State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Alachua County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279111 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$7,167,189.00
2. Total Non-Allowable Costs	$9,326,514.00
3. Total Overhead Costs	$3,814,704.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$20,308,407.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$6,092,522.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,814,704.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$7,167,189.00
2. Total Non-Allowable Costs	$9,326,514.00
3. Sum of Lines B1 and B2	$16,493,703.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4345
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,657,488.89
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$8,824,677.89
2. Total CHD Visits	17,953
3. CHD Rate Per Visit (C1 divided by C2)	$491.54
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$522.28
3. Medicaid Trend Adjustment	($359.02)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Baker County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279129 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,148,040.00
2. Total Non-Allowable Costs	$1,345,779.00
3. Total Overhead Costs	$943,335.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,437,154.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,031,146.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$943,335.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,148,040.00
2. Total Non-Allowable Costs	$1,345,779.00
3. Sum of Lines B1 and B2	$2,493,819.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4604
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$434,311.43
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,582,351.43
2. Total CHD Visits	7,060
3. CHD Rate Per Visit (C1 divided by C2)	$224.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$238.14
3. Medicaid Trend Adjustment	($74.88)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Bradford County Health Department
Audit Status: **Unaudited Cost**
Provider Number: 0279145
Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,666,193.00
2. Total Non-Allowable Costs	$1,234,249.00
3. Total Overhead Costs	$519,453.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,419,895.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,025,968.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$519,453.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,666,193.00
2. Total Non-Allowable Costs	$1,234,249.00
3. Sum of Lines B1 and B2	$2,900,442.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5745
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$298,425.75
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,964,618.75
2. Total CHD Visits	8,527
3. CHD Rate Per Visit (C1 divided by C2)	$230.40
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$244.81
3. Medicaid Trend Adjustment	($81.55)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Broward County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279161 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$11,095,814.00
2. Total Non-Allowable Costs	$45,603,008.00
3. Total Overhead Costs	$13,851,804.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$70,550,626.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$21,165,187.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$13,851,804.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$11,095,814.00
2. Total Non-Allowable Costs	$45,603,008.00
3. Sum of Lines B1 and B2	$56,698,822.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1957
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,710,798.04
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$13,806,612.04
2. Total CHD Visits	87,181
3. CHD Rate Per Visit (C1 divided by C2)	$158.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$168.27
3. Medicaid Trend Adjustment	($15.65)
4. Final Prospective Rate - Effective Date: 07/01/2024	$152.62

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Calhoun County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279170 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$365,152.00
2. Total Non-Allowable Costs	$1,228,893.00
3. Total Overhead Costs	$377,197.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,971,242.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$591,372.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$377,197.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$365,152.00
2. Total Non-Allowable Costs	$1,228,893.00
3. Sum of Lines B1 and B2	$1,594,045.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2291
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$86,415.83
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$451,567.83
2. Total CHD Visits	2,476
3. CHD Rate Per Visit (C1 divided by C2)	$182.38
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$193.78
3. Medicaid Trend Adjustment	($30.52)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Citrus County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279196 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,584,714.00
2. Total Non-Allowable Costs	$3,642,148.00
3. Total Overhead Costs	$1,543,118.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,769,980.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,030,994.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,543,118.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,584,714.00
2. Total Non-Allowable Costs	$3,642,148.00
3. Sum of Lines B1 and B2	$5,226,862.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3032
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$467,873.38
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,052,587.38
2. Total CHD Visits	6,338
3. CHD Rate Per Visit (C1 divided by C2)	$323.85
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$344.10
3. Medicaid Trend Adjustment	($180.84)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Clay County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279200 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,090,376.00
2. Total Non-Allowable Costs	$3,870,238.00
3. Total Overhead Costs	$1,106,186.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,066,800.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,820,040.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,106,186.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,090,376.00
2. Total Non-Allowable Costs	$3,870,238.00
3. Sum of Lines B1 and B2	$4,960,614.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2198
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$243,139.68
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,333,515.68
2. Total CHD Visits	2,765
3. CHD Rate Per Visit (C1 divided by C2)	$482.28
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$512.44
3. Medicaid Trend Adjustment	($349.18)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Collier County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279218

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,232,903.00
2. Total Non-Allowable Costs	$8,198,174.00
3. Total Overhead Costs	$2,573,533.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$14,004,610.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,201,383.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,573,533.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,232,903.00
2. Total Non-Allowable Costs	$8,198,174.00
3. Sum of Lines B1 and B2	$11,431,077.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2828
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$727,795.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,960,698.13
2. Total CHD Visits	15,671
3. CHD Rate Per Visit (C1 divided by C2)	$252.74
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$268.54
3. Medicaid Trend Adjustment	($105.28)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Columbia County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279226

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$915,215.00
2. Total Non-Allowable Costs	$2,267,252.00
3. Total Overhead Costs	$708,693.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,891,160.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,167,348.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$708,693.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$915,215.00
2. Total Non-Allowable Costs	$2,267,252.00
3. Sum of Lines B1 and B2	$3,182,467.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2876
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$203,820.11
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,119,035.11
2. Total CHD Visits	6,902
3. CHD Rate Per Visit (C1 divided by C2)	$162.13
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$172.27
3. Medicaid Trend Adjustment	($16.02)
4. Final Prospective Rate - Effective Date: 07/01/2024	$156.25

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Dade County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279234 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$22,030,242.00
2. Total Non-Allowable Costs	$70,429,660.00
3. Total Overhead Costs	$8,685,022.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$101,144,924.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$30,343,477.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$8,685,022.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$22,030,242.00
2. Total Non-Allowable Costs	$70,429,660.00
3. Sum of Lines B1 and B2	$92,459,902.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2383
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,069,640.74
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$24,099,882.74
2. Total CHD Visits	65,960
3. CHD Rate Per Visit (C1 divided by C2)	$365.37
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$388.22
3. Medicaid Trend Adjustment	($224.96)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: DeSoto County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279242 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,588,944.00
2. Total Non-Allowable Costs	$3,214,781.00
3. Total Overhead Costs	$531,917.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,335,642.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,900,692.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$531,917.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,588,944.00
2. Total Non-Allowable Costs	$3,214,781.00
3. Sum of Lines B1 and B2	$5,803,725.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4461
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$237,288.17
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,826,232.17
2. Total CHD Visits	16,063
3. CHD Rate Per Visit (C1 divided by C2)	$175.95
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$186.95
3. Medicaid Trend Adjustment	($23.69)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Dixie County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279251 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$418,133.00
2. Total Non-Allowable Costs	$751,895.00
3. Total Overhead Costs	$381,827.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,551,855.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$465,556.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$381,827.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$418,133.00
2. Total Non-Allowable Costs	$751,895.00
3. Sum of Lines B1 and B2	$1,170,028.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3574
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$136,464.97
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$554,597.97
2. Total CHD Visits	3,837
3. CHD Rate Per Visit (C1 divided by C2)	$144.54
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$153.58
3. Medicaid Trend Adjustment	($14.28)
4. Final Prospective Rate - Effective Date: 07/01/2024	$139.30

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Duval County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279269 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$7,761,171.00
2. Total Non-Allowable Costs	$18,781,166.00
3. Total Overhead Costs	$7,774,345.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$34,316,682.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,295,004.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$7,774,345.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$7,761,171.00
2. Total Non-Allowable Costs	$18,781,166.00
3. Sum of Lines B1 and B2	$26,542,337.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2924
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,273,218.48
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$10,034,389.48
2. Total CHD Visits	26,910
3. CHD Rate Per Visit (C1 divided by C2)	$372.89
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$396.20
3. Medicaid Trend Adjustment	($232.94)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Flagler County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279285 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,096,809.00
2. Total Non-Allowable Costs	$3,730,912.00
3. Total Overhead Costs	$649,687.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,477,408.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,943,222.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$649,687.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,096,809.00
2. Total Non-Allowable Costs	$3,730,912.00
3. Sum of Lines B1 and B2	$5,827,721.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3598
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$233,757.38
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,330,566.38
2. Total CHD Visits	11,075
3. CHD Rate Per Visit (C1 divided by C2)	$210.43
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$223.59
3. Medicaid Trend Adjustment	($60.33)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Franklin County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279293 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$657,609.00
2. Total Non-Allowable Costs	$1,468,744.00
3. Total Overhead Costs	$505,498.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,631,851.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$789,555.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$505,498.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$657,609.00
2. Total Non-Allowable Costs	$1,468,744.00
3. Sum of Lines B1 and B2	$2,126,353.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3093
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$156,350.53
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$813,959.53
2. Total CHD Visits	3,675
3. CHD Rate Per Visit (C1 divided by C2)	$221.49
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$235.33
3. Medicaid Trend Adjustment	($72.07)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Gadsden County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279307

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$916,375.00
2. Total Non-Allowable Costs	$2,255,730.00
3. Total Overhead Costs	$836,703.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,008,808.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,202,642.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$836,703.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$916,375.00
2. Total Non-Allowable Costs	$2,255,730.00
3. Sum of Lines B1 and B2	$3,172,105.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2889
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$241,723.50
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,158,098.50
2. Total CHD Visits	7,350
3. CHD Rate Per Visit (C1 divided by C2)	$157.56
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$167.42
3. Medicaid Trend Adjustment	($15.57)
4. Final Prospective Rate - Effective Date: 07/01/2024	$151.85

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Gilchrist County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279315 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$540,438.00
2. Total Non-Allowable Costs	$677,794.00
3. Total Overhead Costs	$363,402.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,581,634.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$474,490.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$363,402.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$540,438.00
2. Total Non-Allowable Costs	$677,794.00
3. Sum of Lines B1 and B2	$1,218,232.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4436
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$161,205.13
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$701,643.13
2. Total CHD Visits	5,539
3. CHD Rate Per Visit (C1 divided by C2)	$126.67
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$134.59
3. Medicaid Trend Adjustment	($12.51)
4. Final Prospective Rate - Effective Date: 07/01/2024	$122.08

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Glades County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279323 | Cost Reporting Period: 07/01/2022 Through 06/30/2024

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$285,914.00
2. Total Non-Allowable Costs	$476,514.00
3. Total Overhead Costs	$456,008.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,218,436.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$365,530.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$365,530.80
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$285,914.00
2. Total Non-Allowable Costs	$476,514.00
3. Sum of Lines B1 and B2	$762,428.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3750
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$137,074.05
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$422,988.05
2. Total CHD Visits	1,190
3. CHD Rate Per Visit (C1 divided by C2)	$355.45
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$377.68
3. Medicaid Trend Adjustment	($214.42)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Gulf County Health Department

Provider Number: 0279331

Audit Status: **Unaudited Cost**

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$424,932.00
2. Total Non-Allowable Costs	$1,480,505.00
3. Total Overhead Costs	$842,774.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,748,211.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$824,463.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$824,463.30
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$424,932.00
2. Total Non-Allowable Costs	$1,480,505.00
3. Sum of Lines B1 and B2	$1,905,437.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2230
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$183,855.32
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$608,787.32
2. Total CHD Visits	3,255
3. CHD Rate Per Visit (C1 divided by C2)	$187.03
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$198.73
3. Medicaid Trend Adjustment	($35.47)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Hamilton County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279340 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$584,486.00
2. Total Non-Allowable Costs	$513,819.00
3. Total Overhead Costs	$307,645.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,405,950.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$421,785.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$307,645.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$584,486.00
2. Total Non-Allowable Costs	$513,819.00
3. Sum of Lines B1 and B2	$1,098,305.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.5322
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$163,728.67
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$748,214.67
2. Total CHD Visits	4,824
3. CHD Rate Per Visit (C1 divided by C2)	$155.10
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$164.80
3. Medicaid Trend Adjustment	($15.32)
4. Final Prospective Rate - Effective Date: 07/01/2024	$149.48

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Hardee County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279358 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$402,691.00
2. Total Non-Allowable Costs	$1,319,527.00
3. Total Overhead Costs	$462,635.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,184,853.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$655,455.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$462,635.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$402,691.00
2. Total Non-Allowable Costs	$1,319,527.00
3. Sum of Lines B1 and B2	$1,722,218.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2338
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$108,164.06
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$510,855.06
2. Total CHD Visits	2,580
3. CHD Rate Per Visit (C1 divided by C2)	$198.01
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$210.39
3. Medicaid Trend Adjustment	($47.13)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Hendry County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279366 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,494,269.00
2. Total Non-Allowable Costs	$2,404,158.00
3. Total Overhead Costs	$1,352,441.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,250,868.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,575,260.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,352,441.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,494,269.00
2. Total Non-Allowable Costs	$2,404,158.00
3. Sum of Lines B1 and B2	$3,898,427.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3833
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$518,390.64
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,012,659.64
2. Total CHD Visits	3,782
3. CHD Rate Per Visit (C1 divided by C2)	$532.17
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$565.44
3. Medicaid Trend Adjustment	($402.18)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Hernando County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279374

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,675,689.00
2. Total Non-Allowable Costs	$2,872,395.00
3. Total Overhead Costs	$1,877,662.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,425,746.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,927,723.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,877,662.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,675,689.00
2. Total Non-Allowable Costs	$2,872,395.00
3. Sum of Lines B1 and B2	$4,548,084.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3684
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$691,730.68
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,367,419.68
2. Total CHD Visits	6,405
3. CHD Rate Per Visit (C1 divided by C2)	$369.62
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$392.73
3. Medicaid Trend Adjustment	($229.47)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Highlands County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279382 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$922,655.00
2. Total Non-Allowable Costs	$2,698,057.00
3. Total Overhead Costs	$896,067.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,516,779.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,355,033.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$896,067.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$922,655.00
2. Total Non-Allowable Costs	$2,698,057.00
3. Sum of Lines B1 and B2	$3,620,712.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2548
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$228,317.87
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,150,972.87
2. Total CHD Visits	2,912
3. CHD Rate Per Visit (C1 divided by C2)	$395.25
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$419.97
3. Medicaid Trend Adjustment	($256.71)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Indian River County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279412 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$745,262.00
2. Total Non-Allowable Costs	$2,996,255.00
3. Total Overhead Costs	$1,849,201.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,590,718.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,677,215.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,677,215.40
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$745,262.00
2. Total Non-Allowable Costs	$2,996,255.00
3. Sum of Lines B1 and B2	$3,741,517.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1992
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$334,101.31
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,079,363.31
2. Total CHD Visits	2,800
3. CHD Rate Per Visit (C1 divided by C2)	$385.49
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$409.59
3. Medicaid Trend Adjustment	($246.33)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Jackson County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279421 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,212,838.00
2. Total Non-Allowable Costs	$3,498,929.00
3. Total Overhead Costs	$1,074,745.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,786,512.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,735,953.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,074,745.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,212,838.00
2. Total Non-Allowable Costs	$3,498,929.00
3. Sum of Lines B1 and B2	$4,711,767.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2574
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$276,639.36
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,489,477.36
2. Total CHD Visits	5,521
3. CHD Rate Per Visit (C1 divided by C2)	$269.78
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$286.65
3. Medicaid Trend Adjustment	($123.39)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Jefferson County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279439 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$621,062.00
2. Total Non-Allowable Costs	$1,412,079.00
3. Total Overhead Costs	$361,114.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,394,255.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$718,276.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$361,114.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$621,062.00
2. Total Non-Allowable Costs	$1,412,079.00
3. Sum of Lines B1 and B2	$2,033,141.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3055
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$110,320.33
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$731,382.33
2. Total CHD Visits	2,190
3. CHD Rate Per Visit (C1 divided by C2)	$333.96
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$354.85
3. Medicaid Trend Adjustment	($191.59)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Lee County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279463 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,693,718.00
2. Total Non-Allowable Costs	$12,354,280.00
3. Total Overhead Costs	$3,932,306.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$19,980,304.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$5,994,091.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,932,306.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,693,718.00
2. Total Non-Allowable Costs	$12,354,280.00
3. Sum of Lines B1 and B2	$16,047,998.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2302
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$905,216.84
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,598,934.84
2. Total CHD Visits	6,708
3. CHD Rate Per Visit (C1 divided by C2)	$685.59
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$728.46
3. Medicaid Trend Adjustment	($565.20)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Leon County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279471 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,792,990.00
2. Total Non-Allowable Costs	$6,853,826.00
3. Total Overhead Costs	$2,016,380.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$11,663,196.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,498,958.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,016,380.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,792,990.00
2. Total Non-Allowable Costs	$6,853,826.00
3. Sum of Lines B1 and B2	$9,646,816.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2895
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$583,742.01
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,376,732.01
2. Total CHD Visits	16,645
3. CHD Rate Per Visit (C1 divided by C2)	$202.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$215.55
3. Medicaid Trend Adjustment	($52.29)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Levy County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279480 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,128,975.00
2. Total Non-Allowable Costs	$1,576,096.00
3. Total Overhead Costs	$567,204.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,272,275.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$981,682.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$567,204.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,128,975.00
2. Total Non-Allowable Costs	$1,576,096.00
3. Sum of Lines B1 and B2	$2,705,071.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4174
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$236,750.95
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,365,725.95
2. Total CHD Visits	7,470
3. CHD Rate Per Visit (C1 divided by C2)	$182.83
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$194.26
3. Medicaid Trend Adjustment	($31.00)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Liberty County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279498 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$284,947.00
2. Total Non-Allowable Costs	$771,916.00
3. Total Overhead Costs	$325,066.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,381,929.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$414,578.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$325,066.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$284,947.00
2. Total Non-Allowable Costs	$771,916.00
3. Sum of Lines B1 and B2	$1,056,863.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2696
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$87,637.79
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$372,584.79
2. Total CHD Visits	2,098
3. CHD Rate Per Visit (C1 divided by C2)	$177.59
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$188.70
3. Medicaid Trend Adjustment	($25.44)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Manatee County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279510 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$1,685,970.00
2. Total Non-Allowable Costs	$6,397,611.00
3. Total Overhead Costs	$2,705,415.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,788,996.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,236,698.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,705,415.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,685,970.00
2. Total Non-Allowable Costs	$6,397,611.00
3. Sum of Lines B1 and B2	$8,083,581.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2086
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$564,349.57
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,250,319.57
2. Total CHD Visits	15,750
3. CHD Rate Per Visit (C1 divided by C2)	$142.88
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$151.81
3. Medicaid Trend Adjustment	($14.12)
4. Final Prospective Rate - Effective Date: 07/01/2024	$137.69

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Marion County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279528 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,151,050.00
2. Total Non-Allowable Costs	$8,349,579.00
3. Total Overhead Costs	$3,071,126.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$14,571,755.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,371,526.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,071,126.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,151,050.00
2. Total Non-Allowable Costs	$8,349,579.00
3. Sum of Lines B1 and B2	$11,500,629.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2740
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$841,488.52
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,992,538.52
2. Total CHD Visits	9,726
3. CHD Rate Per Visit (C1 divided by C2)	$410.50
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$436.17
3. Medicaid Trend Adjustment	($272.91)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Martin County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279536 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$898,358.00
2. Total Non-Allowable Costs	$3,652,448.00
3. Total Overhead Costs	$1,884,154.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,434,960.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,930,488.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,884,154.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$898,358.00
2. Total Non-Allowable Costs	$3,652,448.00
3. Sum of Lines B1 and B2	$4,550,806.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1974
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$371,932.00
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,270,290.00
2. Total CHD Visits	4,818
3. CHD Rate Per Visit (C1 divided by C2)	$263.66
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$280.14
3. Medicaid Trend Adjustment	($116.88)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Monroe County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279544 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,185,803.00
2. Total Non-Allowable Costs	$4,419,591.00
3. Total Overhead Costs	$2,018,655.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,624,049.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,587,214.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,018,655.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,185,803.00
2. Total Non-Allowable Costs	$4,419,591.00
3. Sum of Lines B1 and B2	$6,605,394.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3309
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$667,972.94
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,853,775.94
2. Total CHD Visits	6,615
3. CHD Rate Per Visit (C1 divided by C2)	$431.41
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$458.39
3. Medicaid Trend Adjustment	($295.13)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Nassau County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279552 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,189,248.00
2. Total Non-Allowable Costs	$3,237,587.00
3. Total Overhead Costs	$1,174,728.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,601,563.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,680,468.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,174,728.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,189,248.00
2. Total Non-Allowable Costs	$3,237,587.00
3. Sum of Lines B1 and B2	$4,426,835.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2686
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$315,531.94
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,504,779.94
2. Total CHD Visits	9,385
3. CHD Rate Per Visit (C1 divided by C2)	$160.34
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$170.36
3. Medicaid Trend Adjustment	($15.84)
4. Final Prospective Rate - Effective Date: 07/01/2024	$154.52

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Okaloosa County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279561 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,942,390.00
2. Total Non-Allowable Costs	$5,319,027.00
3. Total Overhead Costs	$3,261,860.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,523,277.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,156,983.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,156,983.10
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,942,390.00
2. Total Non-Allowable Costs	$5,319,027.00
3. Sum of Lines B1 and B2	$7,261,417.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2675
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$844,492.98
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,786,882.98
2. Total CHD Visits	11,944
3. CHD Rate Per Visit (C1 divided by C2)	$233.33
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$247.92
3. Medicaid Trend Adjustment	($84.66)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Okeechobee County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279579 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$494,339.00
2. Total Non-Allowable Costs	$1,497,674.00
3. Total Overhead Costs	$699,049.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,691,062.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$807,318.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$699,049.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$494,339.00
2. Total Non-Allowable Costs	$1,497,674.00
3. Sum of Lines B1 and B2	$1,992,013.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2482
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$173,503.96
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$667,842.96
2. Total CHD Visits	3,170
3. CHD Rate Per Visit (C1 divided by C2)	$210.68
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$223.85
3. Medicaid Trend Adjustment	($60.59)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Orange County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279587 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$10,729,159.00
2. Total Non-Allowable Costs	$24,858,364.00
3. Total Overhead Costs	$7,838,425.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$43,425,948.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$13,027,784.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$7,838,425.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$10,729,159.00
2. Total Non-Allowable Costs	$24,858,364.00
3. Sum of Lines B1 and B2	$35,587,523.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3015
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$2,363,285.14
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$13,092,444.14
2. Total CHD Visits	32,105
3. CHD Rate Per Visit (C1 divided by C2)	$407.80
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$433.30
3. Medicaid Trend Adjustment	($270.04)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Osceola County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279595 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,957,763.00
2. Total Non-Allowable Costs	$7,222,260.00
3. Total Overhead Costs	$2,415,330.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$11,595,353.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,478,605.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,415,330.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,957,763.00
2. Total Non-Allowable Costs	$7,222,260.00
3. Sum of Lines B1 and B2	$9,180,023.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2133
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$515,189.89
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,472,952.89
2. Total CHD Visits	14,210
3. CHD Rate Per Visit (C1 divided by C2)	$174.03
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$184.91
3. Medicaid Trend Adjustment	($21.65)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Pasco County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279617 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$2,317,210.00
2. Total Non-Allowable Costs	$9,197,071.00
3. Total Overhead Costs	$2,789,890.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$14,304,171.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,291,251.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,789,890.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,317,210.00
2. Total Non-Allowable Costs	$9,197,071.00
3. Sum of Lines B1 and B2	$11,514,281.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2012
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$561,325.87
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,878,535.87
2. Total CHD Visits	8,960
3. CHD Rate Per Visit (C1 divided by C2)	$321.27
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$341.35
3. Medicaid Trend Adjustment	($178.09)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Pinellas County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279625 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$16,873,605.00
2. Total Non-Allowable Costs	$29,230,436.00
3. Total Overhead Costs	$10,565,109.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$56,669,150.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$17,000,745.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$10,565,109.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$16,873,605.00
2. Total Non-Allowable Costs	$29,230,436.00
3. Sum of Lines B1 and B2	$46,104,041.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3660
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$3,866,829.89
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$20,740,434.89
2. Total CHD Visits	71,755
3. CHD Rate Per Visit (C1 divided by C2)	$289.05
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$307.12
3. Medicaid Trend Adjustment	($143.86)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Polk County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279633

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$9,456,686.00
2. Total Non-Allowable Costs	$22,952,747.00
3. Total Overhead Costs	$3,989,724.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$36,399,157.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$10,919,747.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,989,724.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,456,686.00
2. Total Non-Allowable Costs	$22,952,747.00
3. Sum of Lines B1 and B2	$32,409,433.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2918
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,164,201.46
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$10,620,887.46
2. Total CHD Visits	32,721
3. CHD Rate Per Visit (C1 divided by C2)	$324.59
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$344.89
3. Medicaid Trend Adjustment	($181.63)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Putnam County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279641 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,659,236.00
2. Total Non-Allowable Costs	$1,754,568.00
3. Total Overhead Costs	$1,155,988.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$4,569,792.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,370,937.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,155,988.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,659,236.00
2. Total Non-Allowable Costs	$1,754,568.00
3. Sum of Lines B1 and B2	$3,413,804.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4860
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$561,810.17
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$2,221,046.17
2. Total CHD Visits	12,046
3. CHD Rate Per Visit (C1 divided by C2)	$184.38
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$195.91
3. Medicaid Trend Adjustment	($32.65)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: St. Johns County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279650 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,269,409.00
2. Total Non-Allowable Costs	$3,849,091.00
3. Total Overhead Costs	$1,606,073.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,724,573.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,017,371.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,606,073.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,269,409.00
2. Total Non-Allowable Costs	$3,849,091.00
3. Sum of Lines B1 and B2	$5,118,500.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2480
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$398,306.10
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,667,715.10
2. Total CHD Visits	4,585
3. CHD Rate Per Visit (C1 divided by C2)	$363.73
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$386.48
3. Medicaid Trend Adjustment	($223.22)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: St. Lucie County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279668 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$5,143,357.00
2. Total Non-Allowable Costs	$7,483,779.00
3. Total Overhead Costs	$2,320,733.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$14,947,869.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,484,360.70
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,320,733.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$5,143,357.00
2. Total Non-Allowable Costs	$7,483,779.00
3. Sum of Lines B1 and B2	$12,627,136.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4073
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$945,234.55
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$6,088,591.55
2. Total CHD Visits	23,167
3. CHD Rate Per Visit (C1 divided by C2)	$262.81
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$279.25
3. Medicaid Trend Adjustment	($115.99)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Santa Rosa County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279676 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$668,154.00
2. Total Non-Allowable Costs	$3,098,057.00
3. Total Overhead Costs	$1,841,266.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$5,607,477.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,682,243.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,682,243.10
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$668,154.00
2. Total Non-Allowable Costs	$3,098,057.00
3. Sum of Lines B1 and B2	$3,766,211.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1774
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$298,429.93
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$966,583.93
2. Total CHD Visits	4,375
3. CHD Rate Per Visit (C1 divided by C2)	$220.93
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$234.75
3. Medicaid Trend Adjustment	($71.49)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Sarasota County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279684 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$3,656,668.00
2. Total Non-Allowable Costs	$15,086,059.00
3. Total Overhead Costs	$5,592,535.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$24,335,262.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$7,300,578.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,592,535.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$3,656,668.00
2. Total Non-Allowable Costs	$15,086,059.00
3. Sum of Lines B1 and B2	$18,742,727.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1951
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,091,103.58
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$4,747,771.58
2. Total CHD Visits	17,598
3. CHD Rate Per Visit (C1 divided by C2)	$269.79
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$286.66
3. Medicaid Trend Adjustment	($123.40)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Seminole County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279692

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,290,605.00
2. Total Non-Allowable Costs	$6,582,464.00
3. Total Overhead Costs	$3,171,373.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$12,044,442.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,613,332.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,171,373.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,290,605.00
2. Total Non-Allowable Costs	$6,582,464.00
3. Sum of Lines B1 and B2	$8,873,069.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2582
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$818,848.51
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,109,453.51
2. Total CHD Visits	12,155
3. CHD Rate Per Visit (C1 divided by C2)	$255.82
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$271.81
3. Medicaid Trend Adjustment	($108.55)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
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Provider Name: Sumter County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279706 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$873,735.00
2. Total Non-Allowable Costs	$1,884,240.00
3. Total Overhead Costs	$1,035,288.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,793,263.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$1,137,978.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,035,288.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$873,735.00
2. Total Non-Allowable Costs	$1,884,240.00
3. Sum of Lines B1 and B2	$2,757,975.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3168
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$327,979.24
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,201,714.24
2. Total CHD Visits	1,855
3. CHD Rate Per Visit (C1 divided by C2)	$647.82
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$688.33
3. Medicaid Trend Adjustment	($525.07)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Taylor County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279722 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$446,757.00
2. Total Non-Allowable Costs	$1,123,059.00
3. Total Overhead Costs	$375,265.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,945,081.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$583,524.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$375,265.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$446,757.00
2. Total Non-Allowable Costs	$1,123,059.00
3. Sum of Lines B1 and B2	$1,569,816.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2846
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$106,800.42
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$553,557.42
2. Total CHD Visits	3,850
3. CHD Rate Per Visit (C1 divided by C2)	$143.78
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$152.77
3. Medicaid Trend Adjustment	($14.21)
4. Final Prospective Rate - Effective Date: 07/01/2024	$138.56

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Union County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279731 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,100,541.00
2. Total Non-Allowable Costs	$1,107,063.00
3. Total Overhead Costs	$500,482.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,708,086.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$812,425.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$500,482.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,100,541.00
2. Total Non-Allowable Costs	$1,107,063.00
3. Sum of Lines B1 and B2	$2,207,604.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.4985
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$249,490.28
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,350,031.28
2. Total CHD Visits	5,232
3. CHD Rate Per Visit (C1 divided by C2)	$258.03
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$274.17
3. Medicaid Trend Adjustment	($110.91)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Volusia County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0279749 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$4,680,446.00
2. Total Non-Allowable Costs	$10,652,538.00
3. Total Overhead Costs	$5,104,970.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$20,437,954.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$6,131,386.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$5,104,970.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$4,680,446.00
2. Total Non-Allowable Costs	$10,652,538.00
3. Sum of Lines B1 and B2	$15,332,984.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3053
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,558,547.34
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$6,238,993.34
2. Total CHD Visits	32,020
3. CHD Rate Per Visit (C1 divided by C2)	$194.85
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$207.03
3. Medicaid Trend Adjustment	($43.77)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Wakulla County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0279757

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$719,235.00
2. Total Non-Allowable Costs	$1,774,810.00
3. Total Overhead Costs	$535,209.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$3,029,254.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$908,776.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$535,209.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$719,235.00
2. Total Non-Allowable Costs	$1,774,810.00
3. Sum of Lines B1 and B2	$2,494,045.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2884
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$154,354.28
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$873,589.28
2. Total CHD Visits	4,653
3. CHD Rate Per Visit (C1 divided by C2)	$187.75
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$199.49
3. Medicaid Trend Adjustment	($36.23)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

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State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Washington County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0279773 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$709,275.00
2. Total Non-Allowable Costs	$1,153,042.00
3. Total Overhead Costs	$581,411.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,443,728.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$733,118.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$581,411.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$709,275.00
2. Total Non-Allowable Costs	$1,153,042.00
3. Sum of Lines B1 and B2	$1,862,317.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3809
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$221,459.45
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$930,734.45
2. Total CHD Visits	4,411
3. CHD Rate Per Visit (C1 divided by C2)	$211.00
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$224.20
3. Medicaid Trend Adjustment	($60.94)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Bay County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0290068 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,618,808.00
2. Total Non-Allowable Costs	$4,925,345.00
3. Total Overhead Costs	$3,244,361.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$10,788,514.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$3,236,554.20
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,236,554.20
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,618,808.00
2. Total Non-Allowable Costs	$4,925,345.00
3. Sum of Lines B1 and B2	$7,544,153.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3471
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,123,407.96
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,742,215.96
2. Total CHD Visits	16,164
3. CHD Rate Per Visit (C1 divided by C2)	$231.52
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$245.99
3. Medicaid Trend Adjustment	($82.73)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Lafayette County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0290343 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$217,738.00
2. Total Non-Allowable Costs	$523,216.00
3. Total Overhead Costs	$298,112.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$1,039,066.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$311,719.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$298,112.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$217,738.00
2. Total Non-Allowable Costs	$523,216.00
3. Sum of Lines B1 and B2	$740,954.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2939
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$87,615.12
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$305,353.12
2. Total CHD Visits	754
3. CHD Rate Per Visit (C1 divided by C2)	$404.98
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$430.30
3. Medicaid Trend Adjustment	($267.04)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Madison County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0290408 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$351,028.00
2. Total Non-Allowable Costs	$1,266,858.00
3. Total Overhead Costs	$528,642.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,146,528.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$643,958.40
7. Allowable Overhead Cost (Lesser of A3 or A6)	$528,642.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$351,028.00
2. Total Non-Allowable Costs	$1,266,858.00
3. Sum of Lines B1 and B2	$1,617,886.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2170
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$114,715.31
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$465,743.31
2. Total CHD Visits	1,083
3. CHD Rate Per Visit (C1 divided by C2)	$430.05
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$456.94
3. Medicaid Trend Adjustment	($293.68)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Suwannee County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0518328 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$451,551.00
2. Total Non-Allowable Costs	$1,289,853.00
3. Total Overhead Costs	$435,546.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,176,950.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$653,085.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$435,546.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$451,551.00
2. Total Non-Allowable Costs	$1,289,853.00
3. Sum of Lines B1 and B2	$1,741,404.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2593
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$112,937.08
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$564,488.08
2. Total CHD Visits	4,245
3. CHD Rate Per Visit (C1 divided by C2)	$132.98
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$141.29
3. Medicaid Trend Adjustment	($13.14)
4. Final Prospective Rate - Effective Date: 07/01/2024	$128.15

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Holmes County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0519022

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$603,234.00
2. Total Non-Allowable Costs	$1,474,615.00
3. Total Overhead Costs	$607,763.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$2,685,612.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$805,683.60
7. Allowable Overhead Cost (Lesser of A3 or A6)	$607,763.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$603,234.00
2. Total Non-Allowable Costs	$1,474,615.00
3. Sum of Lines B1 and B2	$2,077,849.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2903
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$176,433.60
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$779,667.60
2. Total CHD Visits	5,411
3. CHD Rate Per Visit (C1 divided by C2)	$144.09
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$153.10
3. Medicaid Trend Adjustment	($14.24)
4. Final Prospective Rate - Effective Date: 07/01/2024	$138.86

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Brevard County Heath Department | Audit Status: **Unaudited Cost**

Provider Number: 0519251 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$5,467,042.00
2. Total Non-Allowable Costs	$11,879,963.00
3. Total Overhead Costs	$3,904,101.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$21,251,106.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$6,375,331.80
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,904,101.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$5,467,042.00
2. Total Non-Allowable Costs	$11,879,963.00
3. Sum of Lines B1 and B2	$17,347,005.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3152
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,230,572.64
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$6,697,614.64
2. Total CHD Visits	23,431
3. CHD Rate Per Visit (C1 divided by C2)	$285.84
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$303.72
3. Medicaid Trend Adjustment	($140.46)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Palm Beach County Health Department — Audit Status: **Unaudited Cost**

Provider Number: 0520331 — Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$20,979,052.00
2. Total Non-Allowable Costs	$33,122,902.00
3. Total Overhead Costs	$12,753,746.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$66,855,700.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$20,056,710.00
7. Allowable Overhead Cost (Lesser of A3 or A6)	$12,753,746.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$20,979,052.00
2. Total Non-Allowable Costs	$33,122,902.00
3. Sum of Lines B1 and B2	$54,101,954.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.3878
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$4,945,902.70
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$25,924,954.70
2. Total CHD Visits	57,217
3. CHD Rate Per Visit (C1 divided by C2)	$453.10
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$481.43
3. Medicaid Trend Adjustment	($318.17)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Charlotte County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0520446

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,052,007.00
2. Total Non-Allowable Costs	$3,992,105.00
3. Total Overhead Costs	$1,623,975.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$6,668,087.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,000,426.10
7. Allowable Overhead Cost (Lesser of A3 or A6)	$1,623,975.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,052,007.00
2. Total Non-Allowable Costs	$3,992,105.00
3. Sum of Lines B1 and B2	$5,044,112.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2086
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$338,761.19
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,390,768.19
2. Total CHD Visits	9,873
3. CHD Rate Per Visit (C1 divided by C2)	$140.87
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$149.67
3. Medicaid Trend Adjustment	($13.92)
4. Final Prospective Rate - Effective Date: 07/01/2024	$135.75

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Hillsborough County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0557269 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	**AMOUNT**
1. Total Allowable Costs of CHD Services	$9,322,951.00
2. Total Non-Allowable Costs	$30,654,015.00
3. Total Overhead Costs	$7,336,245.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$47,313,211.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$14,193,963.30
7. Allowable Overhead Cost (Lesser of A3 or A6)	$7,336,245.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$9,322,951.00
2. Total Non-Allowable Costs	$30,654,015.00
3. Sum of Lines B1 and B2	$39,976,966.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2332
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$1,710,812.33
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$11,033,763.33
2. Total CHD Visits	14,728
3. CHD Rate Per Visit (C1 divided by C2)	$749.17
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$796.01
3. Medicaid Trend Adjustment	($632.75)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Lake County Health Department | Audit Status: **Unaudited Cost**

Provider Number: 0563234 | Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$1,087,060.00
2. Total Non-Allowable Costs	$4,798,958.00
3. Total Overhead Costs	$2,634,355.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$8,520,373.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$2,556,111.90
7. Allowable Overhead Cost (Lesser of A3 or A6)	$2,556,111.90
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$1,087,060.00
2. Total Non-Allowable Costs	$4,798,958.00
3. Sum of Lines B1 and B2	$5,886,018.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.1847
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$472,113.87
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$1,559,173.87
2. Total CHD Visits	5,670
3. CHD Rate Per Visit (C1 divided by C2)	$274.99
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$292.18
3. Medicaid Trend Adjustment	($128.92)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26

State of Florida Agency for Health Care Administration
Medicaid Program Finance
CHD Rate Calculation Sheet
Rate Setting Period 07/01/2024 Through 06/30/2025

Provider Name: Escambia County Health Department

Audit Status: **Unaudited Cost**

Provider Number: 0600181

Cost Reporting Period: 07/01/2022 Through 06/30/2023

PART A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS	AMOUNT
1. Total Allowable Costs of CHD Services	$2,744,996.00
2. Total Non-Allowable Costs	$7,643,254.00
3. Total Overhead Costs	$3,071,655.00
4. Total Costs (Sum of Lines A1 , A2 and A3)	$13,459,905.00
5. Screening Guideline for CHD Overhead Cost	30%
6. CHD Overhead Guideline Amount (Line A4 Multiplied by A5)	$4,037,971.50
7. Allowable Overhead Cost (Lesser of A3 or A6)	$3,071,655.00
PART B - DETERMINATION OF OVERHEAD APPLICABLE TO CHD SERVICES	
1. Total Allowable Costs of CHD Services	$2,744,996.00
2. Total Non-Allowable Costs	$7,643,254.00
3. Sum of Lines B1 and B2	$10,388,250.00
4. Direct Cost Ratio (Line B1 Divided By B3)	0.2642
5. Allowable Overhead Costs Applicable to CHD Services (Line A7 Multiplied by Line B4)	$811,531.25
PART C - DETERMINATION OF CHD RATE	
1. Total CHD Cost (B1 plus B5)	$3,556,527.25
2. Total CHD Visits	6,020
3. CHD Rate Per Visit (C1 divided by C2)	$590.79
PART D - DETERMINATION OF PROSPECTIVE RATE	
1. Inflation Factor	1.06253
2. CHD Prospective Rate (C3 Multiplied by D1)	$627.73
3. Medicaid Trend Adjustment	($464.47)
4. Final Prospective Rate - Effective Date: 07/01/2024	$163.26