

Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

Alachua County Health Departme	nt	Pı	Provider Number: 0279111-00			
224 SE 24th Street730 N.E. Wald	o Road, Suite 500		Date: 07/01/202	4		
Gainesville, FL 32641		F	iscal Year End: 06/30/202	3		
			Audit Status: Unaudited	I Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		163.26	163.26	07/01/2024		
Rate Type						
<u>Interim</u>		X Prospe	<u>ective</u>			
Total Inte		>	<u> </u>			
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs		
<b>DISTRIBUTION:</b> Fiscal Agent	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost	CEL			
Contract Management			CE Jackson, Financial S			
Program Finance			Medicaid Program Fina	nce		
State Health Office						
			For Information O	nly		
			(No Change In Ra	ite)		



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

Baker County Health Department		Provider Number: 0279129-00			
480 West Lowder Street		_	Date: 07/01/202	24	
Macclenny, FL 32063		- Fisc	al Year End: 06/30/202	3	
		-	Audit Status: Unaudited	d Cost	
Provider Type	Curre	ent Rate	New Rate	Effective Date	
<u>CHD</u>	16	63.26	163.26	07/01/2024	
Rate Type					
<u>Interim</u>	>	<u>Prospecti</u>	<u>ve</u>		
Total Interim		X	Total Prospective		
Settlement Bas	ed on Cost		Prospective Adjus	ted For New Costs	
E - - - DISTRIBUTION:	BASIS:  Budget  Unaudited Cost  Desk Reviewed Co  Desk Audited Cost  Field Audited Cost				
Fiscal Agent Contract Management Program Finance State Health Office		_	CE Jackson, Financial S Medicaid Program Fina		
		_	For Information Or (No Change In Ra		



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

Bradford Count	adford County Health Department				Provider Number: 0279145-00			
1801 North Ten	mple Aven	ue				Date	07/01/202	4
Starke, FL 320	)91				Fisc	al Year End:	06/30/202	3
						Audit Status:	Unaudited	Cost
Provider Ty	<u>pe</u>			Curren	nt Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			163.26		163.26		07/01/2024
Rate Type								
<u> </u>	<u>Interim</u>			X	Prospect	<u>ive</u>		
	,	Total Interim			_ X	Total P	rospective	
_		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs
			BASIS:  Budget  Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost				
DISTRIBUTION						00		
Fiscal Age		-1				CEX	-	
Contract M		nt				CE Jackson		
Program Fi State Healt						Medicaid Pro	ogram Finar	nce
State Healt	ui Oilice							
						For Info	ormation Or	nly
					•	(No Ch	ange In Ra	te)



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

Broward Coun	oward County Health Department				Provider Number: 0279161-00			
780 SW 24th 9	Street					Date:	07/01/202	4
ort Lauderda	le, FL 333	315			Fisc	cal Year End:	06/30/202	3
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			152.	.62	152	2.62	07/01/2024
Rate Type								
	<u>Interim</u>			X	Prospect	<u>ive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs
DISTRIBUTIO			BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost		PA		
Fiscal Age						CEX		
Contract N	_	ent				CE Jackson,		
Program F State Hea						Medicaid Pro	ogram Final	nce
						For Info	ormation Or	nly
					-	(No Ch	ange In Ra	te)



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

Calhoun Cour	alhoun County Health Department					Provider Number: 0279170-91			
19611 S.R. 20	0 West					Date	07/01/2024		
Blountstown,	FL 32424				Fis	scal Year End	06/30/2023		
						Audit Status	Unaudited C	Cost	
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			163	.26	16	3.26	07/01/2024	
Rate Type					_				
	<u>Interim</u> -	T.O. H.O. S.		X	Prospec				
		Total Interim			X		rospective	15 N 0 1	
		Settlement Ba	ased on Cost			Prospe	ective Adjuste	d For New Costs	
Program	ent Manageme Finance	ent	Desk Au	ed Cost viewed Cost dited Cost dited Cost			, Financial Sp ogram Financ		
State Hea	alth Office								
						For Inf	ormation Only	/	
						(No Ch	nange In Rate	·)	



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

Citrus County Health Departmen	t	Prov	Provider Number: 0279196-00				
3700 Sovereign Path			Date: 07/01/2024				
Lecanto, FL 34461-8071		 Fis	Fiscal Year End: 06/30/2023				
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		163.26	163.26	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
Total In	terim	X	Total Prospective				
Settlem	ent Based on Cost		Prospective Adjus	ted For New Costs			
<u>DISTRIBUTION:</u>	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost					
Fiscal Agent			CEL				
Contract Management			CE Jackson, Financial S	Specialist			
Program Finance			Medicaid Program Final	nce			
State Health Office							
			For Information Or	nly			
			(No Change In Ra	te)			



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

Clay County Health Department		Pro	Provider Number: 0279200-00				
P.O. Box 578			Date: 07/01/2024				
Green Cove Springs, FL 32043		Fi	Fiscal Year End: 06/30/2023				
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		163.26	163.26	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>ctive</u>				
Total Inte	rim	X	Total Prospective				
Settlemen	nt Based on Cost		Prospective Adjus	sted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	d Cost					
	Desk Rev	riewed Cost					
	Desk Aud	lited Cost					
	Field Aud	ited Cost					
DISTRIBUTION:							
Fiscal Agent			CA				
Contract Management			CE Jackson, Financial	Specialist			
Program Finance			Medicaid Program Fina	-			
State Health Office							
			For Information O	nly			
			(No Change In Ra	ate)			



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

Collier County Health Department					Provider Number: 0279218-00				
P.O. Box 429								Date: 07/01/2024	
Naples, FL 3	4106-0429	)				F	iscal Y	ear End: 06/30/2023	3
							Aud	it Status: Unaudited	Cost
Provider T	уре				Curren	t Rate		New Rate	Effective Date
	CHD				163	.26		163.26	07/01/2024
Rate Type									
	<u>Interim</u>				X	Prospe			
		Total Interim					<u> </u>	Total Prospective	
		Settlement Ba	ased or	n Cost				Prospective Adjuste	ed For New Costs
<b>DISTRIBUTIO</b> Fiscal Ag	ent	ent	X	Budget Unaudited	iewed Cost ited Cost		C	A Singnoid S	no ciclist
	Manageme	ent						Jackson, Financial S	
Program State Had							Med	dicaid Program Finan	ce
State Hea	alth Office								
								For Information On	ly
								– (No Change In Rat	e)



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

Columbia County	Health Department			Provider Number: 0279226-00			
217 North East F	ranklin Street				Date: 07/01/202	4	
Lake City, FL 32	055			Fisc	al Year End: 06/30/202	3	
				,	Audit Status: Unaudited	Cost	
Provider Type	<u>e</u>		Current	Rate	New Rate	Effective Date	
<u>C</u>	CHD		156.2	25	156.25	07/01/2024	
Rate Type							
<u>In</u>	<u>terim</u>		X_ <u>I</u>	Prospecti	<u>ve</u>		
	Total Interim			Χ	Total Prospective		
_	Settlement E	Based on Cost	_		Prospective Adjus	ted For New Costs	
		D 4 010-					
		BASIS:					
		Budget					
		X Unaudited					
			iewed Cost				
		Desk Aud					
		Field Audi	ted Cost				
DISTRIBUTION:					0 0		
Fiscal Agent					CEL		
Contract Ma	nagement			(	CE Jackson, Financial S	Specialist	
Program Fin	ance			_	Medicaid Program Fina		
State Health	Office						
					For Information Or	nly	
				_	—— (No Change In Ra	te)	



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

Dade County Health Dep	partment		Provider Number	: 0279234-00	)
1350 N.W. 14th Street			Date	07/01/2024	
Miami, FL 33125			Fiscal Year End	06/30/2023	
			Audit Status	Unaudited (	Cost
<u>Provider Type</u>		Current Rate	e <u>New</u>	Rate	Effective Date
CHD		163.26	16	3.26	07/01/2024
Rate Type					
<u>Interim</u>		X Pros	<u>spective</u>		
	Total Interim		X Total P	rospective	
	Settlement Based on Cost		Prospe	ctive Adjuste	ed For New Costs
DISTRIBUTION:		viewed Cost dited Cost	0.0		
Fiscal Agent			CEL	_	
Contract Manageme	ent		CE Jackson	, Financial Sp	<u>pecia</u> list
Program Finance			Medicaid Pro	ogram Finand	ce
State Health Office					
			For Info	ormation Onl	у
			—— (No Ch	ange In Rate	<del>)</del> )



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

DeSoto County Heal	lth Department			Provider Number: 0279242-00				
34 South Baldwin Av	/enue				Date: 07/01/2024	4		
Arcadia, FL 33821				Fiscal Year End: 06/30/2023				
				А	udit Status: Unaudited	Cost		
Provider Type			<u>Current l</u>	Rate	New Rate	Effective Date		
<u>CHE</u>	<u>)</u>		163.2	6	163.26	07/01/2024		
Rate Type								
<u>Interi</u>	<u>im</u>		X_ <u>F</u>	Prospectiv	<u>/e</u>			
_	Total Interim			Χ	Total Prospective			
	Settlement Ba	ased on Cost	_		Prospective Adjust	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		—— Desk Rev	iewed Cost					
		—— Desk Aud	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:								
Fiscal Agent					C92			
Contract Manag	ement			C	CE Jackson, Financial S	Specialist		
Program Financ	e			Medicaid Program Finance				
State Health Off	ice							
					For Information Or	nly		
					—— (No Change In Ra	te)		



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

Dixie County I	ixie County Health Department				Provider Number: 0279251-00			
149 NE 241S	Т					Date	07/01/202	4
Cross City, FL	32628				Fise	cal Year End:	06/30/202	3
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	CHD			139	.30	139	9.30	07/01/2024
Rate Type	<u>Interim</u>			X	Prospect	<u>iive</u>		
		Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost		-	Prospe	ctive Adjus	ted For New Costs
			Desk Au	ed Cost eviewed Cost dited Cost dited Cost				
Program	ent Manageme	ent				CE Jackson Medicaid Pro		
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## **Medicaid Reimbursement Rate Change Form for CHDs**

Duval County Hea	uval County Health Department					Provider Number: 0279269-00				
515 West Sixth St	reet							Date: 07/01/2024	4	
Jacksonville, FL 3	32206					F	Fiscal Y	ear End: 06/30/2023	3	
							Aud	lit Status: Unaudited	Cost	
Provider Type	<u>}</u>				<u>Curren</u>	t Rate		New Rate	Effective Date	
CI	<u>HD</u>				163	.26		163.26	07/01/2024	
Rate Type										
<u>Int</u>	<u>erim</u>				X	Prospe				
		Total Interim					<b>(</b>	Total Prospective		
		Settlement Ba	ased o	on Cost				Prospective Adjust  –	ted For New Costs	
			<b>BAS</b>	Budget Unaudited	riewed Cost lited Cost					
DISTRIBUTION: Fiscal Agent Contract Man Program Fina State Health	ince	ent						Jackson, Financial S dicaid Program Finar		
								For Information Or (No Change In Ra	-	



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

Flagler County	agler County Health Department				Provider Number: 0279285-00				
P. O. Box 847	301 South I	Lemon Street				Date	07/01/2024		
Bunnell, FL 3	2110-0847				Fisc	al Year End:	06/30/2023		
						Audit Status:	Unaudited C	Cost	
Provider Ty	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	<u>CHD</u>			163	.26	163	3.26	07/01/2024	
Rate Type									
	<u>Interim</u>			X	Prospect	<u>ive</u>			
		Total Interim			X	Total P	rospective		
	;	Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs	
			Desk Aud	d Cost viewed Cost dited Cost dited Cost					
DISTRIBUTIO Fiscal Ag						CEL			
Contract I	Managemer	nt				CE Jackson	, Financial Sp	<u>ecia</u> list	
Program	Finance					Medicaid Pro	ogram Financ	ce	
State Hea	alth Office								
						For Info	ormation Only	y	
					-	(No Ch	ange In Rate	e)	



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

Franklin County Health I	anklin County Health Department			Provi	der Number:	0279293-0	0	
139 12th Street					Date:	07/01/2024		
Apalachicola, FL 32320				Fiscal Year End: 06/30/2023				
				,	Audit Status:	Unaudited	Cost	
Provider Type			Curren	t Rate	<u>New</u>	Rate_	Effective Date	
CHD		-	163	.26	163	3.26	07/01/2024	
Rate Type								
<u>Interim</u>			X	Prospecti	<u>ve</u>			
	Total Interim			X	Total P	rospective		
	Settlement Bas	ed on Cost			Prospe	ctive Adjuste	ed For New Costs	
DISTRIBUTION	<u> </u>  -  -  -  -	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost					
DISTRIBUTION:					00			
Fiscal Agent	ont				CEX	-		
Contract Manageme Program Finance	znı			-	CE Jackson, Medicaid Pro			
State Health Office					iviculcalu FTC	ografii i iilali	<del>UG</del>	
					For Info	ormation On	ly	
				_	—— (No Ch	ange In Rat	e)	



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

Gadsden County Health Dep	partment	F	Provider Number: 0279307-00				
P. O. Box 1000			Date:	07/01/2024			
Quincy, FL 32353-1000			Fiscal Year End:	06/30/2023			
			Audit Status:	Unaudited Co	st		
Provider Type		Current Rate	<u>New</u>	Rate	Effective Date		
<u>CHD</u>	-	151.85	151	1.85	07/01/2024		
Rate Type							
<u>Interim</u>		X <u>Pros</u> p	<u>ective</u>				
Tot	al Interim		X Total P	rospective			
Set	ttlement Based on Cost		Prospe	ctive Adjusted	For New Costs		
	BASIS:  Budget  Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost red Cost					
DISTRIBUTION:			an				
Fiscal Agent			CEY				
Contract Management				Financial Spec	<u>cia</u> list		
Program Finance			Medicaid Pro	ogram Finance			
State Health Office							
			For Info	ormation Only			
			(No Ch	ange In Rate)			



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

Gilchrist County Health Departmen	ıt	Prov	Provider Number: 0279315-00				
119 N.E. First Street			Date: 07/01/202	24			
Trenton, FL 32693-3459		Fis	cal Year End: 06/30/202	23			
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		122.08	122.08	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
Total Inte	rim	X	Total Prospective				
Settlemen	nt Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	d Cost					
	Desk Rev	iewed Cost					
	Desk Aud	ited Cost					
	Field Audi	ited Cost					
DISTRIBUTION:							
Fiscal Agent			(0)				
Contract Management			CE Jackson, Financial	Specialist			
Program Finance			Medicaid Program Fina				
State Health Office							
			For Information O	nly			
			(No Change In Ra	ate)			



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

Glades County Health Departmen	nt	Pro	Provider Number: 0279323-00				
P. O. Box 489			Date: 07/01/202	4			
Moore Haven, FL 33471		 Fis	scal Year End: 06/30/202	4			
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		163.26	163.26	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
Total Int	erim	X	Total Prospective				
Settleme	ent Based on Cost		Prospective Adjus	ted For New Costs			
DISTRIBUTION:	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audit	ewed Cost ted Cost					
Fiscal Agent			CA				
Contract Management			CE Jackson, Financial S	Specialist			
Program Finance			Medicaid Program Final				
State Health Office							
			For Information Or	nly			
			(No Change In Ra	te)			



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

Gulf County H	ulf County Health Department				Provider Number: 0279331-00				
2475 Garrison	Avenue					Date	07/01/202	4	
Port St. Joe, F	L 32456-5	5265			Fisc	cal Year End:	06/30/202	3	
						Audit Status:	Unaudited	l Cost	
Provider Ty	<u>ype</u>			Currer	nt Rate	<u>New</u>	Rate	Effective Date	
	<u>CHD</u>			163	.26	165	3.26	07/01/2024	
Rate Type									
	<u>Interim</u>			X	Prospect	<u>ive</u>			
	_	Total Interim			X	Total P	rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs	
			Desk Au	ed Cost eviewed Cost idited Cost dited Cost					
DISTRIBUTIO						00			
Fiscal Age		nt.				LEX			
Program I	Manageme Financo	ent				CE Jackson			
State Hea						Medicaid Pro	ogranii Final	IIC <del>C</del>	
2.2.2.100									
						For Info	ormation Or	nly	
						(No Ch	ange In Ra	ite)	



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

Hamilton Cou	amilton County Health Department				Provider Number: 0279340-00				
P. O. Box 267	7					Date	07/01/202	4	
Jasper, FL 32	2052				Fis	cal Year End	06/30/202	3	
						Audit Status	Unaudited	Cost	
Provider T	<u>ype</u>			Curren	t Rate	<u>New</u>	Rate	Effective Date	
	CHD			149	.48	149	9.48	07/01/2024	
Rate Type	<u>Interim</u>			X	Prospec	<u>tive</u>			
	_	Total Interim			- X	Total P	rospective		
		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs	
			Desk Au	ed Cost viewed Cost dited Cost dited Cost					
Program	ent Manageme	ent				CE Jackson Medicaid Pro			
State Het	2						ormation Or ange In Ra		



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

Hardee Count	ardee County Health Department					Provider Number: 0279358-00				
115 K.D. Rev	ell Road							Date: 07/01/2	2024	
Wauchula, FL	. 33873					Fi	iscal Ye	ear End: 06/30/2	2023	
							Audit	Status: Unaudi	ted Cost	
Provider T	<u>ype</u>				Curren	t Rate		New Rate	Effe	ective Date
	<u>CHD</u>				163	.26	_	163.26	07	7/01/2024
Rate Type										
	Interim				X	Prospec				
		Total Interim				X		Total Prospecti	ve	
		Settlement Ba	ased on C	Cost				Prospective Ad	justed For N	ew Costs
DISTRIBUTION Fiscal Ag Contract Program	ent Manageme	ent	X UI	udget naudited esk Revi esk Audi	I Cost iewed Cost ited Cost ted Cost			eckson, Financi		
_	alth Office							os.a i rogiani i		
								For Information	-	
								(No Change In	Rate)	



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

Hendry County Health	endry County Health Department				der Number:	0279366-00	)
P. O. Box 70					Date:	07/01/2024	
_aBelle, FL 33975				Fisc	al Year End:	06/30/2023	
				,	Audit Status:	Unaudited (	Cost
Provider Type			Current	: Rate	<u>New</u>	<u>Rate</u>	Effective Date
CHD		-	163.	26	163	3.26	07/01/2024
Rate Type							
Interim	l		X	Prospecti	<u>ve</u>		
_	Total Interim			X	Total P	rospective	
	Settlement Ba	ased on Cost			Prospe	ctive Adjuste	ed For New Costs
		BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost ted Cost				
DISTRIBUTION:					00		
Fiscal Agent					CEX		
Contract Managen Program Finance	ient			_		Financial Span	
State Health Office	<b>;</b>				viculcalu PIC	ogram Finan	∪ <del>C</del>
					For Info	ormation Onl	у
				_	— (No Ch	ange In Rate	e)



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

Hernando County Health Departm	ent	Pro	Provider Number: 0279374-00				
300 S. Main St.			Date: 07/01/202	24			
Brooksville, FL 34601		 Fis	scal Year End: 06/30/202	23			
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		163.26	163.26	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
Total Inte	rim	X	Total Prospective				
Settlemen	nt Based on Cost		Prospective Adjus	sted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	d Cost					
	Desk Rev	riewed Cost					
	Desk Aud	lited Cost					
	Field Aud	ited Cost					
DISTRIBUTION:			0 0				
Fiscal Agent			CEL				
Contract Management			CE Jackson, Financial	Specialist			
Program Finance			Medicaid Program Fina	nce			
State Health Office							
			For Information O	nly			
			(No Change In Ra	ate)			



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

Highlands County Health Depart	tment	Pro	Provider Number: 0279382-00				
7205 South George Boulevard			Date: 07/01/202	24			
Sebring, FL 33872		 Fis	Fiscal Year End: 06/30/2023				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		163.26	163.26	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>ctive</u>				
Total Ir	nterim	X	Total Prospective				
Settlen	nent Based on Cost		Prospective Adjus	ted For New Costs			
DISTRIBUTION:	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	iewed Cost ited Cost					
DISTRIBUTION:  Fiscal Agent  Contract Management  Program Finance  State Health Office			CE Jackson, Financial S Medicaid Program Fina				
			For Information O	nly			
			(No Change In Ra	ate)			



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

ndian River C	lian River County Health Department				Provider Number: 0279412-00			
1900 27th Str	eet					Date	07/01/202	4
Vero Beach, F	FL 32960				Fis	cal Year End:	06/30/202	3
						Audit Status:	Unaudited	Cost
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date
	CHD			163	.26	165	3.26	07/01/2024
Rate Type	Interim			X	Prospect	tive		
	_	Total Interim			- X		rospective	
		- Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs
			Desk Aud	d Cost viewed Cost dited Cost dited Cost				
Fiscal Ag Contract Program	ent Managem	ent				CE Jackson Medicaid Pro		
State Hea	alth Office							
						For Info	ormation Or	nly
						(No Ch	ange In Ra	te)



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

Jackson Cour	kson County Health Department				Provider Number: 0279421-00				
P. O. Box 310	)							Date: 07/01/202	4
Marianna, FL	32447					F	iscal Y	ear End: 06/30/202	3
							Aud	lit Status: Unaudited	Cost
Provider T	ype				Curren	nt Rate		New Rate	Effective Date
	CHD				163	.26		163.26	07/01/2024
Rate Type									
	<u>Interim</u>				X	_ <u>Prospe</u>	<u>ctive</u>		
		Total Interim				X		Total Prospective	
		Settlement Ba	ased o	on Cost				Prospective Adjust	ted For New Costs
			D.4.6	210					
			BAS						
				Budget					
			X	Unaudited					
				_	iewed Cost				
				Desk Aud					
				Field Audi -	ted Cost				
DISTRIBUTIO	ON:							1 .	
Fiscal Ag	ent						$\mathcal{C}$	2	
Contract l	Managem	ent					CE	Jackson, Financial S	Specialist
Program	Finance							dicaid Program Finar	
State Hea	alth Office								
							_	For Information Or	nly
								_ (No Change In Ra	te)



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

Jefferson Cou	ferson County Health Department					Pr	ovide	er Number: 02	279439-00	1	
1255 W. Wasl	hington St	reet						Date: 0	7/01/2024		
Monticello, FL	32344					F	iscal	Year End: 00	6/30/2023		
							Au	ıdit Status: U	naudited C	Cost	
Provider T	ype				Curren	t Rate		New R	ate	Effective Da	<u>ıte</u>
	CHD				163	.26		163.2	26	07/01/2024	4
Rate Type											
	<u>Interim</u>				X	<u>Prospe</u>	ective	<u> </u>			
		Total Interim				×	(	Total Pros	spective		
		Settlement Ba	ased o	on Cost				Prospecti	ve Adjuste	d For New Costs	
			D.4.6	NO-							
			BAS								
				Budget							
			X	Unaudited							
				_	iewed Cost						
				Desk Audi							
				Field Audi -	ted Cost						
DISTRIBUTIO	ON:							0 0			
Fiscal Ag	ent						(	-82			
Contract	Managem	ent					CE	E Jackson, Fi	nancial Sp	ecialist	
Program	Finance							edicaid Progr			
State Hea	alth Office										
								For Inform	nation Only	У	
								(No Chan	ge In Rate	e)	



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

Lee County Health Departme	ent		Provider Number: 0279463-00				
3920 Michigan Avenue				Date: 07/01/2024	1		
Fort Myers, FL 33916			Fisca	al Year End: 06/30/2023	3		
			Δ	udit Status: Unaudited	Cost		
Provider Type		Current Ra	ate	New Rate	Effective Date		
CHD		163.26		163.26	07/01/2024		
Rate Type							
<u>Interim</u>		X Pro	ospectiv	<u>/e</u>			
Tot	al Interim		X	Total Prospective			
Set	ttlement Based on Cost			Prospective Adjust	ed For New Costs		
	BASIS:						
	Budget						
	X Unaudited	Cost					
		ewed Cost					
	Desk Audi						
	Field Audit						
DISTRIBUTION:							
Fiscal Agent				C 50			
Contract Management			(	CE Jackson Financial S	Specialist		
Program Finance			CE Jackson, Financial Specialist				
State Health Office				Medicaid Program Fina	IIC <del>C</del>		
				For Information O	alv		
			_	(No Change In Ra	-		
				TINU CHAHUE III Ka	(C)		



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

Leon County	on County Health Department				Provider Number: 0279471-00				
2965 Municip	al Way					Date: 07/01/202	4		
Tallahassee,	FL 32304				Fiscal `	Year End: 06/30/202	3		
					Aud	dit Status: Unaudited	Cost		
Provider T	уре			Curren	nt Rate	New Rate	Effective Date		
	<u>CHD</u>			163	.26	163.26	07/01/2024		
Rate Type									
	<u>Interim</u>			X	<u>Prospective</u>				
		Total Interim			X	Total Prospective			
		Settlement Ba	ased on Cost			Prospective Adjust	ted For New Costs		
<b>DISTRIBUTIO</b> Fiscal Ag Contract		ent	Desk R	ed Cost eviewed Cost udited Cost udited Cost		ZZZ Jackson, Financial S	Specialist		
Program	-	On it				dicaid Program Final			
•	alth Office					ŭ			
						For Information Or	nly		
						 (No Change In Ra	te)		



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

_evy County Health Department	vy County Health Department				Provider Number: 0279480-00				
P. O. Box 4066 South Main Stree	et			Date: 0	7/01/2024				
Bronson, FL 32621			Fisca	I Year End: 0	6/30/2023				
			A	udit Status: L	Jnaudited C	ost			
<u>Provider Type</u>		Current Rate		New F	<u>late</u>	Effective Date			
<u>CHD</u>		163.2	26	163.	26	07/01/2024			
Rate Type									
<u>Interim</u>		X	Prospectiv	<u>′e</u>					
Total In	terim		X	Total Pro	spective				
Settlem	ent Based on Cost	_		Prospect	ive Adjusted	d For New Costs			
<u>DISTRIBUTION:</u> Fiscal Agent	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audit	ewed Cost ted Cost		C 40					
Contract Management				Cy-	inanaial Cn	ooialist			
Program Finance			_	E Jackson, F ledicaid Prog					
State Health Office						-			
				For Infor	mation Only				
				— (No Char	nge In Rate	)			



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

_iberty County F	erty County Health Department			Provider Number: 0279498-00				
P. O. Box 48924	47 N. Central Stre	et		Date: 07/01/202	24			
Bristol, FL 3232	21		 Fis	scal Year End: 06/30/202	23			
				Audit Status: Unaudited	d Cost			
Provider Typ	<u>oe</u>		Current Rate	New Rate	Effective Date			
<u>(</u>	<u>CHD</u>		163.26	163.26	07/01/2024			
Rate Type								
<u>lı</u>	<u>nterim</u>		X Prospec	<u>tive</u>				
_	Total Inte	erim	X	Total Prospective				
	Settleme	ent Based on Cost		Prospective Adjus	sted For New Costs			
DISTRIBUTION	<u>!:</u>	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Aud	riewed Cost lited Cost					
Fiscal Agen				(9)				
Contract Ma				CE Jackson, Financial	Snecialist			
Program Fir				Medicaid Program Fina				
State Healtl				Ç				
				For Information O	nly			
				(No Change In Ra	ate)			



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

Manatee County Health Depa	rtment	Pro	Provider Number: 0279510-00				
410 Six Avenue East			Date: 07/01/202	4			
Bradenton, FL 34208		Fis	scal Year End: 06/30/202	3			
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	-	88.52	137.69	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
Tota	l Interim	X	Total Prospective				
Settl	ement Based on Cost		Prospective Adjus	ted For New Costs			
DISTRIBUTION:	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost					
DISTRIBUTION:  Fiscal Agent  Contract Management			CEJ CE Jackson, Financial S	Specialist			
Program Finance			Medicaid Program Final				
State Health Office			-				
			For Information Or	nly			
			(No Change In Ra	te)			



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

Marion County Health Departme	rion County Health Department			Provider Number: 0279528-00				
1801 S.E. 32nd AvenueP. O. Bo	ox 2408		Date: 07/01/202	24				
Ocala, FL 34478-2408		Fis	cal Year End: 06/30/202	23				
			Audit Status: Unaudited	d Cost				
<u>Provider Type</u>		Current Rate	New Rate	Effective Date				
<u>CHD</u>		163.26	163.26	07/01/2024				
Rate Type								
<u>Interim</u>		X Prospect	<u>:ive</u>					
Total Ir	nterim	X	Total Prospective					
Settlen	nent Based on Cost		Prospective Adjus	sted For New Costs				
DISTRIBUTION:	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost						
Fiscal Agent			CEL					
Contract Management			CE Jackson, Financial	Specialist				
Program Finance			Medicaid Program Fina	ince				
State Health Office								
			For Information O	nly				
			 (No Change In Ra	ate)				



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

Martin County Health Departmen	rtin County Health Department			Provider Number: 0279536-00				
3441 SE Willoughby Blvd.			Date: 07/01/202	24				
Stuart, FL 34994-5060		 Fis	scal Year End: 06/30/202	23				
			Audit Status: Unaudited	d Cost				
Provider Type		Current Rate	New Rate	Effective Date				
<u>CHD</u>		163.26	163.26	07/01/2024				
Rate Type								
<u>Interim</u>		X <u>Prospec</u>	<u>tive</u>					
Total Int	erim	x	Total Prospective					
Settleme	ent Based on Cost		Prospective Adjus	sted For New Costs				
DISTRIBUTION:	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost						
Fiscal Agent			CEL					
Contract Management			CE Jackson, Financial					
Program Finance			Medicaid Program Fina	nnce				
State Health Office								
			For Information O	nly				
			(No Change In Ra	ate)				



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

Monroe County Hea	nroe County Health Department				Provider Number: 0279544-00				
5100 College Road					Date:	07/01/2024	4		
Key West, FL 33040	0			Fiscal Year End: 06/30/2023					
					Audit Status:	Unaudited	Cost		
Provider Type			Curren	t Rate	<u>New</u>	Rate	Effective Date		
<u>CH</u> [	<u>)</u>		163	.26	163	3.26	07/01/2024		
Rate Type									
<u>Inter</u>	<u>im</u>		Х	Prospecti	ve				
	Total Interim			X	Total P	rospective			
	Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs		
<b>DISTRIBUTION:</b> Fiscal Agent Contract Manag	rement	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost		CEJ_ CE Jackson,	Financial S	Specialist		
Program Finance				-	CE Jackson, Medicaid Pro				
State Health Off					oaioaia i T				
					For Info	ormation Or	nly		
				_	—— (No Ch	ange In Ra	te)		



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

Nassau County Health Departmen	t	Pro	Provider Number: 0279552-00				
P. O. Box 517			Date: 07/01/202	4			
Fernandina Beach, FL 32035-051	7	 Fis	Fiscal Year End: 06/30/2023				
			Audit Status: Unaudited	l Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		154.52	154.52	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
Total Inte	rim	X	Total Prospective				
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	d Cost					
		riewed Cost					
	Desk Aud						
	Field Aud						
	——— Field Add	ited Cost					
DISTRIBUTION.							
DISTRIBUTION:			00				
Fiscal Agent Contract Management			COX				
Program Finance			CE Jackson, Financial S Medicaid Program Fina				
State Health Office			Medicald Flogram I ma	no <del>c</del>			
State Health Office							
			For Information O	nly			
			(No Change In Ra	ite)			



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

Okaloosa County Health Depa	rtment		Provider Number: 0279561-00				
221 Hospital Drive, N.E.				Date: 07/01/2024	4		
Ft. Walton Beach, FL 32548			Fiscal	Year End: 06/30/2023	3		
			Αι	udit Status: Unaudited	Cost		
Provider Type		Current Ra	<u>te</u>	New Rate	Effective Date		
<u>CHD</u>		163.26		163.26	07/01/2024		
Rate Type							
<u>Interim</u>		X Pro	<u>ospectiv</u>	<u>e</u>			
Total	Interim		Х	Total Prospective			
Settle	ment Based on Cost			Prospective Adjust	ted For New Costs		
<b>DISTRIBUTION:</b> Fiscal Agent Contract Management	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost ited Cost	( C	CJ E Jackson, Financial S	Specialist		
Program Finance				edicaid Program Finar			
State Health Office				-			
				For Information Or	nly		
				(No Change In Ra	te)		



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

Okeechobee C	echobee County Health Department					Provider Number: 0279579-00				
P.O. Box 1879	1728 N.W	. 9th Avenue				Date:	07/01/202	4		
Okeechobee ,	FL 34973	-1879			Fisc	al Year End:	06/30/202	3		
						Audit Status:	Unaudited	l Cost		
Provider Ty	<u>rpe</u>			Currer	nt Rate	New	Rate	Effective Date		
	<u>CHD</u>			163	.26	163	3.26	07/01/2024		
Rate Type										
	<u>Interim</u>			X	Prospect	<u>ive</u>				
		Total Interim			_ X	Total P	rospective			
-		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs		
			Desk Au	ed Cost eviewed Cost idited Cost dited Cost						
DISTRIBUTIOI						00				
Fiscal Age		m4				CEX				
Contract M Program F		nt				CE Jackson,				
State Heal						Medicaid Pro	ogram Final	iic <del>e</del>		
						For Info	ormation Or	nly		
					•	(No Ch	ange In Ra	ite)		



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

Orange County Health Departmen	t	Pro	Provider Number: 0279587-00				
6101 Lake Ellenor Drive			Date: 07/01/202	4			
Orlando, FL 32804		Fis	scal Year End: 06/30/202	3			
			Audit Status: Unaudited	Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>	_	163.26	163.26	07/01/2024			
Rate Type							
<u>Interim</u>		X <u>Prospec</u>	<u>tive</u>				
Total Inte	rim	X	Total Prospective				
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs			
DISTRIBUTION:	BASIS:  Budget  X Unaudited C  Desk Revie  Desk Audite  Field Audite	wed Cost ed Cost					
Fiscal Agent			00				
Contract Management			CE Jackson, Financial S	Specialist			
Program Finance			Medicaid Program Final				
State Health Office			3				
			For Information Or	nly			
			(No Change In Ra	te)			



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

Osceola Cour	ceola County Health Department					Provider Number: 0279595-00				
P. O. Box 450	3091875 I	Boggy Creek R	Road					Date: 07/01/2024	4	
Kissimmee, F	L 34745-0	0309				F	scal \	Year End: 06/30/2023	3	
							Aud	dit Status: Unaudited	Cost	
Provider T	ype				Curren	t Rate		New Rate	Effective Date	
	CHD				163	.26		163.26	07/01/2024	
Rate Type										
	<u>Interim</u>				X	Prospe	ctive			
		Total Interim				X		Total Prospective		
		Settlement Ba	ased c	on Cost				Prospective Adjust	ed For New Costs	
			BAS	SIS:						
				Budget						
			X	_ Unaudited	d Cost					
				Desk Rev	iewed Cost					
				Desk Aud	ited Cost					
				Field Audi -	ited Cost					
DISTRIBUTIO	ON:							1 .		
Fiscal Ag	ent						(	-82		
Contract	Managem	ent					CE	Jackson, Financial S	Specialist	
Program	Finance							dicaid Program Finar		
State Hea	alth Office									
								For Information Or	nly	
								 (No Change In Rat	te)	



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

Pasco County	co County Health Department					Provider Number: 0279617-00				
10841 Little R	Road					Date	07/01/2024			
New Port Rich	hey, FL 34	654			Fis	scal Year End	06/30/2023			
						Audit Status:	Unaudited C	Cost		
Provider T	уре			Curren	t Rate	<u>New</u>	Rate	Effective Date		
	CHD			163	.26	16	3.26	07/01/2024		
Rate Type										
	Interim			X	<u>Prospec</u>					
		Total Interim			X		rospective			
		Settlement Ba	ased on Cost			Prospe	ctive Adjuste	d For New Costs		
<u>DISTRIBUTIC</u> Fiscal Ag	ent		Desk Aud	d Cost viewed Cost dited Cost dited Cost		CEL	_			
	Manageme	ent				CE Jackson	, Financial Sp	pecialist		
Program						Medicaid Pro	ogram Financ	ce		
State Hea	alth Office									
						For Info	ormation Only	у		
						— (No Ch	ange In Rate	e)		



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

Pinellas County Hea	alth Department			Provider Number: 0279625-00				
500 7th Avenue Sou	uth				Date: 07/01/2024	4		
St. Petersburg, FL	33701			Fisca	al Year End: 06/30/202	3		
				Δ	audit Status: Unaudited	Cost		
Provider Type			<u>Current l</u>	Rate	New Rate	Effective Date		
<u>CHI</u>	<u>D</u>		163.2	6	163.26	07/01/2024		
Rate Type								
Inter	<u>rim</u>		X_ <u>F</u>	Prospectiv	<u>/e</u>			
_	Total Interim			Χ	Total Prospective			
	Settlement Ba	ased on Cost	_		Prospective Adjust	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		Desk Rev	iewed Cost					
		Desk Aud	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTION:								
Fiscal Agent					(0)			
Contract Manag	rement			c	CE lackson Financial S	Propiolist		
Program Finance	_			_	CE Jackson, Financial S Medicaid Program Finar			
State Health Of				•				
					For Information Or	nly		
				_	—— (No Change In Ra	te)		



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

Polk County Health Depa	rtment		Provid	er Number:	0279633-00	1
1290 Golfview Avenue, 4t	th Floor			Date:	07/01/2024	
Bartow, FL 33830-6740			Fisca	l Year End:	06/30/2023	
			A	udit Status:	Unaudited C	Cost
Provider Type		Current	Rate	New	<u>Rate</u>	Effective Date
CHD	-	163.	26	163	3.26	07/01/2024
Rate Type						
<u>Interim</u>		X	Prospectiv	<u>'e</u>		
-	Total Interim		X	Total Pr	rospective	
;	Settlement Based on Cost	·		Prospe	ctive Adjuste	d For New Costs
<u>DISTRIBUTION:</u> Fiscal Agent	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audit	ewed Cost ted Cost		CD		
Contract Managemer	nt		C	E Jackson.	· Financial Sp	pecialist
Program Finance					gram Financ	
State Health Office						
				For Info	ormation Only	/
			_	— (No Ch	ange In Rate	)



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

Putnam Coun	nam County Health Department					Provider Number: 0279641-00					
2801 Kenned	y Street							Date: 07/01/2	024		
Palatka, FL 3	2177					Fi	iscal Ye	ear End: 06/30/2	023		
							Audit	Status: Unaudit	ted Cost		
Provider T	<u>ype</u>				Curren	t Rate		New Rate	Effec	tive Date	
	<u>CHD</u>				163	.26		163.26	07/0	1/2024	
Rate Type											
	<u>Interim</u>				X	Prospec					
		Total Interim				X		Total Prospectiv	/e		
		Settlement Ba	ased or	Cost				Prospective Adj	usted For New	Costs	
	ent Manageme	ent		Budget Unaudited	iewed Cost ited Cost			ackson, Financia			
Program State Hea	Finance alth Office						Medi	caid Program Fi	nance		
State Hea	aitii Oilice										
								For Information	Only		
								(No Change In	Rate)		



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

St. Johns Cou	Johns County Health Department					Provider Number: 0279650-00					
1955 US 1 Sc	outh					Date: 07/01/2024					
St. Augustine	, FL 3208	6				F	iscal `	Year End: 06/30/2023	3		
							Aud	dit Status: Unaudited	Cost		
Provider T	ype				Curren	nt Rate		New Rate	Effective Date		
	CHD			-	163	.26		163.26	07/01/2024		
Rate Type											
	<u>Interim</u>				X	Prospe	ctive				
		Total Interim				>	(	Total Prospective			
		Settlement Ba	ased on Co	ost				Prospective Adjust —	ed For New Costs		
			X Una Des	dget audited sk Revi sk Audi	Cost ewed Cost ted Cost ted Cost						
Program	ent Managem	ent						Jackson, Financial S dicaid Program Finar			
								For Information On			
								(No Change In Rat	ie)		



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

St. Lucie Coun	ty Health Department			Provider Number: 0279668-00				
5150 NW Milne	er Drive				Date: 07/01/202	4		
Port Saint Luci	e, FL 34963			Fisca	al Year End: 06/30/202	3		
				А	udit Status: Unaudited	Cost		
<u>Provider Ty</u>	<u>rpe</u>		Current F	Rate	New Rate	Effective Date		
	CHD		163.20	<u> </u>	163.26	07/01/2024		
Rate Type								
	<u>Interim</u>		X_ <u>P</u>	rospectiv	<u>/e</u>			
	Total Interir	n		Х	Total Prospective			
-	Settlement	Based on Cost			Prospective Adjust	ted For New Costs		
		BASIS:						
		Budget						
		X Unaudited	l Cost					
		Desk Rev	iewed Cost					
		Desk Aud	ited Cost					
		Field Audi	ted Cost					
DISTRIBUTIO	<u>N:</u>							
Fiscal Age	ent				C92			
Contract M	Management			C	CE Jackson, Financial S	Specialist		
Program F	inance			_	Medicaid Program Finar			
State Heal	Ith Office							
					For Information Or	nly		
				_	—— (No Change In Ra	te)		



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

Santa Rosa County Hea	lth Department		Provider Number: 0279676-00				
P.O. Box 929				Date: 07/01/202	4		
Milton, FL 32572-0929			Fisca	al Year End: 06/30/202	3		
			A	Audit Status: Unaudited	Cost		
Provider Type		<u>Curre</u>	nt Rate	New Rate	Effective Date		
<u>CHD</u>		163	3.26	163.26	07/01/2024		
Rate Type							
<u>Interim</u>		X	Prospectiv	<u>ve</u>			
	Total Interim		X	Total Prospective			
	Settlement Based on C	ost		Prospective Adjust	ted For New Costs		
DISTRIBUTION:	X Un De	dget dget audited Cost sk Reviewed Cost sk Audited Cost eld Audited Cost	t				
Fiscal Agent Contract Manageme Program Finance State Health Office	ent		_	CE Jackson, Financial S Medicaid Program Finan			
				For Information Or	nly		
			_	(No Change In Ra	te)		



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

Sarasota Cou	ınty Health	Department			Provider Number: 0279684-00				
P. O. Box 265	58			_		Date: 07/01/202	4		
Sarasota, FL	34230-26	58			Fiscal `	Year End: 06/30/202	3		
					Aud	dit Status: Unaudited	Cost		
Provider T	уре			Curren	<u>it Rate</u>	New Rate	Effective Date		
	<u>CHD</u>			163	.26	163.26	07/01/2024		
Rate Type									
	<u>Interim</u>			X	Prospective	!			
		Total Interim			X	Total Prospective			
		Settlement Ba	ased on Cost			Prospective Adjus	ted For New Costs		
	gent Manageme	ent	Desk A	ed Cost eviewed Cost udited Cost udited Cost	CE	Jackson, Financial S			
Program State Hea	Finance alth Office				Me	dicaid Program Fina	nce		
2.52									
						For Information Or	-		
						(No Change In Ra	te)		



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

Seminole Cou	ninole County Health Department				Provider Number: 0279692-00					
400 West Airp	ort Boule	vard						Date:	07/01/2024	
Sanford, FL 3	32773						Fiscal	Year End:	06/30/202	23
							Αι	udit Status:	Unaudited	d Cost
Provider Ty	<u>ype</u>				<u>Curre</u>	nt Rate		<u>New</u>	Rate	Effective Date
	<u>CHD</u>				163	3.26		163.26		07/01/2024
Rate Type										
	<u>Interim</u>				X	<u>Prosp</u>	ectiv	<u>e</u>		
	_	Total Interim					Χ	Total P	rospective	
		Settlement Ba	ased o	n Cost				Prospe	ctive Adjus	sted For New Costs
			DAC	uc.						
			BAS	Budget						
				Unaudited	l Coot					
				Desk Revi		<b>-</b> 4				
				Desk Revi Desk Audi		5l				
				Field Audi						
				- Field Addi	ileu Cosi					
DISTRIBUTION Fiscal Age							(	282		
Contract I	Managem	ent					С	E Jackson,	Financial	Specialist
Program	Finance						M	edicaid Pro	ogram Fina	ance
State Hea	alth Office									
								For Info	ormation O	only
							_	— (No Ch	ange In Ra	ate)



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

Sumter Count	ty Health D	epartment			Prov	ider Number:	0279706-0	01
P. O. Box 98						Date	07/01/202	4
Bushnell, FL	33513				Fis	cal Year End:	06/30/202	3
						Audit Status:	Unaudited	l Cost
Provider T	уре			<u>Curren</u>	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			163	.26	163	3.26	07/01/2024
Rate Type	Interim			X	Prospect	<u>iive</u>		
		Total Interim	and an Coat		Х		rospective	tad For New Coats
		Settlement Ba -	ased on Cost			—— Prospe	ctive Adjus	ted For New Costs
			Desk A					
Fiscal Ag	ent	ont				CEL	-	
Program	Managemo	ent				CE Jackson		
_	alth Office					IVIGUICAIU FIC	ogram i ma	
						For Info	ormation Or	nly
					,	(No Ch	ange In Ra	ite)



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

Taylor County Health Depa	ırtment		Provide	Number: 0279722-0	)1
1215 Peacock Street				Date: 07/01/2024	4
Perry, FL 32347			Fiscal	Year End: 06/30/2023	3
			Au	dit Status: Unaudited	Cost
Provider Type		Current Rate	<u>e</u>	New Rate	Effective Date
<u>CHD</u>	-	138.56		138.56	07/01/2024
Rate Type					
<u>Interim</u>		X Pros	spective		
To	otal Interim		X	Total Prospective	
Se	ettlement Based on Cost			Prospective Adjust	ted For New Costs
	BASIS:				
	Budget				
	X Unaudited	Cost			
	Desk Revi	ewed Cost			
	Desk Audi	ted Cost			
	Field Audit	ted Cost			
DISTRIBUTION:				2 -	
Fiscal Agent			(	-82	
Contract Management			CE	Jackson, Financial S	Specialist
Program Finance			Me	dicaid Program Finar	nce
State Health Office					
				For Information Or	nly
				— (No Change In Rat	te)



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

Union County He	ealth Department			Provi	der Number: 0279731-0	00
495 East Main S	Street				Date: 07/01/2024	4
Lake Butler, FL	32054			Fisc	al Year End: 06/30/2023	3
				,	Audit Status: Unaudited	Cost
<u>Provider Typ</u>	<u>e</u>		Current F	<u>Rate</u>	New Rate	Effective Date
<u>(</u>	CHD CHD		163.2	6	163.26	07/01/2024
Rate Type						
<u>lr</u>	<u>nterim</u>		X_ <u>F</u>	rospecti	<u>ve</u>	
	Total Interi	m		Χ	Total Prospective	
	Settlement	Based on Cost	_		Prospective Adjust	ted For New Costs
		BASIS:				
		Budget				
		X Unaudited	l Cost			
			iewed Cost			
		Desk Aud				
		Field Audi				
DISTRIBUTION:	:					
Fiscal Agen					CA	
Contract Ma	anagement			(	CE Jackson, Financial S	Specialist
Program Fir	nance			_	Medicaid Program Finar	
State Health	n Office					
					For Information Or	nly
				_	—— (No Change In Ra	te)



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

Volusia Count	sia County Health Department					Provider Number: 0279749-00					
P. O. Box 919	0							24	_		
Daytona Beac	h, FL 321	120				i	Fiscal	Year End:	06/30/202	23	_
							Αι	ıdit Status:	Unaudited	d Cost	_
Provider Ty	<u>ype</u>				Curre	nt Rate		<u>New</u>	<u>Rate</u>	Effective Date	3
	<u>CHD</u>			-	163	3.26		163	3.26	07/01/2024	
Rate Type											
	<u>Interim</u>				Χ	Prospe	ectiv	<u>e</u>			
	-	Total Interim				_ ;	X	Total P	rospective		
		Settlement Ba	ased on	Cost				Prospe	ctive Adjus	sted For New Costs	
			D 4 016								
			BASIS								
				udget							
				Inaudited							
					ewed Cos	st					
				esk Audi							
			F	ield Audi	ted Cost						
DISTRIBUTIO	<u>)N:</u>										
Fiscal Age	ent						(	19			
Contract I	Managem	ent					CI	E Jackson,	Financial	Specialist	
Program I	Finance						_	edicaid Pro			
State Hea	alth Office										
								For Info	ormation O	nly	
								— (No Ch	ange In Ra	ate)	



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

Nakulla County Health Dep	artment		Provid	er Number:	0279757-00	0
48 Oak Street				Date:	07/01/2024	
Crawfordville, FL 32327			Fisca	I Year End:	06/30/2023	
			A	udit Status:	Unaudited (	Cost
Provider Type		Current	Rate	New	<u>Rate</u>	Effective Date
<u>CHD</u>	-	163.2	26	163	.26	07/01/2024
Rate Type						
<u>Interim</u>		X	Prospectiv	<u>e</u>		
To	tal Interim		Χ	Total Pr	ospective	
Se	ttlement Based on Cost	_		Prospec	ctive Adjuste	ed For New Costs
<u>DISTRIBUTION:</u> Fiscal Agent	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost ted Cost		CEL		
Contract Management			С	E Jackson,	Financial Sp	pecialist
Program Finance			N	ledicaid Pro	gram Finan	ce
State Health Office						
				For Info	rmation Onl	ly
				— (No Cha	ange In Rate	e)



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

Washington C	County Hea	alth Departmen	t		Prov	der Number:	0279773-0	00
1338 South Bo	oulevard					Date:	07/01/202	4
Chipley, FL 3	2428				Fisc	al Year End:	06/30/202	3
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			Current	t Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			163.	26	163	3.26	07/01/2024
Rate Type								
	<u>Interim</u>			X	Prospect	<u>ive</u>		
	_	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjust	ted For New Costs
<u>DISTRIBUTIO</u> Fiscal Ago	<u></u>		BASIS:  Budget  Unaudited  Desk Revi  Desk Audi  Field Audi	iewed Cost		CD		
_	eni Manageme	ent				CE lookson	- Einanoial S	Propiniint
Program I	_	O. I.C				CE Jackson, Medicaid Pro		
State Hea							. g <b>a</b> .	
						For Info	ormation Or	nly
					_	 (No Ch	ange In Ra	te)



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

Bay County Health De	ounty Health Department /est 11th Street			Provider Number: 0290068-00				
597 West 11th Street					Date:	07/01/2024	4	
Panama City, FL 324	101-2330			Fis	cal Year End:	06/30/2023	3	
					Audit Status:	Unaudited	Cost	
Provider Type			Curren	nt Rate	<u>New</u>	Rate	Effective Date	
<u>CHD</u>			163	.26	163	3.26	07/01/2024	
Rate Type								
Interir	<u>m</u>		X	Prospec	<u>tive</u>			
_	Total Interim			X	Total P	rospective		
Settlement Based on Cost					Prospe	ctive Adjust	ed For New Costs	
		DACIC.						
		BASIS: Budget						
		X Unaudited	l Coot					
			i Cost iewed Cost					
		Desk Aud						
		——— Field Audi						
		—— Field Audi	ied Cosi					
DISTRIBUTION:								
Fiscal Agent					(19)			
Contract Manage	ement				CE Jackson,	- Financial S	Specialist	
Program Finance					Medicaid Pro			
State Health Office	ce							
					For Info	ormation On	nly	
					(No Ch	ange In Rat	te)	



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

Lafayette County H	ette County Health Department Box 1806				Provider Number: 0290343-00				
P.O. Box 1806					4				
Mayo, FL 32066				Fisc	al Year End: 06/30/202	3			
				ı	Audit Status: Unaudited	l Cost			
<u>Provider Type</u>			Current	Rate	New Rate	Effective Date			
<u>C</u> F	<u>ID</u>		163.	26	163.26	07/01/2024			
Rate Type									
Inte	<u>erim</u>		X	<u>Prospecti</u>	<u>ve</u>				
	Total Interim			Χ	Total Prospective				
	Settlement Ba	ased on Cost			Prospective Adjus	ted For New Costs			
		BASIS:							
		Budget							
		X Unaudited	l Cost						
		Desk Revi	iewed Cost						
		Desk Aud	ited Cost						
		Field Audi	ted Cost						
DISTRIBUTION:									
Fiscal Agent					C 50				
Contract Mana	agement				CE Jackson, Financial S	Specialist			
Program Finar				-	Medicaid Program Fina				
State Health C	Office				-				
					For Information O	nly			
				_	—— (No Change In Ra	ite)			



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

Madison Cou	nty Health	Department				Pı	rovider Nu	umber: (	0290408-0	0	
301 S.W. Smi	ith Street							Date: 0	07/01/2024		
Madison, FL	32340					F	Fiscal Yea	ar End: (	06/30/2023	3	
							Audit \$	Status: U	Jnaudited	Cost	
Provider T	уре				Curren	t Rate		New F	Rate	Effectiv	e Date
	CHD				163	.26		163.	26	07/01/	2024
Rate Type	Interim				X	Prospe	ective				
	<u> </u>	Total Interim						Γotal Pro	spective		
		Settlement Ba	ased on C	Cost					•	ed For New C	osts
		_						·	•		
			<b>BASIS</b>	<u>:</u>							
			В	udget							
			X Uı	naudited	l Cost						
			De	esk Rev	iewed Cost						
			D	esk Aud	ited Cost						
			Fi	eld Audi	ted Cost						
DISTRIBUTIO	ON:						_				
Fiscal Ag							C	50			
_	Managem	ent					CE Ja	ckson. F	inancial S	pecialist	
Program	Finance								ram Finan		
State Hea	alth Office										
							F	For Infor	mation On	ly	
							(	(No Cha	nge In Rat	e)	



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

Suwannee County Health D	epartment	Prov	vider Number: 0518328-	00
P. O. Box 6030			Date: 07/01/202	24
Live Oak, FL 32060		 Fis	scal Year End: 06/30/202	23
			Audit Status: Unaudited	d Cost
<u>Provider Type</u>		Current Rate	New Rate	Effective Date
<u>CHD</u>	-	128.15	128.15	07/01/2024
Rate Type				
<u>Interim</u>		X <u>Prospec</u>	<u>tive</u>	
Tot	tal Interim	X	Total Prospective	
Se	ttlement Based on Cost		Prospective Adjus	sted For New Costs
	BASIS:  Budget  X Unaudited  Desk Revie  Desk Audit  Field Audit	ewed Cost red Cost		
DISTRIBUTION:			00	
Fiscal Agent			CEY	
Contract Management Program Finance			CE Jackson, Financial	
State Health Office			Medicaid Program Fina	IIIC <del>C</del>
			For Information O	•
			(No Change In Ra	ate)



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

Holmes County He	nes County Health Department				ider Number:	0519022-0	0
P. O. Box 337603	Scenic Circle				Date:	: 07/01/2024	
Bonifay, FL 32425	5			Fisc	al Year End:	06/30/2023	3
					Audit Status:	Unaudited	Cost
<u>Provider Type</u>			Curren	t Rate	<u>New</u>	<u>Rate</u>	Effective Date
<u>C</u>	<u> 1D</u>		138	.86	138	3.86	07/01/2024
Rate Type							
<u>Int</u>	<u>erim</u>		X	Prospect	<u>ive</u>		
	Total Interim			X	Total Pr	ospective	
	Settlement Ba	ased on Cost			Prospec	ctive Adjust	ed For New Costs
<u>DISTRIBUTION:</u> Fiscal Agent		BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost		CA		
Contract Mana	agement				CE Jackson,	Financial S	specialist
Program Fina	_				Medicaid Pro		
State Health 0	Office						
					For Info	rmation On	ıly
				-	(No Cha	ange In Rat	re)



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

Brevard County Heath Departmen	t	Pro	Provider Number: 0519251-00				
2572 N. Courtenay Parkway			Date: 07/01/2024 Fiscal Year End: 06/30/2023				
Merritt Island, FL 32953-4147							
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
CHD		163.26	163.26	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>ctive</u>				
Total Inte	rim	X	Total Prospective				
Settlemen	nt Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	d Cost					
	Desk Rev	riewed Cost					
	Desk Aud	lited Cost					
	Field Aud	ited Cost					
DISTRIBUTION:							
Fiscal Agent			CA				
Contract Management			CE Jackson, Financial	Specialist			
Program Finance			Medicaid Program Fina				
State Health Office							
			For Information O	nly			
			(No Change In Ra	ate)			



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

Palm Beach County Health Depa	rtment		Provid	er Number: (	0520331-00	)
P. O. Box 29		Date:		: 07/01/2024		
West Palm Beach, FL 33402			Fisca	l Year End: (	06/30/2023	
			А	udit Status: U	Jnaudited (	Cost
Provider Type		Current R	<u>ate</u>	New F	Rate	Effective Date
<u>CHD</u>		163.26	<u> </u>	163.	26	07/01/2024
Rate Type						
<u>Interim</u>		X <u>P</u> i	rospectiv	<u>′e</u>		
 Total Int	erim		X	Total Pro	spective	
Settleme	ent Based on Cost			Prospec	tive Adjuste	d For New Costs
DISTRIBUTION:	BASIS:  Budget  X Unaudited  Desk Revi  Desk Audi  Field Audi	ewed Cost ted Cost		0 0		
Fiscal Agent				CEL		
Contract Management			C	E Jackson, F	inancial Sp	pecialist
Program Finance			N	ledicaid Prog	gram Financ	<del></del> ce
State Health Office						
				For Infor	mation Only	y
				— (No Cha	nge In Rate	<u>;</u> )



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

Charlotte County Health Departme	ent	Prov	vider Number: 0520446-0	00			
514 East Grace Street			Date: 07/01/2024 Fiscal Year End: 06/30/2023				
Punta Gorda, FL 33950		 Fis					
			Audit Status: Unaudited	d Cost			
Provider Type		Current Rate	New Rate	Effective Date			
<u>CHD</u>		135.75	135.75	07/01/2024			
Rate Type							
<u>Interim</u>		X Prospec	<u>tive</u>				
Total Inte	rim	X	Total Prospective				
Settleme	nt Based on Cost		Prospective Adjus	ted For New Costs			
	BASIS:						
	Budget						
	X Unaudited	d Cost					
	Desk Rev	iewed Cost					
	Desk Aud	ited Cost					
	Field Audi	ited Cost					
DISTRIBUTION:							
Fiscal Agent			(2)				
Contract Management			CE Jackson, Financial S	Snecialist			
Program Finance			Medicaid Program Fina				
State Health Office			3				
			For Information O	nly			
			(No Change In Ra	ate)			



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

Hillsborough County Health Depa	rtment	Prov	vider Number: 0557269-	00		
1105 E. Kennedy Boulevard			Date: 07/01/202	e: 07/01/2024		
Tampa, FL 33602		Fis	Fiscal Year End: 06/30/2023			
			Audit Status: Unaudited	d Cost		
Provider Type		Current Rate	New Rate	Effective Date		
<u>CHD</u>		163.26	163.26	07/01/2024		
Rate Type						
<u>Interim</u>		X Prospec	<u>tive</u>			
Total Int	erim	X	Total Prospective			
Settleme	ent Based on Cost	-	Prospective Adjus	sted For New Costs		
DISTRIBUTION:	BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost	00			
Fiscal Agent			CEL			
Contract Management			CE Jackson, Financial			
Program Finance			Medicaid Program Fina	ince		
State Health Office						
			For Information O	nly		
			—— (No Change In Ra	ate)		



Office of Medicaid Program Finance

2727 Mahan Drive - Mail Stop 23 - Tallahassee Florida 32308

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

_ake County I	Health Dep	artment			Prov	ider Number:	0563234-0	00
P. O. Box 1305421 West Main Street					Date:		77/01/2024	
Tavares, FL 3	32778-130	5			Fiscal Year End: 06/30/2023			
						Audit Status:	Unaudited	Cost
Provider Ty	<u>ype</u>			Curren	nt Rate	<u>New</u>	Rate	Effective Date
	<u>CHD</u>			163	.26	165	3.26	07/01/2024
Rate Type								
	<u>Interim</u>			Х	Prospect	<u>ive</u>		
	_	Total Interim			X	Total P	rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs
DISTRIBUTIO	OM:		BASIS:  Budget  X Unaudited  Desk Rev  Desk Aud  Field Audi	iewed Cost ited Cost				
DISTRIBUTIO						00		
Fiscal Age		.nt				CEX		
Program	Manageme	:111				CE Jackson		
_	alth Office					INICUICAIU PI	ogram Fillal	iio <del>c</del>
						For Info	ormation Or	nly
					-	(No Ch	ange In Ra	te)



Office of Medicaid Program Finance

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

Escambia Co	unty Health	n Department			Prov	ider Number	0600181-0	00
1295 West Fa	airfield Driv	е				Date	07/01/202	4
Pensacola, Fl	L 32501				Fiscal Year E		06/30/202	3
						Audit Status	Unaudited	Cost
Provider T	уре			Curren	t Rate	New	Rate	Effective Date
	CHD			163	.26	163	3.26	07/01/2024
Rate Type	Interim			X	Prospect	<u>ive</u>		
		Total Interim			X		rospective	
		Settlement Ba	ased on Cost			Prospe	ctive Adjus	ted For New Costs
			Desk Au	ed Cost eviewed Cost dited Cost dited Cost				
Fiscal Ag		≏nt				CEL	- Einanaial S	Progialist
Program	=	SIIL				CE Jackson Medicaid Pro		
_	alth Office					3	- G	
						For Info	ormation Or	nly
					•	—— (No Ch	ange In Ra	te)