- Unaudited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office  

Rydell Samuel, Administrator  
Medicaid Program Finance  
For Information Only  
(No Change In Rate)
_liberty County Health Department
P. O. Box 489247 N. Central Street
Bristol, FL 32321

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>144.88</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
- **Prospective**

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Adminstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>117.92</td>
<td>95.90</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
- Total Interim
- Settlement Based on Cost
- Prospective
- Total Prospective
- Prospective Adjusted For New Costs

BASIS:
- Budget  
- Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

DISTRIBUTION:  
Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>117.92</td>
<td>95.90</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>117.92</td>
<td>95.90</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
- Prospective

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

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>117.92</td>
<td>95.90</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Marion County Health Department  
1801 S.E. 32nd Avenue P. O. Box 2408  
Ocala, FL 34478-2408

Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0279528-01  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td>X</td>
<td>Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd Avenue, P. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Marion County Health Department
1801 S.E. 32nd Avenue P. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd Avenue
P. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Marion County Health Department
1801 S.E. 32nd Avenue
P. O. Box 2408
Ocala, FL 34478-2408

Provider Number: 0279528-12
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type
- Interim
- Prospective

Total Interim
Settlement Based on Cost

Prospective Adjusted For New Costs

BASIS:
- Budget
- Unaudited Cost
- DeskReviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Marion County Health Department
1801 S.E. 32nd Avenue P. O. Box 2408
Ocala, FL 34478-2408

Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

**Medicaid Reimbursement Rate Change Form for CHDs**

<table>
<thead>
<tr>
<th>Provider Number: 0279528-30</th>
<th>Date: 07/01/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Year End: 06/30/2019</td>
<td>Audit Status: Unaudited Cost</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td>X</td>
<td>Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Marion County Health Department  
1801 S.E. 32nd Avenue, P.O. Box 2408  
Ocala, FL 34478-2408

Provider Number: 0279528-91  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Department  
3441 SE Willoughby Blvd.  
Stuart, FL 34994-5060

Provider Number: 0279536-00  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.19</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>Prospective</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

**Martin County Health Department**  
3441 SE Willoughby Blvd.  
Stuart, FL 34994-5060

**Provider Number:** 0279536-11  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

### Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.19</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

- **Interim**  
- **Prospective**

<table>
<thead>
<tr>
<th>Basis</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Unaudited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk Audited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field Audited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Florida Agency For Health Care Admininstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Martin County Health Department  
3441 SE Willoughby Blvd.  
Stuart, FL  34994-5060

Provider Number: 0279536-91  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.19</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Settlement Based on Cost  
Prospective Adjusted For New Costs

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

DISTRIBUTION:  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Monroe County Health Department  
5100 College Road  
Key West, FL  33040

Provider Number: 0279544-01  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
  - Desk Reviewed Cost
  - Desk Audited Cost
  - Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department  
5100 College Road  
Key West, FL 33040

Provider Number: 0279544-03  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
  - Total Interim
    - Settlement Based on Cost

- **Prospective**
  - Total Prospective
    - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>x Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
</table>

**BASIS:**
- Budget
  - x Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-08
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL  33040

Provider Number: 0279544-13
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
  - Desk Reviewed Cost
  - Desk Audited Cost
  - Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Monroe County Health Department
5100 College Road
Key West, FL  33040

Provider Number: 0279544-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
  - Desk Reviewed Cost
  - Desk Audited Cost
  - Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL  33040

Provider Number: 0279544-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Settlement Based on Cost

BASIS:

<table>
<thead>
<tr>
<th>Budget</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaudited Cost</td>
<td></td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
<td></td>
</tr>
<tr>
<td>Desk Audited Cost</td>
<td></td>
</tr>
<tr>
<td>Field Audited Cost</td>
<td></td>
</tr>
</tbody>
</table>

DISTRIBUTION:

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Monroe County Health Department
5100 College Road
Key West, FL 33040

Provider Number: 0279544-93
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospect Total</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department  
P. O. Box 517  
Fernandina Beach, FL 32035-0517

Provider Number: 0279552-00  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>125.84</td>
<td>97.95</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>X Prospective</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

For Information Only  
(No Change In Rate)

Rydell Samuel, Administrator  
Medicaid Program Finance
Florida Agency For Health Care Admininstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>125.84</td>
<td>97.95</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department
P. O. Box 517
Fernandina Beach, FL 32035-0517

Provider Number: 0279552-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>125.84</td>
<td>97.95</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISTRIBUTION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal Agent</td>
</tr>
<tr>
<td>Contract Management</td>
</tr>
<tr>
<td>Program Finance</td>
</tr>
<tr>
<td>State Health Office</td>
</tr>
</tbody>
</table>

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Nassau County Health Department
P. O. Box 517
Fernandina Beach, FL 32035-0517

Provider Number: 0279552-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>125.84</td>
<td>97.95</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>125.84</td>
<td>97.95</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**
- Interim
- Prospective

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Florida Agency For Health Care Admininstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>158.26</td>
<td>165.33</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
  - Total Interim: X
  - Settlement Based on Cost: 
  - Prospectively Adjusted For New Costs: 

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Okaloosa County Health Department  
221 Hospital Drive, N.E.  
Ft. Walton Beach, FL 32548

Provider Number: 0279561-91  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>158.26</td>
<td>165.33</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- X Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office  

Rydell Samuel, Administrator  
Medicaid Program Finance  
For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department
P.O. Box 18791728 N.W. 9th Avenue
Okeechobee, FL 34973-1879

Provider Number: 0279579-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>131.18</td>
<td>154.03</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

Total Interim
Settlement Based on Cost

Total Prospective
Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Provider Number:** 0279579-01  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>131.18</td>
<td>154.03</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget  
- Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

---

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>131.18</td>
<td>154.03</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Okeechobee County Health Department
P.O. Box 18791728 N.W. 9th Avenue
Okeechobee, FL 34973-1879

Provider Number: 0279579-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>131.18</td>
<td>154.03</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- Prospective

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Okeechobee County Health Department  
P.O. Box 18791728 N.W. 9th Avenue  
Okeechobee, FL 34973-1879

Provider Number: 0279579-04  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>131.18</td>
<td>154.03</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Interim

Settlement Based on Cost

Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID:G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>131.18</td>
<td>154.03</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Signed: Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

Orange County Health Department  
6101 Lake Ellenor Drive  
Orlando, FL  32804  

Provider Number: 0279587-01  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospectively Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>X Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  
For Information Only  
(No Change in Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

<table>
<thead>
<tr>
<th>Budget</th>
<th>X Unaudited Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk Reviewed Cost</td>
<td></td>
</tr>
<tr>
<td>Desk Audited Cost</td>
<td></td>
</tr>
<tr>
<td>Field Audited Cost</td>
<td></td>
</tr>
</tbody>
</table>

**DISTRIBUTION:**

<table>
<thead>
<tr>
<th>Fiscal Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Management</td>
</tr>
<tr>
<td>Program Finance</td>
</tr>
<tr>
<td>State Health Office</td>
</tr>
</tbody>
</table>

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Department  
P. O. Box 4503091875 Boggy Creek Road  
Kissimmee, FL  34745-0309

Provider Number: 0279595-30  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

<table>
<thead>
<tr>
<th>Budget</th>
<th>X Unaudited Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td></td>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Osceola County Health Department  
P. O. Box 4503091875 Boggy Creek Road  
Kissimmee, FL  34745-0309  

| Provider Number: 0279595-92 | Date: 07/01/2020 | Fiscal Year End: 06/30/2019 | Audit Status: Unaudited Cost |

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>X Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Osceola County Health Department  
P. O. Box 4503091875 Boggy Creek Road  
Kissimmee, FL  34745-0309

Provider Number: 0279595-93  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

**Pasco County Health Department**  
10841 Little Road  
New Port Richey, FL 34654

**Provider Number:** 0279617-00  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Provider Type</th>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>Budget</td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td>Unaudited Cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department
10841 Little Road
New Port Richey, FL 34654

Provider Number: 0279617-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Pasco County Health Department
10841 Little Road
New Port Richey, FL  34654

Provider Number: 0279617-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>X Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Pinellas County Health Department  
500 7th Avenue South  
St. Petersburg, FL 33701

Provider Number: 0279625-00  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Florida Agency For Health Care Adminstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Pinellas County Health Department
500 7th Avenue South
St. Petersburg, FL 33701

Provider Number: 0279625-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

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

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0279633-00  
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td></td>
<td>Field Audited Cost</td>
</tr>
<tr>
<td>Propective</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**

**DISTRIBUTION:**

Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

### Provider Information
- **Provider Number:** 0279633-01
- **Date:** 07/01/2020
- **Fiscal Year End:** 06/30/2019
- **Audit Status:** Unaudited Cost

### Provider Type
- **Provider Type:** CHD
  - **Current Rate:** 166.57
  - **New Rate:** 166.59
  - **Effective Date:** 07/01/2020

### Rate Type
- **Interim**
  - Total Interim
  - Settlement Based on Cost
- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

### BASIS:
- **Budget**
- **X** Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

### DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Admininstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td>Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Admininstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department  
1290 Golfview Avenue, 4th Floor  
Bartow, FL 33830-6740

Provider Number: 0279633-05  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  
For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Provider Number: 0279633-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Polk County Health Department
1290 Golfview Avenue, 4th Floor
Bartow, FL 33830-6740

Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Provider Number: 0279633-90
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Settlement Based on Cost
Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
  - Total Interim: 
  - Settlement Based on Cost:

- **Prospective**
  - Total Prospective: Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL  32177

Provider Number: 0279641-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospectively Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost [X]
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM
Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL  32177

Provider Number: 0279641-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL 32177

Provider Number: 0279641-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospectively Adjusted For New Costs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BASIS:</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td></td>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

DISTRIBUTION:
Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Putnam County Health Department
2801 Kennedy Street
Palatka, FL 32177

Provider Number: 0279641-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Putnam County Health Department
2801 Kennedy Street
Palatka, FL  32177

Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0279641-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Settlement Based on Cost

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

St. Johns County Health Department
1955 US 1 South
St. Augustine, FL  32086

Provider Number: 0279650-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

St. Johns County Health Department
1955 US 1 South
St. Augustine, FL 32086

Provider Number: 0279650-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

**St. Lucie County Health Department**  
5150 NW Milner Drive  
Port Saint Lucie, FL  34963  

**Provider Number:** 0279668-00  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**  
- **Prospective**  

<table>
<thead>
<tr>
<th>BASIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Total Interim</th>
<th>X</th>
<th>Prospective</th>
<th>Total Prospective</th>
<th>X</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL  34963

Provider Number: 0279668-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type:  
- Interim
- Prospective  

BASIS:  
- Budget
- Unaudited Cost  
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:  
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-04
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydess Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

**St. Lucie County Health Department**
5150 NW Milner Drive
Port Saint Lucie, FL 34963

**Provider Number:** 0279668-11  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim: Total Interim  
- Prospective: Total Prospective  
- Settlement Based on Cost  
- Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-12
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>X Prospective</th>
<th>x</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

St. Lucie County Health Department
5150 NW Milner Drive
Port Saint Lucie, FL 34963

Provider Number: 0279668-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

### Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

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

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
/providers/0279668-91
/date:07/01/2020
/fiscal-year-end:06/30/2019
/audit-status:unaudited-cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Basis:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**Distribution:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Santa Rosa County Health Department**
P.O. Box 929
Milton, FL 32572-0929

**Provider Number:** 0279676-00  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>150.91</td>
<td>147.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**Basis:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydel Samuell, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department  
P.O. Box 929  
Milton, FL 32572-0929  

Provider Number: 0279676-01  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>150.91</td>
<td>147.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prospective</td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
Santa Rosa County Health Department  
P.O. Box 929  
Milton, FL 32572-0929

Provider Number: 0279676-02  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>150.91</td>
<td>147.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- Prospective

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  
For Information Only  
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department  
P.O. Box 929  
Milton, FL  32572-0929  

Provider Number: 0279676-03  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>150.91</td>
<td>147.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
  - [x] Unaudited Cost  
  - Desk Reviewed Cost  
  - Desk Audited Cost  
  - Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office  

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department  
P.O. Box 929  
Milton, FL 32572-0929

Provider Number: 0279676-04  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>150.91</td>
<td>147.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim Total Interim</th>
<th>Prospective Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- [ ] Budget  
- [x] Unaudited Cost  
- [ ] Desk Reviewed Cost  
- [ ] Desk Audited Cost  
- [ ] Field Audited Cost  

**DISTRIBUTION:**
- [ ] Fiscal Agent  
- [ ] Contract Management  
- [ ] Program Finance  
- [ ] State Health Office  

Rydel Samuel, Administrator  
Medicaid Program Finance  
For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>150.91</td>
<td>147.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th></th>
<th>Prospective</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
<td>Total Prospective</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost (X)
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>150.91</td>
<td>147.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Santa Rosa County Health Department
P.O. Box 929
Milton, FL 32572-0929

Provider Number: 0279676-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>150.91</td>
<td>147.82</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>X</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Prospect</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Sarasota County Health Department  
P. O. Box 2658  
Sarasota, FL  34230-2658

Provider Number: 0279684-00  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.19</td>
<td>161.01</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**  
- Interim  
- Prospective

**BASIS:**  
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Sarasota County Health Department
P. O. Box 2658
Sarasota, FL  34230-2658

Provider Number: 0279684-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.19</td>
<td>161.01</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>X</td>
<td></td>
<td></td>
<td>Total Prospective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Sarasota County Health Department
P. O. Box 2658
Sarasota, FL 34230-2658

Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0279684-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.19</td>
<td>161.01</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.19</td>
<td>161.01</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Department
400 West Airport Boulevard
Sanford, FL 32773

Provider Number: 0279692-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

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

Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydel Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Department
400 West Airport Boulevard
Sanford, FL 32773

Provider Number: 0279692-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BASIS:

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

### DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Seminole County Health Department

Provider Number: 0279692-90
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Sumter County Health Department
P. O. Box 98
Bushnell, FL  33513

Provider Number: 0279706-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>141.52</td>
<td>143.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>X</th>
<th>Prospective</th>
<th>X</th>
<th>Total</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prospectively Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Sumter County Health Department**  
P. O. Box 98  
Bushnell, FL 33513  

**Provider Number:** 0279706-91  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>141.52</td>
<td>143.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**  
- Interim  
- Prospective

**Total Interim**  
- Settlement Based on Cost

**Total Prospective**  
- Prospective Adjusted For New Costs

**BASIS:**  
- Budget  
- Unaudited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

---

(Rydell Samuel, Administrator)  
Medicaid Program Finance  
For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Sumter County Health Department  
P. O. Box 98  
Bushnell, FL  33513  

Provider Number: 0279706-92  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>141.52</td>
<td>143.23</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>X Prospective</th>
<th>Total Interim</th>
<th>X Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASIS:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Budget</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DISTRIBUTION:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fiscal Agent</td>
<td>Contract Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Program Finance</td>
<td>State Health Office</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Taylor County Health Department**
1215 Peacock Street  
Perry, FL 32347

**Provider Number:** 0279722-00  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>106.81</td>
<td>93.41</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X Prospective</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost (X)
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydel Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Taylor County Health Department
1215 Peacock Street
Perry, FL 32347

Provider Number: 0279722-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>106.81</td>
<td>93.41</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Taylor County Health Department  
1215 Peacock Street  
Perry, FL 32347

Provider Number: 0279722-30  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>106.81</td>
<td>93.41</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**  
  - Total Interim
  - Settlement Based on Cost

**Prospective**  
- Total Prospective
- Prospective Adjusted For New Costs

BASIS:

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department  
495 East Main Street  
Lake Butler, FL  32054

Provider Number: 0279731-00  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- [ ] Interim
- [x] Prospective

- __Total Interim__
- __Settlement Based on Cost__
- __Total Prospective__
- __Prospective Adjusted For New Costs__

**BASIS:**

- [ ] Budget
- [x] Unaudited Cost
- [ ] Desk Reviewed Cost
- [ ] Desk Audited Cost
- [ ] Field Audited Cost

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department
495 East Main Street
Lake Butler, FL 32054

Provider Number: 0279731-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Administration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Union County Health Department  
495 East Main Street  
Lake Butler, FL 32054  

Provider Number: 0279731-30  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type  

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
</table>

BASIS:  

<table>
<thead>
<tr>
<th>BASIS</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unaudited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Field Audited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DISTRIBUTION:  

Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0279731-91  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Settlement Based on Cost

Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department
P. O. Box 9190
Daytona Beach, FL 32120

Provider Number: 0279749-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.76</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>Total Prospective</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Volusia County Health Department  
P. O. Box 9190  
Daytona Beach, FL 32120

Provider Number: 0279749-15  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.76</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Volusia County Health Department
P. O. Box 9190
Daytona Beach, FL 32120

Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0279749-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.76</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>Total Interim</td>
<td></td>
</tr>
<tr>
<td></td>
<td>X</td>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td>Total Prospective</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Volusia County Health Department  
P. O. Box 9190  
Daytona Beach, FL 32120

Florida Agency For Health Care Administration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Provider Number: 0279749-93  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.76</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Volusia County Health Department  
P. O. Box 9190  
Daytona Beach, FL 32120

Provider Number: 0279749-97  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>159.76</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospetive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost (X)
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>121.38</td>
<td>117.51</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
  - Unaudited Cost
  - Desk Reviewed Cost
  - Desk Audited Cost
  - Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Florida Agency For Health Care Administration**
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

**Medicaid Reimbursement Rate Change Form for CHDs**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>121.38</td>
<td>117.51</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- Prospective

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Provider Number: 0279757-02
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>121.38</td>
<td>117.51</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Basis</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Budget</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>X Unaudited Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Field Audited Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

DISTRIBUTION:
Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Wakulla County Health Department  
48 Oak Street  
Crawfordville, FL 32327

Provider Number: 0279757-03  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>121.38</td>
<td>117.51</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>121.38</td>
<td>117.51</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost (X)
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Wakulla County Health Department  
48 Oak Street  
Crawfordville, FL  32327  

Provider Number: 0279757-30  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>121.38</td>
<td>117.51</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>121.38</td>
<td>117.51</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prospectively Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost [X]
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Wakulla County Health Department
48 Oak Street
Crawfordville, FL 32327

Provider Number: 0279757-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>121.38</td>
<td>117.51</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.83</td>
<td>162.38</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost (X)
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL  32428

Florida Agency For Health Care Admininstration
Office of Medicaid Program Finance
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.83</td>
<td>162.38</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.83</td>
<td>162.38</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Total Interim</th>
<th>X Prospective</th>
<th>X Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-12
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.83</td>
<td>162.38</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Washington County Health Department
1338 South Boulevard
Chipley, FL 32428

Provider Number: 0279773-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.83</td>
<td>162.38</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Washington County Health Department**

1338 South Boulevard  
Chipley, FL  32428  

**Provider Number:** 0279773-99  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>148.83</td>
<td>162.38</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim  
  - Total Interim
- Prospective  
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Department
597 West 11th Street
Panama City, FL 32401-2330

Provider Number: 0290068-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost (X)
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

Bay County Health Department  
597 West 11th Street  
Panama City, FL 32401-2330

Provider Number: 0290068-96  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- **Budget**  
  - X Unaudited Cost  
  - Desk Reviewed Cost  
  - Desk Audited Cost  
  - Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Lafayette County Health Department
P.O. Box 1806
Mayo, FL 32066

Provider Number: 0290343-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>131.82</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>131.82</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

For Information Only (No Change In Rate)

Rydell Samuel, Administrator
Medicaid Program Finance
Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Department
801 S.W. Smith Street
Madison, FL  32340

Provider Number: 0290408-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Department
801 S.W. Smith Street
Madison, FL 32340

Provider Number: 0290408-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>Total Prospective</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Madison County Health Department
801 S.W. Smith Street
Madison, FL  32340

Provider Number: 0290408-30
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Suwannee County Health Department
P. O. Box 6030
Live Oak, FL 32060

Provider Number: 0518328-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.74</td>
<td>151.22</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Suwannee County Health Department
P. O. Box 6030
Live Oak, FL 32060

Provider Number: 0518328-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>135.74</td>
<td>151.22</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

Basis:

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

Distribution:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>85.42</td>
<td>126.89</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- Interim
- Prospective

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

**Holmes County Health Department**  
P. O. Box 337603 Scenic Circle  
Bonifay, FL 32425

**Provider Number:** 0519022-15  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>85.42</td>
<td>126.89</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**  
- Interim  
- Prospective

**BASIS:**  
- Budget  
- Unaudited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Holmes County Health Department
P. O. Box 337603 Scenic Circle
Bonifay, FL 32425

Provider Number: 0519022-95
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>85.42</td>
<td>126.89</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Health Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.71</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desk Audited Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field Audited Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.71</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Brevard County Health Department  
2572 N. Courtenay Parkway  
Merritt Island, FL 32953-4147

Provider Number: 0519251-04  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.71</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Prospective</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Audited Cost
  - Desk Reviewed Cost
  - Desk Audited Cost
  - Field Audited Cost
- Unaudited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Health Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.71</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim: Total Interim
- Prospective: Total Prospective

Settlement Based on Cost
Prospective Adjusted For New Costs

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.71</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL 32953-4147

Provider Number: 0519251-92
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.71</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

Total Interim
Settlement Based on Cost

Total Prospective
Prospective Adjusted For New Costs

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Brevard County Heath Department
2572 N. Courtenay Parkway
Merritt Island, FL  32953-4147

Provider Number: 0519251-93  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>162.71</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim  
- Prospective

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402

Provider Number: 0520331-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

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

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
# Medicaid Reimbursement Rate Change Form for CHDs

**Palm Beach County Health Department**  
P. O. Box 29  
West Palm Beach, FL 33402  

**Provider Number:** 0520331-09  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**  
Interim X Prospective

<table>
<thead>
<tr>
<th>BASIS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
</tr>
<tr>
<td></td>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td></td>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

**DISTRIBUTION:**  
Fiscal Agent  
Contract Management  
Program Finance  
State Health Office  

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL  33402

Provider Number: 0520331-45
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prospective

<table>
<thead>
<tr>
<th>Basis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget</td>
</tr>
<tr>
<td>X Unaudited Cost</td>
</tr>
<tr>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td>Field Audited Cost</td>
</tr>
</tbody>
</table>

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department
P. O. Box 29
West Palm Beach, FL 33402

Provider Number: 0520331-50
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

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

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- [x] Interim
- [x] Prospective

Total Interim

Total Prospective

Settlement Based on Cost

Prospective Adjusted For New Costs

BASIS:

- [x] Budget
- [x] Unaudited Cost
- [x] Desk Reviewed Cost
- [x] Desk Audited Cost
- [x] Field Audited Cost

Distribution:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only

(No Change In Rate)
Florida Agency For Health Care Admininstration  
Office of Medicaid Program Finance  
2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

Medicaid Reimbursement Rate Change Form for CHDs

Palm Beach County Health Department  
P. O. Box 29  
West Palm Beach, FL  33402

Provider Number: 0520331-95  
Date: 07/01/2020

Fiscal Year End: 06/30/2019

Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Total Interim</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>Total Prospective</td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)

Printed: 7/1/2020 11:47 AM  
Batch ID: G2HR9
Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department
514 East Grace Street
Punta Gorda, FL 33950

Provider Number: 0520446-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>105.36</td>
<td>98.93</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
## Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department  
514 East Grace Street  
Punta Gorda, FL 33950  

Provider Number: 0520446-09  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>105.36</td>
<td>98.93</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

### Rate Type

<table>
<thead>
<tr>
<th>Interim</th>
<th>Total Interim</th>
<th>Prospective</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BASIS:

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

### DISTRIBUTION:

Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydoll Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Charlotte County Health Department
514 East Grace Street
Punta Gorda, FL 33950

Provider Number: 0520446-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>105.36</td>
<td>98.93</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
  - Total Interim
  - Settlement Based on Cost

- Prospective
  - Total Prospective
  - Prospective Adjusted For New Costs

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydel Samuel, Administrator
Medicaid Program Finance

(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

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

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Department
P. O. Box 1305421 West Main Street
Tavares, FL  32778-1305

Provider Number: 0563234-00
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Lake County Health Department
P. O. Box 1305421 West Main Street
Tavares, FL 32778-1305

Provider Number: 0563234-01
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Settlement Based on Cost
Prospective Adjusted For New Costs

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- Interim
- Prospective

BASIS:

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

DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

For Information Only

(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Escambia County Health Department**  
1295 West Fairfield Drive  
Pensacola, FL 32501

**Provider Number:** 0600181-00  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

**Rydell Samuel, Administrator**  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Department  
1295 West Fairfield Drive  
Pensacola, FL 32501

Provider Number: 0600181-01  
Date: 07/01/2020

Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Interim</td>
<td>Total Prospective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Settlement Based on Cost</td>
<td>Prospective Adjusted For New Costs</td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-03
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>x Prospective</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- x Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)

Printed: 7/1/2020 11:47 AM
Batch ID: G2HR9
# Medicaid Reimbursement Rate Change Form for CHDs

**Escambia County Health Department**  
1295 West Fairfield Drive  
Pensacola, FL 32501  

**Provider Number:** 0600181-04  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

## Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

## Rate Type

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

## BASIS:

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

## DISTRIBUTION:

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance  

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-05
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td>Budget X</td>
</tr>
<tr>
<td></td>
<td>Unaudited Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Reviewed Cost</td>
</tr>
<tr>
<td></td>
<td>Desk Audited Cost</td>
</tr>
<tr>
<td></td>
<td>Field Audited Cost</td>
</tr>
<tr>
<td>Prospective</td>
<td>X Settlement Based on Cost</td>
</tr>
<tr>
<td></td>
<td>X Total Prospective</td>
</tr>
<tr>
<td></td>
<td>Prospective Adjusted For New Costs</td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department  
1295 West Fairfield Drive  
Pensacola, FL 32501

Provider Number: 0600181-09  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>X</th>
<th>Prospective</th>
<th>X</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Settlement Based on Cost</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASIS:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Budget</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unaudited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Desk Reviewed Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Desk Audited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Field Audited Cost</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DISTRIBUTION:  
Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

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

**BASIS:**

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

**DISTRIBUTION:**

Fiscal Agent
Contract Management
Program Finance
State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

Rate Type

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**
- Budget
- Unaudited Cost [X]
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department  
1295 West Fairfield Drive  
Pensacola, FL 32501

Provider Number: 0600181-25  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**  
- Budget  
- Unaudited Cost  
- Desk Reviewed Cost  
- Desk Audited Cost  
- Field Audited Cost

**DISTRIBUTION:**  
Fiscal Agent  
Contract Management  
Program Finance  
State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL  32501

Provider Number: 0600181-26
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

*Rate Type*
- Interim
- Prospective

**BASIS:**
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Escambia County Health Department**  
1295 West Fairfield Drive  
Pensacola, FL 32501

**Provider Number:** 0600181-29  
**Date:** 07/01/2020  
**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Settlement Based on Cost</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prospective</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- X Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**  
- Fiscal Agent  
- Contract Management  
- Program Finance  
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
### Medicaid Reimbursement Rate Change Form for CHDs

**Escambia County Health Department**
1295 West Fairfield Drive
Pensacola, FL 32501

**Provider Number:** 0600181-31  
**Date:** 07/01/2020

**Fiscal Year End:** 06/30/2019  
**Audit Status:** Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**
- Budget
- Unaudited Cost (x)
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

**DISTRIBUTION:**
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

---

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change In Rate)
**Medicaid Reimbursement Rate Change Form for CHDs**

Escambia County Health Department  
1295 West Fairfield Drive  
Pensacola, FL 32501  

Provider Number: 0600181-32  
Date: 07/01/2020  
Fiscal Year End: 06/30/2019  
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Prospective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prospective Adjusted For New Costs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator  
Medicaid Program Finance

For Information Only  
(No Change in Rate)
Medicaid Reimbursement Rate Change Form for CHDs

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

**Rate Type**

- **Interim**
  - Total Interim
  - Settlement Based on Cost

- **Prospective**
  - Total Prospective
  - Prospective Adjusted For New Costs

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department
1295 West Fairfield Drive
Pensacola, FL 32501

Provider Number: 0600181-91
Date: 07/01/2020
Fiscal Year End: 06/30/2019
Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Interim</th>
<th>Prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Interim</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BASIS:
- Budget
- Unaudited Cost
- Desk Reviewed Cost
- Desk Audited Cost
- Field Audited Cost

DISTRIBUTION:
- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)
Medicaid Reimbursement Rate Change Form for CHDs

Escambia County Health Department  Provider Number: 0600181-92
1295 West Fairfield Drive  Date: 07/01/2020
Pensacola, FL 32501  Fiscal Year End: 06/30/2019

Audit Status: Unaudited Cost

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Rate</th>
<th>New Rate</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHD</td>
<td>166.57</td>
<td>166.59</td>
<td>07/01/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Type</th>
<th>Total Interim</th>
<th>Total Prospective</th>
<th>Prospective Adjusted For New Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settlement Based on Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BASIS:**

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

**DISTRIBUTION:**

- Fiscal Agent
- Contract Management
- Program Finance
- State Health Office

Rydell Samuel, Administrator
Medicaid Program Finance

For Information Only
(No Change In Rate)