State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Alachua County Health Department
Audit Status: **Unaudited Cost**
Provider Number: 0279111
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,432,004.00
2. Total Non-Allowable Costs	$10,244,330.00
3. Total Overhead Costs	$3,194,781.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$17,871,115.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,361,334.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,194,781.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,432,004.00
2. Total Non-Allowable Costs	$10,244,330.00
3. Sum of Lines B1 and B2	$14,676,334.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3020
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$964,823.86
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,396,827.86
2. Total CHD Visits	31,221
3. CHD Rate Per Visit (C1 divided by C2)	$172.86
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$178.94
3. Medicaid Trend Adjustment	($14.66)
4. Final Prospective Rate - Effective Date: 07/01/2021	$164.28

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Baker County Health Department
Provider Number: 0279129

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,172,886.00
2. Total Non-Allowable Costs	$1,028,796.00
3. Total Overhead Costs	$536,536.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,738,218.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$821,465.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$536,536.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,172,886.00
2. Total Non-Allowable Costs	$1,028,796.00
3. Sum of Lines B1 and B2	$2,201,682.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5327
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$285,812.73
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,458,698.73
2. Total CHD Visits	7,667
3. CHD Rate Per Visit (C1 divided by C2)	$190.26
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$196.95
3. Medicaid Trend Adjustment	($31.69)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Bradford County Health Department
Provider Number: 0279145

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,424,230.00
2. Total Non-Allowable Costs	$702,909.00
3. Total Overhead Costs	$555,727.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,682,866.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$804,859.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$555,727.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,424,230.00
2. Total Non-Allowable Costs	$702,909.00
3. Sum of Lines B1 and B2	$2,127,139.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6696
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$372,114.80
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,796,344.80
2. Total CHD Visits	9,020
3. CHD Rate Per Visit (C1 divided by C2)	$199.15
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$206.16
3. Medicaid Trend Adjustment	($40.90)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Broward County Health Department
Provider Number: 0279161

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$9,709,349.00
2. Total Non-Allowable Costs	$27,579,830.00
3. Total Overhead Costs	$12,732,652.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$50,021,831.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$15,006,549.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$12,732,652.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,709,349.00
2. Total Non-Allowable Costs	$27,579,830.00
3. Sum of Lines B1 and B2	$37,289,179.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2604
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$3,315,582.58
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$13,024,931.58
2. Total CHD Visits	99,021
3. CHD Rate Per Visit (C1 divided by C2)	$131.54
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$136.17
3. Medicaid Trend Adjustment	($11.14)
4. Final Prospective Rate - Effective Date: 07/01/2021	$125.03

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Calhoun County Health Department
Provider Number: 0279170

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$361,273.00
2. Total Non-Allowable Costs	$827,755.00
3. Total Overhead Costs	$471,808.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,660,836.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$498,250.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$471,808.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$361,273.00
2. Total Non-Allowable Costs	$827,755.00
3. Sum of Lines B1 and B2	$1,189,028.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3038
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$143,335.27
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$504,608.27
2. Total CHD Visits	2,281
3. CHD Rate Per Visit (C1 divided by C2)	$221.22
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$229.01
3. Medicaid Trend Adjustment	($63.75)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Citrus County Health Department
Provider Number: 0279196

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,353,224.00
2. Total Non-Allowable Costs	$3,328,612.00
3. Total Overhead Costs	$1,152,420.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,834,256.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,750,276.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,152,420.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,353,224.00
2. Total Non-Allowable Costs	$3,328,612.00
3. Sum of Lines B1 and B2	$4,681,836.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2890
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$333,049.38
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,686,273.38
2. Total CHD Visits	5,895
3. CHD Rate Per Visit (C1 divided by C2)	$286.05
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$296.12
3. Medicaid Trend Adjustment	($130.85)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.27

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Clay County Health Department
Provider Number: 0279200

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,025,127.00
2. Total Non-Allowable Costs	$2,637,009.00
3. Total Overhead Costs	$1,255,228.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,917,364.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,475,209.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,255,228.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,025,127.00
2. Total Non-Allowable Costs	$2,637,009.00
3. Sum of Lines B1 and B2	$3,662,136.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2799
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$351,338.32
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,376,465.32
2. Total CHD Visits	3,120
3. CHD Rate Per Visit (C1 divided by C2)	$441.17
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$456.70
3. Medicaid Trend Adjustment	($291.44)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Collier County Health Department
Provider Number: 0279218

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,869,585.00
2. Total Non-Allowable Costs	$6,576,952.00
3. Total Overhead Costs	$2,284,287.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$11,730,824.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,519,247.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,284,287.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,869,585.00
2. Total Non-Allowable Costs	$6,576,952.00
3. Sum of Lines B1 and B2	$9,446,537.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3038
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$693,966.39
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,563,551.39
2. Total CHD Visits	13,059
3. CHD Rate Per Visit (C1 divided by C2)	$272.88
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$282.48
3. Medicaid Trend Adjustment	($117.22)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Columbia County Health Department
Provider Number: 0279226

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$841,267.00
2. Total Non-Allowable Costs	$1,521,600.00
3. Total Overhead Costs	$521,071.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,883,938.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$865,181.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$521,071.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$841,267.00
2. Total Non-Allowable Costs	$1,521,600.00
3. Sum of Lines B1 and B2	$2,362,867.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3560
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$185,501.28
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,026,768.28
2. Total CHD Visits	4,370
3. CHD Rate Per Visit (C1 divided by C2)	$234.96
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$243.23
3. Medicaid Trend Adjustment	($77.96)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.27

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Dade County Health Department
Provider Number: 0279234

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$18,858,806.00
2. Total Non-Allowable Costs	$36,978,823.00
3. Total Overhead Costs	$9,822,649.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$65,660,278.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$19,698,083.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$9,822,649.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$18,858,806.00
2. Total Non-Allowable Costs	$36,978,823.00
3. Sum of Lines B1 and B2	$55,837,629.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3377
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$3,317,108.57
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$22,175,914.57
2. Total CHD Visits	48,383
3. CHD Rate Per Visit (C1 divided by C2)	$458.34
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$474.47
3. Medicaid Trend Adjustment	($309.21)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: DeSoto County Health Department
Provider Number: 0279242

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,657,203.00
2. Total Non-Allowable Costs	$2,682,533.00
3. Total Overhead Costs	$532,641.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,872,377.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,761,713.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$532,641.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,657,203.00
2. Total Non-Allowable Costs	$2,682,533.00
3. Sum of Lines B1 and B2	$5,339,736.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4976
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$265,042.16
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,922,245.16
2. Total CHD Visits	22,877
3. CHD Rate Per Visit (C1 divided by C2)	$127.74
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$132.23
3. Medicaid Trend Adjustment	($10.83)
4. Final Prospective Rate - Effective Date: 07/01/2021	$121.40

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Dixie County Health Department
Provider Number: 0279251

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$317,842.00
2. Total Non-Allowable Costs	$709,341.00
3. Total Overhead Costs	$349,590.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,376,773.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$413,031.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$349,590.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$317,842.00
2. Total Non-Allowable Costs	$709,341.00
3. Sum of Lines B1 and B2	$1,027,183.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3094
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$108,163.15
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$426,005.15
2. Total CHD Visits	1,377
3. CHD Rate Per Visit (C1 divided by C2)	$309.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$320.26
3. Medicaid Trend Adjustment	($155.00)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Duval County Health Department
Provider Number: 0279269

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$8,794,364.00
2. Total Non-Allowable Costs	$15,736,071.00
3. Total Overhead Costs	$8,223,020.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$32,753,455.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$9,826,036.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$8,223,020.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$8,794,364.00
2. Total Non-Allowable Costs	$15,736,071.00
3. Sum of Lines B1 and B2	$24,530,435.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3585
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,947,952.67
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$11,742,316.67
2. Total CHD Visits	41,265
3. CHD Rate Per Visit (C1 divided by C2)	$284.56
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$294.57
3. Medicaid Trend Adjustment	($129.31)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Flagler County Health Department
Provider Number: 0279285

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,717,303.00
2. Total Non-Allowable Costs	$1,839,541.00
3. Total Overhead Costs	$668,932.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,225,776.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,267,732.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$668,932.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,717,303.00
2. Total Non-Allowable Costs	$1,839,541.00
3. Sum of Lines B1 and B2	$3,556,844.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4828
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$322,960.37
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,040,263.37
2. Total CHD Visits	11,110
3. CHD Rate Per Visit (C1 divided by C2)	$183.64
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$190.10
3. Medicaid Trend Adjustment	($24.84)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Franklin County Health Department
Provider Number: 0279293

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$645,755.00
2. Total Non-Allowable Costs	$1,213,980.00
3. Total Overhead Costs	$388,187.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,247,922.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$674,376.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$388,187.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$645,755.00
2. Total Non-Allowable Costs	$1,213,980.00
3. Sum of Lines B1 and B2	$1,859,735.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3472
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$134,778.53
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$780,533.53
2. Total CHD Visits	929
3. CHD Rate Per Visit (C1 divided by C2)	$840.19
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$869.75
3. Medicaid Trend Adjustment	($704.48)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.27

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Gadsden County Health Department
Provider Number: 0279307

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$675,388.00
2. Total Non-Allowable Costs	$2,009,965.00
3. Total Overhead Costs	$757,538.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,442,891.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,032,867.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$757,538.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$675,388.00
2. Total Non-Allowable Costs	$2,009,965.00
3. Sum of Lines B1 and B2	$2,685,353.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2515
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$190,520.81
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$865,908.81
2. Total CHD Visits	5,600
3. CHD Rate Per Visit (C1 divided by C2)	$154.63
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$160.07
3. Medicaid Trend Adjustment	($13.11)
4. Final Prospective Rate - Effective Date: 07/01/2021	$146.96

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Gilchrist County Health Department
Provider Number: 0279315

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$444,767.00
2. Total Non-Allowable Costs	$529,788.00
3. Total Overhead Costs	$271,137.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,245,692.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$373,707.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$271,137.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$444,767.00
2. Total Non-Allowable Costs	$529,788.00
3. Sum of Lines B1 and B2	$974,555.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4564
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$123,746.93
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$568,513.93
2. Total CHD Visits	2,636
3. CHD Rate Per Visit (C1 divided by C2)	$215.67
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$223.26
3. Medicaid Trend Adjustment	($58.00)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Glades County Health Department
Provider Number: 0279323

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$313,393.00
2. Total Non-Allowable Costs	$479,534.00
3. Total Overhead Costs	$377,111.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,170,038.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$351,011.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$351,011.40
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$313,393.00
2. Total Non-Allowable Costs	$479,534.00
3. Sum of Lines B1 and B2	$792,927.00
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)	$138,719.71
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$452,112.71
2. Total CHD Visits	1,680
3. CHD Rate Per Visit (C1 divided by C2)	$269.11
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$278.58
3. Medicaid Trend Adjustment	($113.32)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Gulf County Health Department
Provider Number: 0279331

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$287,090.00
2. Total Non-Allowable Costs	$1,036,705.00
3. Total Overhead Costs	$817,116.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,140,911.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$642,273.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$642,273.30
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$287,090.00
2. Total Non-Allowable Costs	$1,036,705.00
3. Sum of Lines B1 and B2	$1,323,795.00
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)	$139,309.08
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$426,399.08
2. Total CHD Visits	1,435
3. CHD Rate Per Visit (C1 divided by C2)	$297.14
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$307.60
3. Medicaid Trend Adjustment	($142.34)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Hamilton County Health Department
Provider Number: 0279340

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$494,352.00
2. Total Non-Allowable Costs	$455,505.00
3. Total Overhead Costs	$282,927.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,232,784.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$369,835.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$282,927.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$494,352.00
2. Total Non-Allowable Costs	$455,505.00
3. Sum of Lines B1 and B2	$949,857.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5204
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$147,235.21
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$641,587.21
2. Total CHD Visits	2,714
3. CHD Rate Per Visit (C1 divided by C2)	$236.40
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$244.72
3. Medicaid Trend Adjustment	($79.46)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Hardee County Health Department
Provider Number: 0279358

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$356,733.00
2. Total Non-Allowable Costs	$1,201,625.00
3. Total Overhead Costs	$695,257.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,253,615.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$676,084.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$676,084.50
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$356,733.00
2. Total Non-Allowable Costs	$1,201,625.00
3. Sum of Lines B1 and B2	$1,558,358.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2289
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$154,755.74
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$511,488.74
2. Total CHD Visits	1,481
3. CHD Rate Per Visit (C1 divided by C2)	$345.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$357.52
3. Medicaid Trend Adjustment	($192.26)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Hendry County Health Department
Provider Number: 0279366

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,639,318.00
2. Total Non-Allowable Costs	$2,723,031.00
3. Total Overhead Costs	$1,353,478.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,715,827.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,714,748.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,353,478.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,639,318.00
2. Total Non-Allowable Costs	$2,723,031.00
3. Sum of Lines B1 and B2	$4,362,349.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3758
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$508,637.03
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,147,955.03
2. Total CHD Visits	5,530
3. CHD Rate Per Visit (C1 divided by C2)	$388.42
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$402.08
3. Medicaid Trend Adjustment	($236.82)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Hernando County Health Department
Provider Number: 0279374

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,208,908.00
2. Total Non-Allowable Costs	$2,785,943.00
3. Total Overhead Costs	$2,036,662.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,031,513.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,809,453.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,809,453.90
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,208,908.00
2. Total Non-Allowable Costs	$2,785,943.00
3. Sum of Lines B1 and B2	$3,994,851.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3026
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$547,540.75
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,756,448.75
2. Total CHD Visits	7,070
3. CHD Rate Per Visit (C1 divided by C2)	$248.44
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$257.18
3. Medicaid Trend Adjustment	($91.92)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Highlands County Health Department
Provider Number: 0279382

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,178,054.00
2. Total Non-Allowable Costs	$2,703,778.00
3. Total Overhead Costs	$1,085,176.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,967,008.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,490,102.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,085,176.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,178,054.00
2. Total Non-Allowable Costs	$2,703,778.00
3. Sum of Lines B1 and B2	$3,881,832.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3035
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$329,350.92
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,507,404.92
2. Total CHD Visits	8,795
3. CHD Rate Per Visit (C1 divided by C2)	$171.39
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$177.42
3. Medicaid Trend Adjustment	($14.53)
4. Final Prospective Rate - Effective Date: 07/01/2021	$162.89

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,220,511.00
2. Total Non-Allowable Costs	$2,599,762.00
3. Total Overhead Costs	$1,800,035.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,620,308.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,686,092.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,686,092.40
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,220,511.00
2. Total Non-Allowable Costs	$2,599,762.00
3. Sum of Lines B1 and B2	$3,820,273.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3195
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$538,706.52
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,759,217.52
2. Total CHD Visits	7,983
3. CHD Rate Per Visit (C1 divided by C2)	$220.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$228.12
3. Medicaid Trend Adjustment	($62.86)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Jackson County Health Department
Provider Number: 0279421

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$955,486.00
2. Total Non-Allowable Costs	$2,679,307.00
3. Total Overhead Costs	$1,237,663.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,872,456.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,461,736.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,237,663.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$955,486.00
2. Total Non-Allowable Costs	$2,679,307.00
3. Sum of Lines B1 and B2	$3,634,793.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2629
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$325,381.60
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,280,867.60
2. Total CHD Visits	5,256
3. CHD Rate Per Visit (C1 divided by C2)	$243.70
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$252.27
3. Medicaid Trend Adjustment	($87.01)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Jefferson County Health Department
Provider Number: 0279439

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$586,488.00
2. Total Non-Allowable Costs	$895,164.00
3. Total Overhead Costs	$309,408.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,791,060.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$537,318.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$309,408.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$586,488.00
2. Total Non-Allowable Costs	$895,164.00
3. Sum of Lines B1 and B2	$1,481,652.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3958
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$122,463.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$708,951.69
2. Total CHD Visits	2,899
3. CHD Rate Per Visit (C1 divided by C2)	$244.55
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$253.15
3. Medicaid Trend Adjustment	($87.89)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Lee County Health Department
Provider Number: 0279463

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,897,495.00
2. Total Non-Allowable Costs	$10,126,992.00
3. Total Overhead Costs	$3,196,026.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$16,220,513.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,866,153.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,196,026.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,897,495.00
2. Total Non-Allowable Costs	$10,126,992.00
3. Sum of Lines B1 and B2	$13,024,487.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2225
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$711,115.79
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,608,610.79
2. Total CHD Visits	8,435
3. CHD Rate Per Visit (C1 divided by C2)	$427.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$442.87
3. Medicaid Trend Adjustment	($277.60)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.27

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Leon County Health Department
Provider Number: 0279471

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,885,135.00
2. Total Non-Allowable Costs	$6,218,128.00
3. Total Overhead Costs	$1,932,985.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$11,036,248.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,310,874.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,932,985.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,885,135.00
2. Total Non-Allowable Costs	$6,218,128.00
3. Sum of Lines B1 and B2	$9,103,263.00
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)	$612,562.95
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,497,697.95
2. Total CHD Visits	21,182
3. CHD Rate Per Visit (C1 divided by C2)	$165.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$170.94
3. Medicaid Trend Adjustment	($14.00)
4. Final Prospective Rate - Effective Date: 07/01/2021	$156.94

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Levy County Health Department
Provider Number: 0279480

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$950,240.00
2. Total Non-Allowable Costs	$1,240,744.00
3. Total Overhead Costs	$467,672.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,658,656.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$797,596.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$467,672.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$950,240.00
2. Total Non-Allowable Costs	$1,240,744.00
3. Sum of Lines B1 and B2	$2,190,984.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4337
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$202,829.35
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,153,069.35
2. Total CHD Visits	3,898
3. CHD Rate Per Visit (C1 divided by C2)	$295.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$306.22
3. Medicaid Trend Adjustment	($140.96)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Liberty County Health Department
Provider Number: 0279498

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$268,489.00
2. Total Non-Allowable Costs	$654,132.00
3. Total Overhead Costs	$356,911.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,279,532.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$383,859.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$356,911.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$268,489.00
2. Total Non-Allowable Costs	$654,132.00
3. Sum of Lines B1 and B2	$922,621.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2910
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$103,861.10
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$372,350.10
2. Total CHD Visits	1,546
3. CHD Rate Per Visit (C1 divided by C2)	$240.85
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$249.32
3. Medicaid Trend Adjustment	($84.06)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Manatee County Health Department
Provider Number: 0279510

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,834,876.00
2. Total Non-Allowable Costs	$5,216,216.00
3. Total Overhead Costs	$1,890,185.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,941,277.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,682,383.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,890,185.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,834,876.00
2. Total Non-Allowable Costs	$5,216,216.00
3. Sum of Lines B1 and B2	$7,051,092.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2602
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$491,826.14
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,326,702.14
2. Total CHD Visits	17,500
3. CHD Rate Per Visit (C1 divided by C2)	$132.95
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$137.63
3. Medicaid Trend Adjustment	($11.27)
4. Final Prospective Rate - Effective Date: 07/01/2021	$126.36

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Marion County Health Department
Provider Number: 0279528

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,193,654.00
2. Total Non-Allowable Costs	$7,223,445.00
3. Total Overhead Costs	$2,355,933.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,773,032.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,831,909.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,355,933.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,193,654.00
2. Total Non-Allowable Costs	$7,223,445.00
3. Sum of Lines B1 and B2	$10,417,099.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3066
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$722,329.06
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,915,983.06
2. Total CHD Visits	12,851
3. CHD Rate Per Visit (C1 divided by C2)	$304.72
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$315.44
3. Medicaid Trend Adjustment	($150.18)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Martin County Health Department
Provider Number: 0279536

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$840,334.00
2. Total Non-Allowable Costs	$3,611,004.00
3. Total Overhead Costs	$1,487,161.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,938,499.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,781,549.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,487,161.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$840,334.00
2. Total Non-Allowable Costs	$3,611,004.00
3. Sum of Lines B1 and B2	$4,451,338.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1888
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$280,776.00
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,121,110.00
2. Total CHD Visits	5,328
3. CHD Rate Per Visit (C1 divided by C2)	$210.42
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$217.82
3. Medicaid Trend Adjustment	($52.56)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Monroe County Health Department
Provider Number: 0279544

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,379,074.00
2. Total Non-Allowable Costs	$3,885,018.00
3. Total Overhead Costs	$1,931,386.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,195,478.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,158,643.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,931,386.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,379,074.00
2. Total Non-Allowable Costs	$3,885,018.00
3. Sum of Lines B1 and B2	$5,264,092.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2620
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$506,023.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,885,097.13
2. Total CHD Visits	5,528
3. CHD Rate Per Visit (C1 divided by C2)	$341.01
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$353.01
3. Medicaid Trend Adjustment	($187.75)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Nassau County Health Department
Provider Number: 0279552

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,186,970.00
2. Total Non-Allowable Costs	$2,535,839.00
3. Total Overhead Costs	$934,377.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,657,186.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,397,155.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$934,377.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,186,970.00
2. Total Non-Allowable Costs	$2,535,839.00
3. Sum of Lines B1 and B2	$3,722,809.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3188
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$297,879.39
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,484,849.39
2. Total CHD Visits	12,482
3. CHD Rate Per Visit (C1 divided by C2)	$118.96
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$123.14
3. Medicaid Trend Adjustment	($10.08)
4. Final Prospective Rate - Effective Date: 07/01/2021	$113.06

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Okaloosa County Health Department
Provider Number: 0279561

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,879,494.00
2. Total Non-Allowable Costs	$4,702,958.00
3. Total Overhead Costs	$2,780,614.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,363,066.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,808,919.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,780,614.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,879,494.00
2. Total Non-Allowable Costs	$4,702,958.00
3. Sum of Lines B1 and B2	$6,582,452.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2855
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$793,865.30
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,673,359.30
2. Total CHD Visits	13,651
3. CHD Rate Per Visit (C1 divided by C2)	$195.84
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$202.73
3. Medicaid Trend Adjustment	($37.47)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Okeechobee County Health Department
Provider Number: 0279579

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$256,465.00
2. Total Non-Allowable Costs	$1,481,345.00
3. Total Overhead Costs	$476,017.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,213,827.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$664,148.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$476,017.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$256,465.00
2. Total Non-Allowable Costs	$1,481,345.00
3. Sum of Lines B1 and B2	$1,737,810.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1476
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$70,260.11
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$326,725.11
2. Total CHD Visits	2,966
3. CHD Rate Per Visit (C1 divided by C2)	$110.16
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$114.03
3. Medicaid Trend Adjustment	($9.33)
4. Final Prospective Rate - Effective Date: 07/01/2021	$104.70

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Orange County Health Department
Provider Number: 0279587

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$7,967,491.00
2. Total Non-Allowable Costs	$21,279,737.00
3. Total Overhead Costs	$6,686,021.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$35,933,249.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,779,974.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$6,686,021.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$7,967,491.00
2. Total Non-Allowable Costs	$21,279,737.00
3. Sum of Lines B1 and B2	$29,247,228.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2724
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,821,272.12
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$9,788,763.12
2. Total CHD Visits	36,921
3. CHD Rate Per Visit (C1 divided by C2)	$265.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$274.46
3. Medicaid Trend Adjustment	($109.19)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.27

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Osceola County Health Department
Provider Number: 0279595

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,752,233.00
2. Total Non-Allowable Costs	$5,059,337.00
3. Total Overhead Costs	$2,372,604.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,184,174.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,755,252.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,372,604.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,752,233.00
2. Total Non-Allowable Costs	$5,059,337.00
3. Sum of Lines B1 and B2	$6,811,570.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2572
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$610,233.75
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,362,466.75
2. Total CHD Visits	10,255
3. CHD Rate Per Visit (C1 divided by C2)	$230.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$238.48
3. Medicaid Trend Adjustment	($73.22)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Pasco County Health Department
Provider Number: 0279617

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,046,192.00
2. Total Non-Allowable Costs	$6,017,919.00
3. Total Overhead Costs	$3,204,172.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,268,283.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,980,484.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,204,172.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,046,192.00
2. Total Non-Allowable Costs	$6,017,919.00
3. Sum of Lines B1 and B2	$10,064,111.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4020
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,288,077.14
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,334,269.14
2. Total CHD Visits	25,680
3. CHD Rate Per Visit (C1 divided by C2)	$207.72
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$215.03
3. Medicaid Trend Adjustment	($49.77)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Pinellas County Health Department
Provider Number: 0279625

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$21,051,482.00
2. Total Non-Allowable Costs	$24,464,520.00
3. Total Overhead Costs	$9,141,475.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$54,657,477.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$16,397,243.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$9,141,475.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$21,051,482.00
2. Total Non-Allowable Costs	$24,464,520.00
3. Sum of Lines B1 and B2	$45,516,002.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4625
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,227,932.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$25,279,414.19
2. Total CHD Visits	84,688
3. CHD Rate Per Visit (C1 divided by C2)	$298.50
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$309.00
3. Medicaid Trend Adjustment	($143.74)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Polk County Health Department
Provider Number: 0279633

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$9,372,782.00
2. Total Non-Allowable Costs	$14,639,140.00
3. Total Overhead Costs	$4,165,638.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$28,177,560.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$8,453,268.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$4,165,638.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,372,782.00
2. Total Non-Allowable Costs	$14,639,140.00
3. Sum of Lines B1 and B2	$24,011,922.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3903
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,625,848.51
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$10,998,630.51
2. Total CHD Visits	39,134
3. CHD Rate Per Visit (C1 divided by C2)	$281.05
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$290.94
3. Medicaid Trend Adjustment	($125.68)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Putnam County Health Department
Provider Number: 0279641

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,677,309.00
2. Total Non-Allowable Costs	$2,016,354.00
3. Total Overhead Costs	$952,208.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,645,871.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,393,761.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$952,208.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,677,309.00
2. Total Non-Allowable Costs	$2,016,354.00
3. Sum of Lines B1 and B2	$3,693,663.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4541
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$432,397.65
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,109,706.65
2. Total CHD Visits	2,885
3. CHD Rate Per Visit (C1 divided by C2)	$731.27
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$757.00
3. Medicaid Trend Adjustment	($591.73)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.27

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,653,059.00
2. Total Non-Allowable Costs	$3,124,434.00
3. Total Overhead Costs	$1,068,880.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,846,373.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,753,911.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,068,880.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,653,059.00
2. Total Non-Allowable Costs	$3,124,434.00
3. Sum of Lines B1 and B2	$4,777,493.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3460
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$369,832.48
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,022,891.48
2. Total CHD Visits	9,094
3. CHD Rate Per Visit (C1 divided by C2)	$222.44
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$230.27
3. Medicaid Trend Adjustment	($65.01)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,286,258.00
2. Total Non-Allowable Costs	$6,983,750.00
3. Total Overhead Costs	$1,986,648.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,256,656.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,976,996.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,986,648.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,286,258.00
2. Total Non-Allowable Costs	$6,983,750.00
3. Sum of Lines B1 and B2	$11,270,008.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3803
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$755,522.23
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,041,780.23
2. Total CHD Visits	17,088
3. CHD Rate Per Visit (C1 divided by C2)	$295.05
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$305.43
3. Medicaid Trend Adjustment	($140.17)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,643,282.00
2. Total Non-Allowable Costs	$2,815,927.00
3. Total Overhead Costs	$1,380,356.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,839,565.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,751,869.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,380,356.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,643,282.00
2. Total Non-Allowable Costs	$2,815,927.00
3. Sum of Lines B1 and B2	$4,459,209.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3685
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$508,661.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,151,943.19
2. Total CHD Visits	13,393
3. CHD Rate Per Visit (C1 divided by C2)	$160.68
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$166.33
3. Medicaid Trend Adjustment	($13.62)
4. Final Prospective Rate - Effective Date: 07/01/2021	$152.71

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Sarasota County Health Department
Provider Number: 0279684

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,788,373.00
2. Total Non-Allowable Costs	$16,634,498.00
3. Total Overhead Costs	$4,453,033.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$23,875,904.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$7,162,771.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$4,453,033.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,788,373.00
2. Total Non-Allowable Costs	$16,634,498.00
3. Sum of Lines B1 and B2	$19,422,871.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1436
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$639,455.54
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,427,828.54
2. Total CHD Visits	16,046
3. CHD Rate Per Visit (C1 divided by C2)	$213.63
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$221.14
3. Medicaid Trend Adjustment	($55.88)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Seminole County Health Department
Provider Number: 0279692

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,478,823.00
2. Total Non-Allowable Costs	$5,882,248.00
3. Total Overhead Costs	$3,168,889.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$11,529,960.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,458,988.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,168,889.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,478,823.00
2. Total Non-Allowable Costs	$5,882,248.00
3. Sum of Lines B1 and B2	$8,361,071.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2965
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$939,575.59
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,418,398.59
2. Total CHD Visits	8,903
3. CHD Rate Per Visit (C1 divided by C2)	$383.96
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$397.47
3. Medicaid Trend Adjustment	($232.21)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Sumter County Health Department
Provider Number: 0279706

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$747,949.00
2. Total Non-Allowable Costs	$1,698,407.00
3. Total Overhead Costs	$849,384.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,295,740.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$988,722.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$849,384.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$747,949.00
2. Total Non-Allowable Costs	$1,698,407.00
3. Sum of Lines B1 and B2	$2,446,356.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3057
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$259,656.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,007,605.69
2. Total CHD Visits	3,745
3. CHD Rate Per Visit (C1 divided by C2)	$269.05
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$278.52
3. Medicaid Trend Adjustment	($113.26)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Taylor County Health Department
Provider Number: 0279722

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$647,502.00
2. Total Non-Allowable Costs	$1,067,349.00
3. Total Overhead Costs	$308,251.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,023,102.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$606,930.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$308,251.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$647,502.00
2. Total Non-Allowable Costs	$1,067,349.00
3. Sum of Lines B1 and B2	$1,714,851.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3776
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$116,395.58
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$763,897.58
2. Total CHD Visits	3,205
3. CHD Rate Per Visit (C1 divided by C2)	$238.35
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$246.73
3. Medicaid Trend Adjustment	($81.47)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Union County Health Department
Provider Number: 0279731

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,103,087.00
2. Total Non-Allowable Costs	$765,750.00
3. Total Overhead Costs	$405,783.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,274,620.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$682,386.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$405,783.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,103,087.00
2. Total Non-Allowable Costs	$765,750.00
3. Sum of Lines B1 and B2	$1,868,837.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5903
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$239,533.70
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,342,620.70
2. Total CHD Visits	4,872
3. CHD Rate Per Visit (C1 divided by C2)	$275.58
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$285.28
3. Medicaid Trend Adjustment	($120.01)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.27

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Volusia County Health Department
Provider Number: 0279749

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,509,739.00
2. Total Non-Allowable Costs	$9,909,114.00
3. Total Overhead Costs	$5,280,674.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$19,699,527.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,909,858.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,280,674.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,509,739.00
2. Total Non-Allowable Costs	$9,909,114.00
3. Sum of Lines B1 and B2	$14,418,853.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3128
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,651,794.83
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$6,161,533.83
2. Total CHD Visits	31,097
3. CHD Rate Per Visit (C1 divided by C2)	$198.14
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$205.11
3. Medicaid Trend Adjustment	($39.85)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Wakulla County Health Department
Provider Number: 0279757

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$610,605.00
2. Total Non-Allowable Costs	$1,541,942.00
3. Total Overhead Costs	$436,808.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,589,355.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$776,806.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$436,808.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$610,605.00
2. Total Non-Allowable Costs	$1,541,942.00
3. Sum of Lines B1 and B2	$2,152,547.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2837
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$123,922.43
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$734,527.43
2. Total CHD Visits	3,669
3. CHD Rate Per Visit (C1 divided by C2)	$200.20
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$207.24
3. Medicaid Trend Adjustment	($41.98)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Washington County Health Department
Audit Status: **Unaudited Cost**
Provider Number: 0279773
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$858,141.00
2. Total Non-Allowable Costs	$929,344.00
3. Total Overhead Costs	$425,435.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,212,920.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$663,876.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$425,435.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$858,141.00
2. Total Non-Allowable Costs	$929,344.00
3. Sum of Lines B1 and B2	$1,787,485.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4801
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$204,251.34
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,062,392.34
2. Total CHD Visits	5,716
3. CHD Rate Per Visit (C1 divided by C2)	$185.86
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$192.40
3. Medicaid Trend Adjustment	($27.14)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Bay County Health Department
Provider Number: 0290068

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,605,599.00
2. Total Non-Allowable Costs	$5,192,274.00
3. Total Overhead Costs	$2,781,137.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,579,010.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,173,703.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,781,137.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,605,599.00
2. Total Non-Allowable Costs	$5,192,274.00
3. Sum of Lines B1 and B2	$7,797,873.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3341
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$929,177.87
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,534,776.87
2. Total CHD Visits	18,434
3. CHD Rate Per Visit (C1 divided by C2)	$191.75
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$198.50
3. Medicaid Trend Adjustment	($33.24)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Lafayette County Health Department
Provider Number: 0290343

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$271,198.00
2. Total Non-Allowable Costs	$405,218.00
3. Total Overhead Costs	$289,418.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$965,834.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$289,750.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$289,418.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$271,198.00
2. Total Non-Allowable Costs	$405,218.00
3. Sum of Lines B1 and B2	$676,416.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4009
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$116,027.68
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$387,225.68
2. Total CHD Visits	1,186
3. CHD Rate Per Visit (C1 divided by C2)	$326.50
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$337.98
3. Medicaid Trend Adjustment	($172.72)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Madison County Health Department
Provider Number: 0290408

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$284,955.00
2. Total Non-Allowable Costs	$1,024,945.00
3. Total Overhead Costs	$445,605.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,755,505.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$526,651.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$445,605.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$284,955.00
2. Total Non-Allowable Costs	$1,024,945.00
3. Sum of Lines B1 and B2	$1,309,900.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2175
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$96,919.09
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$381,874.09
2. Total CHD Visits	1,463
3. CHD Rate Per Visit (C1 divided by C2)	$261.02
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$270.21
3. Medicaid Trend Adjustment	($104.94)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.27

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Suwannee County Health Department
Provider Number: 0518328

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$590,693.00
2. Total Non-Allowable Costs	$853,857.00
3. Total Overhead Costs	$592,181.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,036,731.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$611,019.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$592,181.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$590,693.00
2. Total Non-Allowable Costs	$853,857.00
3. Sum of Lines B1 and B2	$1,444,550.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4089
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$242,142.81
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$832,835.81
2. Total CHD Visits	3,158
3. CHD Rate Per Visit (C1 divided by C2)	$263.72
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$273.00
3. Medicaid Trend Adjustment	($107.74)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Holmes County Health Department
Provider Number: 0519022

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$644,965.00
2. Total Non-Allowable Costs	$971,333.00
3. Total Overhead Costs	$485,635.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,101,933.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$630,579.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$485,635.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$644,965.00
2. Total Non-Allowable Costs	$971,333.00
3. Sum of Lines B1 and B2	$1,616,298.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3990
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$193,768.37
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$838,733.37
2. Total CHD Visits	5,910
3. CHD Rate Per Visit (C1 divided by C2)	$141.92
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$146.91
3. Medicaid Trend Adjustment	($12.03)
4. Final Prospective Rate - Effective Date: 07/01/2021	$134.88

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Brevard County Heath Department
Provider Number: 0519251

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$5,294,514.00
2. Total Non-Allowable Costs	$9,228,371.00
3. Total Overhead Costs	$3,206,604.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$17,729,489.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,318,846.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,206,604.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$5,294,514.00
2. Total Non-Allowable Costs	$9,228,371.00
3. Sum of Lines B1 and B2	$14,522,885.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3646
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,169,127.82
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$6,463,641.82
2. Total CHD Visits	31,638
3. CHD Rate Per Visit (C1 divided by C2)	$204.30
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$211.49
3. Medicaid Trend Adjustment	($46.23)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$19,662,495.00
2. Total Non-Allowable Costs	$27,620,519.00
3. Total Overhead Costs	$11,090,258.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$58,373,272.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$17,511,981.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$11,090,258.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$19,662,495.00
2. Total Non-Allowable Costs	$27,620,519.00
3. Sum of Lines B1 and B2	$47,283,014.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4158
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,611,329.28
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$24,273,824.28
2. Total CHD Visits	66,739
3. CHD Rate Per Visit (C1 divided by C2)	$363.71
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$376.51
3. Medicaid Trend Adjustment	($211.25)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Charlotte County Health Department
Provider Number: 0520446

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,016,041.00
2. Total Non-Allowable Costs	$2,755,961.00
3. Total Overhead Costs	$1,445,927.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,217,929.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,565,378.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,445,927.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,016,041.00
2. Total Non-Allowable Costs	$2,755,961.00
3. Sum of Lines B1 and B2	$3,772,002.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2694
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$389,532.73
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,405,573.73
2. Total CHD Visits	9,014
3. CHD Rate Per Visit (C1 divided by C2)	$155.93
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$161.42
3. Medicaid Trend Adjustment	($13.22)
4. Final Prospective Rate - Effective Date: 07/01/2021	$148.20

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Hillsborough County Health Department
Audit Status: **Unaudited Cost**
Provider Number: 0557269
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$9,277,420.00
2. Total Non-Allowable Costs	$26,989,343.00
3. Total Overhead Costs	$5,052,617.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$41,319,380.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$12,395,814.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,052,617.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,277,420.00
2. Total Non-Allowable Costs	$26,989,343.00
3. Sum of Lines B1 and B2	$36,266,763.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2558
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,292,459.43
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$10,569,879.43
2. Total CHD Visits	24,398
3. CHD Rate Per Visit (C1 divided by C2)	$433.23
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$448.47
3. Medicaid Trend Adjustment	($283.21)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Lake County Health Department
Provider Number: 0563234

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,947,496.00
2. Total Non-Allowable Costs	$4,444,770.00
3. Total Overhead Costs	$2,561,242.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,953,508.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,686,052.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,561,242.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,947,496.00
2. Total Non-Allowable Costs	$4,444,770.00
3. Sum of Lines B1 and B2	$6,392,266.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3047
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$780,410.44
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,727,906.44
2. Total CHD Visits	9,493
3. CHD Rate Per Visit (C1 divided by C2)	$287.36
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$297.47
3. Medicaid Trend Adjustment	($132.21)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2021 Through 06/30/2022

Provider Name: Escambia County Health Department
Provider Number: 0600181

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,569,732.00
2. Total Non-Allowable Costs	$7,502,902.00
3. Total Overhead Costs	$2,867,809.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,940,443.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,882,132.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,867,809.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,569,732.00
2. Total Non-Allowable Costs	$7,502,902.00
3. Sum of Lines B1 and B2	$10,072,634.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2551
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$731,578.08
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,301,310.08
2. Total CHD Visits	9,310
3. CHD Rate Per Visit (C1 divided by C2)	$354.60
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03518
2. CHD Prospective Rate (C3 Multiplied by D1)	$367.07
3. Medicaid Trend Adjustment	($201.81)
4. Final Prospective Rate - Effective Date: 07/01/2021	$165.26