State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Alachua County Health Department
Audit Status: **Unaudited Cost**

Provider Number: 0279111
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,796,942.00
2. Total Non-Allowable Costs	$14,624,280.00
3. Total Overhead Costs	$4,026,921.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$23,448,143.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$7,034,442.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$4,026,921.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,796,942.00
2. Total Non-Allowable Costs	$14,624,280.00
3. Sum of Lines B1 and B2	$19,421,222.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2470
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$994,649.49
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,791,591.49
2. Total CHD Visits	29,329
3. CHD Rate Per Visit (C1 divided by C2)	$197.47
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$219.72
3. Medicaid Trend Adjustment	($55.76)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Baker County Health Department
Provider Number: 0279129

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,033,497.00
2. Total Non-Allowable Costs	$1,444,551.00
3. Total Overhead Costs	$497,568.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,975,616.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$892,684.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$497,568.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,033,497.00
2. Total Non-Allowable Costs	$1,444,551.00
3. Sum of Lines B1 and B2	$2,478,048.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4171
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$207,535.61
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,241,032.61
2. Total CHD Visits	7,809
3. CHD Rate Per Visit (C1 divided by C2)	$158.92
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$176.83
3. Medicaid Trend Adjustment	($15.77)
4. Final Prospective Rate - Effective Date: 07/01/2022	$161.06

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Bradford County Health Department
Provider Number: 0279145

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,537,072.00
2. Total Non-Allowable Costs	$1,143,097.00
3. Total Overhead Costs	$476,468.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,156,637.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$946,991.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$476,468.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,537,072.00
2. Total Non-Allowable Costs	$1,143,097.00
3. Sum of Lines B1 and B2	$2,680,169.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5735
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$273,254.40
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,810,326.40
2. Total CHD Visits	8,203
3. CHD Rate Per Visit (C1 divided by C2)	$220.69
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$245.56
3. Medicaid Trend Adjustment	($81.60)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Broward County Health Department
Provider Number: 0279161

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$6,385,664.00
2. Total Non-Allowable Costs	$89,014,886.00
3. Total Overhead Costs	$11,950,597.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$107,351,147.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$32,205,344.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$11,950,597.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$6,385,664.00
2. Total Non-Allowable Costs	$89,014,886.00
3. Sum of Lines B1 and B2	$95,400,550.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.0669
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$799,494.94
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$7,185,158.94
2. Total CHD Visits	22,557
3. CHD Rate Per Visit (C1 divided by C2)	$318.53
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$354.42
3. Medicaid Trend Adjustment	($190.46)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Calhoun County Health Department
Provider Number: 0279170

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$276,159.00
2. Total Non-Allowable Costs	$1,040,364.00
3. Total Overhead Costs	$341,902.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,658,425.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$497,527.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$341,902.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$276,159.00
2. Total Non-Allowable Costs	$1,040,364.00
3. Sum of Lines B1 and B2	$1,316,523.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2098
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$71,731.04
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$347,890.04
2. Total CHD Visits	1,423
3. CHD Rate Per Visit (C1 divided by C2)	$244.48
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$272.02
3. Medicaid Trend Adjustment	($108.06)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Citrus County Health Department
Provider Number: 0279196

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,287,427.00
2. Total Non-Allowable Costs	$4,612,787.00
3. Total Overhead Costs	$1,193,462.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,093,676.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,128,102.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,193,462.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,287,427.00
2. Total Non-Allowable Costs	$4,612,787.00
3. Sum of Lines B1 and B2	$5,900,214.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2182
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$260,413.41
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,547,840.41
2. Total CHD Visits	4,950
3. CHD Rate Per Visit (C1 divided by C2)	$312.70
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$347.93
3. Medicaid Trend Adjustment	($183.97)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Clay County Health Department
Provider Number: 0279200

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$917,641.00
2. Total Non-Allowable Costs	$3,902,924.00
3. Total Overhead Costs	$1,009,139.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,829,704.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,748,911.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,009,139.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$917,641.00
2. Total Non-Allowable Costs	$3,902,924.00
3. Sum of Lines B1 and B2	$4,820,565.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1904
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$192,140.07
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,109,781.07
2. Total CHD Visits	14,035
3. CHD Rate Per Visit (C1 divided by C2)	$79.07
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$87.98
3. Medicaid Trend Adjustment	($7.84)
4. Final Prospective Rate - Effective Date: 07/01/2022	$80.14

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Collier County Health Department
Provider Number: 0279218

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,653,838.00
2. Total Non-Allowable Costs	$8,672,029.00
3. Total Overhead Costs	$2,185,594.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,511,461.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,053,438.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,185,594.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,653,838.00
2. Total Non-Allowable Costs	$8,672,029.00
3. Sum of Lines B1 and B2	$11,325,867.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2343
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$512,084.67
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,165,922.67
2. Total CHD Visits	12,232
3. CHD Rate Per Visit (C1 divided by C2)	$258.82
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$287.98
3. Medicaid Trend Adjustment	($124.02)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Columbia County Health Department
Provider Number: 0279226

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$737,217.00
2. Total Non-Allowable Costs	$1,933,345.00
3. Total Overhead Costs	$500,069.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,170,631.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$951,189.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$500,069.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$737,217.00
2. Total Non-Allowable Costs	$1,933,345.00
3. Sum of Lines B1 and B2	$2,670,562.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2761
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$138,069.05
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$875,286.05
2. Total CHD Visits	3,489
3. CHD Rate Per Visit (C1 divided by C2)	$250.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$279.14
3. Medicaid Trend Adjustment	($115.18)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Dade County Health Department
Provider Number: 0279234

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$18,353,931.00
2. Total Non-Allowable Costs	$58,788,892.00
3. Total Overhead Costs	$10,465,632.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$87,608,455.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$26,282,536.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$10,465,632.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$18,353,931.00
2. Total Non-Allowable Costs	$58,788,892.00
3. Sum of Lines B1 and B2	$77,142,823.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2379
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,489,773.85
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$20,843,704.85
2. Total CHD Visits	63,500
3. CHD Rate Per Visit (C1 divided by C2)	$328.25
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$365.23
3. Medicaid Trend Adjustment	($201.27)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: DeSoto County Health Department
Provider Number: 0279242

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,486,082.00
2. Total Non-Allowable Costs	$3,222,058.00
3. Total Overhead Costs	$451,902.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,160,042.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,848,012.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$451,902.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,486,082.00
2. Total Non-Allowable Costs	$3,222,058.00
3. Sum of Lines B1 and B2	$5,708,140.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4355
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$196,803.32
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,682,885.32
2. Total CHD Visits	21,982
3. CHD Rate Per Visit (C1 divided by C2)	$122.05
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$135.80
3. Medicaid Trend Adjustment	($12.11)
4. Final Prospective Rate - Effective Date: 07/01/2022	$123.69

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Dixie County Health Department
Provider Number: 0279251

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$282,049.00
2. Total Non-Allowable Costs	$727,006.00
3. Total Overhead Costs	$300,696.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,309,751.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$392,925.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$300,696.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$282,049.00
2. Total Non-Allowable Costs	$727,006.00
3. Sum of Lines B1 and B2	$1,009,055.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2795
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$84,044.53
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$366,093.53
2. Total CHD Visits	1,353
3. CHD Rate Per Visit (C1 divided by C2)	$270.58
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$301.06
3. Medicaid Trend Adjustment	($137.10)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Duval County Health Department
Provider Number: 0279269

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$8,444,488.00
2. Total Non-Allowable Costs	$16,585,028.00
3. Total Overhead Costs	$8,059,295.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$33,088,811.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$9,926,643.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$8,059,295.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$8,444,488.00
2. Total Non-Allowable Costs	$16,585,028.00
3. Sum of Lines B1 and B2	$25,029,516.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3374
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,719,206.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$11,163,694.13
2. Total CHD Visits	31,022
3. CHD Rate Per Visit (C1 divided by C2)	$359.86
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$400.41
3. Medicaid Trend Adjustment	($236.45)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Flagler County Health Department
Provider Number: 0279285

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,637,432.00
2. Total Non-Allowable Costs	$2,905,034.00
3. Total Overhead Costs	$703,888.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,246,354.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,573,906.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$703,888.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,637,432.00
2. Total Non-Allowable Costs	$2,905,034.00
3. Sum of Lines B1 and B2	$4,542,466.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3605
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$253,751.62
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,891,183.62
2. Total CHD Visits	8,478
3. CHD Rate Per Visit (C1 divided by C2)	$223.07
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$248.20
3. Medicaid Trend Adjustment	($84.24)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Franklin County Health Department
Provider Number: 0279293

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$550,812.00
2. Total Non-Allowable Costs	$1,401,275.00
3. Total Overhead Costs	$424,486.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,376,573.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$712,971.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$424,486.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$550,812.00
2. Total Non-Allowable Costs	$1,401,275.00
3. Sum of Lines B1 and B2	$1,952,087.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2822
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$119,789.95
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$670,601.95
2. Total CHD Visits	1,960
3. CHD Rate Per Visit (C1 divided by C2)	$342.14
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$380.69
3. Medicaid Trend Adjustment	($216.73)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Gadsden County Health Department
Provider Number: 0279307

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$775,218.00
2. Total Non-Allowable Costs	$2,574,687.00
3. Total Overhead Costs	$836,674.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,186,579.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,255,973.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$836,674.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$775,218.00
2. Total Non-Allowable Costs	$2,574,687.00
3. Sum of Lines B1 and B2	$3,349,905.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2314
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$193,606.36
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$968,824.36
2. Total CHD Visits	5,600
3. CHD Rate Per Visit (C1 divided by C2)	$173.00
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$192.50
3. Medicaid Trend Adjustment	($28.54)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Gilchrist County Health Department
Provider Number: 0279315

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$423,459.00
2. Total Non-Allowable Costs	$645,333.00
3. Total Overhead Costs	$244,822.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,313,614.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$394,084.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$244,822.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$423,459.00
2. Total Non-Allowable Costs	$645,333.00
3. Sum of Lines B1 and B2	$1,068,792.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3962
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$96,998.48
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$520,457.48
2. Total CHD Visits	2,826
3. CHD Rate Per Visit (C1 divided by C2)	$184.17
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$204.92
3. Medicaid Trend Adjustment	($40.96)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Glades County Health Department
Provider Number: 0279323

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$217,302.00
2. Total Non-Allowable Costs	$637,197.00
3. Total Overhead Costs	$358,539.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,213,038.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$363,911.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$358,539.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$217,302.00
2. Total Non-Allowable Costs	$637,197.00
3. Sum of Lines B1 and B2	$854,499.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2543
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$91,176.47
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$308,478.47
2. Total CHD Visits	3,350
3. CHD Rate Per Visit (C1 divided by C2)	$92.08
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$102.46
3. Medicaid Trend Adjustment	($9.14)
4. Final Prospective Rate - Effective Date: 07/01/2022	$93.32

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Gulf County Health Department
Provider Number: 0279331

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$267,405.00
2. Total Non-Allowable Costs	$1,444,167.00
3. Total Overhead Costs	$868,081.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,579,653.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$773,895.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$773,895.90
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$267,405.00
2. Total Non-Allowable Costs	$1,444,167.00
3. Sum of Lines B1 and B2	$1,711,572.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1562
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$120,882.54
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$388,287.54
2. Total CHD Visits	1,960
3. CHD Rate Per Visit (C1 divided by C2)	$198.11
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$220.43
3. Medicaid Trend Adjustment	($56.47)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Hamilton County Health Department
Provider Number: 0279340

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$449,436.00
2. Total Non-Allowable Costs	$598,941.00
3. Total Overhead Costs	$210,423.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,258,800.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$377,640.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$210,423.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$449,436.00
2. Total Non-Allowable Costs	$598,941.00
3. Sum of Lines B1 and B2	$1,048,377.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4287
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$90,208.34
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$539,644.34
2. Total CHD Visits	2,656
3. CHD Rate Per Visit (C1 divided by C2)	$203.18
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$226.07
3. Medicaid Trend Adjustment	($62.11)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Hardee County Health Department
Provider Number: 0279358

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$233,355.98
2. Total Non-Allowable Costs	$1,670,384.56
3. Total Overhead Costs	$436,019.67
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,339,760.21
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$701,928.06
7. Allowable Overhead Cost (Lesser of A3 or A6)	$436,019.67
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$233,355.98
2. Total Non-Allowable Costs	$1,670,384.56
3. Sum of Lines B1 and B2	$1,903,740.54
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1226
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$53,456.01
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$286,811.99
2. Total CHD Visits	875
3. CHD Rate Per Visit (C1 divided by C2)	$327.79
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$364.72
3. Medicaid Trend Adjustment	($200.76)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Hendry County Health Department
Provider Number: 0279366

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,670,421.00
2. Total Non-Allowable Costs	$3,310,358.00
3. Total Overhead Costs	$1,226,347.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,207,126.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,862,137.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,226,347.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,670,421.00
2. Total Non-Allowable Costs	$3,310,358.00
3. Sum of Lines B1 and B2	$4,980,779.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3354
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$411,316.78
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,081,737.78
2. Total CHD Visits	11,370
3. CHD Rate Per Visit (C1 divided by C2)	$183.09
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$203.72
3. Medicaid Trend Adjustment	($39.76)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Hernando County Health Department
Provider Number: 0279374

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,134,426.00
2. Total Non-Allowable Costs	$3,423,396.00
3. Total Overhead Costs	$1,985,480.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,543,302.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,962,990.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,962,990.60
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,134,426.00
2. Total Non-Allowable Costs	$3,423,396.00
3. Sum of Lines B1 and B2	$4,557,822.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2489
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$488,588.36
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,623,014.36
2. Total CHD Visits	7,140
3. CHD Rate Per Visit (C1 divided by C2)	$227.31
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$252.92
3. Medicaid Trend Adjustment	($88.96)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Highlands County Health Department
Provider Number: 0279382

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,113,654.00
2. Total Non-Allowable Costs	$3,297,554.00
3. Total Overhead Costs	$960,691.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,371,899.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,611,569.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$960,691.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,113,654.00
2. Total Non-Allowable Costs	$3,297,554.00
3. Sum of Lines B1 and B2	$4,411,208.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2525
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$242,574.48
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,356,228.48
2. Total CHD Visits	5,891
3. CHD Rate Per Visit (C1 divided by C2)	$230.22
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$256.16
3. Medicaid Trend Adjustment	($92.20)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Indian River County Health Department
Provider Number: 0279412

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$946,752.00
2. Total Non-Allowable Costs	$4,417,034.00
3. Total Overhead Costs	$1,580,675.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,944,461.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,083,338.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,580,675.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$946,752.00
2. Total Non-Allowable Costs	$4,417,034.00
3. Sum of Lines B1 and B2	$5,363,786.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1765
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$278,989.14
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,225,741.14
2. Total CHD Visits	6,965
3. CHD Rate Per Visit (C1 divided by C2)	$175.99
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$195.81
3. Medicaid Trend Adjustment	($31.85)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Jackson County Health Department
Audit Status: **Unaudited Cost**
Provider Number: 0279421
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$936,418.00
2. Total Non-Allowable Costs	$2,961,351.00
3. Total Overhead Costs	$1,107,709.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,005,478.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,501,643.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,107,709.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$936,418.00
2. Total Non-Allowable Costs	$2,961,351.00
3. Sum of Lines B1 and B2	$3,897,769.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2402
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$266,071.70
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,202,489.70
2. Total CHD Visits	4,821
3. CHD Rate Per Visit (C1 divided by C2)	$249.43
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$277.53
3. Medicaid Trend Adjustment	($113.57)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Jefferson County Health Department
Provider Number: 0279439

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$492,925.00
2. Total Non-Allowable Costs	$1,304,501.00
3. Total Overhead Costs	$314,557.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,111,983.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$633,594.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$314,557.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$492,925.00
2. Total Non-Allowable Costs	$1,304,501.00
3. Sum of Lines B1 and B2	$1,797,426.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2742
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$86,251.53
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$579,176.53
2. Total CHD Visits	2,016
3. CHD Rate Per Visit (C1 divided by C2)	$287.29
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$319.66
3. Medicaid Trend Adjustment	($155.70)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Lee County Health Department
Provider Number: 0279463

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,817,355.00
2. Total Non-Allowable Costs	$11,185,156.00
3. Total Overhead Costs	$3,603,259.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$18,605,770.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,581,731.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,603,259.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,817,355.00
2. Total Non-Allowable Costs	$11,185,156.00
3. Sum of Lines B1 and B2	$15,002,511.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2544
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$916,669.09
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,734,024.09
2. Total CHD Visits	8,470
3. CHD Rate Per Visit (C1 divided by C2)	$558.92
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$621.89
3. Medicaid Trend Adjustment	($457.93)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Leon County Health Department
Provider Number: 0279471

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,814,229.00
2. Total Non-Allowable Costs	$9,365,455.00
3. Total Overhead Costs	$1,713,338.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,893,022.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,167,906.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,713,338.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,814,229.00
2. Total Non-Allowable Costs	$9,365,455.00
3. Sum of Lines B1 and B2	$12,179,684.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2311
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$395,952.41
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,210,181.41
2. Total CHD Visits	17,927
3. CHD Rate Per Visit (C1 divided by C2)	$179.07
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$199.25
3. Medicaid Trend Adjustment	($35.29)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Levy County Health Department
Provider Number: 0279480

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$925,546.00
2. Total Non-Allowable Costs	$1,778,198.00
3. Total Overhead Costs	$509,780.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,213,524.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$964,057.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$509,780.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$925,546.00
2. Total Non-Allowable Costs	$1,778,198.00
3. Sum of Lines B1 and B2	$2,703,744.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3423
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$174,497.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,100,043.69
2. Total CHD Visits	3,306
3. CHD Rate Per Visit (C1 divided by C2)	$332.74
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$370.23
3. Medicaid Trend Adjustment	($206.27)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Liberty County Health Department
Provider Number: 0279498

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$199,980.00
2. Total Non-Allowable Costs	$687,664.00
3. Total Overhead Costs	$419,332.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,306,976.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$392,092.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$392,092.80
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$199,980.00
2. Total Non-Allowable Costs	$687,664.00
3. Sum of Lines B1 and B2	$887,644.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2253
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$88,338.51
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$288,318.51
2. Total CHD Visits	1,271
3. CHD Rate Per Visit (C1 divided by C2)	$226.84
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$252.40
3. Medicaid Trend Adjustment	($88.44)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Manatee County Health Department
Provider Number: 0279510

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,668,525.00
2. Total Non-Allowable Costs	$8,938,511.00
3. Total Overhead Costs	$2,474,489.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,081,525.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,924,457.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,474,489.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,668,525.00
2. Total Non-Allowable Costs	$8,938,511.00
3. Sum of Lines B1 and B2	$10,607,036.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1573
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$389,237.12
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,057,762.12
2. Total CHD Visits	15,750
3. CHD Rate Per Visit (C1 divided by C2)	$130.65
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$145.37
3. Medicaid Trend Adjustment	($12.96)
4. Final Prospective Rate - Effective Date: 07/01/2022	$132.41

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Marion County Health Department
Provider Number: 0279528

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,790,291.00
2. Total Non-Allowable Costs	$7,931,535.00
3. Total Overhead Costs	$2,642,857.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,364,683.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,009,404.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,642,857.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,790,291.00
2. Total Non-Allowable Costs	$7,931,535.00
3. Sum of Lines B1 and B2	$10,721,826.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2602
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$687,671.39
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,477,962.39
2. Total CHD Visits	9,993
3. CHD Rate Per Visit (C1 divided by C2)	$348.04
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$387.25
3. Medicaid Trend Adjustment	($223.29)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Martin County Health Department
Provider Number: 0279536

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$663,990.00
2. Total Non-Allowable Costs	$4,674,535.00
3. Total Overhead Costs	$1,646,606.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,985,131.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,095,539.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,646,606.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$663,990.00
2. Total Non-Allowable Costs	$4,674,535.00
3. Sum of Lines B1 and B2	$5,338,525.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1244
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$204,837.79
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$868,827.79
2. Total CHD Visits	4,349
3. CHD Rate Per Visit (C1 divided by C2)	$199.78
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$222.29
3. Medicaid Trend Adjustment	($58.33)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Monroe County Health Department
Provider Number: 0279544

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,578,677.00
2. Total Non-Allowable Costs	$4,244,943.00
3. Total Overhead Costs	$1,899,811.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,723,431.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,317,029.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,899,811.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,578,677.00
2. Total Non-Allowable Costs	$4,244,943.00
3. Sum of Lines B1 and B2	$5,823,620.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2711
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$515,038.76
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,093,715.76
2. Total CHD Visits	7,667
3. CHD Rate Per Visit (C1 divided by C2)	$273.08
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$303.85
3. Medicaid Trend Adjustment	($139.89)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Nassau County Health Department
Provider Number: 0279552

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,143,144.00
2. Total Non-Allowable Costs	$3,837,893.00
3. Total Overhead Costs	$809,911.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,790,948.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,737,284.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$809,911.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,143,144.00
2. Total Non-Allowable Costs	$3,837,893.00
3. Sum of Lines B1 and B2	$4,981,037.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2295
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$185,874.57
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,329,018.57
2. Total CHD Visits	8,308
3. CHD Rate Per Visit (C1 divided by C2)	$159.97
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$177.99
3. Medicaid Trend Adjustment	($15.87)
4. Final Prospective Rate - Effective Date: 07/01/2022	$162.12

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Okaloosa County Health Department
Provider Number: 0279561

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,818,624.00
2. Total Non-Allowable Costs	$7,116,041.00
3. Total Overhead Costs	$2,487,601.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$11,422,266.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,426,679.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,487,601.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,818,624.00
2. Total Non-Allowable Costs	$7,116,041.00
3. Sum of Lines B1 and B2	$8,934,665.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2035
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$506,226.80
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,324,850.80
2. Total CHD Visits	13,036
3. CHD Rate Per Visit (C1 divided by C2)	$178.34
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$198.43
3. Medicaid Trend Adjustment	($34.47)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Okeechobee County Health Department
Provider Number: 0279579

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$230,381.00
2. Total Non-Allowable Costs	$1,864,557.00
3. Total Overhead Costs	$437,039.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,531,977.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$759,593.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$437,039.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$230,381.00
2. Total Non-Allowable Costs	$1,864,557.00
3. Sum of Lines B1 and B2	$2,094,938.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1100
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$48,074.29
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$278,455.29
2. Total CHD Visits	2,612
3. CHD Rate Per Visit (C1 divided by C2)	$106.61
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$118.62
3. Medicaid Trend Adjustment	($10.58)
4. Final Prospective Rate - Effective Date: 07/01/2022	$108.04

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Orange County Health Department
Provider Number: 0279587

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$7,618,327.00
2. Total Non-Allowable Costs	$27,968,332.00
3. Total Overhead Costs	$7,577,040.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$43,163,699.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$12,949,109.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$7,577,040.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$7,618,327.00
2. Total Non-Allowable Costs	$27,968,332.00
3. Sum of Lines B1 and B2	$35,586,659.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2141
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,622,244.26
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$9,240,571.26
2. Total CHD Visits	31,458
3. CHD Rate Per Visit (C1 divided by C2)	$293.74
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$326.84
3. Medicaid Trend Adjustment	($162.88)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Osceola County Health Department
Provider Number: 0279595

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,390,883.00
2. Total Non-Allowable Costs	$6,904,110.00
3. Total Overhead Costs	$2,394,184.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,689,177.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,206,753.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,394,184.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,390,883.00
2. Total Non-Allowable Costs	$6,904,110.00
3. Sum of Lines B1 and B2	$8,294,993.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1677
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$401,504.66
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,792,387.66
2. Total CHD Visits	13,475
3. CHD Rate Per Visit (C1 divided by C2)	$133.02
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$148.00
3. Medicaid Trend Adjustment	($13.19)
4. Final Prospective Rate - Effective Date: 07/01/2022	$134.81

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Pasco County Health Department
Provider Number: 0279617

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,344,734.53
2. Total Non-Allowable Costs	$8,918,096.53
3. Total Overhead Costs	$2,792,741.82
4. Total Costs (Sum of Lines A1 , A2 and A3)	$14,055,572.88
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,216,671.86
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,792,741.82
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,344,734.53
2. Total Non-Allowable Costs	$8,918,096.53
3. Sum of Lines B1 and B2	$11,262,831.06
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2082
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$581,448.85
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,926,183.38
2. Total CHD Visits	8,451
3. CHD Rate Per Visit (C1 divided by C2)	$346.25
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$385.26
3. Medicaid Trend Adjustment	($221.30)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Pinellas County Health Department
Provider Number: 0279625

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$15,866,517.00
2. Total Non-Allowable Costs	$33,147,359.00
3. Total Overhead Costs	$8,618,023.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$57,631,899.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$17,289,569.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$8,618,023.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$15,866,517.00
2. Total Non-Allowable Costs	$33,147,359.00
3. Sum of Lines B1 and B2	$49,013,876.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3237
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,789,654.05
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$18,656,171.05
2. Total CHD Visits	81,687
3. CHD Rate Per Visit (C1 divided by C2)	$228.39
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$254.12
3. Medicaid Trend Adjustment	($90.16)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Polk County Health Department
Provider Number: 0279633

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$8,296,226.00
2. Total Non-Allowable Costs	$18,930,703.00
3. Total Overhead Costs	$3,892,717.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$31,119,646.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$9,335,893.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,892,717.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$8,296,226.00
2. Total Non-Allowable Costs	$18,930,703.00
3. Sum of Lines B1 and B2	$27,226,929.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3047
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,186,110.87
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$9,482,336.87
2. Total CHD Visits	32,923
3. CHD Rate Per Visit (C1 divided by C2)	$288.02
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$320.47
3. Medicaid Trend Adjustment	($156.51)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Putnam County Health Department
Provider Number: 0279641

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,802,819.00
2. Total Non-Allowable Costs	$2,137,745.00
3. Total Overhead Costs	$883,096.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,823,660.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,447,098.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$883,096.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,802,819.00
2. Total Non-Allowable Costs	$2,137,745.00
3. Sum of Lines B1 and B2	$3,940,564.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4575
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$404,016.42
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,206,835.42
2. Total CHD Visits	4,094
3. CHD Rate Per Visit (C1 divided by C2)	$539.04
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$599.77
3. Medicaid Trend Adjustment	($435.81)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: St. Johns County Health Department
Provider Number: 0279650

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$596,426.00
2. Total Non-Allowable Costs	$6,127,268.00
3. Total Overhead Costs	$1,097,727.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,821,421.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,346,426.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,097,727.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$596,426.00
2. Total Non-Allowable Costs	$6,127,268.00
3. Sum of Lines B1 and B2	$6,723,694.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.0887
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$97,368.38
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$693,794.38
2. Total CHD Visits	1,330
3. CHD Rate Per Visit (C1 divided by C2)	$521.65
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$580.42
3. Medicaid Trend Adjustment	($416.46)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: St. Lucie County Health Department
Provider Number: 0279668

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,735,945.00
2. Total Non-Allowable Costs	$9,375,962.00
3. Total Overhead Costs	$1,890,750.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$15,002,657.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,500,797.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,890,750.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,735,945.00
2. Total Non-Allowable Costs	$9,375,962.00
3. Sum of Lines B1 and B2	$13,111,907.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2849
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$538,674.68
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,274,619.68
2. Total CHD Visits	13,846
3. CHD Rate Per Visit (C1 divided by C2)	$308.73
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$343.51
3. Medicaid Trend Adjustment	($179.55)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Santa Rosa County Health Department
Audit Status: **Unaudited Cost**
Provider Number: 0279676
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$840,417.00
2. Total Non-Allowable Costs	$3,913,517.00
3. Total Overhead Costs	$1,310,398.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,064,332.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,819,299.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,310,398.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$840,417.00
2. Total Non-Allowable Costs	$3,913,517.00
3. Sum of Lines B1 and B2	$4,753,934.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1768
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$231,678.37
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,072,095.37
2. Total CHD Visits	4,196
3. CHD Rate Per Visit (C1 divided by C2)	$255.50
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$284.29
3. Medicaid Trend Adjustment	($120.33)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Sarasota County Health Department
Provider Number: 0279684

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,433,578.00
2. Total Non-Allowable Costs	$16,131,118.00
3. Total Overhead Costs	$4,286,071.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$22,850,767.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$6,855,230.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$4,286,071.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,433,578.00
2. Total Non-Allowable Costs	$16,131,118.00
3. Sum of Lines B1 and B2	$18,564,696.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1311
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$561,903.91
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,995,481.91
2. Total CHD Visits	13,270
3. CHD Rate Per Visit (C1 divided by C2)	$225.73
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$251.17
3. Medicaid Trend Adjustment	($87.21)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Seminole County Health Department
Provider Number: 0279692

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,250,961.00
2. Total Non-Allowable Costs	$9,040,766.00
3. Total Overhead Costs	$2,792,472.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$14,084,199.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,225,259.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,792,472.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,250,961.00
2. Total Non-Allowable Costs	$9,040,766.00
3. Sum of Lines B1 and B2	$11,291,727.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1993
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$556,539.67
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,807,500.67
2. Total CHD Visits	8,285
3. CHD Rate Per Visit (C1 divided by C2)	$338.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$377.04
3. Medicaid Trend Adjustment	($213.08)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Sumter County Health Department
Provider Number: 0279706

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$609,023.00
2. Total Non-Allowable Costs	$2,617,618.00
3. Total Overhead Costs	$841,699.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,068,340.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,220,502.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$841,699.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$609,023.00
2. Total Non-Allowable Costs	$2,617,618.00
3. Sum of Lines B1 and B2	$3,226,641.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1887
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$158,828.60
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$767,851.60
2. Total CHD Visits	1,855
3. CHD Rate Per Visit (C1 divided by C2)	$413.94
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$460.57
3. Medicaid Trend Adjustment	($296.61)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Taylor County Health Department
Provider Number: 0279722

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$528,443.00
2. Total Non-Allowable Costs	$1,271,086.00
3. Total Overhead Costs	$377,874.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,177,403.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$653,220.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$377,874.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$528,443.00
2. Total Non-Allowable Costs	$1,271,086.00
3. Sum of Lines B1 and B2	$1,799,529.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2937
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$110,981.59
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$639,424.59
2. Total CHD Visits	3,180
3. CHD Rate Per Visit (C1 divided by C2)	$201.08
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$223.73
3. Medicaid Trend Adjustment	($59.77)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Union County Health Department
Provider Number: 0279731

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,242,183.00
2. Total Non-Allowable Costs	$1,071,319.00
3. Total Overhead Costs	$317,740.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,631,242.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$789,372.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$317,740.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,242,183.00
2. Total Non-Allowable Costs	$1,071,319.00
3. Sum of Lines B1 and B2	$2,313,502.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5369
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$170,594.61
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,412,777.61
2. Total CHD Visits	4,363
3. CHD Rate Per Visit (C1 divided by C2)	$323.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$360.29
3. Medicaid Trend Adjustment	($196.33)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Volusia County Health Department
Provider Number: 0279749

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,229,072.92
2. Total Non-Allowable Costs	$11,015,708.08
3. Total Overhead Costs	$5,160,417.02
4. Total Costs (Sum of Lines A1 , A2 and A3)	$20,405,198.02
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$6,121,559.41
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,160,417.02
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,229,072.92
2. Total Non-Allowable Costs	$11,015,708.08
3. Sum of Lines B1 and B2	$15,244,781.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2774
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,431,499.68
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,660,572.60
2. Total CHD Visits	21,314
3. CHD Rate Per Visit (C1 divided by C2)	$265.58
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$295.50
3. Medicaid Trend Adjustment	($131.54)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Wakulla County Health Department
Provider Number: 0279757

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$473,663.00
2. Total Non-Allowable Costs	$1,703,115.00
3. Total Overhead Costs	$486,334.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,663,112.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$798,933.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$486,334.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$473,663.00
2. Total Non-Allowable Costs	$1,703,115.00
3. Sum of Lines B1 and B2	$2,176,778.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2176
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$105,826.28
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$579,489.28
2. Total CHD Visits	2,560
3. CHD Rate Per Visit (C1 divided by C2)	$226.36
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$251.87
3. Medicaid Trend Adjustment	($87.91)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Washington County Health Department
Provider Number: 0279773

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$765,516.00
2. Total Non-Allowable Costs	$1,156,710.00
3. Total Overhead Costs	$572,938.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,495,164.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$748,549.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$572,938.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$765,516.00
2. Total Non-Allowable Costs	$1,156,710.00
3. Sum of Lines B1 and B2	$1,922,226.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3982
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$228,143.91
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$993,659.91
2. Total CHD Visits	5,097
3. CHD Rate Per Visit (C1 divided by C2)	$194.95
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$216.91
3. Medicaid Trend Adjustment	($52.95)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Bay County Health Department
Provider Number: 0290068

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,121,351.00
2. Total Non-Allowable Costs	$5,433,061.00
3. Total Overhead Costs	$2,890,163.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,444,575.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,133,372.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,890,163.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,121,351.00
2. Total Non-Allowable Costs	$5,433,061.00
3. Sum of Lines B1 and B2	$7,554,412.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2808
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$811,557.77
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,932,908.77
2. Total CHD Visits	20,315
3. CHD Rate Per Visit (C1 divided by C2)	$144.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$160.64
3. Medicaid Trend Adjustment	($14.32)
4. Final Prospective Rate - Effective Date: 07/01/2022	$146.32

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Lafayette County Health Department
Provider Number: 0290343

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$242,782.00
2. Total Non-Allowable Costs	$555,318.00
3. Total Overhead Costs	$293,356.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,091,456.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$327,436.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$293,356.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$242,782.00
2. Total Non-Allowable Costs	$555,318.00
3. Sum of Lines B1 and B2	$798,100.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3042
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$89,238.90
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$332,020.90
2. Total CHD Visits	1,041
3. CHD Rate Per Visit (C1 divided by C2)	$318.94
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$354.88
3. Medicaid Trend Adjustment	($190.92)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Madison County Health Department
Provider Number: 0290408

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$331,096.00
2. Total Non-Allowable Costs	$1,415,977.00
3. Total Overhead Costs	$316,359.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,063,432.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$619,029.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$316,359.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$331,096.00
2. Total Non-Allowable Costs	$1,415,977.00
3. Sum of Lines B1 and B2	$1,747,073.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1895
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$59,950.03
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$391,046.03
2. Total CHD Visits	1,201
3. CHD Rate Per Visit (C1 divided by C2)	$325.60
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$362.29
3. Medicaid Trend Adjustment	($198.33)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Suwannee County Health Department
Provider Number: 0518328

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$474,453.00
2. Total Non-Allowable Costs	$1,188,570.00
3. Total Overhead Costs	$498,812.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,161,835.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$648,550.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$498,812.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$474,453.00
2. Total Non-Allowable Costs	$1,188,570.00
3. Sum of Lines B1 and B2	$1,663,023.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2853
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$142,311.06
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$616,764.06
2. Total CHD Visits	3,281
3. CHD Rate Per Visit (C1 divided by C2)	$187.98
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$209.16
3. Medicaid Trend Adjustment	($45.20)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Holmes County Health Department
Provider Number: 0519022

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$545,508.00
2. Total Non-Allowable Costs	$1,214,386.00
3. Total Overhead Costs	$513,079.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,272,973.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$681,891.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$513,079.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$545,508.00
2. Total Non-Allowable Costs	$1,214,386.00
3. Sum of Lines B1 and B2	$1,759,894.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3100
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$159,054.49
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$704,562.49
2. Total CHD Visits	4,999
3. CHD Rate Per Visit (C1 divided by C2)	$140.94
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$156.82
3. Medicaid Trend Adjustment	($13.98)
4. Final Prospective Rate - Effective Date: 07/01/2022	$142.84

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Brevard County Heath Department
Audit Status: **Unaudited Cost**
Provider Number: 0519251
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$5,513,796.00
2. Total Non-Allowable Costs	$12,291,009.00
3. Total Overhead Costs	$2,432,813.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$20,237,618.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$6,071,285.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,432,813.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$5,513,796.00
2. Total Non-Allowable Costs	$12,291,009.00
3. Sum of Lines B1 and B2	$17,804,805.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3097
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$753,442.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$6,267,238.19
2. Total CHD Visits	29,210
3. CHD Rate Per Visit (C1 divided by C2)	$214.56
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$238.73
3. Medicaid Trend Adjustment	($74.77)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Palm Beach County Health Department
Provider Number: 0520331

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$18,453,974.00
2. Total Non-Allowable Costs	$39,891,397.00
3. Total Overhead Costs	$12,770,376.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$71,115,747.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$21,334,724.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$12,770,376.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$18,453,974.00
2. Total Non-Allowable Costs	$39,891,397.00
3. Sum of Lines B1 and B2	$58,345,371.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3163
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,039,269.93
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$22,493,243.93
2. Total CHD Visits	51,364
3. CHD Rate Per Visit (C1 divided by C2)	$437.92
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$487.26
3. Medicaid Trend Adjustment	($323.30)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Charlotte County Health Department
Provider Number: 0520446

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$875,348.00
2. Total Non-Allowable Costs	$3,980,638.00
3. Total Overhead Costs	$1,438,564.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,294,550.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,888,365.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,438,564.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$875,348.00
2. Total Non-Allowable Costs	$3,980,638.00
3. Sum of Lines B1 and B2	$4,855,986.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1803
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$259,373.09
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,134,721.09
2. Total CHD Visits	6,319
3. CHD Rate Per Visit (C1 divided by C2)	$179.57
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$199.81
3. Medicaid Trend Adjustment	($35.85)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Hillsborough County Health Department
Provider Number: 0557269

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$10,844,719.00
2. Total Non-Allowable Costs	$32,392,300.00
3. Total Overhead Costs	$2,408,570.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$45,645,589.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$13,693,676.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,408,570.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$10,844,719.00
2. Total Non-Allowable Costs	$32,392,300.00
3. Sum of Lines B1 and B2	$43,237,019.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2508
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$604,069.36
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$11,448,788.36
2. Total CHD Visits	16,556
3. CHD Rate Per Visit (C1 divided by C2)	$691.52
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$769.43
3. Medicaid Trend Adjustment	($605.47)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Lake County Health Department
Provider Number: 0563234

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,071,089.00
2. Total Non-Allowable Costs	$6,022,499.00
3. Total Overhead Costs	$2,294,938.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,388,526.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,816,557.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,294,938.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,071,089.00
2. Total Non-Allowable Costs	$6,022,499.00
3. Sum of Lines B1 and B2	$7,093,588.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1510
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$346,535.64
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,417,624.64
2. Total CHD Visits	5,130
3. CHD Rate Per Visit (C1 divided by C2)	$276.34
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$307.47
3. Medicaid Trend Adjustment	($143.51)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2022 Through 06/30/2023

Provider Name: Escambia County Health Department
Provider Number: 0600181

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2020 Through 06/30/2021

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,489,294.00
2. Total Non-Allowable Costs	$8,215,681.00
3. Total Overhead Costs	$2,799,007.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,503,982.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,051,194.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,799,007.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,489,294.00
2. Total Non-Allowable Costs	$8,215,681.00
3. Sum of Lines B1 and B2	$10,704,975.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2325
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$650,769.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,140,063.13
2. Total CHD Visits	9,205
3. CHD Rate Per Visit (C1 divided by C2)	$341.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.11267
2. CHD Prospective Rate (C3 Multiplied by D1)	$379.56
3. Medicaid Trend Adjustment	($215.60)
4. Final Prospective Rate - Effective Date: 07/01/2022	$163.96