

**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: Escambia County Health Department

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

Provider Number: 0600181

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	\$4,757,281.00
2. Total Non-Allowable Costs	\$12,999,846.00
3. Total Overhead Costs	\$4,062,586.00
4. Total Costs (Sum of Lines A1, A2 and A3)	\$21,819,713.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$6,545,913.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$4,062,586.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$4,757,281.00
2. Total Non-Allowable Costs	\$12,999,846.00
3. Sum of Lines B1 and B2	\$17,757,127.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2679
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$1,088,366.79
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$5,845,647.79
2. Total CHD Visits	31,319
3. CHD Rate Per Visit (C1 divided by C2)	\$186.65
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03581
2. CHD Prospective Rate (C3 Multiplied by D1)	193.33
3. Medicaid Trend Adjustment	0.00
4. Final Prospective Rate - Effective Date: 7/1/2010	193.33