State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

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

Provider Number: 0279111 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,571,447.00
2. Total Non-Allowable Costs	$9,242,028.00
3. Total Overhead Costs	$2,994,028.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$16,807,503.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,042,250.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,994,028.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,571,447.00
2. Total Non-Allowable Costs	$9,242,028.00
3. Sum of Lines B1 and B2	$13,813,475.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3309
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$990,723.87
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,562,170.87
2. Total CHD Visits	26,678
3. CHD Rate Per Visit (C1 divided by C2)	$208.49
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$217.26
3. Medicaid Trend Adjustment	($50.69)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Baker County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279129 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,114,256.00
2. Total Non-Allowable Costs	$918,806.00
3. Total Overhead Costs	$465,483.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,498,545.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,049,563.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$465,483.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,114,256.00
2. Total Non-Allowable Costs	$918,806.00
3. Sum of Lines B1 and B2	$3,033,062.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6971
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$324,488.20
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,438,744.20
2. Total CHD Visits	16,205
3. CHD Rate Per Visit (C1 divided by C2)	$150.49
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$156.82
3. Medicaid Trend Adjustment	($11.70)
4. Final Prospective Rate - Effective Date: 07/01/2019	$145.12

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Bradford County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279145

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,354,467.00
2. Total Non-Allowable Costs	$702,896.00
3. Total Overhead Costs	$396,295.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,453,658.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$736,097.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$396,295.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,354,467.00
2. Total Non-Allowable Costs	$702,896.00
3. Sum of Lines B1 and B2	$2,057,363.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6584
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$260,920.63
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,615,387.63
2. Total CHD Visits	8,869
3. CHD Rate Per Visit (C1 divided by C2)	$182.14
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$189.80
3. Medicaid Trend Adjustment	($23.23)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Broward County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279161 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$9,774,184.00
2. Total Non-Allowable Costs	$29,551,340.00
3. Total Overhead Costs	$11,703,754.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$51,029,278.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$15,308,783.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$11,703,754.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,774,184.00
2. Total Non-Allowable Costs	$29,551,340.00
3. Sum of Lines B1 and B2	$39,325,524.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2485
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,908,382.87
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$12,682,566.87
2. Total CHD Visits	89,696
3. CHD Rate Per Visit (C1 divided by C2)	$141.40
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$147.34
3. Medicaid Trend Adjustment	($19.27)
4. Final Prospective Rate - Effective Date: 07/01/2019	$128.07

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Calhoun County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279170 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$401,796.00
2. Total Non-Allowable Costs	$867,966.00
3. Total Overhead Costs	$252,356.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,522,118.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$456,635.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$252,356.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$401,796.00
2. Total Non-Allowable Costs	$867,966.00
3. Sum of Lines B1 and B2	$1,269,762.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3164
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$79,845.44
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$481,641.44
2. Total CHD Visits	3,859
3. CHD Rate Per Visit (C1 divided by C2)	$124.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$130.06
3. Medicaid Trend Adjustment	($9.70)
4. Final Prospective Rate - Effective Date: 07/01/2019	$120.36

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Citrus County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279196 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,636,442.00
2. Total Non-Allowable Costs	$2,861,651.00
3. Total Overhead Costs	$1,195,192.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,693,285.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,707,985.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,195,192.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,636,442.00
2. Total Non-Allowable Costs	$2,861,651.00
3. Sum of Lines B1 and B2	$4,498,093.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3638
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$434,810.85
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,071,252.85
2. Total CHD Visits	7,090
3. CHD Rate Per Visit (C1 divided by C2)	$292.14
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$304.42
3. Medicaid Trend Adjustment	($137.85)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Clay County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279200 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,114,523.00
2. Total Non-Allowable Costs	$2,505,577.00
3. Total Overhead Costs	$1,214,466.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,834,566.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,450,369.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,214,466.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,114,523.00
2. Total Non-Allowable Costs	$2,505,577.00
3. Sum of Lines B1 and B2	$3,620,100.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3079
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$373,934.08
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,488,457.08
2. Total CHD Visits	3,370
3. CHD Rate Per Visit (C1 divided by C2)	$441.68
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$460.25
3. Medicaid Trend Adjustment	($293.68)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Collier County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279218

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,627,690.00
2. Total Non-Allowable Costs	$6,572,607.00
3. Total Overhead Costs	$2,358,604.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,558,901.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,767,670.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,358,604.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,627,690.00
2. Total Non-Allowable Costs	$6,572,607.00
3. Sum of Lines B1 and B2	$10,200,297.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3556
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$838,719.58
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,466,409.58
2. Total CHD Visits	20,796
3. CHD Rate Per Visit (C1 divided by C2)	$214.77
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$223.80
3. Medicaid Trend Adjustment	($57.23)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Columbia County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279226 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$828,913.00
2. Total Non-Allowable Costs	$1,293,187.00
3. Total Overhead Costs	$410,756.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,532,856.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$759,856.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$410,756.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$828,913.00
2. Total Non-Allowable Costs	$1,293,187.00
3. Sum of Lines B1 and B2	$2,122,100.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3906
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$160,441.29
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$989,354.29
2. Total CHD Visits	4,516
3. CHD Rate Per Visit (C1 divided by C2)	$219.08
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$228.29
3. Medicaid Trend Adjustment	($61.72)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Dade County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279234 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$18,403,518.00
2. Total Non-Allowable Costs	$40,761,772.00
3. Total Overhead Costs	$10,563,474.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$69,728,764.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$20,918,629.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$10,563,474.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$18,403,518.00
2. Total Non-Allowable Costs	$40,761,772.00
3. Sum of Lines B1 and B2	$59,165,290.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3111
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$3,286,296.76
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$21,689,814.76
2. Total CHD Visits	64,914
3. CHD Rate Per Visit (C1 divided by C2)	$334.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$348.18
3. Medicaid Trend Adjustment	($181.61)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: DeSoto County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279242

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,519,866.00
2. Total Non-Allowable Costs	$2,773,163.00
3. Total Overhead Costs	$544,789.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,837,818.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,751,345.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$544,789.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,519,866.00
2. Total Non-Allowable Costs	$2,773,163.00
3. Sum of Lines B1 and B2	$5,293,029.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4761
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$259,374.04
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,779,240.04
2. Total CHD Visits	19,755
3. CHD Rate Per Visit (C1 divided by C2)	$140.69
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$146.60
3. Medicaid Trend Adjustment	($10.94)
4. Final Prospective Rate - Effective Date: 07/01/2019	$135.66

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Dixie County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279251 | Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$298,491.00
2. Total Non-Allowable Costs	$675,510.00
3. Total Overhead Costs	$335,791.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,309,792.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$392,937.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$335,791.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$298,491.00
2. Total Non-Allowable Costs	$675,510.00
3. Sum of Lines B1 and B2	$974,001.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3065
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$102,919.94
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$401,410.94
2. Total CHD Visits	2,925
3. CHD Rate Per Visit (C1 divided by C2)	$137.23
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$143.00
3. Medicaid Trend Adjustment	($18.13)
4. Final Prospective Rate - Effective Date: 07/01/2019	$124.87

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Duval County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279269

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$11,234,968.00
2. Total Non-Allowable Costs	$14,977,929.00
3. Total Overhead Costs	$11,448,566.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$37,661,463.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$11,298,438.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$11,298,438.90
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$11,234,968.00
2. Total Non-Allowable Costs	$14,977,929.00
3. Sum of Lines B1 and B2	$26,212,897.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4286
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,842,510.91
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$16,077,478.91
2. Total CHD Visits	51,636
3. CHD Rate Per Visit (C1 divided by C2)	$311.36
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$324.45
3. Medicaid Trend Adjustment	($157.88)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Flagler County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279285 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,625,718.00
2. Total Non-Allowable Costs	$1,401,536.00
3. Total Overhead Costs	$620,128.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,647,382.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,094,214.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$620,128.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,625,718.00
2. Total Non-Allowable Costs	$1,401,536.00
3. Sum of Lines B1 and B2	$3,027,254.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5370
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$333,008.74
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,958,726.74
2. Total CHD Visits	11,798
3. CHD Rate Per Visit (C1 divided by C2)	$166.02
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$173.00
3. Medicaid Trend Adjustment	($20.68)
4. Final Prospective Rate - Effective Date: 07/01/2019	$152.32

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Franklin County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279293

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$376,092.00
2. Total Non-Allowable Costs	$1,515,332.00
3. Total Overhead Costs	$415,798.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,307,222.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$692,166.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$415,798.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$376,092.00
2. Total Non-Allowable Costs	$1,515,332.00
3. Sum of Lines B1 and B2	$1,891,424.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1988
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$82,660.64
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$458,752.64
2. Total CHD Visits	1,184
3. CHD Rate Per Visit (C1 divided by C2)	$387.46
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$403.75
3. Medicaid Trend Adjustment	($237.18)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Gadsden County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279307 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$645,307.00
2. Total Non-Allowable Costs	$1,999,187.00
3. Total Overhead Costs	$663,672.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,308,166.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$992,449.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$663,672.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$645,307.00
2. Total Non-Allowable Costs	$1,999,187.00
3. Sum of Lines B1 and B2	$2,644,494.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2440
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$161,935.97
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$807,242.97
2. Total CHD Visits	3,850
3. CHD Rate Per Visit (C1 divided by C2)	$209.67
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$218.49
3. Medicaid Trend Adjustment	($51.92)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Gilchrist County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279315 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$510,120.00
2. Total Non-Allowable Costs	$528,031.00
3. Total Overhead Costs	$239,805.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,277,956.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$383,386.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$239,805.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$510,120.00
2. Total Non-Allowable Costs	$528,031.00
3. Sum of Lines B1 and B2	$1,038,151.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4914
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$117,840.18
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$627,960.18
2. Total CHD Visits	2,999
3. CHD Rate Per Visit (C1 divided by C2)	$209.39
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$218.19
3. Medicaid Trend Adjustment	($51.62)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Glades County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279323 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$232,924.00
2. Total Non-Allowable Costs	$567,546.00
3. Total Overhead Costs	$323,653.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,124,123.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$337,236.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$323,653.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$232,924.00
2. Total Non-Allowable Costs	$567,546.00
3. Sum of Lines B1 and B2	$800,470.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2910
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$94,183.02
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$327,107.02
2. Total CHD Visits	1,653
3. CHD Rate Per Visit (C1 divided by C2)	$197.89
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$206.21
3. Medicaid Trend Adjustment	($39.64)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Gulf County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279331 | Cost Reporting Period: 07/01/2017 Through 06/23/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$414,985.00
2. Total Non-Allowable Costs	$1,301,241.00
3. Total Overhead Costs	$642,660.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,358,886.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$707,665.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$642,660.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$414,985.00
2. Total Non-Allowable Costs	$1,301,241.00
3. Sum of Lines B1 and B2	$1,716,226.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2418
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$155,395.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$570,380.19
2. Total CHD Visits	1,128
3. CHD Rate Per Visit (C1 divided by C2)	$505.66
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$526.92
3. Medicaid Trend Adjustment	($360.35)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Hamilton County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279340 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$462,360.00
2. Total Non-Allowable Costs	$527,496.00
3. Total Overhead Costs	$229,174.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,219,030.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$365,709.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$229,174.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$462,360.00
2. Total Non-Allowable Costs	$527,496.00
3. Sum of Lines B1 and B2	$989,856.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4671
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$107,047.18
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$569,407.18
2. Total CHD Visits	3,322
3. CHD Rate Per Visit (C1 divided by C2)	$171.40
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$178.61
3. Medicaid Trend Adjustment	($13.32)
4. Final Prospective Rate - Effective Date: 07/01/2019	$165.29

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Hardee County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279358 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$379,842.00
2. Total Non-Allowable Costs	$1,200,658.00
3. Total Overhead Costs	$406,826.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,987,326.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$596,197.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$406,826.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$379,842.00
2. Total Non-Allowable Costs	$1,200,658.00
3. Sum of Lines B1 and B2	$1,580,500.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2403
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$97,760.29
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$477,602.29
2. Total CHD Visits	1,508
3. CHD Rate Per Visit (C1 divided by C2)	$316.71
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$330.03
3. Medicaid Trend Adjustment	($163.46)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Hendry County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279366 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,923,916.00
2. Total Non-Allowable Costs	$1,795,302.00
3. Total Overhead Costs	$1,114,464.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,833,682.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,450,104.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,114,464.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,923,916.00
2. Total Non-Allowable Costs	$1,795,302.00
3. Sum of Lines B1 and B2	$3,719,218.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5173
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$576,512.23
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,500,428.23
2. Total CHD Visits	5,501
3. CHD Rate Per Visit (C1 divided by C2)	$454.54
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$473.65
3. Medicaid Trend Adjustment	($307.08)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Hernando County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279374 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,169,830.00
2. Total Non-Allowable Costs	$2,560,925.00
3. Total Overhead Costs	$2,398,800.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,129,555.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,838,866.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,838,866.50
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,169,830.00
2. Total Non-Allowable Costs	$2,560,925.00
3. Sum of Lines B1 and B2	$3,730,755.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3136
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$576,668.53
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,746,498.53
2. Total CHD Visits	8,925
3. CHD Rate Per Visit (C1 divided by C2)	$195.69
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$203.91
3. Medicaid Trend Adjustment	($63.96)
4. Final Prospective Rate - Effective Date: 07/01/2019	$139.95

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Highlands County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279382 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,407,139.00
2. Total Non-Allowable Costs	$2,389,554.00
3. Total Overhead Costs	$1,017,858.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,814,551.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,444,365.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,017,858.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,407,139.00
2. Total Non-Allowable Costs	$2,389,554.00
3. Sum of Lines B1 and B2	$3,796,693.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3706
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$377,218.17
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,784,357.17
2. Total CHD Visits	11,849
3. CHD Rate Per Visit (C1 divided by C2)	$150.59
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$156.92
3. Medicaid Trend Adjustment	($29.21)
4. Final Prospective Rate - Effective Date: 07/01/2019	$127.71

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Indian River County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279412

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$3,239,507.00
2. Total Non-Allowable Costs	$2,654,753.00
3. Total Overhead Costs	$2,089,109.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,983,369.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,395,010.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,089,109.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,239,507.00
2. Total Non-Allowable Costs	$2,654,753.00
3. Sum of Lines B1 and B2	$5,894,260.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5496
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,148,174.31
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,387,681.31
2. Total CHD Visits	23,370
3. CHD Rate Per Visit (C1 divided by C2)	$187.75
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$195.64
3. Medicaid Trend Adjustment	($47.58)
4. Final Prospective Rate - Effective Date: 07/01/2019	$148.06

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Jackson County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279421 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,317,947.00
2. Total Non-Allowable Costs	$2,143,990.00
3. Total Overhead Costs	$862,640.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,324,577.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,297,373.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$862,640.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,317,947.00
2. Total Non-Allowable Costs	$2,143,990.00
3. Sum of Lines B1 and B2	$3,461,937.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3807
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$328,407.05
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,646,354.05
2. Total CHD Visits	8,212
3. CHD Rate Per Visit (C1 divided by C2)	$200.48
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$208.91
3. Medicaid Trend Adjustment	($42.34)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Jefferson County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279439 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$696,318.00
2. Total Non-Allowable Costs	$881,338.00
3. Total Overhead Costs	$286,729.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,864,385.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$559,315.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$286,729.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$696,318.00
2. Total Non-Allowable Costs	$881,338.00
3. Sum of Lines B1 and B2	$1,577,656.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4414
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$126,562.18
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$822,880.18
2. Total CHD Visits	3,482
3. CHD Rate Per Visit (C1 divided by C2)	$236.32
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$246.26
3. Medicaid Trend Adjustment	($79.69)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Lee County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279463 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,564,823.00
2. Total Non-Allowable Costs	$8,782,359.00
3. Total Overhead Costs	$3,338,673.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$15,685,855.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,705,756.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,338,673.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,564,823.00
2. Total Non-Allowable Costs	$8,782,359.00
3. Sum of Lines B1 and B2	$12,347,182.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2887
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$963,874.90
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,528,697.90
2. Total CHD Visits	10,955
3. CHD Rate Per Visit (C1 divided by C2)	$413.39
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$430.77
3. Medicaid Trend Adjustment	($264.20)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Leon County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279471

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,476,539.00
2. Total Non-Allowable Costs	$5,455,526.00
3. Total Overhead Costs	$1,827,326.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,759,391.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,227,817.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,827,326.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,476,539.00
2. Total Non-Allowable Costs	$5,455,526.00
3. Sum of Lines B1 and B2	$8,932,065.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3892
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$711,195.28
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,187,734.28
2. Total CHD Visits	25,156
3. CHD Rate Per Visit (C1 divided by C2)	$166.47
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$173.47
3. Medicaid Trend Adjustment	($14.41)
4. Final Prospective Rate - Effective Date: 07/01/2019	$159.06

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Levy County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279480 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$923,693.00
2. Total Non-Allowable Costs	$1,330,683.00
3. Total Overhead Costs	$456,341.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,710,717.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$813,215.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$456,341.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$923,693.00
2. Total Non-Allowable Costs	$1,330,683.00
3. Sum of Lines B1 and B2	$2,254,376.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4097
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$186,962.91
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,110,655.91
2. Total CHD Visits	6,083
3. CHD Rate Per Visit (C1 divided by C2)	$182.58
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$190.26
3. Medicaid Trend Adjustment	($23.69)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Liberty County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279498 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$266,785.00
2. Total Non-Allowable Costs	$588,294.00
3. Total Overhead Costs	$206,747.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,061,826.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$318,547.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$206,747.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$266,785.00
2. Total Non-Allowable Costs	$588,294.00
3. Sum of Lines B1 and B2	$855,079.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3120
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$64,505.06
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$331,290.06
2. Total CHD Visits	2,205
3. CHD Rate Per Visit (C1 divided by C2)	$150.24
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$156.56
3. Medicaid Trend Adjustment	($11.68)
4. Final Prospective Rate - Effective Date: 07/01/2019	$144.88

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Manatee County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279510 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,407,355.00
2. Total Non-Allowable Costs	$4,762,525.00
3. Total Overhead Costs	$2,133,987.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,303,867.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,491,160.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,133,987.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,407,355.00
2. Total Non-Allowable Costs	$4,762,525.00
3. Sum of Lines B1 and B2	$6,169,880.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2281
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$486,762.43
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,894,117.43
2. Total CHD Visits	14,175
3. CHD Rate Per Visit (C1 divided by C2)	$133.62
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$139.24
3. Medicaid Trend Adjustment	($21.32)
4. Final Prospective Rate - Effective Date: 07/01/2019	$117.92

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Marion County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279528 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,718,524.00
2. Total Non-Allowable Costs	$6,587,735.00
3. Total Overhead Costs	$2,524,802.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,831,061.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,849,318.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,524,802.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,718,524.00
2. Total Non-Allowable Costs	$6,587,735.00
3. Sum of Lines B1 and B2	$10,306,259.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3608
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$910,948.56
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,629,472.56
2. Total CHD Visits	15,655
3. CHD Rate Per Visit (C1 divided by C2)	$295.72
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$308.15
3. Medicaid Trend Adjustment	($141.58)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Martin County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279536 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$840,112.00
2. Total Non-Allowable Costs	$3,413,049.00
3. Total Overhead Costs	$1,698,479.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,951,640.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,785,492.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,698,479.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$840,112.00
2. Total Non-Allowable Costs	$3,413,049.00
3. Sum of Lines B1 and B2	$4,253,161.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1975
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$335,449.60
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,175,561.60
2. Total CHD Visits	5,969
3. CHD Rate Per Visit (C1 divided by C2)	$196.94
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$205.23
3. Medicaid Trend Adjustment	($43.04)
4. Final Prospective Rate - Effective Date: 07/01/2019	$162.19

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Monroe County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279544 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,772,528.00
2. Total Non-Allowable Costs	$4,107,768.00
3. Total Overhead Costs	$1,579,784.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,460,080.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,238,024.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,579,784.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,772,528.00
2. Total Non-Allowable Costs	$4,107,768.00
3. Sum of Lines B1 and B2	$5,880,296.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3014
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$476,146.90
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,248,674.90
2. Total CHD Visits	6,175
3. CHD Rate Per Visit (C1 divided by C2)	$364.16
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$379.47
3. Medicaid Trend Adjustment	($212.90)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Nassau County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279552

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,224,156.00
2. Total Non-Allowable Costs	$2,171,222.00
3. Total Overhead Costs	$1,052,617.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,447,995.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,334,398.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,052,617.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,224,156.00
2. Total Non-Allowable Costs	$2,171,222.00
3. Sum of Lines B1 and B2	$3,395,378.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3605
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$379,468.43
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,603,624.43
2. Total CHD Visits	11,839
3. CHD Rate Per Visit (C1 divided by C2)	$135.45
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$141.15
3. Medicaid Trend Adjustment	($15.31)
4. Final Prospective Rate - Effective Date: 07/01/2019	$125.84

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Okaloosa County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279561 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,759,283.00
2. Total Non-Allowable Costs	$3,453,366.00
3. Total Overhead Costs	$2,736,988.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$7,949,637.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,384,891.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,384,891.10
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,759,283.00
2. Total Non-Allowable Costs	$3,453,366.00
3. Sum of Lines B1 and B2	$5,212,649.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3375
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$804,900.75
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,564,183.75
2. Total CHD Visits	13,989
3. CHD Rate Per Visit (C1 divided by C2)	$183.30
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$191.01
3. Medicaid Trend Adjustment	($32.75)
4. Final Prospective Rate - Effective Date: 07/01/2019	$158.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Okeechobee County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279579 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$423,307.00
2. Total Non-Allowable Costs	$1,514,803.00
3. Total Overhead Costs	$360,172.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,298,282.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$689,484.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$360,172.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$423,307.00
2. Total Non-Allowable Costs	$1,514,803.00
3. Sum of Lines B1 and B2	$1,938,110.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2184
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$78,661.56
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$501,968.56
2. Total CHD Visits	3,690
3. CHD Rate Per Visit (C1 divided by C2)	$136.03
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$141.75
3. Medicaid Trend Adjustment	($10.57)
4. Final Prospective Rate - Effective Date: 07/01/2019	$131.18

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Medicaid Program Finance
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Provider Name: Orange County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279587

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$10,516,708.00
2. Total Non-Allowable Costs	$18,927,411.00
3. Total Overhead Costs	$5,814,065.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$35,258,184.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,577,455.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,814,065.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$10,516,708.00
2. Total Non-Allowable Costs	$18,927,411.00
3. Sum of Lines B1 and B2	$29,444,119.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3572
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,076,784.02
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$12,593,492.02
2. Total CHD Visits	41,960
3. CHD Rate Per Visit (C1 divided by C2)	$300.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$312.75
3. Medicaid Trend Adjustment	($146.18)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
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Provider Name: Osceola County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279595 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,026,686.00
2. Total Non-Allowable Costs	$4,824,024.00
3. Total Overhead Costs	$2,829,126.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$11,679,836.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,503,950.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,829,126.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,026,686.00
2. Total Non-Allowable Costs	$4,824,024.00
3. Sum of Lines B1 and B2	$8,850,710.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4550
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,287,252.33
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,313,938.33
2. Total CHD Visits	19,563
3. CHD Rate Per Visit (C1 divided by C2)	$271.63
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$283.05
3. Medicaid Trend Adjustment	($116.48)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
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Provider Name: Pasco County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279617 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,834,879.00
2. Total Non-Allowable Costs	$6,261,715.00
3. Total Overhead Costs	$2,744,570.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,841,164.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,852,349.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,744,570.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,834,879.00
2. Total Non-Allowable Costs	$6,261,715.00
3. Sum of Lines B1 and B2	$10,096,594.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3798
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,042,387.69
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,877,266.69
2. Total CHD Visits	18,247
3. CHD Rate Per Visit (C1 divided by C2)	$267.29
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$278.53
3. Medicaid Trend Adjustment	($111.96)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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Medicaid Program Finance
CHD Rate Calculation Sheet
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Provider Name: Pinellas County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279625 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$21,169,934.00
2. Total Non-Allowable Costs	$23,081,515.00
3. Total Overhead Costs	$9,592,729.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$53,844,178.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$16,153,253.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$9,592,729.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$21,169,934.00
2. Total Non-Allowable Costs	$23,081,515.00
3. Sum of Lines B1 and B2	$44,251,449.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4784
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,589,161.55
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$25,759,095.55
2. Total CHD Visits	96,113
3. CHD Rate Per Visit (C1 divided by C2)	$268.01
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$279.28
3. Medicaid Trend Adjustment	($112.71)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Polk County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279633 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$11,204,730.00
2. Total Non-Allowable Costs	$13,039,716.00
3. Total Overhead Costs	$4,628,264.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$28,872,710.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$8,661,813.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$4,628,264.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$11,204,730.00
2. Total Non-Allowable Costs	$13,039,716.00
3. Sum of Lines B1 and B2	$24,244,446.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4622
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,139,183.62
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$13,343,913.62
2. Total CHD Visits	57,912
3. CHD Rate Per Visit (C1 divided by C2)	$230.42
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$240.11
3. Medicaid Trend Adjustment	($73.54)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Putnam County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279641 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,657,718.00
2. Total Non-Allowable Costs	$1,836,126.00
3. Total Overhead Costs	$792,750.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,286,594.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,285,978.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$792,750.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,657,718.00
2. Total Non-Allowable Costs	$1,836,126.00
3. Sum of Lines B1 and B2	$3,493,844.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4745
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$376,159.88
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,033,877.88
2. Total CHD Visits	4,086
3. CHD Rate Per Visit (C1 divided by C2)	$497.77
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$518.70
3. Medicaid Trend Adjustment	($352.13)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: St. Johns County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279650 — Cost Reporting Period: 07/01/2017 Through 06/23/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,348,740.00
2. Total Non-Allowable Costs	$2,470,115.00
3. Total Overhead Costs	$1,046,450.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,865,305.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,459,591.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,046,450.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,348,740.00
2. Total Non-Allowable Costs	$2,470,115.00
3. Sum of Lines B1 and B2	$3,818,855.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3532
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$369,606.14
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,718,346.14
2. Total CHD Visits	7,189
3. CHD Rate Per Visit (C1 divided by C2)	$239.02
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$249.07
3. Medicaid Trend Adjustment	($82.50)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: St. Lucie County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279668 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$4,614,970.00
2. Total Non-Allowable Costs	$6,779,591.00
3. Total Overhead Costs	$1,808,769.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,203,330.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,960,999.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,808,769.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,614,970.00
2. Total Non-Allowable Costs	$6,779,591.00
3. Sum of Lines B1 and B2	$11,394,561.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4050
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$732,551.45
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,347,521.45
2. Total CHD Visits	19,556
3. CHD Rate Per Visit (C1 divided by C2)	$273.45
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$284.94
3. Medicaid Trend Adjustment	($118.37)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Santa Rosa County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279676 — Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,352,563.00
2. Total Non-Allowable Costs	$2,638,499.00
3. Total Overhead Costs	$1,192,789.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,183,851.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,555,155.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,192,789.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,352,563.00
2. Total Non-Allowable Costs	$2,638,499.00
3. Sum of Lines B1 and B2	$3,991,062.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3389
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$404,236.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,756,799.19
2. Total CHD Visits	10,048
3. CHD Rate Per Visit (C1 divided by C2)	$174.84
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$182.19
3. Medicaid Trend Adjustment	($31.28)
4. Final Prospective Rate - Effective Date: 07/01/2019	$150.91

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Sarasota County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279684 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$14,288,018.00
2. Total Non-Allowable Costs	$14,272,732.00
3. Total Overhead Costs	$5,924,367.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$34,485,117.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,345,535.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,924,367.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$14,288,018.00
2. Total Non-Allowable Costs	$14,272,732.00
3. Sum of Lines B1 and B2	$28,560,750.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5003
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,963,960.81
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$17,251,978.81
2. Total CHD Visits	96,108
3. CHD Rate Per Visit (C1 divided by C2)	$179.51
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$187.05
3. Medicaid Trend Adjustment	($38.86)
4. Final Prospective Rate - Effective Date: 07/01/2019	$148.19

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Seminole County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279692

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,253,534.00
2. Total Non-Allowable Costs	$5,107,257.00
3. Total Overhead Costs	$2,287,001.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,647,792.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,894,337.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,287,001.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,253,534.00
2. Total Non-Allowable Costs	$5,107,257.00
3. Sum of Lines B1 and B2	$7,360,791.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3062
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$700,279.71
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,953,813.71
2. Total CHD Visits	11,575
3. CHD Rate Per Visit (C1 divided by C2)	$255.19
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$265.92
3. Medicaid Trend Adjustment	($99.35)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Sumter County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279706 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$721,909.00
2. Total Non-Allowable Costs	$1,468,998.00
3. Total Overhead Costs	$884,428.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,075,335.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$922,600.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$884,428.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$721,909.00
2. Total Non-Allowable Costs	$1,468,998.00
3. Sum of Lines B1 and B2	$2,190,907.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3295
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$291,419.03
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,013,328.03
2. Total CHD Visits	5,250
3. CHD Rate Per Visit (C1 divided by C2)	$193.01
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$201.13
3. Medicaid Trend Adjustment	($59.61)
4. Final Prospective Rate - Effective Date: 07/01/2019	$141.52

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Taylor County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279722

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$723,335.00
2. Total Non-Allowable Costs	$1,102,114.00
3. Total Overhead Costs	$292,236.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,117,685.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$635,305.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$292,236.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$723,335.00
2. Total Non-Allowable Costs	$1,102,114.00
3. Sum of Lines B1 and B2	$1,825,449.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3963
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$115,813.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$839,148.13
2. Total CHD Visits	7,576
3. CHD Rate Per Visit (C1 divided by C2)	$110.76
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$115.42
3. Medicaid Trend Adjustment	($8.61)
4. Final Prospective Rate - Effective Date: 07/01/2019	$106.81

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Union County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279731 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,211,581.00
2. Total Non-Allowable Costs	$733,153.00
3. Total Overhead Costs	$369,556.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,314,290.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$694,287.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$369,556.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,211,581.00
2. Total Non-Allowable Costs	$733,153.00
3. Sum of Lines B1 and B2	$1,944,734.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6230
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$230,233.39
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,441,814.39
2. Total CHD Visits	8,007
3. CHD Rate Per Visit (C1 divided by C2)	$180.07
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$187.64
3. Medicaid Trend Adjustment	($21.07)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Volusia County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279749 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$5,966,328.00
2. Total Non-Allowable Costs	$9,209,809.00
3. Total Overhead Costs	$5,544,556.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$20,720,693.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$6,216,207.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,544,556.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$5,966,328.00
2. Total Non-Allowable Costs	$9,209,809.00
3. Sum of Lines B1 and B2	$15,176,137.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3931
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,179,564.96
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$8,145,892.96
2. Total CHD Visits	43,640
3. CHD Rate Per Visit (C1 divided by C2)	$186.66
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$194.51
3. Medicaid Trend Adjustment	($27.94)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Wakulla County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279757 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$659,268.00
2. Total Non-Allowable Costs	$1,424,068.00
3. Total Overhead Costs	$354,169.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,437,505.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$731,251.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$354,169.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$659,268.00
2. Total Non-Allowable Costs	$1,424,068.00
3. Sum of Lines B1 and B2	$2,083,336.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3164
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$112,059.07
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$771,327.07
2. Total CHD Visits	6,128
3. CHD Rate Per Visit (C1 divided by C2)	$125.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$131.16
3. Medicaid Trend Adjustment	($9.78)
4. Final Prospective Rate - Effective Date: 07/01/2019	$121.38

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

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

Provider Number: 0279765   Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,077,858.00
2. Total Non-Allowable Costs	$1,832,590.00
3. Total Overhead Costs	$1,812,617.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,723,065.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,016,919.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,812,617.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,077,858.00
2. Total Non-Allowable Costs	$1,832,590.00
3. Sum of Lines B1 and B2	$4,910,448.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.6268
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,136,148.34
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,214,006.34
2. Total CHD Visits	17,504
3. CHD Rate Per Visit (C1 divided by C2)	$240.75
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$250.87
3. Medicaid Trend Adjustment	($84.30)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Washington County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279773 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$918,806.00
2. Total Non-Allowable Costs	$871,820.00
3. Total Overhead Costs	$576,378.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,367,004.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$710,101.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$576,378.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$918,806.00
2. Total Non-Allowable Costs	$871,820.00
3. Sum of Lines B1 and B2	$1,790,626.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5131
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$295,739.55
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,214,545.55
2. Total CHD Visits	7,527
3. CHD Rate Per Visit (C1 divided by C2)	$161.36
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$168.14
3. Medicaid Trend Adjustment	($19.31)
4. Final Prospective Rate - Effective Date: 07/01/2019	$148.83

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Bay County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0290068 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,645,158.00
2. Total Non-Allowable Costs	$4,955,360.00
3. Total Overhead Costs	$2,398,542.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,999,060.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,999,718.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,398,542.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,645,158.00
2. Total Non-Allowable Costs	$4,955,360.00
3. Sum of Lines B1 and B2	$7,600,518.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3480
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$834,692.62
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,479,850.62
2. Total CHD Visits	15,589
3. CHD Rate Per Visit (C1 divided by C2)	$223.22
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$232.61
3. Medicaid Trend Adjustment	($66.04)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Lafayette County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0290343 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$206,664.00
2. Total Non-Allowable Costs	$385,582.00
3. Total Overhead Costs	$230,862.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$823,108.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$246,932.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$230,862.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$206,664.00
2. Total Non-Allowable Costs	$385,582.00
3. Sum of Lines B1 and B2	$592,246.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3489
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$80,547.75
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$287,211.75
2. Total CHD Visits	1,932
3. CHD Rate Per Visit (C1 divided by C2)	$148.66
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$154.91
3. Medicaid Trend Adjustment	($23.09)
4. Final Prospective Rate - Effective Date: 07/01/2019	$131.82

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Madison County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0290408 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$425,621.00
2. Total Non-Allowable Costs	$962,819.00
3. Total Overhead Costs	$330,564.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,719,004.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$515,701.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$330,564.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$425,621.00
2. Total Non-Allowable Costs	$962,819.00
3. Sum of Lines B1 and B2	$1,388,440.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3065
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$101,317.87
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$526,938.87
2. Total CHD Visits	2,233
3. CHD Rate Per Visit (C1 divided by C2)	$235.98
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$245.90
3. Medicaid Trend Adjustment	($79.33)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Suwannee County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0518328 | Cost Reporting Period: 07/01/2019 Through 06/30/2020

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$501,130.00
2. Total Non-Allowable Costs	$747,021.00
3. Total Overhead Costs	$546,670.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,794,821.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$538,446.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$538,446.30
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$501,130.00
2. Total Non-Allowable Costs	$747,021.00
3. Sum of Lines B1 and B2	$1,248,151.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4015
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$216,186.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$717,316.19
2. Total CHD Visits	4,584
3. CHD Rate Per Visit (C1 divided by C2)	$156.48
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$163.06
3. Medicaid Trend Adjustment	($27.32)
4. Final Prospective Rate - Effective Date: 07/01/2019	$135.74

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Holmes County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0519022 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$687,195.00
2. Total Non-Allowable Costs	$1,000,887.00
3. Total Overhead Costs	$491,386.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,179,468.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$653,840.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$491,386.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$687,195.00
2. Total Non-Allowable Costs	$1,000,887.00
3. Sum of Lines B1 and B2	$1,688,082.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4071
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$200,043.24
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$887,238.24
2. Total CHD Visits	6,847
3. CHD Rate Per Visit (C1 divided by C2)	$129.58
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$135.03
3. Medicaid Trend Adjustment	($49.61)
4. Final Prospective Rate - Effective Date: 07/01/2019	$85.42

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Brevard County Heath Department | Audit Status: **Unaudited Cost**

Provider Number: 0519251 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$6,794,340.00
2. Total Non-Allowable Costs	$8,567,931.00
3. Total Overhead Costs	$3,363,826.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$18,726,097.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,617,829.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,363,826.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$6,794,340.00
2. Total Non-Allowable Costs	$8,567,931.00
3. Sum of Lines B1 and B2	$15,362,271.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4423
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,487,820.24
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$8,282,160.24
2. Total CHD Visits	42,503
3. CHD Rate Per Visit (C1 divided by C2)	$194.86
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$203.05
3. Medicaid Trend Adjustment	($40.34)
4. Final Prospective Rate - Effective Date: 07/01/2019	$162.71

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Palm Beach County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0520331 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$19,520,300.00
2. Total Non-Allowable Costs	$26,844,461.00
3. Total Overhead Costs	$11,614,113.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$57,978,874.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$17,393,662.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$11,614,113.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$19,520,300.00
2. Total Non-Allowable Costs	$26,844,461.00
3. Sum of Lines B1 and B2	$46,364,761.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4210
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,889,541.57
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$24,409,841.57
2. Total CHD Visits	69,117
3. CHD Rate Per Visit (C1 divided by C2)	$353.17
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$368.02
3. Medicaid Trend Adjustment	($201.45)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Charlotte County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0520446 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,081,995.00
2. Total Non-Allowable Costs	$2,631,542.00
3. Total Overhead Costs	$1,368,419.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,081,956.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,524,586.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,368,419.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,081,995.00
2. Total Non-Allowable Costs	$2,631,542.00
3. Sum of Lines B1 and B2	$3,713,537.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2914
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$398,757.30
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,480,752.30
2. Total CHD Visits	9,870
3. CHD Rate Per Visit (C1 divided by C2)	$150.03
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$156.33
3. Medicaid Trend Adjustment	($50.97)
4. Final Prospective Rate - Effective Date: 07/01/2019	$105.36

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Hillsborough County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0557269 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$9,143,023.00
2. Total Non-Allowable Costs	$23,222,168.00
3. Total Overhead Costs	$5,653,388.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$38,018,579.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$11,405,573.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,653,388.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,143,023.00
2. Total Non-Allowable Costs	$23,222,168.00
3. Sum of Lines B1 and B2	$32,365,191.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2825
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,597,082.11
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$10,740,105.11
2. Total CHD Visits	24,951
3. CHD Rate Per Visit (C1 divided by C2)	$430.45
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$448.55
3. Medicaid Trend Adjustment	($281.98)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Lake County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0563234 | Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,669,020.00
2. Total Non-Allowable Costs	$4,398,399.00
3. Total Overhead Costs	$2,122,964.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$9,190,383.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,757,114.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,122,964.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,669,020.00
2. Total Non-Allowable Costs	$4,398,399.00
3. Sum of Lines B1 and B2	$7,067,419.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3777
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$801,843.50
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,470,863.50
2. Total CHD Visits	15,880
3. CHD Rate Per Visit (C1 divided by C2)	$218.57
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$227.76
3. Medicaid Trend Adjustment	($61.19)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2019 Through 06/30/2020

Provider Name: Escambia County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0600181

Cost Reporting Period: 07/01/2017 Through 06/30/2018

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$4,378,737.00
2. Total Non-Allowable Costs	$8,005,013.00
3. Total Overhead Costs	$3,348,863.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$15,732,613.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,719,783.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,348,863.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,378,737.00
2. Total Non-Allowable Costs	$8,005,013.00
3. Sum of Lines B1 and B2	$12,383,750.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3536
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,184,157.96
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$5,562,894.96
2. Total CHD Visits	28,319
3. CHD Rate Per Visit (C1 divided by C2)	$196.44
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.04205
2. CHD Prospective Rate (C3 Multiplied by D1)	$204.70
3. Medicaid Trend Adjustment	($38.13)
4. Final Prospective Rate - Effective Date: 07/01/2019	$166.57

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