

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: Hamilton County Health Department

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

Provider Number: 0279340

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	\$566,516.00
2. Total Non-Allowable Costs	\$492,744.00
3. Total Overhead Costs	\$290,879.00
4. Total Costs (Sum of Lines A1, A2 and A3)	\$1,350,139.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$405,041.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$290,879.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$566,516.00
2. Total Non-Allowable Costs	\$492,744.00
3. Sum of Lines B1 and B2	\$1,059,260.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5348
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$155,562.09
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$722,078.09
2. Total CHD Visits	5,040
3. CHD Rate Per Visit (C1 divided by C2)	\$143.27
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03581
2. CHD Prospective Rate (C3 Multiplied by D1)	148.40
3. Medicaid Trend Adjustment	2.29
4. Final Prospective Rate - Effective Date: 7/1/2010	146.11