State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

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

Provider Number: 0279111
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,803,542.00
2. Total Non-Allowable Costs	$7,898,465.00
3. Total Overhead Costs	$3,383,096.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$16,085,103.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,825,530.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,383,096.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,803,542.00
2. Total Non-Allowable Costs	$7,898,465.00
3. Sum of Lines B1 and B2	$12,702,007.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3782
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,279,486.91
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$6,083,028.91
2. Total CHD Visits	30,576
3. CHD Rate Per Visit (C1 divided by C2)	$198.95
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$205.86
3. Medicaid Trend Adjustment	($42.91)
4. Final Prospective Rate - Effective Date: 07/01/2018	$162.95

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Baker County Health Department
Provider Number: 0279129

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,212,877.00
2. Total Non-Allowable Costs	$747,813.00
3. Total Overhead Costs	$554,742.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,515,432.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,054,629.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$554,742.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,212,877.00
2. Total Non-Allowable Costs	$747,813.00
3. Sum of Lines B1 and B2	$2,960,690.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.7474
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$414,614.17
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,627,491.17
2. Total CHD Visits	15,329
3. CHD Rate Per Visit (C1 divided by C2)	$171.41
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$177.36
3. Medicaid Trend Adjustment	($10.27)
4. Final Prospective Rate - Effective Date: 07/01/2018	$167.09

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Bradford County Health Department
Provider Number: 0279145

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,263,060.00
2. Total Non-Allowable Costs	$744,282.00
3. Total Overhead Costs	$388,609.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,395,951.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$718,785.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$388,609.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,263,060.00
2. Total Non-Allowable Costs	$744,282.00
3. Sum of Lines B1 and B2	$2,007,342.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6292
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$244,512.78
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,507,572.78
2. Total CHD Visits	6,553
3. CHD Rate Per Visit (C1 divided by C2)	$230.06
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$238.05
3. Medicaid Trend Adjustment	($68.48)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Broward County Health Department
Provider Number: 0279161

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$8,310,630.00
2. Total Non-Allowable Costs	$27,351,540.00
3. Total Overhead Costs	$11,920,285.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$47,582,455.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$14,274,736.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$11,920,285.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$8,310,630.00
2. Total Non-Allowable Costs	$27,351,540.00
3. Sum of Lines B1 and B2	$35,662,170.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2330
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,777,426.41
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$11,088,056.41
2. Total CHD Visits	65,385
3. CHD Rate Per Visit (C1 divided by C2)	$169.58
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$175.47
3. Medicaid Trend Adjustment	($26.14)
4. Final Prospective Rate - Effective Date: 07/01/2018	$149.33

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Calhoun County Health Department
Provider Number: 0279170

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$374,630.00
2. Total Non-Allowable Costs	$735,808.00
3. Total Overhead Costs	$272,984.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,383,422.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$415,026.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$272,984.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$374,630.00
2. Total Non-Allowable Costs	$735,808.00
3. Sum of Lines B1 and B2	$1,110,438.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3374
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$92,104.80
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$466,734.80
2. Total CHD Visits	4,082
3. CHD Rate Per Visit (C1 divided by C2)	$114.34
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$118.31
3. Medicaid Trend Adjustment	($6.85)
4. Final Prospective Rate - Effective Date: 07/01/2018	$111.46

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Citrus County Health Department
Provider Number: 0279196

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,446,763.00
2. Total Non-Allowable Costs	$2,477,680.00
3. Total Overhead Costs	$1,392,592.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,317,035.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,595,110.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,392,592.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,446,763.00
2. Total Non-Allowable Costs	$2,477,680.00
3. Sum of Lines B1 and B2	$3,924,443.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3687
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$513,448.67
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,960,211.67
2. Total CHD Visits	9,702
3. CHD Rate Per Visit (C1 divided by C2)	$202.04
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$209.06
3. Medicaid Trend Adjustment	($86.34)
4. Final Prospective Rate - Effective Date: 07/01/2018	$122.72

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Clay County Health Department
Provider Number: 0279200

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,344,022.00
2. Total Non-Allowable Costs	$2,263,014.00
3. Total Overhead Costs	$1,228,067.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,835,103.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,450,530.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,228,067.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,344,022.00
2. Total Non-Allowable Costs	$2,263,014.00
3. Sum of Lines B1 and B2	$3,607,036.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3726
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$457,577.76
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,801,599.76
2. Total CHD Visits	6,731
3. CHD Rate Per Visit (C1 divided by C2)	$267.66
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$276.96
3. Medicaid Trend Adjustment	($107.39)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Collier County Health Department
Provider Number: 0279218

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,465,469.00
2. Total Non-Allowable Costs	$6,688,497.00
3. Total Overhead Costs	$2,750,867.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,904,833.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,871,449.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,750,867.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,465,469.00
2. Total Non-Allowable Costs	$6,688,497.00
3. Sum of Lines B1 and B2	$10,153,966.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3413
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$938,870.91
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,404,339.91
2. Total CHD Visits	22,171
3. CHD Rate Per Visit (C1 divided by C2)	$198.65
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$205.55
3. Medicaid Trend Adjustment	($35.98)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Columbia County Health Department
Provider Number: 0279226

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$935,543.00
2. Total Non-Allowable Costs	$1,309,900.00
3. Total Overhead Costs	$483,281.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,728,724.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$818,617.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$483,281.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$935,543.00
2. Total Non-Allowable Costs	$1,309,900.00
3. Sum of Lines B1 and B2	$2,245,443.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4166
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$201,334.86
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,136,877.86
2. Total CHD Visits	5,682
3. CHD Rate Per Visit (C1 divided by C2)	$200.08
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$207.04
3. Medicaid Trend Adjustment	($37.47)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Dade County Health Department
Provider Number: 0279234

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$20,478,966.00
2. Total Non-Allowable Costs	$43,869,453.00
3. Total Overhead Costs	$10,650,111.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$74,998,530.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$22,499,559.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$10,650,111.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$20,478,966.00
2. Total Non-Allowable Costs	$43,869,453.00
3. Sum of Lines B1 and B2	$64,348,419.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3183
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$3,389,930.33
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$23,868,896.33
2. Total CHD Visits	91,151
3. CHD Rate Per Visit (C1 divided by C2)	$261.86
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$270.96
3. Medicaid Trend Adjustment	($101.39)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: DeSoto County Health Department
Provider Number: 0279242

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,054,895.00
2. Total Non-Allowable Costs	$2,901,196.00
3. Total Overhead Costs	$492,696.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,448,787.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,634,636.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$492,696.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,054,895.00
2. Total Non-Allowable Costs	$2,901,196.00
3. Sum of Lines B1 and B2	$4,956,091.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4146
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$204,271.76
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,259,166.76
2. Total CHD Visits	19,054
3. CHD Rate Per Visit (C1 divided by C2)	$118.57
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$122.69
3. Medicaid Trend Adjustment	($7.18)
4. Final Prospective Rate - Effective Date: 07/01/2018	$115.51

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Dixie County Health Department
Provider Number: 0279251

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$289,036.00
2. Total Non-Allowable Costs	$728,216.00
3. Total Overhead Costs	$338,560.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,355,812.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$406,743.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$338,560.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$289,036.00
2. Total Non-Allowable Costs	$728,216.00
3. Sum of Lines B1 and B2	$1,017,252.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2841
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$96,184.90
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$385,220.90
2. Total CHD Visits	2,729
3. CHD Rate Per Visit (C1 divided by C2)	$141.16
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$146.06
3. Medicaid Trend Adjustment	($15.30)
4. Final Prospective Rate - Effective Date: 07/01/2018	$130.76

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Duval County Health Department
Provider Number: 0279269

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$11,778,301.00
2. Total Non-Allowable Costs	$15,245,943.00
3. Total Overhead Costs	$10,692,574.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$37,716,818.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$11,315,045.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$10,692,574.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$11,778,301.00
2. Total Non-Allowable Costs	$15,245,943.00
3. Sum of Lines B1 and B2	$27,024,244.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4358
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,659,823.75
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$16,438,124.75
2. Total CHD Visits	62,612
3. CHD Rate Per Visit (C1 divided by C2)	$262.54
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$271.66
3. Medicaid Trend Adjustment	($102.09)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Flagler County Health Department
Provider Number: 0279285

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,320,228.00
2. Total Non-Allowable Costs	$1,210,054.00
3. Total Overhead Costs	$566,051.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,096,333.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$928,899.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$566,051.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,320,228.00
2. Total Non-Allowable Costs	$1,210,054.00
3. Sum of Lines B1 and B2	$2,530,282.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5218
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$295,365.41
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,615,593.41
2. Total CHD Visits	10,699
3. CHD Rate Per Visit (C1 divided by C2)	$151.00
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$156.25
3. Medicaid Trend Adjustment	($9.05)
4. Final Prospective Rate - Effective Date: 07/01/2018	$147.20

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Franklin County Health Department
Provider Number: 0279293

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$326,458.00
2. Total Non-Allowable Costs	$1,477,581.00
3. Total Overhead Costs	$458,851.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,262,890.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$678,867.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$458,851.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$326,458.00
2. Total Non-Allowable Costs	$1,477,581.00
3. Sum of Lines B1 and B2	$1,804,039.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1810
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$83,052.03
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$409,510.03
2. Total CHD Visits	1,610
3. CHD Rate Per Visit (C1 divided by C2)	$254.35
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$263.19
3. Medicaid Trend Adjustment	($93.62)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Gadsden County Health Department
Provider Number: 0279307

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$601,662.00
2. Total Non-Allowable Costs	$1,807,376.00
3. Total Overhead Costs	$731,584.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,140,622.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$942,186.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$731,584.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$601,662.00
2. Total Non-Allowable Costs	$1,807,376.00
3. Sum of Lines B1 and B2	$2,409,038.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2498
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$182,749.68
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$784,411.68
2. Total CHD Visits	3,150
3. CHD Rate Per Visit (C1 divided by C2)	$249.02
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$257.67
3. Medicaid Trend Adjustment	($88.10)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Gilchrist County Health Department
Provider Number: 0279315

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$506,877.00
2. Total Non-Allowable Costs	$467,213.00
3. Total Overhead Costs	$225,463.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,199,553.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$359,865.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$225,463.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$506,877.00
2. Total Non-Allowable Costs	$467,213.00
3. Sum of Lines B1 and B2	$974,090.00
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)	$117,330.95
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$624,207.95
2. Total CHD Visits	4,717
3. CHD Rate Per Visit (C1 divided by C2)	$132.33
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$136.93
3. Medicaid Trend Adjustment	($7.93)
4. Final Prospective Rate - Effective Date: 07/01/2018	$129.00

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Glades County Health Department
Provider Number: 0279323

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$257,061.00
2. Total Non-Allowable Costs	$443,929.00
3. Total Overhead Costs	$225,786.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$926,776.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$278,032.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$225,786.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$257,061.00
2. Total Non-Allowable Costs	$443,929.00
3. Sum of Lines B1 and B2	$700,990.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3667
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$82,795.73
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$339,856.73
2. Total CHD Visits	1,470
3. CHD Rate Per Visit (C1 divided by C2)	$231.20
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$239.23
3. Medicaid Trend Adjustment	($69.66)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Gulf County Health Department
Provider Number: 0279331

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$442,708.00
2. Total Non-Allowable Costs	$1,034,982.00
3. Total Overhead Costs	$786,667.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,264,357.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$679,307.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$679,307.10
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$442,708.00
2. Total Non-Allowable Costs	$1,034,982.00
3. Sum of Lines B1 and B2	$1,477,690.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2996
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$203,520.41
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$646,228.41
2. Total CHD Visits	1,435
3. CHD Rate Per Visit (C1 divided by C2)	$450.33
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$465.98
3. Medicaid Trend Adjustment	($296.41)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Hamilton County Health Department
Provider Number: 0279340

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$324,006.00
2. Total Non-Allowable Costs	$575,615.00
3. Total Overhead Costs	$365,903.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,265,524.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$379,657.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$365,903.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$324,006.00
2. Total Non-Allowable Costs	$575,615.00
3. Sum of Lines B1 and B2	$899,621.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3602
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$131,798.26
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$455,804.26
2. Total CHD Visits	3,528
3. CHD Rate Per Visit (C1 divided by C2)	$129.20
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$133.68
3. Medicaid Trend Adjustment	($18.96)
4. Final Prospective Rate - Effective Date: 07/01/2018	$114.72

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Hardee County Health Department
Provider Number: 0279358

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$372,580.00
2. Total Non-Allowable Costs	$1,023,470.00
3. Total Overhead Costs	$466,150.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,862,200.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$558,660.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$466,150.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$372,580.00
2. Total Non-Allowable Costs	$1,023,470.00
3. Sum of Lines B1 and B2	$1,396,050.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2669
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$124,415.44
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$496,995.44
2. Total CHD Visits	1,317
3. CHD Rate Per Visit (C1 divided by C2)	$377.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$390.48
3. Medicaid Trend Adjustment	($220.91)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Hendry County Health Department
Provider Number: 0279366

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,670,282.00
2. Total Non-Allowable Costs	$1,626,746.00
3. Total Overhead Costs	$1,202,641.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,499,669.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,349,900.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,202,641.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,670,282.00
2. Total Non-Allowable Costs	$1,626,746.00
3. Sum of Lines B1 and B2	$3,297,028.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5066
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$609,257.93
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,279,539.93
2. Total CHD Visits	4,697
3. CHD Rate Per Visit (C1 divided by C2)	$485.32
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$502.18
3. Medicaid Trend Adjustment	($332.61)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Hernando County Health Department
Provider Number: 0279374

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,392,065.00
2. Total Non-Allowable Costs	$2,482,345.00
3. Total Overhead Costs	$2,282,190.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,156,600.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,146,980.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,146,980.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,392,065.00
2. Total Non-Allowable Costs	$2,482,345.00
3. Sum of Lines B1 and B2	$4,874,410.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4907
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,053,523.09
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,445,588.09
2. Total CHD Visits	15,420
3. CHD Rate Per Visit (C1 divided by C2)	$223.45
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$231.21
3. Medicaid Trend Adjustment	($61.64)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Highlands County Health Department
Provider Number: 0279382

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,408,536.00
2. Total Non-Allowable Costs	$2,118,700.00
3. Total Overhead Costs	$1,055,053.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,582,289.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,374,686.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,055,053.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,408,536.00
2. Total Non-Allowable Costs	$2,118,700.00
3. Sum of Lines B1 and B2	$3,527,236.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3993
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$421,282.66
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,829,818.66
2. Total CHD Visits	9,596
3. CHD Rate Per Visit (C1 divided by C2)	$190.69
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$197.31
3. Medicaid Trend Adjustment	($36.52)
4. Final Prospective Rate - Effective Date: 07/01/2018	$160.79

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,992,044.00
2. Total Non-Allowable Costs	$2,542,299.00
3. Total Overhead Costs	$2,160,966.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,695,309.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,608,592.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,160,966.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,992,044.00
2. Total Non-Allowable Costs	$2,542,299.00
3. Sum of Lines B1 and B2	$6,534,343.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6109
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,320,134.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,312,178.13
2. Total CHD Visits	27,839
3. CHD Rate Per Visit (C1 divided by C2)	$190.82
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$197.45
3. Medicaid Trend Adjustment	($44.14)
4. Final Prospective Rate - Effective Date: 07/01/2018	$153.31

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Jackson County Health Department
Provider Number: 0279421

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,236,108.00
2. Total Non-Allowable Costs	$1,905,565.00
3. Total Overhead Costs	$1,002,372.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,144,045.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,243,213.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,002,372.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,236,108.00
2. Total Non-Allowable Costs	$1,905,565.00
3. Sum of Lines B1 and B2	$3,141,673.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3935
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$394,433.38
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,630,541.38
2. Total CHD Visits	14,634
3. CHD Rate Per Visit (C1 divided by C2)	$111.42
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$115.29
3. Medicaid Trend Adjustment	($11.23)
4. Final Prospective Rate - Effective Date: 07/01/2018	$104.06

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Jefferson County Health Department
Provider Number: 0279439

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$634,470.00
2. Total Non-Allowable Costs	$853,853.00
3. Total Overhead Costs	$303,153.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,791,476.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$537,442.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$303,153.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$634,470.00
2. Total Non-Allowable Costs	$853,853.00
3. Sum of Lines B1 and B2	$1,488,323.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4263
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$129,234.12
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$763,704.12
2. Total CHD Visits	3,018
3. CHD Rate Per Visit (C1 divided by C2)	$253.05
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$261.84
3. Medicaid Trend Adjustment	($92.27)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Lee County Health Department
Provider Number: 0279463

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,398,865.00
2. Total Non-Allowable Costs	$9,732,563.00
3. Total Overhead Costs	$2,868,926.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$16,000,354.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,800,106.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,868,926.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,398,865.00
2. Total Non-Allowable Costs	$9,732,563.00
3. Sum of Lines B1 and B2	$13,131,428.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2588
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$742,478.05
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,141,343.05
2. Total CHD Visits	10,282
3. CHD Rate Per Visit (C1 divided by C2)	$402.78
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$416.77
3. Medicaid Trend Adjustment	($247.20)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Leon County Health Department
Provider Number: 0279471

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,437,476.00
2. Total Non-Allowable Costs	$5,259,022.00
3. Total Overhead Costs	$1,757,157.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,453,655.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,136,096.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,757,157.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,437,476.00
2. Total Non-Allowable Costs	$5,259,022.00
3. Sum of Lines B1 and B2	$8,696,498.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3953
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$694,604.16
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,132,080.16
2. Total CHD Visits	25,359
3. CHD Rate Per Visit (C1 divided by C2)	$162.94
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$168.60
3. Medicaid Trend Adjustment	($18.31)
4. Final Prospective Rate - Effective Date: 07/01/2018	$150.29

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Levy County Health Department
Provider Number: 0279480

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$804,001.00
2. Total Non-Allowable Costs	$1,180,245.00
3. Total Overhead Costs	$518,489.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,502,735.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$750,820.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$518,489.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$804,001.00
2. Total Non-Allowable Costs	$1,180,245.00
3. Sum of Lines B1 and B2	$1,984,246.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4052
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$210,091.74
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,014,092.74
2. Total CHD Visits	5,516
3. CHD Rate Per Visit (C1 divided by C2)	$183.85
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$190.23
3. Medicaid Trend Adjustment	($20.66)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Liberty County Health Department
Provider Number: 0279498

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$312,196.00
2. Total Non-Allowable Costs	$378,347.00
3. Total Overhead Costs	$287,109.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$977,652.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$293,295.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$287,109.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$312,196.00
2. Total Non-Allowable Costs	$378,347.00
3. Sum of Lines B1 and B2	$690,543.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4521
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$129,801.98
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$441,997.98
2. Total CHD Visits	2,560
3. CHD Rate Per Visit (C1 divided by C2)	$172.66
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$178.65
3. Medicaid Trend Adjustment	($26.11)
4. Final Prospective Rate - Effective Date: 07/01/2018	$152.54

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Manatee County Health Department
Provider Number: 0279510

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,454,483.00
2. Total Non-Allowable Costs	$5,152,255.00
3. Total Overhead Costs	$2,172,272.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,779,010.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,633,703.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,172,272.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,454,483.00
2. Total Non-Allowable Costs	$5,152,255.00
3. Sum of Lines B1 and B2	$6,606,738.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2202
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$478,334.29
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,932,817.29
2. Total CHD Visits	9,065
3. CHD Rate Per Visit (C1 divided by C2)	$213.22
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$220.63
3. Medicaid Trend Adjustment	($55.64)
4. Final Prospective Rate - Effective Date: 07/01/2018	$164.99

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Marion County Health Department
Provider Number: 0279528

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,882,798.00
2. Total Non-Allowable Costs	$6,498,548.00
3. Total Overhead Costs	$2,435,791.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$11,817,137.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,545,141.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,435,791.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,882,798.00
2. Total Non-Allowable Costs	$6,498,548.00
3. Sum of Lines B1 and B2	$9,381,346.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3073
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$748,518.57
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,631,316.57
2. Total CHD Visits	14,730
3. CHD Rate Per Visit (C1 divided by C2)	$246.53
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$255.09
3. Medicaid Trend Adjustment	($85.52)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Martin County Health Department
Provider Number: 0279536

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$825,437.00
2. Total Non-Allowable Costs	$3,424,664.00
3. Total Overhead Costs	$1,668,597.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,918,698.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,775,609.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,668,597.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$825,437.00
2. Total Non-Allowable Costs	$3,424,664.00
3. Sum of Lines B1 and B2	$4,250,101.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1942
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$324,041.54
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,149,478.54
2. Total CHD Visits	5,373
3. CHD Rate Per Visit (C1 divided by C2)	$213.94
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$221.37
3. Medicaid Trend Adjustment	($51.80)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Monroe County Health Department
Provider Number: 0279544

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,880,331.00
2. Total Non-Allowable Costs	$4,302,619.00
3. Total Overhead Costs	$1,829,232.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,012,182.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,403,654.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,829,232.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,880,331.00
2. Total Non-Allowable Costs	$4,302,619.00
3. Sum of Lines B1 and B2	$6,182,950.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3041
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$556,269.45
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,436,600.45
2. Total CHD Visits	6,020
3. CHD Rate Per Visit (C1 divided by C2)	$404.75
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$418.81
3. Medicaid Trend Adjustment	($249.24)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Nassau County Health Department
Provider Number: 0279552

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,194,411.00
2. Total Non-Allowable Costs	$2,091,450.00
3. Total Overhead Costs	$1,044,852.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,330,713.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,299,213.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,044,852.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,194,411.00
2. Total Non-Allowable Costs	$2,091,450.00
3. Sum of Lines B1 and B2	$3,285,861.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3635
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$379,803.70
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,574,214.70
2. Total CHD Visits	11,533
3. CHD Rate Per Visit (C1 divided by C2)	$136.50
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$141.24
3. Medicaid Trend Adjustment	($13.67)
4. Final Prospective Rate - Effective Date: 07/01/2018	$127.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Okaloosa County Health Department
Provider Number: 0279561

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,607,425.00
2. Total Non-Allowable Costs	$2,865,806.00
3. Total Overhead Costs	$2,695,613.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,168,844.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,150,653.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,150,653.20
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,607,425.00
2. Total Non-Allowable Costs	$2,865,806.00
3. Sum of Lines B1 and B2	$4,473,231.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3593
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$772,729.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,380,154.69
2. Total CHD Visits	12,230
3. CHD Rate Per Visit (C1 divided by C2)	$194.62
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$201.38
3. Medicaid Trend Adjustment	($48.63)
4. Final Prospective Rate - Effective Date: 07/01/2018	$152.75

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Okeechobee County Health Department
Provider Number: 0279579

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$521,754.00
2. Total Non-Allowable Costs	$1,380,973.00
3. Total Overhead Costs	$508,589.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,411,316.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$723,394.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$508,589.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$521,754.00
2. Total Non-Allowable Costs	$1,380,973.00
3. Sum of Lines B1 and B2	$1,902,727.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2742
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$139,455.10
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$661,209.10
2. Total CHD Visits	4,327
3. CHD Rate Per Visit (C1 divided by C2)	$152.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$158.12
3. Medicaid Trend Adjustment	($10.79)
4. Final Prospective Rate - Effective Date: 07/01/2018	$147.33

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Orange County Health Department
Provider Number: 0279587

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$10,737,338.00
2. Total Non-Allowable Costs	$17,812,693.00
3. Total Overhead Costs	$5,536,826.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$34,086,857.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,226,057.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,536,826.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$10,737,338.00
2. Total Non-Allowable Costs	$17,812,693.00
3. Sum of Lines B1 and B2	$28,550,031.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3761
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,082,400.26
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$12,819,738.26
2. Total CHD Visits	48,990
3. CHD Rate Per Visit (C1 divided by C2)	$261.68
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$270.77
3. Medicaid Trend Adjustment	($101.20)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Osceola County Health Department
Provider Number: 0279595

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$8,601,509.00
2. Total Non-Allowable Costs	$4,903,597.00
3. Total Overhead Costs	$4,184,998.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$17,690,104.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,307,031.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$4,184,998.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$8,601,509.00
2. Total Non-Allowable Costs	$4,903,597.00
3. Sum of Lines B1 and B2	$13,505,106.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6369
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,665,425.23
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$11,266,934.23
2. Total CHD Visits	50,846
3. CHD Rate Per Visit (C1 divided by C2)	$221.59
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$229.29
3. Medicaid Trend Adjustment	($59.72)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Pasco County Health Department
Provider Number: 0279617

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,814,981.00
2. Total Non-Allowable Costs	$5,437,834.00
3. Total Overhead Costs	$3,258,974.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,511,789.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,753,536.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,258,974.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,814,981.00
2. Total Non-Allowable Costs	$5,437,834.00
3. Sum of Lines B1 and B2	$9,252,815.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4123
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,343,674.98
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,158,655.98
2. Total CHD Visits	17,783
3. CHD Rate Per Visit (C1 divided by C2)	$290.09
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$300.17
3. Medicaid Trend Adjustment	($130.60)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Pinellas County Health Department
Provider Number: 0279625

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$20,977,363.00
2. Total Non-Allowable Costs	$21,841,912.00
3. Total Overhead Costs	$9,293,888.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$52,113,163.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$15,633,948.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$9,293,888.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$20,977,363.00
2. Total Non-Allowable Costs	$21,841,912.00
3. Sum of Lines B1 and B2	$42,819,275.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4899
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,553,075.73
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$25,530,438.73
2. Total CHD Visits	106,666
3. CHD Rate Per Visit (C1 divided by C2)	$239.35
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$247.66
3. Medicaid Trend Adjustment	($78.09)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Polk County Health Department
Provider Number: 0279633

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$10,665,206.00
2. Total Non-Allowable Costs	$12,220,891.00
3. Total Overhead Costs	$4,270,805.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$27,156,902.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$8,147,070.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$4,270,805.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$10,665,206.00
2. Total Non-Allowable Costs	$12,220,891.00
3. Sum of Lines B1 and B2	$22,886,097.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4660
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,990,195.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$12,655,401.13
2. Total CHD Visits	59,264
3. CHD Rate Per Visit (C1 divided by C2)	$213.54
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$220.96
3. Medicaid Trend Adjustment	($51.39)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Putnam County Health Department
Provider Number: 0279641

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,620,081.00
2. Total Non-Allowable Costs	$1,797,658.00
3. Total Overhead Costs	$746,523.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,164,262.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,249,278.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$746,523.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,620,081.00
2. Total Non-Allowable Costs	$1,797,658.00
3. Sum of Lines B1 and B2	$3,417,739.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4740
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$353,851.90
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,973,932.90
2. Total CHD Visits	4,615
3. CHD Rate Per Visit (C1 divided by C2)	$427.72
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$442.58
3. Medicaid Trend Adjustment	($273.01)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,967,753.00
2. Total Non-Allowable Costs	$2,084,933.00
3. Total Overhead Costs	$1,008,441.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,061,127.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,518,338.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,008,441.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,967,753.00
2. Total Non-Allowable Costs	$2,084,933.00
3. Sum of Lines B1 and B2	$4,052,686.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4855
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$489,598.11
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,457,351.11
2. Total CHD Visits	8,689
3. CHD Rate Per Visit (C1 divided by C2)	$282.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$292.64
3. Medicaid Trend Adjustment	($123.07)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,136,227.00
2. Total Non-Allowable Costs	$8,243,740.00
3. Total Overhead Costs	$1,863,098.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,243,065.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,972,919.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,863,098.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,136,227.00
2. Total Non-Allowable Costs	$8,243,740.00
3. Sum of Lines B1 and B2	$11,379,967.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2756
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$513,469.81
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,649,696.81
2. Total CHD Visits	17,145
3. CHD Rate Per Visit (C1 divided by C2)	$212.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$220.27
3. Medicaid Trend Adjustment	($50.70)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Santa Rosa County Health Department
Audit Status: **Unaudited Cost**
Provider Number: 0279676
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$792,171.00
2. Total Non-Allowable Costs	$2,399,347.00
3. Total Overhead Costs	$1,128,927.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,320,445.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,296,133.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,128,927.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$792,171.00
2. Total Non-Allowable Costs	$2,399,347.00
3. Sum of Lines B1 and B2	$3,191,518.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2482
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$280,199.68
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,072,370.68
2. Total CHD Visits	8,250
3. CHD Rate Per Visit (C1 divided by C2)	$129.98
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$134.50
3. Medicaid Trend Adjustment	($33.55)
4. Final Prospective Rate - Effective Date: 07/01/2018	$100.95

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Sarasota County Health Department
Provider Number: 0279684

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$13,658,010.00
2. Total Non-Allowable Costs	$14,275,244.00
3. Total Overhead Costs	$5,882,621.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$33,815,875.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,144,762.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,882,621.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$13,658,010.00
2. Total Non-Allowable Costs	$14,275,244.00
3. Sum of Lines B1 and B2	$27,933,254.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4890
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,876,601.67
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$16,534,611.67
2. Total CHD Visits	91,695
3. CHD Rate Per Visit (C1 divided by C2)	$180.32
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$186.59
3. Medicaid Trend Adjustment	($35.47)
4. Final Prospective Rate - Effective Date: 07/01/2018	$151.12

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Seminole County Health Department
Provider Number: 0279692

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,393,875.00
2. Total Non-Allowable Costs	$5,243,076.00
3. Total Overhead Costs	$2,384,435.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,021,386.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,006,415.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,384,435.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,393,875.00
2. Total Non-Allowable Costs	$5,243,076.00
3. Sum of Lines B1 and B2	$7,636,951.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3135
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$747,520.37
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,141,395.37
2. Total CHD Visits	19,615
3. CHD Rate Per Visit (C1 divided by C2)	$160.15
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$165.72
3. Medicaid Trend Adjustment	($35.50)
4. Final Prospective Rate - Effective Date: 07/01/2018	$130.22

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Sumter County Health Department
Provider Number: 0279706

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$678,350.00
2. Total Non-Allowable Costs	$1,300,032.00
3. Total Overhead Costs	$952,391.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,930,773.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$879,231.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$879,231.90
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$678,350.00
2. Total Non-Allowable Costs	$1,300,032.00
3. Sum of Lines B1 and B2	$1,978,382.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3429
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$301,488.62
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$979,838.62
2. Total CHD Visits	4,585
3. CHD Rate Per Visit (C1 divided by C2)	$213.71
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$221.13
3. Medicaid Trend Adjustment	($65.34)
4. Final Prospective Rate - Effective Date: 07/01/2018	$155.79

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Taylor County Health Department
Provider Number: 0279722

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$430,245.00
2. Total Non-Allowable Costs	$1,094,142.00
3. Total Overhead Costs	$505,377.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,029,764.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$608,929.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$505,377.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$430,245.00
2. Total Non-Allowable Costs	$1,094,142.00
3. Sum of Lines B1 and B2	$1,524,387.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2822
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$142,617.39
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$572,862.39
2. Total CHD Visits	4,540
3. CHD Rate Per Visit (C1 divided by C2)	$126.18
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$130.56
3. Medicaid Trend Adjustment	($13.58)
4. Final Prospective Rate - Effective Date: 07/01/2018	$116.98

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Union County Health Department
Provider Number: 0279731

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,343,595.00
2. Total Non-Allowable Costs	$561,245.00
3. Total Overhead Costs	$429,288.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,334,128.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$700,238.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$429,288.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,343,595.00
2. Total Non-Allowable Costs	$561,245.00
3. Sum of Lines B1 and B2	$1,904,840.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.7054
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$302,819.76
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,646,414.76
2. Total CHD Visits	6,877
3. CHD Rate Per Visit (C1 divided by C2)	$239.41
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$247.73
3. Medicaid Trend Adjustment	($78.16)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Volusia County Health Department
Provider Number: 0279749

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$5,819,553.00
2. Total Non-Allowable Costs	$8,489,949.00
3. Total Overhead Costs	$5,432,939.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$19,742,441.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,922,732.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,432,939.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$5,819,553.00
2. Total Non-Allowable Costs	$8,489,949.00
3. Sum of Lines B1 and B2	$14,309,502.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4067
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,209,576.29
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$8,029,129.29
2. Total CHD Visits	35,491
3. CHD Rate Per Visit (C1 divided by C2)	$226.23
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$234.09
3. Medicaid Trend Adjustment	($64.52)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Wakulla County Health Department
Provider Number: 0279757

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$677,288.00
2. Total Non-Allowable Costs	$1,160,346.00
3. Total Overhead Costs	$340,267.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,177,901.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$653,370.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$340,267.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$677,288.00
2. Total Non-Allowable Costs	$1,160,346.00
3. Sum of Lines B1 and B2	$1,837,634.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3686
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$125,422.42
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$802,710.42
2. Total CHD Visits	4,840
3. CHD Rate Per Visit (C1 divided by C2)	$165.85
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$171.61
3. Medicaid Trend Adjustment	($9.94)
4. Final Prospective Rate - Effective Date: 07/01/2018	$161.67

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Walton County Health Department
Provider Number: 0279765

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,252,436.00
2. Total Non-Allowable Costs	$1,917,689.00
3. Total Overhead Costs	$1,404,898.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,575,023.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,972,506.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,404,898.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,252,436.00
2. Total Non-Allowable Costs	$1,917,689.00
3. Sum of Lines B1 and B2	$5,170,125.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6291
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$883,821.33
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,136,257.33
2. Total CHD Visits	18,396
3. CHD Rate Per Visit (C1 divided by C2)	$224.85
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$232.66
3. Medicaid Trend Adjustment	($63.09)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Washington County Health Department
Provider Number: 0279773

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$986,517.00
2. Total Non-Allowable Costs	$827,069.00
3. Total Overhead Costs	$552,759.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,366,345.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$709,903.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$552,759.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$986,517.00
2. Total Non-Allowable Costs	$827,069.00
3. Sum of Lines B1 and B2	$1,813,586.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5440
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$300,700.90
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,287,217.90
2. Total CHD Visits	8,348
3. CHD Rate Per Visit (C1 divided by C2)	$154.19
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$159.55
3. Medicaid Trend Adjustment	($14.29)
4. Final Prospective Rate - Effective Date: 07/01/2018	$145.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Bay County Health Department
Provider Number: 0290068

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,479,167.00
2. Total Non-Allowable Costs	$4,984,582.00
3. Total Overhead Costs	$2,645,809.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,109,558.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,032,867.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,645,809.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,479,167.00
2. Total Non-Allowable Costs	$4,984,582.00
3. Sum of Lines B1 and B2	$7,463,749.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3322
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$878,937.75
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,358,104.75
2. Total CHD Visits	27,916
3. CHD Rate Per Visit (C1 divided by C2)	$120.29
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$124.47
3. Medicaid Trend Adjustment	($28.04)
4. Final Prospective Rate - Effective Date: 07/01/2018	$96.43

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Lafayette County Health Department
Provider Number: 0290343

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$243,346.00
2. Total Non-Allowable Costs	$278,520.00
3. Total Overhead Costs	$197,819.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$719,685.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$215,905.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$197,819.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$243,346.00
2. Total Non-Allowable Costs	$278,520.00
3. Sum of Lines B1 and B2	$521,866.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4663
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$92,243.00
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$335,589.00
2. Total CHD Visits	1,674
3. CHD Rate Per Visit (C1 divided by C2)	$200.47
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$207.44
3. Medicaid Trend Adjustment	($37.87)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Madison County Health Department
Provider Number: 0290408

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$413,037.00
2. Total Non-Allowable Costs	$930,066.00
3. Total Overhead Costs	$326,914.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,670,017.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$501,005.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$326,914.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$413,037.00
2. Total Non-Allowable Costs	$930,066.00
3. Sum of Lines B1 and B2	$1,343,103.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3075
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$100,526.06
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$513,563.06
2. Total CHD Visits	2,509
3. CHD Rate Per Visit (C1 divided by C2)	$204.69
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$211.80
3. Medicaid Trend Adjustment	($44.25)
4. Final Prospective Rate - Effective Date: 07/01/2018	$167.55

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Suwannee County Health Department
Provider Number: 0518328

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$544,659.00
2. Total Non-Allowable Costs	$775,816.00
3. Total Overhead Costs	$479,961.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,800,436.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$540,130.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$479,961.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$544,659.00
2. Total Non-Allowable Costs	$775,816.00
3. Sum of Lines B1 and B2	$1,320,475.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4125
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$197,983.91
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$742,642.91
2. Total CHD Visits	4,091
3. CHD Rate Per Visit (C1 divided by C2)	$181.53
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$187.84
3. Medicaid Trend Adjustment	($22.66)
4. Final Prospective Rate - Effective Date: 07/01/2018	$165.18

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Holmes County Health Department
Provider Number: 0519022

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$904,419.00
2. Total Non-Allowable Costs	$927,707.00
3. Total Overhead Costs	$541,924.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,374,050.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$712,215.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$541,924.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$904,419.00
2. Total Non-Allowable Costs	$927,707.00
3. Sum of Lines B1 and B2	$1,832,126.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4936
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$267,493.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,171,912.69
2. Total CHD Visits	7,350
3. CHD Rate Per Visit (C1 divided by C2)	$159.44
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$164.98
3. Medicaid Trend Adjustment	($25.40)
4. Final Prospective Rate - Effective Date: 07/01/2018	$139.58

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Brevard County Heath Department
Provider Number: 0519251

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$6,701,729.00
2. Total Non-Allowable Costs	$8,499,838.00
3. Total Overhead Costs	$3,603,421.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$18,804,988.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,641,496.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,603,421.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$6,701,729.00
2. Total Non-Allowable Costs	$8,499,838.00
3. Sum of Lines B1 and B2	$15,201,567.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4409
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,588,748.32
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$8,290,477.32
2. Total CHD Visits	39,541
3. CHD Rate Per Visit (C1 divided by C2)	$209.67
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$216.95
3. Medicaid Trend Adjustment	($47.38)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

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

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$14,225,724.00
2. Total Non-Allowable Costs	$26,839,207.00
3. Total Overhead Costs	$15,140,444.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$56,205,375.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$16,861,612.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$15,140,444.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$14,225,724.00
2. Total Non-Allowable Costs	$26,839,207.00
3. Sum of Lines B1 and B2	$41,064,931.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3464
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$5,244,649.80
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$19,470,373.80
2. Total CHD Visits	60,792
3. CHD Rate Per Visit (C1 divided by C2)	$320.28
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$331.41
3. Medicaid Trend Adjustment	($161.84)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Charlotte County Health Department
Provider Number: 0520446

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,160,937.00
2. Total Non-Allowable Costs	$2,673,924.00
3. Total Overhead Costs	$1,364,200.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,199,061.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,559,718.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,364,200.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,160,937.00
2. Total Non-Allowable Costs	$2,673,924.00
3. Sum of Lines B1 and B2	$3,834,861.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3027
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$412,943.34
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,573,880.34
2. Total CHD Visits	9,546
3. CHD Rate Per Visit (C1 divided by C2)	$164.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$170.60
3. Medicaid Trend Adjustment	($64.43)
4. Final Prospective Rate - Effective Date: 07/01/2018	$106.17

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Hillsborough County Health Department
Provider Number: 0557269

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$9,196,598.00
2. Total Non-Allowable Costs	$24,710,153.00
3. Total Overhead Costs	$5,407,404.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$39,314,155.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$11,794,246.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,407,404.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,196,598.00
2. Total Non-Allowable Costs	$24,710,153.00
3. Sum of Lines B1 and B2	$33,906,751.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2712
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,466,487.96
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$10,663,085.96
2. Total CHD Visits	25,987
3. CHD Rate Per Visit (C1 divided by C2)	$410.32
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$424.58
3. Medicaid Trend Adjustment	($255.01)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Lake County Health Department
Provider Number: 0563234

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,760,661.00
2. Total Non-Allowable Costs	$4,077,050.00
3. Total Overhead Costs	$2,246,595.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,084,306.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,725,291.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,246,595.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,760,661.00
2. Total Non-Allowable Costs	$4,077,050.00
3. Sum of Lines B1 and B2	$6,837,711.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4037
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$906,950.40
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,667,611.40
2. Total CHD Visits	14,758
3. CHD Rate Per Visit (C1 divided by C2)	$248.52
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$257.15
3. Medicaid Trend Adjustment	($87.58)
4. Final Prospective Rate - Effective Date: 07/01/2018	$169.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2018 Through 06/30/2019

Provider Name: Escambia County Health Department
Provider Number: 0600181

Audit Status: **Unaudited Cost**
Cost Reporting Period: 07/01/2016 Through 06/30/2017

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,286,196.00
2. Total Non-Allowable Costs	$8,574,172.00
3. Total Overhead Costs	$3,450,656.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$16,311,024.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,893,307.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,450,656.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,286,196.00
2. Total Non-Allowable Costs	$8,574,172.00
3. Sum of Lines B1 and B2	$12,860,368.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3333
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,150,103.64
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,436,299.64
2. Total CHD Visits	31,331
3. CHD Rate Per Visit (C1 divided by C2)	$173.51
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03474
2. CHD Prospective Rate (C3 Multiplied by D1)	$179.54
3. Medicaid Trend Adjustment	($22.65)
4. Final Prospective Rate - Effective Date: 07/01/2018	$156.89