

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: Liberty County Health Department

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

Provider Number: 0279498

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	\$1,287,933.00
2. Total Non-Allowable Costs	\$475,877.00
3. Total Overhead Costs	\$551,457.00
4. Total Costs (Sum of Lines A1, A2 and A3)	\$2,315,267.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	\$694,580.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	\$551,457.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	\$1,287,933.00
2. Total Non-Allowable Costs	\$475,877.00
3. Sum of Lines B1 and B2	\$1,763,810.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.7302
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	\$402,673.90
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	\$1,690,606.90
2. Total CHD Visits	11,546
3. CHD Rate Per Visit (C1 divided by C2)	\$146.42
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.03581
2. CHD Prospective Rate (C3 Multiplied by D1)	151.66
3. Medicaid Trend Adjustment	16.06
4. Final Prospective Rate - Effective Date: 7/1/2010	135.60