

**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: Dixie County Health Department

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

Provider Number: 0279251

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	\$1,944,395.00
2. Total Non-Allowable Costs	\$350,984.00
3. Total Overhead Costs	\$402,158.00
4. Total Costs (Sum of Lines A1, A2 and A3)	\$2,697,537.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$809,261.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$402,158.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,944,395.00
2. Total Non-Allowable Costs	\$350,984.00
3. Sum of Lines B1 and B2	\$2,295,379.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.8471
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$340,668.04
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,285,063.04
2. Total CHD Visits	16,485
3. CHD Rate Per Visit (C1 divided by C2)	\$138.61
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03581
2. CHD Prospective Rate (C3 Multiplied by D1)	143.57
3. Medicaid Trend Adjustment	-0.01
4. Final Prospective Rate - Effective Date: 7/1/2010	143.58