

State of Florida Agency for Health Care Administration
Medicaid Cost Reimbursement
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2010 Through 06/30/2011

Provider Name: Baker County Health Department

Rate Based On: **Unaudited Costs**
 Audit Status: **Unaudited [1]**

Provider Number: 0279129

Cost Reporting Period: 07/01/2008 Through 06/30/2009

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	\$2,282,728.00
2. Total Non-Allowable Costs	\$898,444.00
3. Total Overhead Costs	\$752,991.00
4. Total Costs (Sum of Lines A1, A2 and A3)	\$3,934,163.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,180,248.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$752,991.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$2,282,728.00
2. Total Non-Allowable Costs	\$898,444.00
3. Sum of Lines B1 and B2	\$3,181,172.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.7176
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$540,346.34
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,823,074.34
2. Total CHD Visits	18,520
3. CHD Rate Per Visit (C1 divided by C2)	\$152.43
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03581
2. CHD Prospective Rate (C3 Multiplied by D1)	157.89
3. Medicaid Trend Adjustment	42.89
4. Final Prospective Rate - Effective Date: 7/1/2010	115.00