

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: Clay County Health Department

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

Provider Number: 0279200

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	\$1,862,068.00
2. Total Non-Allowable Costs	\$2,622,480.00
3. Total Overhead Costs	\$1,733,043.00
4. Total Costs (Sum of Lines A1, A2 and A3)	\$6,217,591.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$1,865,277.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$1,733,043.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,862,068.00
2. Total Non-Allowable Costs	\$2,622,480.00
3. Sum of Lines B1 and B2	\$4,484,548.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4152
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$719,559.45
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$2,581,627.45
2. Total CHD Visits	9,446
3. CHD Rate Per Visit (C1 divided by C2)	\$273.30
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03581
2. CHD Prospective Rate (C3 Multiplied by D1)	283.09
3. Medicaid Trend Adjustment	153.12
4. Final Prospective Rate - Effective Date: 7/1/2010	129.97