State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

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

Provider Number: 0279111
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,315,771.00
2. Total Non-Allowable Costs	$9,316,032.00
3. Total Overhead Costs	$3,360,193.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$16,991,996.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,097,598.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,360,193.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,315,771.00
2. Total Non-Allowable Costs	$9,316,032.00
3. Sum of Lines B1 and B2	$13,631,803.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3166
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,063,837.10
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,379,608.10
2. Total CHD Visits	25,206
3. CHD Rate Per Visit (C1 divided by C2)	$213.43
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$219.03
3. Medicaid Trend Adjustment	($52.44)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Baker County Health Department
Provider Number: 0279129

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,688,786.00
2. Total Non-Allowable Costs	$837,418.00
3. Total Overhead Costs	$608,061.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,134,265.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$940,279.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$608,061.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,688,786.00
2. Total Non-Allowable Costs	$837,418.00
3. Sum of Lines B1 and B2	$2,526,204.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6685
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$406,488.78
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,095,274.78
2. Total CHD Visits	10,627
3. CHD Rate Per Visit (C1 divided by C2)	$197.17
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$202.34
3. Medicaid Trend Adjustment	($38.58)
4. Final Prospective Rate - Effective Date: 07/01/2020	$163.76

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Bradford County Health Department
Provider Number: 0279145

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,511,772.00
2. Total Non-Allowable Costs	$657,854.00
3. Total Overhead Costs	$422,794.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,592,420.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$777,726.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$422,794.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,511,772.00
2. Total Non-Allowable Costs	$657,854.00
3. Sum of Lines B1 and B2	$2,169,626.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6968
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$294,602.86
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,806,374.86
2. Total CHD Visits	8,878
3. CHD Rate Per Visit (C1 divided by C2)	$203.47
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$208.81
3. Medicaid Trend Adjustment	($42.22)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Broward County Health Department
Provider Number: 0279161

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$10,404,748.00
2. Total Non-Allowable Costs	$26,405,344.00
3. Total Overhead Costs	$12,594,982.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$49,405,074.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$14,821,522.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$12,594,982.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$10,404,748.00
2. Total Non-Allowable Costs	$26,405,344.00
3. Sum of Lines B1 and B2	$36,810,092.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2827
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$3,560,601.41
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$13,965,349.41
2. Total CHD Visits	136,255
3. CHD Rate Per Visit (C1 divided by C2)	$102.49
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$105.19
3. Medicaid Trend Adjustment	($8.50)
4. Final Prospective Rate - Effective Date: 07/01/2020	$96.69

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Calhoun County Health Department
Provider Number: 0279170

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$380,390.00
2. Total Non-Allowable Costs	$678,164.00
3. Total Overhead Costs	$300,623.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,359,177.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$407,753.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$300,623.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$380,390.00
2. Total Non-Allowable Costs	$678,164.00
3. Sum of Lines B1 and B2	$1,058,554.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3593
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$108,013.84
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$488,403.84
2. Total CHD Visits	2,661
3. CHD Rate Per Visit (C1 divided by C2)	$183.54
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$188.36
3. Medicaid Trend Adjustment	($21.77)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Citrus County Health Department
Provider Number: 0279196

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,547,259.00
2. Total Non-Allowable Costs	$2,778,469.00
3. Total Overhead Costs	$1,231,121.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,556,849.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,667,054.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,231,121.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,547,259.00
2. Total Non-Allowable Costs	$2,778,469.00
3. Sum of Lines B1 and B2	$4,325,728.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3577
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$440,371.98
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,987,630.98
2. Total CHD Visits	6,533
3. CHD Rate Per Visit (C1 divided by C2)	$304.24
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$312.23
3. Medicaid Trend Adjustment	($145.64)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Clay County Health Department
Audit Status: **Unaudited Cost**
Provider Number: 0279200
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$773,567.00
2. Total Non-Allowable Costs	$2,550,858.00
3. Total Overhead Costs	$1,411,596.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,736,021.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,420,806.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,411,596.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$773,567.00
2. Total Non-Allowable Costs	$2,550,858.00
3. Sum of Lines B1 and B2	$3,324,425.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2327
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$328,478.39
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,102,045.39
2. Total CHD Visits	2,240
3. CHD Rate Per Visit (C1 divided by C2)	$491.98
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$504.90
3. Medicaid Trend Adjustment	($338.31)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Collier County Health Department
Provider Number: 0279218

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,806,562.00
2. Total Non-Allowable Costs	$6,212,684.00
3. Total Overhead Costs	$2,338,990.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,358,236.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,707,470.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,338,990.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,806,562.00
2. Total Non-Allowable Costs	$6,212,684.00
3. Sum of Lines B1 and B2	$10,019,246.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3799
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$888,582.30
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,695,144.30
2. Total CHD Visits	20,586
3. CHD Rate Per Visit (C1 divided by C2)	$228.07
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$234.06
3. Medicaid Trend Adjustment	($67.47)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Columbia County Health Department
Provider Number: 0279226

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$833,628.00
2. Total Non-Allowable Costs	$1,313,140.00
3. Total Overhead Costs	$547,471.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,694,239.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$808,271.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$547,471.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$833,628.00
2. Total Non-Allowable Costs	$1,313,140.00
3. Sum of Lines B1 and B2	$2,146,768.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3883
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$212,582.99
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,046,210.99
2. Total CHD Visits	4,356
3. CHD Rate Per Visit (C1 divided by C2)	$240.18
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$246.48
3. Medicaid Trend Adjustment	($79.89)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Dade County Health Department
Provider Number: 0279234

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$19,031,382.00
2. Total Non-Allowable Costs	$33,021,666.00
3. Total Overhead Costs	$10,229,980.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$62,283,028.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$18,684,908.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$10,229,980.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$19,031,382.00
2. Total Non-Allowable Costs	$33,021,666.00
3. Sum of Lines B1 and B2	$52,053,048.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3656
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$3,740,080.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$22,771,462.69
2. Total CHD Visits	61,677
3. CHD Rate Per Visit (C1 divided by C2)	$369.21
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$378.90
3. Medicaid Trend Adjustment	($212.31)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: DeSoto County Health Department
Provider Number: 0279242

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,660,613.00
2. Total Non-Allowable Costs	$2,661,132.00
3. Total Overhead Costs	$565,787.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,887,532.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,766,259.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$565,787.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,660,613.00
2. Total Non-Allowable Costs	$2,661,132.00
3. Sum of Lines B1 and B2	$5,321,745.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5000
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$282,893.50
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,943,506.50
2. Total CHD Visits	22,804
3. CHD Rate Per Visit (C1 divided by C2)	$129.08
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$132.47
3. Medicaid Trend Adjustment	($9.87)
4. Final Prospective Rate - Effective Date: 07/01/2020	$122.60

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Dixie County Health Department
Provider Number: 0279251

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$355,193.00
2. Total Non-Allowable Costs	$614,410.00
3. Total Overhead Costs	$338,767.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,308,370.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$392,511.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$338,767.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$355,193.00
2. Total Non-Allowable Costs	$614,410.00
3. Sum of Lines B1 and B2	$969,603.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3663
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$124,090.35
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$479,283.35
2. Total CHD Visits	1,480
3. CHD Rate Per Visit (C1 divided by C2)	$323.84
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$332.34
3. Medicaid Trend Adjustment	($165.75)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Duval County Health Department
Provider Number: 0279269

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$9,964,168.00
2. Total Non-Allowable Costs	$13,583,481.00
3. Total Overhead Costs	$10,050,764.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$33,598,413.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,079,523.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$10,050,764.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,964,168.00
2. Total Non-Allowable Costs	$13,583,481.00
3. Sum of Lines B1 and B2	$23,547,649.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4231
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,252,478.25
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$14,216,646.25
2. Total CHD Visits	49,045
3. CHD Rate Per Visit (C1 divided by C2)	$289.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$297.48
3. Medicaid Trend Adjustment	($130.89)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Flagler County Health Department
Provider Number: 0279285

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,825,603.00
2. Total Non-Allowable Costs	$1,603,928.00
3. Total Overhead Costs	$504,955.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,934,486.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,180,345.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$504,955.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,825,603.00
2. Total Non-Allowable Costs	$1,603,928.00
3. Sum of Lines B1 and B2	$3,429,531.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5323
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$268,787.55
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,094,390.55
2. Total CHD Visits	12,972
3. CHD Rate Per Visit (C1 divided by C2)	$161.45
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$165.69
3. Medicaid Trend Adjustment	($21.38)
4. Final Prospective Rate - Effective Date: 07/01/2020	$144.31

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Franklin County Health Department
Provider Number: 0279293

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$351,775.00
2. Total Non-Allowable Costs	$1,249,059.00
3. Total Overhead Costs	$770,521.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,371,355.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$711,406.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$711,406.50
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$351,775.00
2. Total Non-Allowable Costs	$1,249,059.00
3. Sum of Lines B1 and B2	$1,600,834.00
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)	$156,296.01
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$508,071.01
2. Total CHD Visits	1,107
3. CHD Rate Per Visit (C1 divided by C2)	$458.96
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$471.01
3. Medicaid Trend Adjustment	($304.42)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Gadsden County Health Department
Provider Number: 0279307

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$634,621.00
2. Total Non-Allowable Costs	$1,942,480.00
3. Total Overhead Costs	$749,988.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,327,089.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$998,126.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$749,988.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$634,621.00
2. Total Non-Allowable Costs	$1,942,480.00
3. Sum of Lines B1 and B2	$2,577,101.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2463
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$184,722.04
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$819,343.04
2. Total CHD Visits	7,350
3. CHD Rate Per Visit (C1 divided by C2)	$111.48
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$114.40
3. Medicaid Trend Adjustment	($8.52)
4. Final Prospective Rate - Effective Date: 07/01/2020	$105.88

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Gilchrist County Health Department
Provider Number: 0279315

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$474,413.00
2. Total Non-Allowable Costs	$457,730.00
3. Total Overhead Costs	$234,271.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,166,414.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$349,924.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$234,271.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$474,413.00
2. Total Non-Allowable Costs	$457,730.00
3. Sum of Lines B1 and B2	$932,143.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5089
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$119,220.51
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$593,633.51
2. Total CHD Visits	2,698
3. CHD Rate Per Visit (C1 divided by C2)	$220.03
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$225.80
3. Medicaid Trend Adjustment	($59.21)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Glades County Health Department
Provider Number: 0279323

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$327,146.00
2. Total Non-Allowable Costs	$559,690.00
3. Total Overhead Costs	$387,365.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,274,201.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$382,260.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$382,260.30
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$327,146.00
2. Total Non-Allowable Costs	$559,690.00
3. Sum of Lines B1 and B2	$886,836.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3689
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$141,015.82
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$468,161.82
2. Total CHD Visits	1,680
3. CHD Rate Per Visit (C1 divided by C2)	$278.67
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$285.98
3. Medicaid Trend Adjustment	($119.39)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Gulf County Health Department
Provider Number: 0279331

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$451,630.00
2. Total Non-Allowable Costs	$1,029,550.00
3. Total Overhead Costs	$806,275.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,287,455.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$686,236.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$686,236.50
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$451,630.00
2. Total Non-Allowable Costs	$1,029,550.00
3. Sum of Lines B1 and B2	$1,481,180.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3049
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$209,233.51
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$660,863.51
2. Total CHD Visits	1,029
3. CHD Rate Per Visit (C1 divided by C2)	$642.24
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$659.10
3. Medicaid Trend Adjustment	($492.51)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Hamilton County Health Department
Provider Number: 0279340

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$485,586.00
2. Total Non-Allowable Costs	$452,414.00
3. Total Overhead Costs	$304,762.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,242,762.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$372,828.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$304,762.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$485,586.00
2. Total Non-Allowable Costs	$452,414.00
3. Sum of Lines B1 and B2	$938,000.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5177
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$157,775.29
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$643,361.29
2. Total CHD Visits	3,101
3. CHD Rate Per Visit (C1 divided by C2)	$207.47
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$212.92
3. Medicaid Trend Adjustment	($46.33)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Hardee County Health Department
Provider Number: 0279358

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$343,877.00
2. Total Non-Allowable Costs	$1,045,597.00
3. Total Overhead Costs	$827,005.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,216,479.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$664,943.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$664,943.70
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$343,877.00
2. Total Non-Allowable Costs	$1,045,597.00
3. Sum of Lines B1 and B2	$1,389,474.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2475
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$164,573.57
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$508,450.57
2. Total CHD Visits	1,275
3. CHD Rate Per Visit (C1 divided by C2)	$398.78
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$409.26
3. Medicaid Trend Adjustment	($242.67)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Hendry County Health Department
Provider Number: 0279366

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,713,904.00
2. Total Non-Allowable Costs	$2,163,762.00
3. Total Overhead Costs	$1,204,755.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,082,421.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,524,726.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,204,755.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,713,904.00
2. Total Non-Allowable Costs	$2,163,762.00
3. Sum of Lines B1 and B2	$3,877,666.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4420
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$532,501.71
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,246,405.71
2. Total CHD Visits	5,530
3. CHD Rate Per Visit (C1 divided by C2)	$406.22
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$416.89
3. Medicaid Trend Adjustment	($250.30)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Hernando County Health Department
Provider Number: 0279374

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,249,604.00
2. Total Non-Allowable Costs	$2,691,593.00
3. Total Overhead Costs	$2,252,324.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,193,521.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,858,056.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,858,056.30
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,249,604.00
2. Total Non-Allowable Costs	$2,691,593.00
3. Sum of Lines B1 and B2	$3,941,197.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3171
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$589,189.65
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,838,793.65
2. Total CHD Visits	7,770
3. CHD Rate Per Visit (C1 divided by C2)	$236.65
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$242.87
3. Medicaid Trend Adjustment	($76.28)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Highlands County Health Department
Provider Number: 0279382

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,630,938.00
2. Total Non-Allowable Costs	$2,365,468.00
3. Total Overhead Costs	$892,447.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,888,853.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,466,655.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$892,447.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,630,938.00
2. Total Non-Allowable Costs	$2,365,468.00
3. Sum of Lines B1 and B2	$3,996,406.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4081
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$364,207.62
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,995,145.62
2. Total CHD Visits	11,842
3. CHD Rate Per Visit (C1 divided by C2)	$168.48
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$172.90
3. Medicaid Trend Adjustment	($37.05)
4. Final Prospective Rate - Effective Date: 07/01/2020	$135.85

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,704,489.00
2. Total Non-Allowable Costs	$2,430,545.00
3. Total Overhead Costs	$1,903,223.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,038,257.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,111,477.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,903,223.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,704,489.00
2. Total Non-Allowable Costs	$2,430,545.00
3. Sum of Lines B1 and B2	$5,135,034.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5267
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,002,427.55
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,706,916.55
2. Total CHD Visits	20,132
3. CHD Rate Per Visit (C1 divided by C2)	$184.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$188.97
3. Medicaid Trend Adjustment	($41.82)
4. Final Prospective Rate - Effective Date: 07/01/2020	$147.15

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Jackson County Health Department
Provider Number: 0279421

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,009,016.00
2. Total Non-Allowable Costs	$2,433,933.00
3. Total Overhead Costs	$989,219.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,432,168.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,329,650.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$989,219.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,009,016.00
2. Total Non-Allowable Costs	$2,433,933.00
3. Sum of Lines B1 and B2	$3,442,949.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2931
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$289,940.09
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,298,956.09
2. Total CHD Visits	7,392
3. CHD Rate Per Visit (C1 divided by C2)	$175.72
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$180.34
3. Medicaid Trend Adjustment	($21.11)
4. Final Prospective Rate - Effective Date: 07/01/2020	$159.23

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Jefferson County Health Department
Provider Number: 0279439

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$646,936.00
2. Total Non-Allowable Costs	$799,572.00
3. Total Overhead Costs	$395,879.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,842,387.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$552,716.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$395,879.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$646,936.00
2. Total Non-Allowable Costs	$799,572.00
3. Sum of Lines B1 and B2	$1,446,508.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4472
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$177,037.09
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$823,973.09
2. Total CHD Visits	3,544
3. CHD Rate Per Visit (C1 divided by C2)	$232.50
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$238.60
3. Medicaid Trend Adjustment	($78.03)
4. Final Prospective Rate - Effective Date: 07/01/2020	$160.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Lee County Health Department
Provider Number: 0279463

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,325,320.00
2. Total Non-Allowable Costs	$8,985,382.00
3. Total Overhead Costs	$2,822,662.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$15,133,364.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,540,009.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,822,662.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,325,320.00
2. Total Non-Allowable Costs	$8,985,382.00
3. Sum of Lines B1 and B2	$12,310,702.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2701
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$762,401.01
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,087,721.01
2. Total CHD Visits	9,065
3. CHD Rate Per Visit (C1 divided by C2)	$450.93
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$462.77
3. Medicaid Trend Adjustment	($296.18)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Leon County Health Department
Provider Number: 0279471

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,941,609.00
2. Total Non-Allowable Costs	$5,736,659.00
3. Total Overhead Costs	$1,657,387.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,335,655.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,100,696.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,657,387.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,941,609.00
2. Total Non-Allowable Costs	$5,736,659.00
3. Sum of Lines B1 and B2	$8,678,268.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3390
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$561,854.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,503,463.19
2. Total CHD Visits	25,512
3. CHD Rate Per Visit (C1 divided by C2)	$137.33
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$140.93
3. Medicaid Trend Adjustment	($22.11)
4. Final Prospective Rate - Effective Date: 07/01/2020	$118.82

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Levy County Health Department
Provider Number: 0279480

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$951,336.00
2. Total Non-Allowable Costs	$1,259,074.00
3. Total Overhead Costs	$437,696.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,648,106.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$794,431.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$437,696.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$951,336.00
2. Total Non-Allowable Costs	$1,259,074.00
3. Sum of Lines B1 and B2	$2,210,410.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4304
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$188,384.36
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,139,720.36
2. Total CHD Visits	4,290
3. CHD Rate Per Visit (C1 divided by C2)	$265.67
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$272.64
3. Medicaid Trend Adjustment	($106.05)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Liberty County Health Department
Provider Number: 0279498

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$311,669.00
2. Total Non-Allowable Costs	$450,293.00
3. Total Overhead Costs	$276,145.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,038,107.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$311,432.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$276,145.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$311,669.00
2. Total Non-Allowable Costs	$450,293.00
3. Sum of Lines B1 and B2	$761,962.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4090
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$112,943.31
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$424,612.31
2. Total CHD Visits	1,928
3. CHD Rate Per Visit (C1 divided by C2)	$220.23
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$226.02
3. Medicaid Trend Adjustment	($59.43)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Manatee County Health Department
Provider Number: 0279510

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,527,926.00
2. Total Non-Allowable Costs	$4,898,795.00
3. Total Overhead Costs	$2,378,362.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,805,083.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,641,524.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,378,362.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,527,926.00
2. Total Non-Allowable Costs	$4,898,795.00
3. Sum of Lines B1 and B2	$6,426,721.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2377
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$565,336.65
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,093,262.65
2. Total CHD Visits	16,835
3. CHD Rate Per Visit (C1 divided by C2)	$124.34
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$127.60
3. Medicaid Trend Adjustment	($31.70)
4. Final Prospective Rate - Effective Date: 07/01/2020	$95.90

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Marion County Health Department
Provider Number: 0279528

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,910,028.00
2. Total Non-Allowable Costs	$6,313,007.00
3. Total Overhead Costs	$2,451,992.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,675,027.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,802,508.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,451,992.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,910,028.00
2. Total Non-Allowable Costs	$6,313,007.00
3. Sum of Lines B1 and B2	$10,223,035.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3825
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$937,886.94
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,847,914.94
2. Total CHD Visits	16,839
3. CHD Rate Per Visit (C1 divided by C2)	$287.90
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$295.46
3. Medicaid Trend Adjustment	($128.87)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Martin County Health Department
Provider Number: 0279536

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$938,657.00
2. Total Non-Allowable Costs	$3,488,978.00
3. Total Overhead Costs	$1,715,039.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,142,674.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,842,802.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,715,039.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$938,657.00
2. Total Non-Allowable Costs	$3,488,978.00
3. Sum of Lines B1 and B2	$4,427,635.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2120
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$363,588.27
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,302,245.27
2. Total CHD Visits	6,199
3. CHD Rate Per Visit (C1 divided by C2)	$210.07
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$215.59
3. Medicaid Trend Adjustment	($49.00)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Monroe County Health Department
Provider Number: 0279544

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,708,492.00
2. Total Non-Allowable Costs	$4,527,019.00
3. Total Overhead Costs	$1,684,955.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,920,466.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,376,139.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,684,955.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,708,492.00
2. Total Non-Allowable Costs	$4,527,019.00
3. Sum of Lines B1 and B2	$6,235,511.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2740
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$461,677.67
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,170,169.67
2. Total CHD Visits	5,647
3. CHD Rate Per Visit (C1 divided by C2)	$384.30
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$394.40
3. Medicaid Trend Adjustment	($227.81)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Nassau County Health Department
Provider Number: 0279552

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,163,576.00
2. Total Non-Allowable Costs	$2,375,975.00
3. Total Overhead Costs	$996,161.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,535,712.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,360,713.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$996,161.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,163,576.00
2. Total Non-Allowable Costs	$2,375,975.00
3. Sum of Lines B1 and B2	$3,539,551.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3287
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$327,438.12
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,491,014.12
2. Total CHD Visits	14,029
3. CHD Rate Per Visit (C1 divided by C2)	$106.28
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$109.07
3. Medicaid Trend Adjustment	($11.12)
4. Final Prospective Rate - Effective Date: 07/01/2020	$97.95

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Okaloosa County Health Department
Provider Number: 0279561

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,772,618.00
2. Total Non-Allowable Costs	$3,889,255.00
3. Total Overhead Costs	$2,503,392.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,165,265.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,449,579.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,449,579.50
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,772,618.00
2. Total Non-Allowable Costs	$3,889,255.00
3. Sum of Lines B1 and B2	$5,661,873.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3131
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$766,963.34
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,539,581.34
2. Total CHD Visits	14,181
3. CHD Rate Per Visit (C1 divided by C2)	$179.08
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$183.79
3. Medicaid Trend Adjustment	($18.46)
4. Final Prospective Rate - Effective Date: 07/01/2020	$165.33

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Okeechobee County Health Department
Provider Number: 0279579

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$385,249.00
2. Total Non-Allowable Costs	$1,391,205.00
3. Total Overhead Costs	$458,232.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,234,686.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$670,405.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$458,232.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$385,249.00
2. Total Non-Allowable Costs	$1,391,205.00
3. Sum of Lines B1 and B2	$1,776,454.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2169
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$99,390.52
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$484,639.52
2. Total CHD Visits	2,912
3. CHD Rate Per Visit (C1 divided by C2)	$166.43
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$170.80
3. Medicaid Trend Adjustment	($16.77)
4. Final Prospective Rate - Effective Date: 07/01/2020	$154.03

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Orange County Health Department
Provider Number: 0279587

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$8,896,162.00
2. Total Non-Allowable Costs	$19,990,548.00
3. Total Overhead Costs	$6,415,383.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$35,302,093.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,590,627.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$6,415,383.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$8,896,162.00
2. Total Non-Allowable Costs	$19,990,548.00
3. Sum of Lines B1 and B2	$28,886,710.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3080
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,975,937.96
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$10,872,099.96
2. Total CHD Visits	35,956
3. CHD Rate Per Visit (C1 divided by C2)	$302.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$310.31
3. Medicaid Trend Adjustment	($143.72)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Osceola County Health Department
Provider Number: 0279595

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,694,764.00
2. Total Non-Allowable Costs	$4,776,990.00
3. Total Overhead Costs	$3,399,524.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,871,278.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,261,383.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,261,383.40
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,694,764.00
2. Total Non-Allowable Costs	$4,776,990.00
3. Sum of Lines B1 and B2	$7,471,754.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3607
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,176,380.99
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,871,144.99
2. Total CHD Visits	8,505
3. CHD Rate Per Visit (C1 divided by C2)	$455.16
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$467.11
3. Medicaid Trend Adjustment	($300.52)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Pasco County Health Department
Provider Number: 0279617

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,890,472.00
2. Total Non-Allowable Costs	$5,954,138.00
3. Total Overhead Costs	$3,069,420.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,914,030.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,874,209.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,069,420.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,890,472.00
2. Total Non-Allowable Costs	$5,954,138.00
3. Sum of Lines B1 and B2	$9,844,610.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3952
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,213,034.78
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,103,506.78
2. Total CHD Visits	19,080
3. CHD Rate Per Visit (C1 divided by C2)	$267.48
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$274.50
3. Medicaid Trend Adjustment	($107.91)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Pinellas County Health Department
Provider Number: 0279625

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$21,223,084.00
2. Total Non-Allowable Costs	$22,756,065.00
3. Total Overhead Costs	$9,503,233.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$53,482,382.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$16,044,714.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$9,503,233.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$21,223,084.00
2. Total Non-Allowable Costs	$22,756,065.00
3. Sum of Lines B1 and B2	$43,979,149.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4826
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,586,260.25
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$25,809,344.25
2. Total CHD Visits	97,719
3. CHD Rate Per Visit (C1 divided by C2)	$264.12
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$271.05
3. Medicaid Trend Adjustment	($104.46)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Polk County Health Department
Provider Number: 0279633

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$10,465,308.00
2. Total Non-Allowable Costs	$13,598,056.00
3. Total Overhead Costs	$3,969,368.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$28,032,732.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$8,409,819.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,969,368.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$10,465,308.00
2. Total Non-Allowable Costs	$13,598,056.00
3. Sum of Lines B1 and B2	$24,063,364.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4349
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,726,278.14
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$12,191,586.14
2. Total CHD Visits	52,761
3. CHD Rate Per Visit (C1 divided by C2)	$231.07
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$237.14
3. Medicaid Trend Adjustment	($70.55)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Putnam County Health Department
Provider Number: 0279641

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,073,907.00
2. Total Non-Allowable Costs	$1,828,344.00
3. Total Overhead Costs	$386,646.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,288,897.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,286,669.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$386,646.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,073,907.00
2. Total Non-Allowable Costs	$1,828,344.00
3. Sum of Lines B1 and B2	$3,902,251.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5315
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$205,502.35
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,279,409.35
2. Total CHD Visits	4,230
3. CHD Rate Per Visit (C1 divided by C2)	$538.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$553.02
3. Medicaid Trend Adjustment	($386.43)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,767,807.00
2. Total Non-Allowable Costs	$2,146,504.00
3. Total Overhead Costs	$1,131,045.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,045,356.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,513,606.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,131,045.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,767,807.00
2. Total Non-Allowable Costs	$2,146,504.00
3. Sum of Lines B1 and B2	$3,914,311.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4516
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$510,779.92
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,278,586.92
2. Total CHD Visits	8,816
3. CHD Rate Per Visit (C1 divided by C2)	$258.46
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$265.25
3. Medicaid Trend Adjustment	($98.66)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,599,176.00
2. Total Non-Allowable Costs	$6,613,419.00
3. Total Overhead Costs	$1,771,610.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,984,205.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,895,261.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,771,610.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,599,176.00
2. Total Non-Allowable Costs	$6,613,419.00
3. Sum of Lines B1 and B2	$11,212,595.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4102
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$726,714.42
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,325,890.42
2. Total CHD Visits	22,683
3. CHD Rate Per Visit (C1 divided by C2)	$234.80
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$240.96
3. Medicaid Trend Adjustment	($74.37)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,567,333.00
2. Total Non-Allowable Costs	$2,672,746.00
3. Total Overhead Costs	$1,359,655.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,599,734.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,679,920.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,359,655.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,567,333.00
2. Total Non-Allowable Costs	$2,672,746.00
3. Sum of Lines B1 and B2	$4,240,079.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3696
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$502,528.49
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,069,861.49
2. Total CHD Visits	12,186
3. CHD Rate Per Visit (C1 divided by C2)	$169.86
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$174.32
3. Medicaid Trend Adjustment	($26.50)
4. Final Prospective Rate - Effective Date: 07/01/2020	$147.82

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Sarasota County Health Department
Provider Number: 0279684

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,826,661.00
2. Total Non-Allowable Costs	$20,135,102.00
3. Total Overhead Costs	$5,427,100.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$30,388,863.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$9,116,658.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,427,100.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,826,661.00
2. Total Non-Allowable Costs	$20,135,102.00
3. Sum of Lines B1 and B2	$24,961,763.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1934
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,049,601.14
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,876,262.14
2. Total CHD Visits	29,208
3. CHD Rate Per Visit (C1 divided by C2)	$201.19
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$206.47
3. Medicaid Trend Adjustment	($45.46)
4. Final Prospective Rate - Effective Date: 07/01/2020	$161.01

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Seminole County Health Department
Provider Number: 0279692

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,499,581.00
2. Total Non-Allowable Costs	$4,551,888.00
3. Total Overhead Costs	$2,655,375.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,706,844.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,912,053.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,655,375.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,499,581.00
2. Total Non-Allowable Costs	$4,551,888.00
3. Sum of Lines B1 and B2	$7,051,469.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3545
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$941,330.44
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,440,911.44
2. Total CHD Visits	10,390
3. CHD Rate Per Visit (C1 divided by C2)	$331.18
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$339.87
3. Medicaid Trend Adjustment	($173.28)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Sumter County Health Department
Provider Number: 0279706

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$699,664.00
2. Total Non-Allowable Costs	$1,529,151.00
3. Total Overhead Costs	$892,899.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,121,714.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$936,514.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$892,899.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$699,664.00
2. Total Non-Allowable Costs	$1,529,151.00
3. Sum of Lines B1 and B2	$2,228,815.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3139
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$280,281.00
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$979,945.00
2. Total CHD Visits	5,180
3. CHD Rate Per Visit (C1 divided by C2)	$189.18
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$194.15
3. Medicaid Trend Adjustment	($50.92)
4. Final Prospective Rate - Effective Date: 07/01/2020	$143.23

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Taylor County Health Department
Provider Number: 0279722

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$719,769.00
2. Total Non-Allowable Costs	$959,111.00
3. Total Overhead Costs	$318,509.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,997,389.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$599,216.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$318,509.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$719,769.00
2. Total Non-Allowable Costs	$959,111.00
3. Sum of Lines B1 and B2	$1,678,880.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4287
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$136,544.81
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$856,313.81
2. Total CHD Visits	8,464
3. CHD Rate Per Visit (C1 divided by C2)	$101.17
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$103.83
3. Medicaid Trend Adjustment	($10.42)
4. Final Prospective Rate - Effective Date: 07/01/2020	$93.41

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Union County Health Department
Provider Number: 0279731

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,078,190.00
2. Total Non-Allowable Costs	$761,591.00
3. Total Overhead Costs	$328,714.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,168,495.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$650,548.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$328,714.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,078,190.00
2. Total Non-Allowable Costs	$761,591.00
3. Sum of Lines B1 and B2	$1,839,781.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5860
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$192,626.40
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,270,816.40
2. Total CHD Visits	5,328
3. CHD Rate Per Visit (C1 divided by C2)	$238.52
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$244.78
3. Medicaid Trend Adjustment	($78.19)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Volusia County Health Department
Provider Number: 0279749

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,949,198.00
2. Total Non-Allowable Costs	$8,538,444.00
3. Total Overhead Costs	$5,887,688.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$19,375,330.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,812,599.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,812,599.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,949,198.00
2. Total Non-Allowable Costs	$8,538,444.00
3. Sum of Lines B1 and B2	$13,487,642.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3669
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,132,642.57
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$7,081,840.57
2. Total CHD Visits	41,021
3. CHD Rate Per Visit (C1 divided by C2)	$172.64
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$177.17
3. Medicaid Trend Adjustment	($17.41)
4. Final Prospective Rate - Effective Date: 07/01/2020	$159.76

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Wakulla County Health Department
Provider Number: 0279757

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$719,225.00
2. Total Non-Allowable Costs	$1,439,198.00
3. Total Overhead Costs	$480,664.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,639,087.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$791,726.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$480,664.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$719,225.00
2. Total Non-Allowable Costs	$1,439,198.00
3. Sum of Lines B1 and B2	$2,158,423.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3332
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$160,157.24
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$879,382.24
2. Total CHD Visits	6,919
3. CHD Rate Per Visit (C1 divided by C2)	$127.10
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$130.43
3. Medicaid Trend Adjustment	($12.92)
4. Final Prospective Rate - Effective Date: 07/01/2020	$117.51

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Washington County Health Department
Provider Number: 0279773

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$915,810.00
2. Total Non-Allowable Costs	$896,296.00
3. Total Overhead Costs	$593,357.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,405,463.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$721,638.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$593,357.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$915,810.00
2. Total Non-Allowable Costs	$896,296.00
3. Sum of Lines B1 and B2	$1,812,106.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5054
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$299,882.63
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,215,692.63
2. Total CHD Visits	6,928
3. CHD Rate Per Visit (C1 divided by C2)	$175.48
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$180.08
3. Medicaid Trend Adjustment	($17.70)
4. Final Prospective Rate - Effective Date: 07/01/2020	$162.38

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Bay County Health Department
Provider Number: 0290068

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,024,966.00
2. Total Non-Allowable Costs	$4,297,843.00
3. Total Overhead Costs	$2,434,442.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,757,251.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,927,175.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,434,442.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,024,966.00
2. Total Non-Allowable Costs	$4,297,843.00
3. Sum of Lines B1 and B2	$7,322,809.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4131
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,005,667.99
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,030,633.99
2. Total CHD Visits	15,528
3. CHD Rate Per Visit (C1 divided by C2)	$259.57
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$266.39
3. Medicaid Trend Adjustment	($99.80)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Lafayette County Health Department
Provider Number: 0290343

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$268,922.00
2. Total Non-Allowable Costs	$447,135.00
3. Total Overhead Costs	$346,020.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,062,077.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$318,623.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$318,623.10
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$268,922.00
2. Total Non-Allowable Costs	$447,135.00
3. Sum of Lines B1 and B2	$716,057.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3756
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$119,674.84
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$388,596.84
2. Total CHD Visits	1,891
3. CHD Rate Per Visit (C1 divided by C2)	$205.50
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$210.89
3. Medicaid Trend Adjustment	($44.30)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Madison County Health Department
Provider Number: 0290408

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$430,626.00
2. Total Non-Allowable Costs	$928,065.00
3. Total Overhead Costs	$391,139.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,749,830.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$524,949.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$391,139.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$430,626.00
2. Total Non-Allowable Costs	$928,065.00
3. Sum of Lines B1 and B2	$1,358,691.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3169
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$123,951.95
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$554,577.95
2. Total CHD Visits	2,383
3. CHD Rate Per Visit (C1 divided by C2)	$232.72
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$238.83
3. Medicaid Trend Adjustment	($72.24)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Suwannee County Health Department
Provider Number: 0518328

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$525,133.00
2. Total Non-Allowable Costs	$744,488.00
3. Total Overhead Costs	$603,017.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,872,638.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$561,791.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$561,791.40
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$525,133.00
2. Total Non-Allowable Costs	$744,488.00
3. Sum of Lines B1 and B2	$1,269,621.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4136
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$232,356.92
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$757,489.92
2. Total CHD Visits	4,236
3. CHD Rate Per Visit (C1 divided by C2)	$178.82
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$183.52
3. Medicaid Trend Adjustment	($32.30)
4. Final Prospective Rate - Effective Date: 07/01/2020	$151.22

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Holmes County Health Department
Provider Number: 0519022

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$706,050.00
2. Total Non-Allowable Costs	$957,146.00
3. Total Overhead Costs	$509,030.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,172,226.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$651,667.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$509,030.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$706,050.00
2. Total Non-Allowable Costs	$957,146.00
3. Sum of Lines B1 and B2	$1,663,196.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4245
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$216,083.24
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$922,133.24
2. Total CHD Visits	6,679
3. CHD Rate Per Visit (C1 divided by C2)	$138.06
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$141.69
3. Medicaid Trend Adjustment	($14.80)
4. Final Prospective Rate - Effective Date: 07/01/2020	$126.89

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Brevard County Heath Department
Provider Number: 0519251

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$6,149,040.00
2. Total Non-Allowable Costs	$8,746,180.00
3. Total Overhead Costs	$3,603,631.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$18,498,851.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,549,655.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,603,631.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$6,149,040.00
2. Total Non-Allowable Costs	$8,746,180.00
3. Sum of Lines B1 and B2	$14,895,220.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4128
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,487,578.88
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$7,636,618.88
2. Total CHD Visits	39,667
3. CHD Rate Per Visit (C1 divided by C2)	$192.52
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$197.57
3. Medicaid Trend Adjustment	($30.98)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$19,874,881.00
2. Total Non-Allowable Costs	$26,145,850.00
3. Total Overhead Costs	$11,369,587.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$57,390,318.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$17,217,095.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$11,369,587.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$19,874,881.00
2. Total Non-Allowable Costs	$26,145,850.00
3. Sum of Lines B1 and B2	$46,020,731.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4319
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,910,524.63
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$24,785,405.63
2. Total CHD Visits	63,189
3. CHD Rate Per Visit (C1 divided by C2)	$392.24
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$402.54
3. Medicaid Trend Adjustment	($235.95)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Charlotte County Health Department
Provider Number: 0520446

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,107,835.00
2. Total Non-Allowable Costs	$2,537,038.00
3. Total Overhead Costs	$990,847.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,635,720.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,390,716.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$990,847.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,107,835.00
2. Total Non-Allowable Costs	$2,537,038.00
3. Sum of Lines B1 and B2	$3,644,873.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3039
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$301,118.40
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,408,953.40
2. Total CHD Visits	8,901
3. CHD Rate Per Visit (C1 divided by C2)	$158.29
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$162.45
3. Medicaid Trend Adjustment	($63.52)
4. Final Prospective Rate - Effective Date: 07/01/2020	$98.93

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Hillsborough County Health Department
Provider Number: 0557269

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$9,082,418.00
2. Total Non-Allowable Costs	$25,369,240.00
3. Total Overhead Costs	$4,859,440.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$39,311,098.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$11,793,329.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$4,859,440.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,082,418.00
2. Total Non-Allowable Costs	$25,369,240.00
3. Sum of Lines B1 and B2	$34,451,658.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2636
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,280,948.38
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$10,363,366.38
2. Total CHD Visits	24,813
3. CHD Rate Per Visit (C1 divided by C2)	$417.66
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$428.63
3. Medicaid Trend Adjustment	($262.04)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Lake County Health Department
Provider Number: 0563234

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,698,220.00
2. Total Non-Allowable Costs	$4,061,204.00
3. Total Overhead Costs	$2,461,656.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,221,080.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,766,324.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,461,656.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,698,220.00
2. Total Non-Allowable Costs	$4,061,204.00
3. Sum of Lines B1 and B2	$6,759,424.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3992
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$982,693.08
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,680,913.08
2. Total CHD Visits	13,931
3. CHD Rate Per Visit (C1 divided by C2)	$264.22
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$271.16
3. Medicaid Trend Adjustment	($104.57)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2020 Through 06/30/2021

Provider Name: Escambia County Health Department
Provider Number: 0600181

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2018 Through 06/30/2019

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,767,438.00
2. Total Non-Allowable Costs	$7,627,654.00
3. Total Overhead Costs	$2,978,906.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$14,373,998.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,312,199.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,978,906.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,767,438.00
2. Total Non-Allowable Costs	$7,627,654.00
3. Sum of Lines B1 and B2	$11,395,092.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3306
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$984,826.32
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,752,264.32
2. Total CHD Visits	17,677
3. CHD Rate Per Visit (C1 divided by C2)	$268.84
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.02626
2. CHD Prospective Rate (C3 Multiplied by D1)	$275.90
3. Medicaid Trend Adjustment	($109.31)
4. Final Prospective Rate - Effective Date: 07/01/2020	$166.59