

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Alachua County Health Department

Audit Status:

Unaudited Cost

Provider Number: 0279111

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$4,817,033.00
2. Total Non-Allowable Costs	\$13,592,563.00
3. Total Overhead Costs	\$3,328,655.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$21,738,251.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$6,521,475.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$3,328,655.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$4,817,033.00
2. Total Non-Allowable Costs	\$13,592,563.00
3. Sum of Lines B1 and B2	\$18,409,596.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2617
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$871,109.01
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$5,688,142.01
2. Total CHD Visits	23,545
3. CHD Rate Per Visit (C1 divided by C2)	\$241.59
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$266.54
3. Medicaid Trend Adjustment	(\$103.27)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Baker County Health Department
 Provider Number: 0279129

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,197,878.00
2. Total Non-Allowable Costs	\$1,492,747.00
3. Total Overhead Costs	\$1,019,042.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$3,709,667.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,112,900.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,019,042.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,197,878.00
2. Total Non-Allowable Costs	\$1,492,747.00
3. Sum of Lines B1 and B2	\$2,690,625.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4452
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$453,677.50
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,651,555.50
2. Total CHD Visits	7,120
3. CHD Rate Per Visit (C1 divided by C2)	\$231.96
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$255.92
3. Medicaid Trend Adjustment	(\$92.65)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Bradford County Health Department
 Provider Number: 0279145

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,547,457.00
2. Total Non-Allowable Costs	\$1,137,671.00
3. Total Overhead Costs	\$477,005.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$3,162,133.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$948,639.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$477,005.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,547,457.00
2. Total Non-Allowable Costs	\$1,137,671.00
3. Sum of Lines B1 and B2	\$2,685,128.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5763
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$274,897.98
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,822,354.98
2. Total CHD Visits	8,377
3. CHD Rate Per Visit (C1 divided by C2)	\$217.54
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$240.01
3. Medicaid Trend Adjustment	(\$76.74)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Broward County Health Department
 Provider Number: 0279161

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$7,653,619.00
2. Total Non-Allowable Costs	\$79,162,432.00
3. Total Overhead Costs	\$13,106,740.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$99,922,791.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$29,976,837.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$13,106,740.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$7,653,619.00
2. Total Non-Allowable Costs	\$79,162,432.00
3. Sum of Lines B1 and B2	\$86,816,051.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.0882
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$1,156,014.47
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$8,809,633.47
2. Total CHD Visits	26,870
3. CHD Rate Per Visit (C1 divided by C2)	\$327.86
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$361.72
3. Medicaid Trend Adjustment	(\$198.45)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Calhoun County Health Department
 Provider Number: 0279170

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$546,109.00
2. Total Non-Allowable Costs	\$1,025,816.00
3. Total Overhead Costs	\$140,471.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$1,712,396.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$513,718.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$140,471.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$546,109.00
2. Total Non-Allowable Costs	\$1,025,816.00
3. Sum of Lines B1 and B2	\$1,571,925.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3474
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$48,799.63
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$594,908.63
2. Total CHD Visits	1,663
3. CHD Rate Per Visit (C1 divided by C2)	\$357.73
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$394.68
3. Medicaid Trend Adjustment	(\$231.41)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Citrus County Health Department
 Provider Number: 0279196

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,563,728.00
2. Total Non-Allowable Costs	\$3,955,884.00
3. Total Overhead Costs	\$1,311,482.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$6,831,094.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$2,049,328.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,311,482.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,563,728.00
2. Total Non-Allowable Costs	\$3,955,884.00
3. Sum of Lines B1 and B2	\$5,519,612.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2833
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$371,542.85
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,935,270.85
2. Total CHD Visits	4,951
3. CHD Rate Per Visit (C1 divided by C2)	\$390.88
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$431.25
3. Medicaid Trend Adjustment	(\$267.98)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Clay County Health Department
 Provider Number: 0279200

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,000,371.00
2. Total Non-Allowable Costs	\$3,883,985.00
3. Total Overhead Costs	\$1,111,286.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$5,995,642.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,798,692.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,111,286.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,000,371.00
2. Total Non-Allowable Costs	\$3,883,985.00
3. Sum of Lines B1 and B2	\$4,884,356.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2048
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$227,591.37
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,227,962.37
2. Total CHD Visits	10,500
3. CHD Rate Per Visit (C1 divided by C2)	\$116.95
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$129.03
3. Medicaid Trend Adjustment	(\$11.99)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$117.04

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Collier County Health Department
 Provider Number: 0279218

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$3,133,053.00
2. Total Non-Allowable Costs	\$8,137,852.00
3. Total Overhead Costs	\$2,265,759.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$13,536,664.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$4,060,999.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,265,759.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$3,133,053.00
2. Total Non-Allowable Costs	\$8,137,852.00
3. Sum of Lines B1 and B2	\$11,270,905.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2780
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$629,881.00
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$3,762,934.00
2. Total CHD Visits	14,377
3. CHD Rate Per Visit (C1 divided by C2)	\$261.73
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$288.76
3. Medicaid Trend Adjustment	(\$125.49)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Columbia County Health Department
 Provider Number: 0279226

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$838,591.00
2. Total Non-Allowable Costs	\$1,751,056.00
3. Total Overhead Costs	\$513,713.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$3,103,360.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$931,008.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$513,713.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$838,591.00
2. Total Non-Allowable Costs	\$1,751,056.00
3. Sum of Lines B1 and B2	\$2,589,647.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3238
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$166,340.27
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,004,931.27
2. Total CHD Visits	3,303
3. CHD Rate Per Visit (C1 divided by C2)	\$304.25
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$335.67
3. Medicaid Trend Adjustment	(\$172.40)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Dade County Health Department
 Provider Number: 0279234

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$20,860,560.00
2. Total Non-Allowable Costs	\$61,049,676.00
3. Total Overhead Costs	\$10,141,660.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$92,051,896.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$27,615,568.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$10,141,660.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$20,860,560.00
2. Total Non-Allowable Costs	\$61,049,676.00
3. Sum of Lines B1 and B2	\$81,910,236.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2547
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$2,583,080.80
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$23,443,640.80
2. Total CHD Visits	61,428
3. CHD Rate Per Visit (C1 divided by C2)	\$381.64
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$421.06
3. Medicaid Trend Adjustment	(\$257.79)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: DeSoto County Health Department
 Provider Number: 0279242

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$2,703,760.00
2. Total Non-Allowable Costs	\$3,171,016.00
3. Total Overhead Costs	\$456,543.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$6,331,319.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,899,395.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$456,543.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$2,703,760.00
2. Total Non-Allowable Costs	\$3,171,016.00
3. Sum of Lines B1 and B2	\$5,874,776.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4602
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$210,101.09
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,913,861.09
2. Total CHD Visits	17,745
3. CHD Rate Per Visit (C1 divided by C2)	\$164.21
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$181.17
3. Medicaid Trend Adjustment	(\$17.90)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Dixie County Health Department
 Provider Number: 0279251

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$326,451.00
2. Total Non-Allowable Costs	\$796,914.00
3. Total Overhead Costs	\$317,204.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$1,440,569.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$432,170.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$317,204.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$326,451.00
2. Total Non-Allowable Costs	\$796,914.00
3. Sum of Lines B1 and B2	\$1,123,365.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2906
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$92,179.48
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$418,630.48
2. Total CHD Visits	1,544
3. CHD Rate Per Visit (C1 divided by C2)	\$271.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$299.13
3. Medicaid Trend Adjustment	(\$135.86)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Duval County Health Department
 Provider Number: 0279269

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$7,874,284.00
2. Total Non-Allowable Costs	\$17,860,782.00
3. Total Overhead Costs	\$7,690,491.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$33,425,557.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$10,027,667.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$7,690,491.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$7,874,284.00
2. Total Non-Allowable Costs	\$17,860,782.00
3. Sum of Lines B1 and B2	\$25,735,066.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3060
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$2,353,290.25
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$10,227,574.25
2. Total CHD Visits	30,828
3. CHD Rate Per Visit (C1 divided by C2)	\$331.76
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$366.03
3. Medicaid Trend Adjustment	(\$202.76)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Flagler County Health Department
 Provider Number: 0279285

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,893,101.00
2. Total Non-Allowable Costs	\$2,639,275.00
3. Total Overhead Costs	\$756,578.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$5,288,954.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,586,686.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$756,578.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,893,101.00
2. Total Non-Allowable Costs	\$2,639,275.00
3. Sum of Lines B1 and B2	\$4,532,376.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4177
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$316,022.63
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,209,123.63
2. Total CHD Visits	11,790
3. CHD Rate Per Visit (C1 divided by C2)	\$187.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$206.72
3. Medicaid Trend Adjustment	(\$43.45)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Franklin County Health Department
 Provider Number: 0279293

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$400,920.00
2. Total Non-Allowable Costs	\$1,492,614.00
3. Total Overhead Costs	\$520,008.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,413,542.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$724,062.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$520,008.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$400,920.00
2. Total Non-Allowable Costs	\$1,492,614.00
3. Sum of Lines B1 and B2	\$1,893,534.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2117
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$110,085.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$511,005.69
2. Total CHD Visits	2,135
3. CHD Rate Per Visit (C1 divided by C2)	\$239.35
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$264.07
3. Medicaid Trend Adjustment	(\$100.80)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Gadsden County Health Department
 Provider Number: 0279307

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$800,655.00
2. Total Non-Allowable Costs	\$2,812,937.00
3. Total Overhead Costs	\$833,929.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$4,447,521.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,334,256.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$833,929.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$800,655.00
2. Total Non-Allowable Costs	\$2,812,937.00
3. Sum of Lines B1 and B2	\$3,613,592.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2216
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$184,798.67
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$985,453.67
2. Total CHD Visits	6,475
3. CHD Rate Per Visit (C1 divided by C2)	\$152.19
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$167.91
3. Medicaid Trend Adjustment	(\$15.60)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$152.31

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Gilchrist County Health Department
 Provider Number: 0279315

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$477,102.00
2. Total Non-Allowable Costs	\$746,012.00
3. Total Overhead Costs	\$234,180.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$1,457,294.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$437,188.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$234,180.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$477,102.00
2. Total Non-Allowable Costs	\$746,012.00
3. Sum of Lines B1 and B2	\$1,223,114.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3901
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$91,353.62
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$568,455.62
2. Total CHD Visits	3,076
3. CHD Rate Per Visit (C1 divided by C2)	\$184.80
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$203.89
3. Medicaid Trend Adjustment	(\$40.62)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Glades County Health Department
 Provider Number: 0279323

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$315,637.00
2. Total Non-Allowable Costs	\$606,863.00
3. Total Overhead Costs	\$337,157.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$1,259,657.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$377,897.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$337,157.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$315,637.00
2. Total Non-Allowable Costs	\$606,863.00
3. Sum of Lines B1 and B2	\$922,500.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3422
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$115,375.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$431,012.13
2. Total CHD Visits	10,920
3. CHD Rate Per Visit (C1 divided by C2)	\$39.47
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$43.55
3. Medicaid Trend Adjustment	(\$4.05)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$39.50

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Gulf County Health Department
 Provider Number: 0279331

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$296,573.00
2. Total Non-Allowable Costs	\$1,414,824.00
3. Total Overhead Costs	\$850,366.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,561,763.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$768,528.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$768,528.90
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$296,573.00
2. Total Non-Allowable Costs	\$1,414,824.00
3. Sum of Lines B1 and B2	\$1,711,397.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1733
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$133,186.06
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$429,759.06
2. Total CHD Visits	1,960
3. CHD Rate Per Visit (C1 divided by C2)	\$219.26
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$241.91
3. Medicaid Trend Adjustment	(\$78.64)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Hamilton County Health Department
 Provider Number: 0279340

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$532,818.00
2. Total Non-Allowable Costs	\$490,559.00
3. Total Overhead Costs	\$231,247.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$1,254,624.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$376,387.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$231,247.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$532,818.00
2. Total Non-Allowable Costs	\$490,559.00
3. Sum of Lines B1 and B2	\$1,023,377.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5206
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$120,387.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$653,205.19
2. Total CHD Visits	3,942
3. CHD Rate Per Visit (C1 divided by C2)	\$165.70
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$182.82
3. Medicaid Trend Adjustment	(\$19.55)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Hardee County Health Department
 Provider Number: 0279358

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$294,981.00
2. Total Non-Allowable Costs	\$1,450,163.00
3. Total Overhead Costs	\$471,032.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,216,176.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$664,852.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$471,032.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$294,981.00
2. Total Non-Allowable Costs	\$1,450,163.00
3. Sum of Lines B1 and B2	\$1,745,144.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1690
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$79,604.41
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$374,585.41
2. Total CHD Visits	2,351
3. CHD Rate Per Visit (C1 divided by C2)	\$159.33
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$175.78
3. Medicaid Trend Adjustment	(\$16.33)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$159.45

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Hendry County Health Department
 Provider Number: 0279366

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,739,618.00
2. Total Non-Allowable Costs	\$2,709,199.00
3. Total Overhead Costs	\$1,047,807.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$5,496,624.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,648,987.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,047,807.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,739,618.00
2. Total Non-Allowable Costs	\$2,709,199.00
3. Sum of Lines B1 and B2	\$4,448,817.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3910
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$409,692.54
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,149,310.54
2. Total CHD Visits	13,118
3. CHD Rate Per Visit (C1 divided by C2)	\$163.84
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$180.77
3. Medicaid Trend Adjustment	(\$17.50)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Hernando County Health Department
 Provider Number: 0279374

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,385,840.00
2. Total Non-Allowable Costs	\$3,058,307.00
3. Total Overhead Costs	\$2,222,481.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$6,666,628.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,999,988.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,999,988.40
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,385,840.00
2. Total Non-Allowable Costs	\$3,058,307.00
3. Sum of Lines B1 and B2	\$4,444,147.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3118
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$623,596.38
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,009,436.38
2. Total CHD Visits	6,685
3. CHD Rate Per Visit (C1 divided by C2)	\$300.59
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$331.63
3. Medicaid Trend Adjustment	(\$168.36)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Highlands County Health Department
 Provider Number: 0279382

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,092,863.00
2. Total Non-Allowable Costs	\$2,704,488.00
3. Total Overhead Costs	\$914,216.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$4,711,567.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,413,470.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$914,216.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,092,863.00
2. Total Non-Allowable Costs	\$2,704,488.00
3. Sum of Lines B1 and B2	\$3,797,351.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2878
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$263,111.36
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,355,974.36
2. Total CHD Visits	5,216
3. CHD Rate Per Visit (C1 divided by C2)	\$259.96
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$286.81
3. Medicaid Trend Adjustment	(\$123.54)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

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

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$954,027.00
2. Total Non-Allowable Costs	\$4,198,178.00
3. Total Overhead Costs	\$1,682,274.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$6,834,479.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$2,050,343.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,682,274.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$954,027.00
2. Total Non-Allowable Costs	\$4,198,178.00
3. Sum of Lines B1 and B2	\$5,152,205.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1852
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$311,557.14
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,265,584.14
2. Total CHD Visits	4,445
3. CHD Rate Per Visit (C1 divided by C2)	\$284.72
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$314.13
3. Medicaid Trend Adjustment	(\$150.86)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Jackson County Health Department
 Provider Number: 0279421

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,114,624.00
2. Total Non-Allowable Costs	\$3,379,261.00
3. Total Overhead Costs	\$980,836.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$5,474,721.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,642,416.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$980,836.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,114,624.00
2. Total Non-Allowable Costs	\$3,379,261.00
3. Sum of Lines B1 and B2	\$4,493,885.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2480
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$243,247.33
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,357,871.33
2. Total CHD Visits	5,099
3. CHD Rate Per Visit (C1 divided by C2)	\$266.30
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$293.80
3. Medicaid Trend Adjustment	(\$130.53)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Jefferson County Health Department
 Provider Number: 0279439

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$506,989.00
2. Total Non-Allowable Costs	\$1,344,947.00
3. Total Overhead Costs	\$274,998.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,126,934.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$638,080.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$274,998.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$506,989.00
2. Total Non-Allowable Costs	\$1,344,947.00
3. Sum of Lines B1 and B2	\$1,851,936.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2738
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$75,294.45
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$582,283.45
2. Total CHD Visits	1,948
3. CHD Rate Per Visit (C1 divided by C2)	\$298.91
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$329.78
3. Medicaid Trend Adjustment	(\$166.51)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Lee County Health Department
 Provider Number: 0279463

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$3,271,208.00
2. Total Non-Allowable Costs	\$12,772,505.00
3. Total Overhead Costs	\$3,916,669.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$19,960,382.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$5,988,114.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$3,916,669.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$3,271,208.00
2. Total Non-Allowable Costs	\$12,772,505.00
3. Sum of Lines B1 and B2	\$16,043,713.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2039
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$798,608.81
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$4,069,816.81
2. Total CHD Visits	8,050
3. CHD Rate Per Visit (C1 divided by C2)	\$505.57
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$557.78
3. Medicaid Trend Adjustment	(\$394.51)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Leon County Health Department
 Provider Number: 0279471

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$2,674,189.00
2. Total Non-Allowable Costs	\$8,357,638.00
3. Total Overhead Costs	\$1,952,081.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$12,983,908.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$3,895,172.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,952,081.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$2,674,189.00
2. Total Non-Allowable Costs	\$8,357,638.00
3. Sum of Lines B1 and B2	\$11,031,827.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2424
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$473,184.43
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$3,147,373.43
2. Total CHD Visits	17,140
3. CHD Rate Per Visit (C1 divided by C2)	\$183.63
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$202.59
3. Medicaid Trend Adjustment	(\$39.32)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Levy County Health Department
 Provider Number: 0279480

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,061,283.00
2. Total Non-Allowable Costs	\$1,755,029.00
3. Total Overhead Costs	\$487,804.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$3,304,116.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$991,234.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$487,804.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,061,283.00
2. Total Non-Allowable Costs	\$1,755,029.00
3. Sum of Lines B1 and B2	\$2,816,312.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3768
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$183,804.55
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,245,087.55
2. Total CHD Visits	3,504
3. CHD Rate Per Visit (C1 divided by C2)	\$355.33
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$392.03
3. Medicaid Trend Adjustment	(\$228.76)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Liberty County Health Department
 Provider Number: 0279498

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$395,008.00
2. Total Non-Allowable Costs	\$805,688.00
3. Total Overhead Costs	\$177,734.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$1,378,430.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$413,529.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$177,734.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$395,008.00
2. Total Non-Allowable Costs	\$805,688.00
3. Sum of Lines B1 and B2	\$1,200,696.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3290
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$58,474.49
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$453,482.49
2. Total CHD Visits	1,399
3. CHD Rate Per Visit (C1 divided by C2)	\$324.15
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$357.62
3. Medicaid Trend Adjustment	(\$194.35)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Manatee County Health Department
 Provider Number: 0279510

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,616,356.00
2. Total Non-Allowable Costs	\$9,088,607.00
3. Total Overhead Costs	\$2,601,085.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$13,306,048.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$3,991,814.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,601,085.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,616,356.00
2. Total Non-Allowable Costs	\$9,088,607.00
3. Sum of Lines B1 and B2	\$10,704,963.00
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)	\$392,763.84
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,009,119.84
2. Total CHD Visits	11,725
3. CHD Rate Per Visit (C1 divided by C2)	\$171.35
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$189.05
3. Medicaid Trend Adjustment	(\$25.78)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Marion County Health Department
 Provider Number: 0279528

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$3,086,830.00
2. Total Non-Allowable Costs	\$8,182,986.00
3. Total Overhead Costs	\$2,717,397.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$13,987,213.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$4,196,163.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,717,397.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$3,086,830.00
2. Total Non-Allowable Costs	\$8,182,986.00
3. Sum of Lines B1 and B2	\$11,269,816.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2739
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$744,295.04
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$3,831,125.04
2. Total CHD Visits	10,101
3. CHD Rate Per Visit (C1 divided by C2)	\$379.28
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$418.45
3. Medicaid Trend Adjustment	(\$255.18)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Martin County Health Department
 Provider Number: 0279536

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$784,636.00
2. Total Non-Allowable Costs	\$3,912,940.00
3. Total Overhead Costs	\$1,952,570.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$6,650,146.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,995,043.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,952,570.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$784,636.00
2. Total Non-Allowable Costs	\$3,912,940.00
3. Sum of Lines B1 and B2	\$4,697,576.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1670
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$326,079.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,110,715.19
2. Total CHD Visits	4,601
3. CHD Rate Per Visit (C1 divided by C2)	\$241.41
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$266.34
3. Medicaid Trend Adjustment	(\$103.07)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Monroe County Health Department
 Provider Number: 0279544

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,765,898.00
2. Total Non-Allowable Costs	\$4,341,409.00
3. Total Overhead Costs	\$1,972,383.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$8,079,690.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$2,423,907.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,972,383.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,765,898.00
2. Total Non-Allowable Costs	\$4,341,409.00
3. Sum of Lines B1 and B2	\$6,107,307.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2891
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$570,215.93
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,336,113.93
2. Total CHD Visits	7,665
3. CHD Rate Per Visit (C1 divided by C2)	\$304.78
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$336.25
3. Medicaid Trend Adjustment	(\$172.98)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Nassau County Health Department
 Provider Number: 0279552

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,117,881.00
2. Total Non-Allowable Costs	\$3,336,373.00
3. Total Overhead Costs	\$1,097,797.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$5,552,051.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,665,615.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,097,797.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,117,881.00
2. Total Non-Allowable Costs	\$3,336,373.00
3. Sum of Lines B1 and B2	\$4,454,254.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2510
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$275,547.05
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,393,428.05
2. Total CHD Visits	9,071
3. CHD Rate Per Visit (C1 divided by C2)	\$153.61
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$169.48
3. Medicaid Trend Adjustment	(\$15.75)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$153.73

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Okaloosa County Health Department
 Provider Number: 0279561

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,949,609.00
2. Total Non-Allowable Costs	\$6,044,261.00
3. Total Overhead Costs	\$2,915,456.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$10,909,326.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$3,272,797.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,915,456.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,949,609.00
2. Total Non-Allowable Costs	\$6,044,261.00
3. Sum of Lines B1 and B2	\$7,993,870.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2439
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$711,079.72
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,660,688.72
2. Total CHD Visits	12,461
3. CHD Rate Per Visit (C1 divided by C2)	\$213.52
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$235.57
3. Medicaid Trend Adjustment	(\$72.30)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Okeechobee County Health Department
 Provider Number: 0279579

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$410,923.00
2. Total Non-Allowable Costs	\$2,021,135.00
3. Total Overhead Costs	\$719,972.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$3,152,030.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$945,609.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$719,972.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$410,923.00
2. Total Non-Allowable Costs	\$2,021,135.00
3. Sum of Lines B1 and B2	\$2,432,058.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1690
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$121,675.27
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$532,598.27
2. Total CHD Visits	3,969
3. CHD Rate Per Visit (C1 divided by C2)	\$134.19
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$148.05
3. Medicaid Trend Adjustment	(\$13.76)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$134.29

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Orange County Health Department
 Provider Number: 0279587

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$10,792,926.00
2. Total Non-Allowable Costs	\$25,793,039.00
3. Total Overhead Costs	\$6,968,894.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$43,554,859.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$13,066,457.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$6,968,894.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$10,792,926.00
2. Total Non-Allowable Costs	\$25,793,039.00
3. Sum of Lines B1 and B2	\$36,585,965.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2950
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$2,055,823.73
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$12,848,749.73
2. Total CHD Visits	28,610
3. CHD Rate Per Visit (C1 divided by C2)	\$449.10
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$495.48
3. Medicaid Trend Adjustment	(\$332.21)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Osceola County Health Department
 Provider Number: 0279595

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,955,208.00
2. Total Non-Allowable Costs	\$7,051,742.00
3. Total Overhead Costs	\$2,177,622.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$11,184,572.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$3,355,371.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,177,622.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,955,208.00
2. Total Non-Allowable Costs	\$7,051,742.00
3. Sum of Lines B1 and B2	\$9,006,950.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2171
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$472,761.74
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,427,969.74
2. Total CHD Visits	7,945
3. CHD Rate Per Visit (C1 divided by C2)	\$305.60
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$337.16
3. Medicaid Trend Adjustment	(\$173.89)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Pasco County Health Department
 Provider Number: 0279617

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$2,533,083.00
2. Total Non-Allowable Costs	\$7,374,812.00
3. Total Overhead Costs	\$2,946,945.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$12,854,840.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$3,856,452.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,946,945.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$2,533,083.00
2. Total Non-Allowable Costs	\$7,374,812.00
3. Sum of Lines B1 and B2	\$9,907,895.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2557
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$753,533.84
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$3,286,616.84
2. Total CHD Visits	11,900
3. CHD Rate Per Visit (C1 divided by C2)	\$276.19
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$304.71
3. Medicaid Trend Adjustment	(\$141.44)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Pinellas County Health Department
 Provider Number: 0279625

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$16,456,594.00
2. Total Non-Allowable Costs	\$31,037,911.00
3. Total Overhead Costs	\$10,014,272.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$57,508,777.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$17,252,633.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$10,014,272.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$16,456,594.00
2. Total Non-Allowable Costs	\$31,037,911.00
3. Sum of Lines B1 and B2	\$47,494,505.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3465
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$3,469,945.25
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$19,926,539.25
2. Total CHD Visits	86,780
3. CHD Rate Per Visit (C1 divided by C2)	\$229.62
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$253.34
3. Medicaid Trend Adjustment	(\$90.07)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Polk County Health Department
 Provider Number: 0279633

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$8,844,286.00
2. Total Non-Allowable Costs	\$19,755,689.00
3. Total Overhead Costs	\$4,083,919.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$32,683,894.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$9,805,168.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$4,083,919.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$8,844,286.00
2. Total Non-Allowable Costs	\$19,755,689.00
3. Sum of Lines B1 and B2	\$28,599,975.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3092
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$1,262,747.75
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$10,107,033.75
2. Total CHD Visits	35,041
3. CHD Rate Per Visit (C1 divided by C2)	\$288.43
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$318.22
3. Medicaid Trend Adjustment	(\$154.95)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Putnam County Health Department
 Provider Number: 0279641

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,863,639.00
2. Total Non-Allowable Costs	\$2,053,465.00
3. Total Overhead Costs	\$1,111,054.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$5,028,158.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,508,447.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,111,054.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,863,639.00
2. Total Non-Allowable Costs	\$2,053,465.00
3. Sum of Lines B1 and B2	\$3,917,104.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4758
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$528,639.49
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,392,278.49
2. Total CHD Visits	11,013
3. CHD Rate Per Visit (C1 divided by C2)	\$217.22
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$239.66
3. Medicaid Trend Adjustment	(\$76.39)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

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

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,409,100.00
2. Total Non-Allowable Costs	\$4,064,877.00
3. Total Overhead Costs	\$1,030,588.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$6,504,565.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,951,369.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,030,588.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,409,100.00
2. Total Non-Allowable Costs	\$4,064,877.00
3. Sum of Lines B1 and B2	\$5,473,977.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2574
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$265,273.35
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,674,373.35
2. Total CHD Visits	1,232
3. CHD Rate Per Visit (C1 divided by C2)	\$1,359.07
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$1499.43
3. Medicaid Trend Adjustment	(\$1336.16)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

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

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$4,546,455.00
2. Total Non-Allowable Costs	\$8,545,985.00
3. Total Overhead Costs	\$2,621,006.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$15,713,446.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$4,714,033.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,621,006.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$4,546,455.00
2. Total Non-Allowable Costs	\$8,545,985.00
3. Sum of Lines B1 and B2	\$13,092,440.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3473
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$910,275.38
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$5,456,730.38
2. Total CHD Visits	17,787
3. CHD Rate Per Visit (C1 divided by C2)	\$306.78
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$338.46
3. Medicaid Trend Adjustment	(\$175.19)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Santa Rosa County Health Department
 Provider Number: 0279676

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$574,905.00
2. Total Non-Allowable Costs	\$3,677,855.00
3. Total Overhead Costs	\$1,521,579.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$5,774,339.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,732,301.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,521,579.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$574,905.00
2. Total Non-Allowable Costs	\$3,677,855.00
3. Sum of Lines B1 and B2	\$4,252,760.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1352
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$205,717.48
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$780,622.48
2. Total CHD Visits	4,018
3. CHD Rate Per Visit (C1 divided by C2)	\$194.28
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$214.35
3. Medicaid Trend Adjustment	(\$51.08)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Sarasota County Health Department
 Provider Number: 0279684

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$3,137,124.00
2. Total Non-Allowable Costs	\$15,738,766.00
3. Total Overhead Costs	\$4,483,003.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$23,358,893.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$7,007,667.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$4,483,003.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$3,137,124.00
2. Total Non-Allowable Costs	\$15,738,766.00
3. Sum of Lines B1 and B2	\$18,875,890.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1662
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$745,075.10
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$3,882,199.10
2. Total CHD Visits	17,147
3. CHD Rate Per Visit (C1 divided by C2)	\$226.41
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$249.79
3. Medicaid Trend Adjustment	(\$86.52)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Seminole County Health Department
 Provider Number: 0279692

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$2,406,126.00
2. Total Non-Allowable Costs	\$8,547,658.00
3. Total Overhead Costs	\$2,794,700.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$13,748,484.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$4,124,545.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,794,700.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$2,406,126.00
2. Total Non-Allowable Costs	\$8,547,658.00
3. Sum of Lines B1 and B2	\$10,953,784.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2197
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$613,995.59
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$3,020,121.59
2. Total CHD Visits	8,205
3. CHD Rate Per Visit (C1 divided by C2)	\$368.08
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$406.10
3. Medicaid Trend Adjustment	(\$242.83)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Sumter County Health Department
 Provider Number: 0279706

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$809,561.00
2. Total Non-Allowable Costs	\$2,042,825.00
3. Total Overhead Costs	\$1,102,027.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$3,954,413.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,186,323.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,102,027.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$809,561.00
2. Total Non-Allowable Costs	\$2,042,825.00
3. Sum of Lines B1 and B2	\$2,852,386.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2838
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$312,755.26
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,122,316.26
2. Total CHD Visits	1,820
3. CHD Rate Per Visit (C1 divided by C2)	\$616.66
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$680.34
3. Medicaid Trend Adjustment	(\$517.07)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Taylor County Health Department
 Provider Number: 0279722

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$368,074.00
2. Total Non-Allowable Costs	\$1,308,069.00
3. Total Overhead Costs	\$354,357.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,030,500.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$609,150.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$354,357.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$368,074.00
2. Total Non-Allowable Costs	\$1,308,069.00
3. Sum of Lines B1 and B2	\$1,676,143.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2196
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$77,816.80
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$445,890.80
2. Total CHD Visits	1,939
3. CHD Rate Per Visit (C1 divided by C2)	\$229.96
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$253.71
3. Medicaid Trend Adjustment	(\$90.44)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Union County Health Department
 Provider Number: 0279731

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,029,876.00
2. Total Non-Allowable Costs	\$1,044,250.00
3. Total Overhead Costs	\$514,360.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,588,486.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$776,545.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$514,360.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,029,876.00
2. Total Non-Allowable Costs	\$1,044,250.00
3. Sum of Lines B1 and B2	\$2,074,126.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4965
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$255,379.74
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,285,255.74
2. Total CHD Visits	5,259
3. CHD Rate Per Visit (C1 divided by C2)	\$244.39
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$269.63
3. Medicaid Trend Adjustment	(\$106.36)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Volusia County Health Department
 Provider Number: 0279749

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$5,312,356.00
2. Total Non-Allowable Costs	\$10,732,933.00
3. Total Overhead Costs	\$4,367,852.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$20,413,141.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$6,123,942.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$4,367,852.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$5,312,356.00
2. Total Non-Allowable Costs	\$10,732,933.00
3. Sum of Lines B1 and B2	\$16,045,289.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3311
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$1,446,195.80
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$6,758,551.80
2. Total CHD Visits	28,450
3. CHD Rate Per Visit (C1 divided by C2)	\$237.56
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$262.09
3. Medicaid Trend Adjustment	(\$98.82)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Wakulla County Health Department
 Provider Number: 0279757

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$569,659.00
2. Total Non-Allowable Costs	\$1,891,491.00
3. Total Overhead Costs	\$512,725.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,973,875.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$892,162.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$512,725.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$569,659.00
2. Total Non-Allowable Costs	\$1,891,491.00
3. Sum of Lines B1 and B2	\$2,461,150.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2315
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$118,695.84
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$688,354.84
2. Total CHD Visits	3,035
3. CHD Rate Per Visit (C1 divided by C2)	\$226.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$250.23
3. Medicaid Trend Adjustment	(\$86.96)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Washington County Health Department
 Provider Number: 0279773

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$844,431.00
2. Total Non-Allowable Costs	\$1,143,086.00
3. Total Overhead Costs	\$600,605.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,588,122.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$776,436.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$600,605.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$844,431.00
2. Total Non-Allowable Costs	\$1,143,086.00
3. Sum of Lines B1 and B2	\$1,987,517.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4249
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$255,197.06
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,099,628.06
2. Total CHD Visits	5,982
3. CHD Rate Per Visit (C1 divided by C2)	\$183.82
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$202.81
3. Medicaid Trend Adjustment	(\$39.54)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Bay County Health Department
 Provider Number: 0290068

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$2,319,938.00
2. Total Non-Allowable Costs	\$5,251,803.00
3. Total Overhead Costs	\$2,523,236.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$10,094,977.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$3,028,493.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,523,236.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$2,319,938.00
2. Total Non-Allowable Costs	\$5,251,803.00
3. Sum of Lines B1 and B2	\$7,571,741.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3064
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$773,119.51
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$3,093,057.51
2. Total CHD Visits	13,052
3. CHD Rate Per Visit (C1 divided by C2)	\$236.98
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$261.45
3. Medicaid Trend Adjustment	(\$98.18)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Lafayette County Health Department
 Provider Number: 0290343

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$291,242.00
2. Total Non-Allowable Costs	\$630,549.00
3. Total Overhead Costs	\$201,009.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$1,122,800.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$336,840.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$201,009.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$291,242.00
2. Total Non-Allowable Costs	\$630,549.00
3. Sum of Lines B1 and B2	\$921,791.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3160
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$63,518.84
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$354,760.84
2. Total CHD Visits	1,945
3. CHD Rate Per Visit (C1 divided by C2)	\$182.40
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$201.23
3. Medicaid Trend Adjustment	(\$37.96)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Madison County Health Department
 Provider Number: 0290408

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$344,401.00
2. Total Non-Allowable Costs	\$1,385,662.00
3. Total Overhead Costs	\$397,436.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,127,499.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$638,249.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$397,436.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$344,401.00
2. Total Non-Allowable Costs	\$1,385,662.00
3. Sum of Lines B1 and B2	\$1,730,063.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1991
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$79,129.51
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$423,530.51
2. Total CHD Visits	1,265
3. CHD Rate Per Visit (C1 divided by C2)	\$334.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$369.38
3. Medicaid Trend Adjustment	(\$206.11)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Suwannee County Health Department
 Provider Number: 0518328

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$500,922.00
2. Total Non-Allowable Costs	\$1,210,186.00
3. Total Overhead Costs	\$438,943.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,150,051.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$645,015.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$438,943.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$500,922.00
2. Total Non-Allowable Costs	\$1,210,186.00
3. Sum of Lines B1 and B2	\$1,711,108.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2927
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$128,478.62
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$629,400.62
2. Total CHD Visits	4,643
3. CHD Rate Per Visit (C1 divided by C2)	\$135.56
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$149.56
3. Medicaid Trend Adjustment	(\$13.90)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$135.66

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Holmes County Health Department
 Provider Number: 0519022

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$572,643.00
2. Total Non-Allowable Costs	\$1,410,842.00
3. Total Overhead Costs	\$537,027.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$2,520,512.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$756,153.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$537,027.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$572,643.00
2. Total Non-Allowable Costs	\$1,410,842.00
3. Sum of Lines B1 and B2	\$1,983,485.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2887
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$155,039.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$727,682.69
2. Total CHD Visits	5,118
3. CHD Rate Per Visit (C1 divided by C2)	\$142.18
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$156.86
3. Medicaid Trend Adjustment	(\$14.58)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$142.28

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Brevard County Health Department
 Provider Number: 0519251

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$4,984,219.00
2. Total Non-Allowable Costs	\$11,183,489.00
3. Total Overhead Costs	\$3,647,018.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$19,814,726.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$5,944,417.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$3,647,018.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$4,984,219.00
2. Total Non-Allowable Costs	\$11,183,489.00
3. Sum of Lines B1 and B2	\$16,167,708.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3083
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$1,124,375.65
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$6,108,594.65
2. Total CHD Visits	29,188
3. CHD Rate Per Visit (C1 divided by C2)	\$209.28
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$230.90
3. Medicaid Trend Adjustment	(\$67.63)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

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

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$17,391,383.00
2. Total Non-Allowable Costs	\$39,966,532.00
3. Total Overhead Costs	\$11,434,874.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$68,792,789.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$20,637,836.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$11,434,874.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$17,391,383.00
2. Total Non-Allowable Costs	\$39,966,532.00
3. Sum of Lines B1 and B2	\$57,357,915.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3032
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$3,467,053.80
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$20,858,436.80
2. Total CHD Visits	63,536
3. CHD Rate Per Visit (C1 divided by C2)	\$328.29
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$362.20
3. Medicaid Trend Adjustment	(\$198.93)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Charlotte County Health Department
 Provider Number: 0520446

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$760,652.00
2. Total Non-Allowable Costs	\$4,354,046.00
3. Total Overhead Costs	\$1,551,453.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$6,666,151.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,999,845.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,551,453.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$760,652.00
2. Total Non-Allowable Costs	\$4,354,046.00
3. Sum of Lines B1 and B2	\$5,114,698.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1487
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$230,701.06
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$991,353.06
2. Total CHD Visits	6,110
3. CHD Rate Per Visit (C1 divided by C2)	\$162.25
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$179.01
3. Medicaid Trend Adjustment	(\$16.64)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$162.37

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Hillsborough County Health Department
 Provider Number: 0557269

Audit Status:

Unaudited Cost

Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$9,163,091.00
2. Total Non-Allowable Costs	\$32,578,671.00
3. Total Overhead Costs	\$5,777,817.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$47,519,579.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$14,255,873.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$5,777,817.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$9,163,091.00
2. Total Non-Allowable Costs	\$32,578,671.00
3. Sum of Lines B1 and B2	\$41,741,762.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2195
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$1,268,230.83
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$10,431,321.83
2. Total CHD Visits	20,072
3. CHD Rate Per Visit (C1 divided by C2)	\$519.70
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$573.37
3. Medicaid Trend Adjustment	(\$410.10)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Lake County Health Department
 Provider Number: 0563234

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$1,114,019.00
2. Total Non-Allowable Costs	\$5,623,028.00
3. Total Overhead Costs	\$2,410,482.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$9,147,529.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$2,744,258.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$2,410,482.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,114,019.00
2. Total Non-Allowable Costs	\$5,623,028.00
3. Sum of Lines B1 and B2	\$6,737,047.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1654
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$398,693.72
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,512,712.72
2. Total CHD Visits	5,670
3. CHD Rate Per Visit (C1 divided by C2)	\$266.79
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$294.35
3. Medicaid Trend Adjustment	(\$131.08)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27

**State of Florida Agency for Health Care Administration
 Medicaid Program Finance
 CHD Rate Calculation Sheet
 Rate Setting Period 07/01/2023 Through 06/30/2024**

Provider Name: Escambia County Health Department
 Provider Number: 0600181

Audit Status: **Unaudited Cost**
 Cost Reporting Period: 07/01/2021 Through 06/30/2022

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$2,529,988.00
2. Total Non-Allowable Costs	\$7,926,085.00
3. Total Overhead Costs	\$3,023,361.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	\$13,479,434.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$4,043,830.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$3,023,361.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$2,529,988.00
2. Total Non-Allowable Costs	\$7,926,085.00
3. Sum of Lines B1 and B2	\$10,456,073.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2420
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$731,653.36
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$3,261,641.36
2. Total CHD Visits	12,635
3. CHD Rate Per Visit (C1 divided by C2)	\$258.14
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.10327
2. CHD Prospective Rate (C3 Multiplied by D1)	\$284.80
3. Medicaid Trend Adjustment	(\$121.53)
4. Final Prospective Rate - Effective Date: 07/01/2023	\$163.27