

CFRS

**COST & FINANCIAL REPORTING
SYSTEM**

FISCAL YEAR 2010-2011



INSTRUCTION MANUAL

Mental Health Plan Cost Reporting

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Detail Forms for ALL Legal Entities

This section details the following forms and their requirements for ALL Legal Entities. This includes county and contract legal entities.

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MH 1900**Information Worksheet**

The information worksheet is the starting point for completing the automated SD/MC Cost Report. The information provided here is automatically linked to forms and schedules in the cost report. This worksheet eliminates the redundant entry of county name and code, legal entity name and number on cost report forms and schedules. The information provided here applies to county and contract legal entities for Medi-Cal and non-Medi-Cal Cost Reports.

The Information Worksheet is divided into two sections. Section I should be completed by **all legal entities** and Section II should be completed by **county legal entities only**.

Section I: All Legal Entities

- **Name of Preparer:** Please enter the name of the person who prepared the cost report.
- **Date:** Please enter the date the cost report was completed.
- **Legal Entity Name:** Please enter the name of the legal entity for which this cost report was prepared.
- **Legal Entity Number:** Please enter the five digit legal entity number assigned by the Department of Mental Health to the legal entity for which this cost report was prepared.
- **County:** Please enter the name of the county for which this cost report was prepared.
- **County Code:** Please enter the two digit county code of the county for which this cost report was prepared.
- **Is this a County Legal Entity Report? (Y or N):** Please enter "Yes" if this cost report was prepared for a county legal entity or enter "No" if this cost report was prepared for a non-County provider.
- **Are you reporting SD/MC? (Y or N):** Please enter "Yes" if this cost report includes SD/MC units of service on the MH 1901_Schedule B or enter "No" if this cost report does not include SD/MC units of service on the MH 1901_Schedule B.

Section II: County Legal Entities Only

Address: If the cost report is prepared for a county legal entity, please enter the county legal entity's address.

Phone Number: If the cost report is prepared for a county legal entity, please enter the county legal entity's phone number.

County Population: Over 125,000? (Y or N): If the cost report is prepared for a county legal entity, please enter "Yes" if the county's population is more than 125,000 or enter "No" if the county's population is less than or equal to 125,000. Each county legal entity is required to respond to this question.

Contract Provider Other Medi-Cal Direct Service Gross Reimbursement (Used to Populate MH 1979 Line 2): If this cost report is prepared for a county legal entity, please report the gross payments to contract providers for other Medi-Cal inpatient and outpatient services. The amounts reported here populate the MH 1979, Line 2, Columns B and C, which are used to determine the 15% limit applied to Medi-Cal administrative reimbursement. The amount to report for outpatient services is equal to the sum of MH 1968, Lines 9, 9A, 9B, 14, 18, and 22 Column K for all contract providers that reported Medi-Cal units on the MH 1901 Schedule B. The amount to report for inpatient services is equal to the sum of MH 1968, Lines 9, 9A, 9B, 14, 18, and 22, Column E plus the gross payments to FFS/MC hospitals.

Contract Provider SD/MC Enhanced (Children) Direct Service Gross Reimbursement (Used to populate MH 1979 Line 14): If this cost report is prepared for a county legal entity, please report the gross payments to contract providers for SD/MC Enhanced (Children) inpatient and outpatient services. The amounts reported here populate the MH 1979, Line 14, Columns B and C, which are used to determine the 15% limit applied to SD/MC Enhanced (Children) administrative reimbursement. The amount to report on these lines is equal to the sum of MH 1968, Line 13, Columns E and K for all contract providers that reported SD/MC Enhanced (Children) units on the MH 1901 Schedule B.

Contract Provider Healthy Families Direct Service Gross Reimbursement (Used to populate MH 1979 Line 8): If this cost report is prepared for a county legal entity, please report the gross payments to contract provider for Healthy Families inpatient and outpatient services. The amounts reported here populate the MH 1979, Line 8, Columns B and C, which are used to determine the 10% limit applied to Healthy Families administrative reimbursement. The amount to report on these lines is equal to the sum of MH 1968, Line 30, Columns E and K for all contract providers that reported Healthy Families (SED) units on the MH 1901 Schedule B.

Total State Share of SD/MC Cost: No entry required. This cell is automatically populated from the MH 1979.

Fee for Service – Mental Health Specialty Provider Numbers For Individual and Group Providers: If this cost report is being prepared for a county legal entity and it is reporting units of service for mental health specialty individual and group providers on the MH 1901_Schedule B, please enter the legal entity number and provider numbers for those providers.

Adjust Medi-Cal and Healthy Families FFP due to Costs in Excess of CPE by Mode of Service (Used to Calculate FFP on the MH 1992): Please enter any adjustments to FFP due to costs in excess of the county's certified public expenditure by mode of service. These figures are used to calculate FFP on the MH 1992. The sum of adjustments to FFP by mode of service should equal the sum of adjustments to FFP by settlement group.

Adjust Medi-Cal and Healthy Families FFP due to Costs in Excess of CPE by Settlement Group (Used to Populate MH 1979 Column K): Please enter any adjustments to FFP due to costs in excess of the county's certified public expenditures by settlement group. These figures are used to populate the MH 1979, Column K. The sum of adjustments to FFP by settlement group should equal the sum of adjustments to FFP by mode of service.

MH 1901 SCHEDULE A**Statewide Maximum Allowances and Published Charges**

MH 1901 Schedule A requires information on published charges (PC) for all authorized services. The form layout is by Mode and Service Function and includes the Fiscal Year 2010-11 SD/MC Schedule of Maximum Allowances (SMA). While the SMA rates are provided, each legal entity must input the PC data for all authorized services. The form serves as a source document that will enable the SMA and PC rates to be cell referenced to other applicable forms.

Column D – Published Charge (PC)

Enter published charge rates for appropriate Modes and Service Functions reported. Note that Outreach (including MAA) and Support Services are excluded. A legal entity's published charge is the usual and customary charge prevalent in the public mental health sector that is used to bill the general public, insurers, or other non-Medi-Cal payors. Legal entities with more than one published charge rate for a service function may report a weighted average published charge rate for the service function, or provide a separate supporting schedule with the following information: 1) each service function; 2) time period covered by each published charge; 3) each published charge per unit of service; 4) Medi-Cal units of service provided for each published charge; and 5) total published charges for each service function (published charge per unit multiplied by the units of service). The published charge for Mode 05, Service Function 19, Hospital Administrative Days, should include physician and ancillary costs.

Column D, Rows 31-35 – Medi-Cal Eligibility Factor

Please enter the Medi-Cal Eligibility Factor for each quarter of the fiscal year if the legal entity participated in the Medi-Cal Administrative Activities (MAA) claiming process. A separate eligibility factor should be reported for each quarter claimed and should be consistent with quarterly MAA invoices submitted to DMH.

Column E, County Non-Medi-Cal Contract Rate

A provider may enter the non-Medi-Cal contract rates agreed to between the county and its service provider for non-Medi-Cal modes and service functions. Do not enter Medi-Cal contract rates in this column.

Column F, Rate for Allocation

This column picks up the Non-Medi-Cal Contract Rate entered in Column E.

MH 1901 SCHEDULE B**Worksheet for Units of Service and Revenues by Mode and Service Function**

MH 1901 Schedule B is an all purpose type worksheet. Data reported here is used to populate the MH 1901_Schedule C and the MH 1966 for each mode of service. This worksheet identifies services according to “settlement type”, modes and service functions, settlement group, and the period of service. You should complete the MH 1991 if you report units of service for Mode 05, Service Function 19.

Total units of service and units allocated to SD/MC, Medicare/Medi-Cal Crossovers, Enhanced Medi-Cal, Medi-Cal Administrative Activities, and Healthy Families are accounted for here. Total units reported must equal the sum of Columns H, L, P, R, T, V, X and Z. Patient and other payor revenues must also be reported on this worksheet. If unable to isolate patient and other payor revenues at the service function level, revenues may be reported at the mode of service level under the first reported service function within each mode.

Column A – Settlement Type

Enter the settlement type (CR, TBS, ASO, MAA, MHS, CAW, and HOSP) in Column A. Settlement type identifies the method used to determine reimbursement limits due to the application of each program’s rules.

- **CR** Cost Reimbursement (CR) method of reimbursement is based on actual cost.
- **TBS** Therapeutic Behavioral Services (TBS) are individual or group providers that contract with county mental health plans (MHP) to provide TBS only services. These providers are not required to submit annual cost reports to the State. County MHPs should reimburse this provider type and report these costs to DMH as actual costs to the county under the county legal entity number in Program 2 – TBS costs.
- **ASO** Administrative Services Organization (ASP) method of reimbursement is actual cost to the county. Counties are allowed to claim actual costs for payments made to the fiscal intermediary (FI) for the provision of services to children placed outside of the county. Administrative fees paid to the FI must be included as part of the County’s administrative costs reported on the MH 1960.
- **MAA** Medi-Cal Administrative Activities (MAA) method of reimbursement is based on actual costs to the county for counties participating in mental health MAA. Participation includes submission of a claiming plan, State and Federal level approval of a County Mental Health MAA Plan, and the submission of invoices to DMH during the year. All MAA invoices must be submitted by the time the cost report is due, and the units of service identified on the cost report must

- match the invoiced units. Please contact your MAA Coordinator for additional participation requirements.
- **MHS** Mental Health Specialty (MHS) method of reimbursement is actual cost to the county. Counties are allowed to claim actual costs for payments made to Fee-For-Service individual or group providers for mental health specialty services.
 - **CAW** California Work Opportunity and Responsibility to Kids (CalWORKS) program is to prepare clients for work and assist them to obtain and maintain employment so they can effectively support their families. Under CalWORKS, case aid to families is time-limited and able-bodied adults in the families must meet certain work requirements to remain eligible. County welfare departments under the supervision of California Department of Social Services administer this program.
 - **HOSP** Hospital (HOSP) services include mode 05 psychiatric inpatient hospital services (Mode 05, service function code 10-18), administrative day services (Mode 05, Service Function Code 19), day services (Mode 10), and outpatient services (Mode 15) provided by a hospital. Costs associated with these services are reported on the forms MH 1960_HOSP_COSTS, MH 1960_HOSP_05, MH 1960_PHYS_05, MH 1960_HOSP_10, MH 1960_PHYS_10, MH 1960_HOSP_15, MH 1960_PHYS_15. Please use this settlement type to separately identify units of service associated with costs reported by hospital providers.

Column B – Mode

Enter the mode of service.

Column C – Service Function

Enter the service function.

Column D – Total Units of Service

Enter the total units of service for each mode and service function.

Column E – SD/MC Units (July 1, 2010 – December 31, 2010)

Enter the total regular SD/MC units of service for each Medi-Cal service function for the period 07/1/10 through 12/31/10. Do not include Medicare/Medi-Cal crossover units or enhanced SD/MC units here.

Column F – SD/MC Units (January 1, 2011 – March 31, 2011)

Enter the total regular SD/MC units of service for each Medi-Cal service function for the period 1/1/11 through 03/31/11. Do not include Medicare/Medi-Cal crossover units or enhanced SD/MC units here.

Column G – SD/MC Units (April 1, 2011 – June 30, 2011)

Enter the total regular SD/MC units of service for each Medi-Cal service function for the period 4/1/11 through 06/30/11. Do not include Medicare/Medi-Cal crossover units or enhanced SD/MC units here.

Column H – Total SD/MC Units

No entry. This column sums Columns E through G..

Column I – Medicare/Medi-Cal Crossover Units (July 1, 2010 – December 31, 2010)

Enter the total Medicare/Medi-Cal Crossover units of service for each Medi-Cal service function for the period 07/1/10 through 12/31/10. Do not include regular SD/MC units or enhanced SD/MC units here.

Column J – Medicare/Medi-Cal Crossover Units (January 1, 2011 – March 31, 2011)

Enter the total Medicare/Medi-Cal Crossover units of service for each Medi-Cal service function for the period 1/1/11 through 03/31/11. Do not include regular SD/MC units or enhanced SD/MC units here.

Column K – Medicare/Medi-Cal Crossover Units (April 1, 2011 – June 30, 2011)

Enter the total Medicare/Medi-Cal Crossover units of service for each Medi-Cal service function for the period 4/1/11 through 06/30/11. Do not include regular SD/MC units or enhanced SD/MC units here.

Column L – Total Medicare/Medi-Cal Crossover Units

No entry. This column sums Columns I through K.

Columns M, N and O – Medi-Cal Patient and Other Payor Revenue

In Column M, enter the third party revenue received by the agency and attributed to regular SD/MC and Medicare/Medi-Cal Crossover units of service for the period July 1, 2010 – December 31, 2010. In Column N, enter the third party revenue received by the agency and attributed to regular SD/MC and Medicare/Medi-Cal Crossover units of service for the period January 1, 2011 – March 31, 2011. In Column O, enter the third party revenue received by the agency and attributed to regular SD/MC and Medicare/Medi-Cal Crossover units of service for the period April 1, 2011 – June 30, 2011.

Third party revenue should include patient fees for Medi-Cal share of costs, patient insurance, Medicare, and other revenues received on behalf of Medi-Cal clients in providing Medi-Cal units of service. This does not include realignment funding. Revenues should be reported on an accrual basis and should be identified as directly as possible to service function or mode level. If revenues cannot be directly identified, use a reasonable method to allocate revenues between inpatient and outpatient services.

Medicare revenues include revenue for services provided during this cost report fiscal year. **Prior year** Medicare revenues should **not** be included in the cost report.

Column P – Units of Service for Enhanced SD/MC – Children (July 1, 2010 – June 30, 2011)

Enter the units of service for each service function for Enhanced SD/MC – Children for the period July 1, 2010 – June 30, 2011.

Column Q – Third Party Revenue Enhanced SD/MC – Children

Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - Children units of service for the period July 1, 2010 – June 30, 2011. See Columns M, N & O for more information.

Column R – Units of Service for Enhanced SD/MC – BCCTP (July 1, 2010 – June 30, 2011)

Enter the units of services for each service function for Enhanced SD/MC – BCCTP for the period of July 1, 2010 – June 30, 2011.

Column S – 3rd Party Revenue Enhanced SD/MC – BCCTP

Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - BCCTP units of service for the period July 1, 2010 – June 30, 2011. See Columns M, N & O for more information.

Column T – Units of Service for Enhanced SD/MC – Pregnancy

Enter units of service for each service function for Enhanced SD/MC – Pregnancy for the period July 1, 2010 – June 30, 2011.

Column U – 3rd Party Revenue Enhanced SD/MC – Pregnancy

Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - Pregnancy units of service for the period July 1, 2010 – June 30, 2011. See Columns M, N & O for more information.

Column V – Units of Service for Enhanced SD/MC – Refugee

Enter units of service for each service function for Enhanced SD/MC – Refugee for the period July 1, 2010 – June 30, 2011.

Column W – 3rd Party Revenue Enhanced SD/MC – Refugee

Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - Refugee units of service for the period July 1, 2010 – June 30, 2011. See Columns M, N & O for more information.

Column X – Units of Service for Healthy Families – SED (July 1, 2010 – June 30, 2011)

Enter units of service for each service function for Healthy Families – SED for the period of July 1, 2010 – June 30, 2011.

Column Y – 3rd Party Revenue Healthy Families – SED

Enter the third party revenue received by the agency and attributed to Healthy Families – SED units of service for the period July 1, 2010 – June 30, 2011. See Columns M, N & O for more information.

Column Z – Non-Medi-Cal Units

No entry. This column calculates the total units less all SD/MC and Healthy Families units. Column Z equals Column D less Columns H, L, P, R, T, V, and X. If the sum of columns H, L, P, R, T, V, and X is greater than Column D, Column Z will display an error.

MH 1901 SCHEDULE C**Supporting Documentation for the Method Used to Allocate Total Cost to Mode of Service and Service Function**

MH 1901 Schedule C is designed to allocate the **mode costs** determined on Line 34, Column J of the MH 1960. This worksheet is also designed to automatically distribute mode costs to modes and service functions through the application of any of the three approved allocation methods: Costs determined at the service function level, time study, and relative value. The calculations performed here automatically populate MH 1966, programs 1 and 2. Selection of an "Allocation Method" from the Allocation Box will allow the distribution of mode costs to modes and service functions. For example, if the user selects SMA Rate as an allocation option from the Allocation Box, this worksheet will perform a relative value calculation using information from MH 1901 Schedule A to allocate mode costs to modes and service functions.

The method chosen must be applied consistently and uniformly to all mode costs, and must be consistent from year to year. A legal entity may request to change its allocation method by writing DMH.

Allocation Methodology**1. Costs Determined at Service Function Level**

Some legal entities have the technology and reporting mechanisms to capture costs at the service function level. Legal entities with this capability should allocate costs in this manner.

2. Time Study

The time study procedure used previously to allocate costs between modes of service may be used to allocate costs between service functions. To accomplish this, hours must be reported at the service function level rather than at the mode of service level. The percentage of total is calculated by dividing the costed hours for each service function by the total costed hours.

3. Relative Value

Units of service/time multiplied by the legal entity's charge for each service function determines the relative value assigned to each service function. A legal entity's charge for each service function is: 1) the legal entity's published charge; 2) the legal entity's usual and customary charge; or 3) the legal entity's charge to the general public for providing services. The SMA rate for each service function may be substituted for the legal entity's charge. The relative value for each service function is divided by the sum of all relative values to determine the percentage of the total for each service function. This method should be used by legal entities whose charges are established and updated annually based on the costs of providing the service. The relative value method may not be used to

allocate Mode 05, Service Functions 10 through 19, service costs according to the Department's Fiscal Audits Unit.

Allocation Method Option Box – Select an Allocation Method

1. **Rate for Allocation** – Select “Rate for Allocation” to use the relative value method based on the county non-Medi-Cal contract rates to allocate costs to modes and service functions. Do not select this option if you have not negotiated all your service functions for a Mode of Service.
2. **Statewide Maximum Allowances (SMA) Rate** – Select “SMA” for relative value method of cost allocation based on SMAs, if there are SMA rates for all the modes of service functions to be allocated.
3. **Published Charge** – Select “Published Charges” for relative value method of cost allocation based on published charges, if you reported published charge rates for all the modes and service functions.
4. **Directly Allocated** – Select “Directly Allocated” for the direct cost allocation method. This method may be used if costs were developed based on a time study or any other approved costing method.

Column A – Settlement Type

No entry. This column automatically populates from MH 1901 Schedule B, Column A.

Column B – Mode

No entry. This column automatically populated from MH 1901 Schedule B, Column B.

Column C – Service Function

No entry. This column automatically populated from MH 1901 Schedule B, Column C.

Column D – Total Units

No entry. This column automatically populates from MH 1901 Schedule B, Column D.

Column E – Eligible Direct Cost

Enter costs associated with TBS, ASO, MHS, and CAW. These costs, except for CAW, are reported on MH 1966, Program 2. Non-Medi-Cal costs for Modes 45 and 60 may also be entered in this column.

Column F – Directly Allocated Data

Enter costs directly assigned to each service function on MH 1966, Program 1. Please select the “Directly Allocated” option from the allocation method option box when entering data in this column. Do not report costs associated with TBS, ASO, MHS and CAW.

Column G – Relative Value

No entry. This column computes the relative value using the selected allocation base. Relative value is the product of multiplying the rate for allocation, SMA, or published charge by the service function total units of service. For example, if published charge is the selected allocation base from the “Allocation Method” option box, the amount

generated and placed in column G will be the product of the published charge rate from MH 1901 Schedule A published charge column and the total units reported on MH 1901 Schedule C, Column D for each service function.

To compute a relative value, please select an allocation base from the allocation box (i.e., rate for allocation, published charge, or SMA). Do not enter data into Column E or F next to the service functions for which a relative value statistic is to be calculated.

Column H – Allocation Percentage

No entry. This column computes the allocation percentages for each service function that is allocating costs using the relative value method. This is achieved by dividing each service function relative value statistic by the aggregate of all the service functions relative value statistics.

Column I – Allocated Costs

No entry. This column computes the allocated cost for each service function.

MH 1960**Calculation of Program Costs****MH 1960 – CALCULATION OF PROGRAM COSTS**

The purpose of the form MH 1960 is to determine the legal entity's allowable costs applicable to the following cost objectives: 1) administration, utilization review, research and evaluation, and modes of service. The purpose of lines 1 – 23 is to capture indirect costs incurred by the legal entity. Indirect costs include all costs that are incurred for a common or joint purpose benefitting more than one final cost objective, that are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved. The purpose of lines 24 – 33 is to capture direct costs incurred by the legal entity. Direct costs include all costs that can be identified with a final cost objective. Legal entities should enter cost data in Columns A and B directly from their trial balance. The designation of costs as direct and indirect should be consistent with the county's indirect cost rate plan (ICRP) as approved by the Federal government. Report costs on the line that is most appropriate given the definitions below

Indirect Cost Centers

Line 1 - Land: Please enter expenditures for the acquisition of land, which is used by the legal entity to benefit more than one cost objective and/or is not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 2 - Buildings and Improvements: Please enter expenditures for the acquisition of structures and improvements, which are used by the legal entity to benefit more than one cost objective and/or is not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 3 - Equipment: Please enter expenditures for the acquisition of physical property of a permanent nature, other than land and buildings and improvements, which are used by the legal entity to benefit more than one cost objective and/or is not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 4 - Rents and Leases – Equipment: Please enter expenditures for renting or leasing equipment and other articles that are used by the legal entity to benefit more than one cost objective and/or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 5 - Rents and Leases – Buildings and Improvements: Please enter expenditures for renting or leasing land, structures and improvements that are used by the legal entity to benefit more than one cost objective and/or are not readily assignable

to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 6 - Taxes and Assessments: Please enter expenditures for taxes and assessments levied against the legal entity by a governmental agency.

Line 7 - Insurance: Please enter expenditures for liability insurance, such as general liability or malpractice insurance, which benefits more than one cost objective and/or is not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved. Do not include expenditures for health, dental, and other group insurance made available to employees.

Line 8 - Maintenance – Equipment: Please enter expenditures for keeping equipment, whether or not capitalized, in efficient operating condition, when the equipment is used by the legal entity to benefit more than one cost objective and/or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 9 - Maintenance – Buildings and Improvements: Please enter expenditures for maintaining the useful life of buildings and improvements that are used by the legal entity to benefit more than one cost objective and/or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 10 - Utilities: Please enter expenditures for utilities that are used by the legal entity to benefit more than one cost objective and/or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved. Utilities include coal, wood, electricity, heating and cooling supplies, natural gas, butane, fuel oil, sewage disposal, street lighting on county grounds, and water.

Line 11 - Household Expenses: Please enter expenditures for household items that are used by the legal entity to benefit more than one cost objective and/or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved. Household items include items such as custodial services, toilet tissue, and drinking water.

Line 12 - Interest on Bonds: Please enter expenditures for interest on bonded debt that is used by the legal entity to benefit more than one cost objective and/or is not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 13 - Interest on Other Long-Term Debt: Please enter expenditures for interest on long-term debt, other than bonded debt, that is used by the legal entity to benefit more than one cost objective and/or is not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 14 - Contracts Administration: Please enter legal entity expenditures for administration of contracts that benefit more than one cost objective.

Line 15 - Legal and Accounting: Please enter legal entity expenditures for legal and accounting activities that benefit more than one cost objective and/or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 16 - Data Processing: Please enter legal entity expenditures for data processing activities that benefit more than one cost objective and/or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 17 - Personnel Administration: Please enter legal entity expenditures for personnel administration activities that benefit more than one cost objective and/or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 18 - Medical Records: Please enter legal entity expenditures for maintaining mental health patient records that benefit more than one cost objective or are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 19 - Professional and Specialized Services: Please enter legal entity expenditures for professional and specialized services purchased from outside vendors that benefit more than one cost objective or is not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.
Do not include payments to direct service contract providers on this line.

Line 20 - Transportation and Travel: Please enter legal entity expenditures for transportation of persons and things that benefit more than cost objective or is not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved.

Line 21 – Communications: Please enter legal entity expenditures for telephone, telegraph, teletype, radio, microwave, and messenger services; and fax machines, pagers, and cell phones. Please do not include radio report services and supplies. Enter these expenditures on line 8, Maintenance – Equipment. Please do not include rental of communication equipment. Enter these expenditures on line 4 Rents and Leases – Equipment.

Line 22 – Other: Please enter legal entity indirect costs that are not properly classified in any of the available cost centers.

Line 23 - Countywide Cost Allocation (COWCAP): Please enter the external county costs allocated to the Department of Mental Health pursuant to the County's countywide

cost allocation plan prepared in accordance with the State Controller's Office *Handbook of Cost Plan Procedures for California Counties*.

Direct Cost Centers

Line 24 – 28: Administrative Costs: County legal entities should report total administrative costs on line 24. Administrative costs include expenditures incurred for activities necessary for the proper and efficient administration of community mental health programs. Proper and efficient administration includes outreach, eligibility intake, contract administration, program planning and policy development, administrative case management, program coordination and claims administration. Please refer to DMH Letter 11-01 for guidance regarding costs that may be directly allocated to administration. Administrative costs should be reclassified to lines 25 (Short-Doyle Medi-Cal – Other), 26 (Health Families Program), 27 (M-CHIP), and 28 (non-Medi-Cal) on the MH 1965. Please use one of the following methods to determine the amount of administrative costs to apportion to each program:

1. The percentage of program beneficiaries in the population served by the county
2. Relative values based on units and published charges
3. Gross costs of each program

Lines 29 - 32 – Utilization Review Costs (County Only): County legal entities should report total utilization review costs on line 29. The total utilization review costs must be reclassified to lines 30 (Skilled Professional Medical Personnel Utilization Review), 31 (Other SD/MC Utilization Review), and 32 (Non-SD/MC Utilization Review) on the MH 1965. The amount reported on line 30 is reimbursed at the enhanced rate of 75%. Documentation supporting the amount on line 30 must be maintained by the county legal entity. The MAA Instruction Manual provides a detailed discussion of how to identify Skilled Professional Medical Personnel.

Line 33 – Non-Hospital Mode Costs (Direct Service and MAA): All legal entities must enter the direct service and MAA costs on line 31. Direct service and MAA costs include all direct costs of providing mental health services and Medi-Cal Administrative Activities.

Line 34 – Total Direct Costs – Line 34 is equal to the sum of lines 24, 29, and 33.

Column A – Please enter the salary and benefit costs accumulated in each indirect cost center listed on lines 1-23, and each direct cost center listed on lines 24, 29, and 33.

Column B – Please enter all costs other than salary and benefit costs accumulated in each indirect cost center listed on lines 1 – 23 and each direct cost center listed on lines 24, 29, and 33.

Column C – No entry. This column calculates the sum of Columns A and B for each cost center listed in lines 1-33.

Column D – No entry. This column is automatically populated from data entered on form MH 1965.

Column E – No entry. This column is automatically populated from data entered on form MH 1961. .

Column F – No entry. This column is automatically populated from data entered on form MH 1962.

Column G – No entry. This column is automatically populated from data entered on the form MH 1963.

Column H – No entry. This column calculates the sum of Columns C, D, E, F, and G. Please enter, as a positive number, the amount of indirect costs to be allocated to each cost center (Administrative Costs, Utilization Review Costs, Research and Evaluation, and Mode Costs).

Column I, Lines 1 – 23 – No entry. This column converts the amount in Column H to a negative number.

Column I, Lines 24 – 33 – Please enter the amount allocated to each direct cost center from the indirect cost centers.

Column J – No entry. This column calculates the sum of Columns H and I.

MH 1960 HOSP COSTS**Calculation of Cost Per Day and Cost To Charge Ratios – Hospital Legal Entities**

The purpose of the form MH 1960_HOSP_COSTS is to determine the hospital's cost per day for routine cost centers, and its cost to charge ratio for ancillary, outpatient, and non-physician practitioner cost centers applicable for providing psychiatric inpatient hospital services (mode 05), day services (mode 10), and outpatient services (mode 15). A hospital legal entity must first complete the CMS 2552-96, Hospital and Hospital Health Care Complex Medicare or Medi-Cal cost report. A hospital that does not submit a CMS 2552-96 to CMS and/or DHCS must at least complete worksheets A, A6, A7, A8, A8-2, A8-4, and worksheet B, Part I of the CMS 2552-96.

Column 1 – Costs per W/S B, Part I

Please enter the costs from the CMS-2552, Worksheet B, Part I, Column 27 for all cost centers.

Column 2 – Graduate Medical Education (GME) Costs

Please enter the intern and resident cost and post step down adjustments from Worksheet B, Part I, Column 26 of the CMS 2552.

Column 3 – Total Costs

No entry. This column calculates the sum of columns A, B and C.

Column 4 – Total Medi-Cal Days/Charges

Please enter total inpatient days, including administrative days, for each routine cost center and total charges for each ancillary cost center, each outpatient cost center, and each non-physician practitioner cost center from the hospital's records.

Column 5 – Cost Per Day/Cost to Charge Ratio

No entry. This column divides costs by days for each routine cost center to calculate the cost per day and by charges for each ancillary, outpatient, and non-physician practitioner cost center to calculate the cost to charge ratio.

Column 6 – Physician Professional Component Costs (From W/S A8-2, Column 4)

Please enter total physician professional component costs as reported on Worksheet A8-2 of the CMS 2552-96.

Column 7 – Physician and Non Physician Practitioner Professional Costs (W/S A-8)

Please enter physician and non-physician practitioner professional costs as reported on Worksheet A-8 of the CMS 2552-96.

Column 8 – Physician Professional Component Related Administrative, Data Processing, and Patient Business Office Costs (W/S A-8)

Please enter any costs associated with physician administrative, data processing, and patient business office costs for physicians as reported on Worksheet A-8 of the CMS 2552-96.

Column 9 – Total Physician Professional Component Related Costs

No entry. This column calculates the sum of columns 6, 7 and 8.

Column 10 – Total Physician Billed Professional Charges/RVU

Please enter total charges or an approved RVU for physician and non-physician practitioner services.

Column 11 – Ratio of Physician Professional Costs to Billed Professional Charges

No entry. Column 11 calculates the ratio of column 9 to column 10 (Column 9/Column 10).

Column 12 – Medi-Cal SMHS Mode 05 Hospital Costs

No entry. Column 12 is automatically populated with data from Column 24 of the MH 1960_HOSP_05.

Column 13 – Medi-Cal SMHS Mode 05 Physician Costs

No entry. Column 13 is automatically populated with data from Column 24 of the MH 1960_PHYS_05.

Column 14 - Medi-Cal SMHS Mode 05 Total Costs

No entry. Column 14 is equal to the sum of columns 13 and 14.

Column 15 – Medi-Cal SMHS Mode 10 Hospital Costs

No entry. Column 15 is automatically populated with data from Column 24 of the MH 1960_HOSP_10.

Column 16 – Medi-Cal SMHS Mode 10 Physician Costs

No entry. Column 16 is automatically populated with data from Column 24 of the MH 1960_PHYS_10.

Column 17 - Medi-Cal SMHS Mode 10 Total Costs

No entry. Column 17 is equal to the sum of columns 15 and 16.

Column 18 – Medi-Cal SMHS Mode 15 Hospital Costs

No entry. Column 18 is automatically populated with data from Column 24 of the MH 1960_HOSP_15.

Column 19 – Medi-Cal SMHS Mode 15 Physician Costs

No entry. Column 19 is automatically populated with data from Column 24 of the MH 1960_PHYS_15.

Column 20 - Medi-Cal SMHS Mode 15 Total Costs

No entry. Column 20 is equal to the sum of columns 18 and 19.

Column 21 - Medi-Cal SMHS Total Costs

No entry. Column 21 is equal to the sum of columns 14, 17, and 20.

MH 1960_HOSP_05**Calculation of Mode 05 (Hospital Inpatient) Program Costs – Hospital Legal Entities**

The purpose of the form MH 1960_HOSP_05 is to apportion the hospital's costs of acute psychiatric inpatient hospital services to the appropriate settlement groups using the cost per day and cost-to-charge ratios calculated on form MH 1960_HOSP_COSTS.

Column 1 – Costs Per Day/Cost-to-Charge Ratio

No entry. The cost per day for routine cost centers and the cost-to-charge ratio for all other costs centers are automatically populated with data from Column 5 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/10 – 12/31/10)

For routine cost centers, please enter the total inpatient days for SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010. For all other cost centers, please enter the total charges for SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/10 – 12/31/10)

No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – SD/MC Days/Charges/RVU (01/01/11 – 03/31/11)

For routine cost centers, please enter the total inpatient days for SD/MC beneficiaries for the period January 1, 2011 through March 31, 2011. For all other cost centers, please enter the total charges for SD/MC beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – SD/MC Costs (01/01/11 – 03/31/11)

No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Days/Charges/RVU (04/01/11 – 06/30/11)

For routine cost centers, please enter the total inpatient days for SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011. For all other cost centers, please enter the total charges for SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Costs (04/01/11 – 06/30/11)

No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – Medi-Medi X-Over Days/Charges/RVU (07/01/10 – 12/31/10)

For routine cost centers, please enter the total inpatient days for Medi-Medi X-Over beneficiaries for the period July 1, 2010 through December 31, 2011. For all other cost centers, please enter the total charges for SD/MC beneficiaries during the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – Medi-Medi X-Over Costs (07/01/10 – 12/31/10)

No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – Medi-Medi X-Over Days/Charges/RVU (01/01/11 – 03/31/11)

For routine cost centers, please enter the total inpatient days for Medi-Medi X-Over beneficiaries for the period January 1, 2011 through March 31, 2011. For all other cost centers, please enter the total charges for Medi-Medi X-Over beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – Medi-Medi X-Over Costs (01/01/11 – 03/31/11)

No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – Medi-Medi X-Over Days/Charges/RVU (04/01/11 – 06/30/11)

For routine cost centers, please enter the total inpatient days for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011. For all other cost centers, please enter the total charges for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – Medi-Medi X-Over Costs (04/01/11 – 06/30/11)

No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Children) Days/Charges/RVU

For routine cost centers, please enter the total inpatient days for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Children) Costs

No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – SD/MC Enhanced (BCCTP) Days/Charges/RVU

For routine cost centers, please enter the total inpatient days for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – SD/MC Enhanced (BCCTP) Costs

No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU

For routine cost centers, please enter the total inpatient days for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – SD/MC Enhanced (Pregnancy) Costs

No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – SD/MC Enhanced (Refugee) Days/Charges/RVU

For routine cost centers, please enter the total inpatient days for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – SD/MC Enhanced (Refugee) Costs

No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Healthy Families (SED) Days/Charges/RVU

For routine cost centers, please enter the total inpatient days for Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Healthy Families (SED) Costs

No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Costs

No Entry. Column 24 is equal to the sum of Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, and 23.

MH 1960_PHYS_05**Calculation of Mode 05 (Hospital Inpatient) Physician Costs – Hospital Legal Entities**

The purpose of the form MH 1960_PHYS_05 is to apportion the hospital's physician and non-physician practitioner professional costs related to acute psychiatric inpatient hospital services to the appropriate settlement groups using the cost per day and cost-to-charge ratios calculated for physician professional costs on form MH 1960_HOSP_COSTS.

Column 1 – Cost-to-Charge Ratio/RVU

No entry. The cost-to-charge ratio/RVU for each applicable costs center is automatically populated with data from Column 11 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/10 – 12/31/10)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/10 – 12/31/10)

No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – SD/MC Days/Charges/RVU (01/01/11 – 03/31/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – SD/MC Costs (01/01/11 – 03/31/11)

No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Days/Charges/RVU (04/01/11 – 06/30/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Costs (04/01/11 – 06/30/11)

No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – Medi-Medi X-Over Days/Charges/RVU (07/01/10 – 12/31/10)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries

for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – Medi-Medi X-Over Costs (07/01/10 – 12/31/10)

No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – Medi-Medi X-Over Days/Charges/RVU (01/01/11 – 03/31/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for the period January 1, 2011 through March 31, 2011. For all other cost centers, please enter the total charges for Medi-Medi X-Over beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – Medi-Medi X-Over Costs (01/01/11 – 03/31/11)

No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – Medi-Medi X-Over Days/Charges/RVU (04/01/11 – 06/30/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011. For all other cost centers, please enter the total charges for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – Medi-Medi X-Over Costs (04/01/11 – 06/30/11)

No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Children) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Children) Costs

No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – SD/MC Enhanced (BCCTP) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – SD/MC Enhanced (BCCTP) Costs

No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – SD/MC Enhanced (Pregnancy) Costs

No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – SD/MC Enhanced (Refugee) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – SD/MC Enhanced (Refugee) Costs

No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Healthy Families (SED) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Healthy Families (SED) Costs

No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Costs

No Entry. Column 24 is equal to the sum of Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, and 23.

MH 1960 HOSP 05 ADMIN**Calculation of Mode 05 (Hospital Administrative Days) Program Costs – Hospital Legal Entities**

The purpose of the form MH 1960_HOSP_05_ADMIN is to apportion the hospital's costs of hospital administrative days to the appropriate settlement groups using the cost per day and cost-to-charge ratios calculated on form MH 1960_HOSP_COSTS.

Column 1 – Costs Per Day/Cost-to-Charge Ratio

No entry. The cost per day for routine cost centers and the cost-to-charge ratio for all other costs centers are automatically populated with data from Column 5 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/10 – 12/31/10)

For routine cost centers, please enter the total hospital administrative days for SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/10 – 12/31/10)

No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – SD/MC Days/Charges/RVU (01/01/11 – 03/31/11)

For routine cost centers, please enter the total hospital administrative days for SD/MC beneficiaries for the period January 1, 2011 through March 31, 2011. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – SD/MC Costs (01/01/11 – 03/31/11)

No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Days/Charges/RVU (04/01/11 – 06/30/11)

For routine cost centers, please enter the total hospital administrative days for SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Costs (04/01/11 – 06/30/11)

No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – Medi-Medi X-Over Days/Charges/RVU (07/01/10 – 12/31/10)

For routine cost centers, please enter the total hospital administrative days for Medi-Medi X-Over beneficiaries for the period July 1, 2010 through December 31, 2011. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC beneficiaries during the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – Medi-Medi X-Over Costs (07/01/10 – 12/31/10)

No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – Medi-Medi X-Over Days/Charges/RVU (01/01/11 – 03/31/11)

For routine cost centers, please enter the total hospital administrative days for Medi-Medi X-Over beneficiaries for the period January 1, 2011 through March 31, 2011. For all other cost centers, please enter the total charges for hospital administrative days for Medi-Medi X-Over beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – Medi-Medi X-Over Costs (01/01/11 – 03/31/11)

No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – Medi-Medi X-Over Days/Charges/RVU (04/01/11 – 06/30/11)

For routine cost centers, please enter the total hospital administrative days for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011. For all other cost centers, please enter the total charges for hospital administrative days for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – Medi-Medi X-Over Costs (04/01/11 – 06/30/11)

No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Children) Days/Charges/RVU

For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Children) Costs

No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – SD/MC Enhanced (BCCTP) Days/Charges/RVU

For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – SD/MC Enhanced (BCCTP) Costs

No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU

For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – SD/MC Enhanced (Pregnancy) Costs

No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – SD/MC Enhanced (Refugee) Days/Charges/RVU

For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – SD/MC Enhanced (Refugee) Costs

No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Healthy Families (SED) Days/Charges/RVU

For routine cost centers, please enter the total hospital administrative days for Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011. For all other cost centers, please enter the total charges for hospital administrative days for Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Healthy Families (SED) Costs

No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Costs

No Entry. Column 24 is equal to the sum of Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, and 23.

MH 1960 PHYS 05 ADMIN**Calculation of Mode 05 (Hospital Administrative Days) Physician Costs – Hospital Legal Entities**

The purpose of the form MH 1960_PHYS_05_ADMIN is to apportion the hospital's physician and non-physician practitioner professional costs related to hospital administrative days to the appropriate settlement groups using the cost per day and cost-to-charge ratios calculated for physician professional costs on form MH 1960_HOSP_COSTS.

Column 1 – Cost-to-Charge Ratio/RVU

No entry. The cost-to-charge ratio/RVU for each applicable costs center is automatically populated with data from Column 11 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/10 – 12/31/10)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for hospital administrative days for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/10 – 12/31/10)

No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – SD/MC Days/Charges/RVU (01/01/11 – 03/31/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for hospital administrative days for the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – SD/MC Costs (01/01/11 – 03/31/11)

No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Days/Charges/RVU (04/01/11 – 06/30/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for hospital administrative days for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Costs (04/01/11 – 06/30/11)

No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – Medi-Medi X-Over Days/Charges/RVU (07/01/10 – 12/31/10)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for hospital administrative days for the period July 1, 2010 through December 31, 2010

or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – Medi-Medi X-Over Costs (07/01/10 – 12/31/10)

No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – Medi-Medi X-Over Days/Charges/RVU (01/01/11 – 03/31/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for hospital administrative days for the period January 1, 2011 through March 31, 2011.

Column 11 – Medi-Medi X-Over Costs (01/01/11 – 03/31/11)

No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – Medi-Medi X-Over Days/Charges/RVU (04/01/11 – 06/30/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for hospital administrative days for the period April 1, 2011 through June 30, 2011.

Column 13 – Medi-Medi X-Over Costs (04/01/11 – 06/30/11)

No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Children) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Children) beneficiaries for hospital administrative days for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Children) Costs

No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – SD/MC Enhanced (BCCTP) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (BCCTP) beneficiaries for hospital administrative days for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – SD/MC Enhanced (BCCTP) Costs

No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Pregnancy) beneficiaries for hospital administrative days for the period July 1, 2010 through June

30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – SD/MC Enhanced (Pregnancy) Costs

No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – SD/MC Enhanced (Refugee) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Refugee) beneficiaries for hospital administrative days for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – SD/MC Enhanced (Refugee) Costs

No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Healthy Families (SED) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Healthy Families (SED) beneficiaries for hospital administrative days for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Healthy Families (SED) Costs

No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Costs

No Entry. Column 24 is equal to the sum of Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, and 23.

MH 1960_HOSP_10**Calculation of Mode 10 (Day Services) Program Costs – Hospital Legal Entities**

The purpose of the form MH 1960_HOSP_10 is to apportion the hospital's costs of day services to the appropriate settlement groups using the cost per day and cost-to-charge ratios calculated on form MH 1960_HOSP_COSTS.

Column 1 – Costs Per Day/Cost-to-Charge Ratio

No entry. The cost per day for routine cost centers and the cost-to-charge ratio for all other costs centers are automatically populated with data from Column 5 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/10 – 12/31/10)

Please enter the total charges for SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/10 – 12/31/10)

No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – SD/MC Days/Charges/RVU (01/01/11 – 03/31/11)

Please enter the total charges for SD/MC beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – SD/MC Costs (01/01/11 – 03/31/11)

No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Days/Charges/RVU (04/01/11 – 06/30/11)

Please enter the total charges for SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Costs (04/01/11 – 06/30/11)

No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – Medi-Medi X-Over Days/Charges/RVU (07/01/10 – 12/31/10)

Please enter the total charges for SD/MC beneficiaries during the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – Medi-Medi X-Over Costs (07/01/10 – 12/31/10)

No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – Medi-Medi X-Over Days/Charges/RVU (01/01/11 – 03/31/11)

Please enter the total charges for Medi-Medi X-Over beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – Medi-Medi X-Over Costs (01/01/11 – 03/31/11)

No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – Medi-Medi X-Over Days/Charges/RVU (04/01/11 – 06/30/11)

Please enter the total charges for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – Medi-Medi X-Over Costs (04/01/11 – 06/30/11)

No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Children) Days/Charges/RVU

Please enter the total charges for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Children) Costs

No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – SD/MC Enhanced (BCCTP) Days/Charges/RVU

Please enter the total charges for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – SD/MC Enhanced (BCCTP) Costs

No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU

Please enter the total charges for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – SD/MC Enhanced (Pregnancy) Costs

No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – SD/MC Enhanced (Refugee) Days/Charges/RVU

Please enter the total charges for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – SD/MC Enhanced (Refugee) Costs

No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Healthy Families (SED) Days/Charges/RVU

Please enter the total charges for Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Healthy Families (SED) Costs

No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Costs

No Entry. Column 24 is equal to the sum of Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, and 23.

MH 1960_PHYS_10**Calculation of Mode 10 (Day Services) Physician Costs – Hospital Legal Entities**

The purpose of the form MH 1960_PHYS_10 is to apportion the hospital's physician and non-physician practitioner professional costs associated with the provision of day services to the appropriate settlement groups using the cost per day and cost-to-charge ratios calculated for physician professional costs on form MH 1960_HOSP_COSTS.

Column 1 – Cost-to-Charge Ratio/RVU

No entry. The cost-to-charge ratio/RVU for each applicable costs center is automatically populated with data from Column 11 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/10 – 12/31/10)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/10 – 12/31/10)

No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – SD/MC Days/Charges/RVU (01/01/11 – 03/31/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – SD/MC Costs (01/01/11 – 03/31/11)

No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Days/Charges/RVU (04/01/11 – 06/30/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Costs (04/01/11 – 06/30/11)

No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – Medi-Medi X-Over Days/Charges/RVU (07/01/10 – 12/31/10)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – Medi-Medi X-Over Costs (07/01/10 – 12/31/10)

No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – Medi-Medi X-Over Days/Charges/RVU (01/01/11 – 03/31/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for the period January 1, 2011 through March 31, 2011. For all other cost centers, please enter the total charges for Medi-Medi X-Over beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – Medi-Medi X-Over Costs (01/01/11 – 03/31/11)

No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – Medi-Medi X-Over Days/Charges/RVU (04/01/11 – 06/30/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011. For all other cost centers, please enter the total charges for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – Medi-Medi X-Over Costs (04/01/11 – 06/30/11)

No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Children) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Children) Costs

No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – SD/MC Enhanced (BCCTP) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – SD/MC Enhanced (BCCTP) Costs

No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Pregnancy)

beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – SD/MC Enhanced (Pregnancy) Costs

No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – SD/MC Enhanced (Refugee) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – SD/MC Enhanced (Refugee) Costs

No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Healthy Families (SED) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Healthy Families (SED) Costs

No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Costs

No Entry. Column 24 is equal to the sum of Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, and 23.

MH 1960_HOSP_15**Calculation of Mode 15 (Outpatient Services) Program Costs – Hospital Legal Entities**

The purpose of the form MH 1960_HOSP_15 is to apportion the hospital's costs to the appropriate settlement groups using the cost per day and cost-to-charge ratios calculated on form MH 1960_HOSP_COSTS.

Column 1 – Costs Per Day/Cost-to-Charge Ratio

No entry. The cost per day for routine cost centers and the cost-to-charge ratio for all other costs centers are automatically populated with data from Column 5 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/10 – 12/31/10)

Please enter the total charges for SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/10 – 12/31/10)

No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – SD/MC Days/Charges/RVU (01/01/11 – 03/31/11)

Please enter the total charges for SD/MC beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – SD/MC Costs (01/01/11 – 03/31/11)

No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Days/Charges/RVU (04/01/11 – 06/30/11)

Please enter the total charges for SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Costs (04/01/11 – 06/30/11)

No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – Medi-Medi X-Over Days/Charges/RVU (07/01/10 – 12/31/10)

Please enter the total charges for SD/MC beneficiaries during the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – Medi-Medi X-Over Costs (07/01/10 – 12/31/10)

No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – Medi-Medi X-Over Days/Charges/RVU (01/01/11 – 03/31/11)

Please enter the total charges for Medi-Medi X-Over beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – Medi-Medi X-Over Costs (01/01/11 – 03/31/11)

No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – Medi-Medi X-Over Days/Charges/RVU (04/01/11 – 06/30/11)

Please enter the total charges for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – Medi-Medi X-Over Costs (04/01/11 – 06/30/11)

No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Children) Days/Charges/RVU

Please enter the total charges for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Children) Costs

No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – SD/MC Enhanced (BCCTP) Days/Charges/RVU

Please enter the total charges for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – SD/MC Enhanced (BCCTP) Costs

No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU

Please enter the total charges for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – SD/MC Enhanced (Pregnancy) Costs

No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – SD/MC Enhanced (Refugee) Days/Charges/RVU

Please enter the total charges for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – SD/MC Enhanced (Refugee) Costs

No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Healthy Families (SED) Days/Charges/RVU

Please enter the total charges for Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Healthy Families (SED) Costs

No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Costs

No Entry. Column 24 is equal to the sum of Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, and 23.

MH 1960_PHYS_15**Calculation of Mode 15 (Outpatient Services) Physician Costs – Hospital Legal Entities**

The purpose of the form MH 1960_PHYS_15 is to apportion the hospital's physician and non-physician practitioner professional costs to the appropriate settlement groups using the cost per day and cost-to-charge ratios calculated for physician professional costs on form MH 1960_HOSP_COSTS.

Column 1 – Cost-to-Charge Ratio/RVU

No entry. The cost-to-charge ratio/RVU for each applicable costs center is automatically populated with data from Column 11 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/10 – 12/31/10)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/10 – 12/31/10)

No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – SD/MC Days/Charges/RVU (01/01/11 – 03/31/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – SD/MC Costs (01/01/11 – 03/31/11)

No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Days/Charges/RVU (04/01/11 – 06/30/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Costs (04/01/11 – 06/30/11)

No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – Medi-Medi X-Over Days/Charges/RVU (07/01/10 – 12/31/10)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for the period July 1, 2010 through December 31, 2010 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – Medi-Medi X-Over Costs (07/01/10 – 12/31/10)

No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – Medi-Medi X-Over Days/Charges/RVU (01/01/11 – 03/31/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for the period January 1, 2011 through March 31, 2011. For all other cost centers, please enter the total charges for Medi-Medi X-Over beneficiaries during the period January 1, 2011 through March 31, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – Medi-Medi X-Over Costs (01/01/11 – 03/31/11)

No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – Medi-Medi X-Over Days/Charges/RVU (04/01/11 – 06/30/11)

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011. For all other cost centers, please enter the total charges for Medi-Medi X-Over beneficiaries for the period April 1, 2011 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – Medi-Medi X-Over Costs (04/01/11 – 06/30/11)

No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Children) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Children) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Children) Costs

No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – SD/MC Enhanced (BCCTP) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – SD/MC Enhanced (BCCTP) Costs

No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – SD/MC Enhanced (Pregnancy) Costs

No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – SD/MC Enhanced (Refugee) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – SD/MC Enhanced (Refugee) Costs

No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Healthy Families (SED) Days/Charges/RVU

For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Healthy Families (SED) beneficiaries for the period July 1, 2010 through June 30, 2011 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Healthy Families (SED) Costs

No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Costs

No Entry. Column 24 is equal to the sum of Columns 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, and 23.

MH 1961**Medi-Cal Adjustments to Cost**

The purpose of MH 1961 is to calculate adjustments to costs for Medi-Cal and Medicare principles of allowable costs. Adjustments identified on this form are transferred to the appropriate line in column E of the MH 1960. Refer to the Centers for Medicare and Medicaid Services (CMS) Publication 15, Provider Reimbursement Manual for further explanation of Medi-Cal allowable and non-allowable costs.

Line 1 – Depreciation Adjustment

The principles of reimbursement for provider costs provide that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to beneficiaries. The CMS Provider Reimbursement Manual, Part I, Chapter 1 provides instructions for how assets may be depreciated. Costs reported on the MH 1960 may need to be adjusted to comply with this principal of reimbursement. Please enter any adjustments for depreciation expenses

Line 2 – Bad Debt

Bad debts are not to be included in allowable costs unless attributable to deductibles and coinsurance amounts. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 3 for guidance regarding how to treat bad debt. Please enter any adjustments to costs due to bad debts on line 2.

Line 3 – Unallowable Tax Expenses

Certain taxes levied on providers are not allowable costs. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Section 2122.2 for more information about unallowable tax expenses. Please make any adjustments due to unallowable tax expenses on line 3.

Line 4 – Unallowable Advertising Costs

Whether or not advertising costs are allowable depends on whether they are appropriate and helpful in developing, maintaining, and furnishing covered services to Medi-Cal beneficiaries by providers of services. To be allowable, such costs must be common and accepted occurrences in the field of the provider's activity. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Sections 2136 through 2136.2 for guidance regarding allowable and unallowable advertising costs. Please enter any adjustments to costs due to advertising on line 4. .

Line 5 – Political and Lobbying Activities

Provider political and lobbying activities are not related to the care of patient and are therefore not allowable costs. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Sections 2139 through 2139.3 for guidance regarding unallowable political and lobbying activities. Please enter any adjustments to costs due to political and lobbying activities on line 5. .

Line 6 – Unallowable Central Service Costs

The following expenditures are not allowable: 1) general administrative costs of local governments – such as the general expenses of local governments in carrying out the coordinating, fiscal and administrative functions of government, and public services such as fire, police, sanitation, tax administration and collection, and water, 2) chief executive officer's expenditures – includes salaries and expenditures of the office of the chief executive of a political subdivision, 3) legislative expenditures – including salaries and other expenditures of the local governmental lawmaking bodies such as county supervisors and city councils, and 4) tax anticipation warrants and property tax functions. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Section 2156.1 for guidance regarding unallowable central service costs. Please enter any adjustments to costs due to unallowable central service costs on line 6..

Line 7 – Unallowable Liability Losses

Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Section 2160.2 for guidance regarding allowable liability losses. Please enter any adjustments to costs due to unallowable liability losses on line 7..

Line 8 – Abandonment of Construction in Progress

Where a provider begins construction of a new facility to expand, rebuild, or relocate its present certified facility and then later abandons the partially completed asset. The cost of this abandoned asset, excluding planning costs, is an investment loss and is not allowable. If a provider abandons a partially constructed asset which would have become a newly certified facility, the loss, including abandoned planning costs, is not allowable. Please refer the CMS Provider Reimbursement Manual, Part I, Chapter 12, Section 12154ff for a description of planning costs. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Section 2155 for more information about how to treat costs of abandoned construction in progress. Please enter any adjustments to costs due to abandonment of construction in process on line 8..

Lines 9-19 – Other Adjustments to Cost

Please enter any other adjustments to costs to comply with Medi-Cal principles of reimbursement on lines 9-19. Please refer to the CMS Provider Reimbursement Manual, Part I, for guidance regarding allowable and unallowable costs.

Line 20 – Total Adjustments

No entry. Line 20 is equal to the sum of lines 1-19.

MH 1962**Other Adjustment**

The purpose of the MH 1962 is to provide detail information of other adjustments for each cost center. Use this form to make additional positive or negative adjustments to cost that are not captured on the MH 1961. For example, if the amount reported on the MH 1960 includes costs of the county substance abuse division, the costs of the substance abuse division would be deducted. Information entered here will automatically populate the appropriate line in Column F of the MH 1960.

Column A – Description

Please enter a brief description of the purpose for the adjustment.

Column B – Amount

Please enter the amount of the adjustment. Enter reductions in cost as a negative number and increases in costs as a positive number. The amount entered in column A will automatically populate the appropriate line in Column F of the MH 1960.

Column C – MH 1960 Line Number

Please enter the line on the MH 1960 with the costs that are to be adjusted. The amount entered in Column B will automatically populate the line on the MH 1960 that is entered in Column C.

Column D – MH 1960 Description

No entry. This column is automatically populated when a line number is entered in Column C.

MH 1963**Payments TO Contract Providers (County Only)**

The purpose of the MH 1963 is to capture payments to contract providers for services provided in the cost reporting fiscal year. Information entered here automatically populates MH 1960, Line 33, Column G.

Payments to contract provider legal entities include all interim payments to providers with which the county has a service contract and should be reported in the year in which services/units are provided. This does not include payments to hospitals operated by other county departments. Payments for fee-for-service vendor contracts should not be included on this form. Most county legal entities will not record the Fee-for-Service/Medi-Cal (FFS/MC) payments in their auditor-controller's report because these payments are pass-through funds to the hospital. **If payments to FFS/MC hospitals contracted under inpatient consolidation are included on MH 1960, Line 31**, these expenditures should be included on this form in order to reduce total mental health expenditures by the FFS/MC amount. Payments to contract providers should be reported in the year in which services/units are provided.

Column B – Legal Entity Name

Please enter the contract provider's legal entity name or one entry for the FFS/MC hospitals.

Column C – Legal Entity Number

Please enter the contract provider's legal entity number.

Column D – Total Payments (07/01/10 – 06/01/11)

Please enter the amount paid to the contract provider for all mental health services provided in the cost report fiscal year. This amount should equal at least the amount on the legal entity's cost report. A cost report should be submitted for each contract provider payment listed.

Column E – SD/MC Payments (07/01/10 – 12/31/10)

Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Columns E and I of the MH 1901_Schedule B. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on line 24, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 24, Column D, of the MH 1979, please enter an appropriate adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on line 24, Column D of the MH 1979 minus the Medi-Cal payment entered on Column E of the MH 1963 multiplied by 61.59%.

Column F – SD/MC Payments (01/01/11 – 03/31/11)

Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Columns F and J of the MH 1901_Schedule B. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on line 24A, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 24A, Column D, of the MH 1979, please enter an appropriate adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on line 24A, Column D of the MH 1979 minus the Medi-Cal payment entered on Column F of the MH 1963 multiplied by 58.77%.

Column G – SD/MC Payments (04/01/11 – 06/30/11)

Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Columns G and K of the MH 1901_Schedule B. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on line 24B, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 24B, Column D, of the MH 1979, please enter an appropriate adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on line 24B, Column D of the MH 1979 minus the Medi-Cal payment entered on Column G of the MH 1963 multiplied by 56.88%.

Column H – Enhanced SD/MC Payments – Children (07/01/10 – 06/30/10)

Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column P of the MH 1901_Schedule B. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on line 25, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 25, Column D, of the MH 1979, please enter an appropriate adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on line 25, Column D of the MH 1979 minus the Medi-Cal payment entered on Column H of the MH 1963 multiplied by 65%.

Column I – Enhanced SD/MC Payments - BCCTP (07/01/10 – 06/30/10)

Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column R of the MH 1901_Schedule B. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on line 26, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 26, Column D, of the MH 1979, please enter an appropriate adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on

line 26, Column D of the MH 1979 minus the Medi-Cal payment entered on Column I of the MH 1963 multiplied by 65%.

Column J – Enhanced SD/MC Payments – Pregnancy (07/01/10 – 06/30/10)

Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column T of the MH 1901_Schedule B. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on line 27, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 27, Column D, of the MH 1979, please enter an appropriate adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on line 27, Column D of the MH 1979 minus the Medi-Cal payment entered on Column J of the MH 1963 multiplied by 65%.

Column K – Enhanced SD/MC Payments – Refugee (07/01/10 – 06/30/10)

Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column V of the MH 1901_Schedule B. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on line 28, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 28, Column D, of the MH 1979, please enter an appropriate adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on line 28, Column D of the MH 1979 minus the Medi-Cal payment entered on Column K of the MH 1963 multiplied by 100%.

Column L – Healthy Families Program Payments (07/01/10 – 06/30/10)

Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Columns X of the MH 1901_Schedule B. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on line 32, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 32, Column D, of the MH 1979, please enter an appropriate adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on line 32, Column D of the MH 1979 minus the Medi-Cal payment entered on Column L of the MH 1963 multiplied by 65%.

Column M – Medi-Cal Administrative Activities (07/01/10 – 06/30/10)

Please enter the amount paid to the contract provider for the performance of mental health Medi-Cal Administrative Activities the contractor reported on its cost report under Mode 55. This amount should be equal to or greater than the sum of the contract provider's total costs subject to reimbursement on lines 19 and 20, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 32, Column D, of the MH 1979, please enter an appropriate

adjustment to the legal entity's FFP on the MH 1900_Info of the legal entity's cost report. The adjustment to FFP must be equal to the contract provider's total costs subject to reimbursement on line 32, Column D of the MH 1979 minus the Medi-Cal payment entered on Column L of the MH 1963 multiplied by 65%.

MH 1964**Allocation of Costs to Modes of Service**

The purpose of MH 1964 is to distribute mode costs to various modes of service, including MAA.

Line 1 – Mode Costs (Direct Service and MAA) from MH 1960

No entry. This line is automatically populated from E134, I131 and K134 of the MH1901 Schedule C..

Line 2 through 8 – Modes

No entry. These lines are automatically populated from the MH 1901 Schedule C, Column I.

Line 9 – Total – Lines 2 through 8

No entry. This line sums lines 2 through 8. The amount on line 9 should equal the amount on line 1. Any difference between the two amounts should be corrected on MH 1960 before proceeding.

MH 1965**Reclassification(s) of Program Costs**

The purpose of the MH 1965 is to reclassify costs from one cost center to another cost center on the MH 1960. For example, administrative costs reported in Column C of line 24 must be reclassified to lines 25, 26, 27, and 28 as appropriate; and utilization review/quality assurance costs reported in Column C, line 30 must be reclassified to lines 31, 32, and 33 as appropriate.

Explanation of Reclassification

Please enter a brief explanation of the reason the costs are being reclassified. For example, the purpose may be to distribute administrative costs to the SD/MC, Healthy Families, MCHIP, and non-SD/MC programs.

Column A – Code

Please enter a letter in each line that contains data to identify each entry.

Column B – Cost Center

Please enter the name of the cost center on the MH 1960 to which costs are being reclassified.

Column C – MH 1960 Line #

Please enter the line number on the MH 1960 to which the costs are being reclassified.

Column D – Costs

Please enter the amount of costs to be reclassified to the cost center identified in Columns B and C. Column D must always be a positive number. The absolute value of the sum of all entries in Column D must equal the absolute value of the sum of all entries in Column G.

Column E – Cost Center

Please enter the name of the cost center on the MH 1960 from which costs are to be reclassified.

Column F – MH 1960 Line #

Please enter the line number on the MH 1960 from which costs are to be reclassified.

Column G – Costs

Please enter the amount of costs to be reclassified from the cost center identified in Columns E and F. Column G must always be a negative number. The absolute value of the sum of entries in Column G must equal the absolute value of the sum of all entries in Column D.

MH 1966 Program 1 and Program 2**Allocation of Costs to Service Functions – Mode Total**

MH 1966, Program 1 and Program 2 distribute mode costs among Medi-Cal, Healthy Families, and non-Medi-Cal units of service. Program 2 accounts for pass-through costs incurred by fee-for-service contract providers, TBS-only contract providers, non-organizational MHS providers, and Administrative Service Organization (ASO) providers.

The MH 1966 forms for Modes 45 and 60 are simplified from the other MH 1966 forms and determine non-Medi-Cal costs for each mode of service. The MH 1966 for Mode 55 is also simplified from other MH 1966 forms and identify the MAA costs for those participating in the MAA program.

The MH 1966 automatically populates from the MH 1901 Schedules A, B, and C. Separate MH 1966 forms are automatically populated for each mode of service.

Line 1 – Allocation Percentage

No entry. The allocation percentage is determined by taking the Total Allocated Cost for each service function from the MH 1901 Schedule C divided by the Total Allocated Cost for the respective mode of service.

Line 2 – Total Units

No entry. This field is automatically populated from the MH 1901 Schedule C, Column D.

Line 3 – Gross Cost

No entry. This field is automatically populated from the MH 1901 Schedule C, Column I. The distribution of the amount on line 3, Column A, to the appropriate service functions is completed automatically from the MH 1901 Schedule C.

Line 4 – Cost Per Unit

No entry. Starting in Column B, line 4 is automatically calculated as line 3 divided by line 2.

Line 5 – SMA per Unit

No entry. Starting in Column B, this field is automatically populated from MH 1901 Schedule A, Column C.

Line 6 – Published Charge per Unit

No entry. Starting in Column B, this field is automatically populated from the MH 1901 Schedule A, Column D.. Please see the MH 1901 Schedule A instructions for more information about the published charge.

Lines 7, 7A & 7B – Med-Cal Units

No entry. Starting in Column B, Medi-Cal units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Columns E, F and G.

Lines 8, 8A & 8B – Medicare/Medi-Cal Crossover Units

No entry. Starting in Column B, Medicare/Medi-Cal crossover units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Columns I, J and K.

Lines 9 – Enhanced SD/MC (Children) Units

No entry. Starting in Column B, Enhanced SD/MC (Children) units (from billing records) for each Medi-Cal service functions fills in automatically from the MH 1901 Schedule B, Column P.

Line 10– Enhanced SD/MC (BCCTP) Units

No entry. Starting in Column B, Enhanced SD/MC (BCCTP) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column R.

Lines 11 – Enhanced SD/MC (Pregnancy)

No entry. Starting in Column B, units for each Enhanced SD/MC (Pregnancy) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Columns T.

Line 12 – Enhanced SD/MC (Refugee)

No entry. Starting in Column B, units for each Enhanced SD/MC (Refugee) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Columns V.

Line 13 – Healthy Families (SED) Units

No entry. Starting in Column B, Healthy Families units (from billing records) for each Healthy Families service function fills in automatically from the MH 1901 Schedule B, Column X.

Line 14 – Non Medi-Cal Units

No entry. Starting in Column B, non-Medi-Cal units for each service function fills in automatically from MH 1901 Schedule B, Column Z.

Lines 15, 15A & 15B – Medi-Cal Costs

No entry. Starting in Column B, line 4 is multiplied by lines 7, 7A and 7B for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Lines 15, 15A and 15B.

Lines 16, 16A & 16B – Medi-Cal SMA Upper Limits

No entry. Starting in Column B, line 5 is multiplied by lines 7, 7A and 7B for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Lines 16, 16A and 16B.

Lines 17, 17A & 17B – Medi-Cal Published Charges

No entry. Starting in Column B, line 6 is multiplied by lines 7, 7A and 7B for each SD/MC service function. The product of all SD/MC service functions computed are summed up on Column A, Lines 17, 17A and 17B.

Lines 18, 18A & 18B – Medicare/Medi-Cal Crossover Costs

No entry. Starting in Column B, line 4 is multiplied by lines 8, 8A and 8B for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Lines 18, 18A and 18B.

Lines 19, 19A & 19B – Medicare/Medi-Cal Crossover SMA Upper Limits

No entry. Starting in Column B, line 5 is multiplied by lines 8, 8A and 8B for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Lines 19, 19A and 19B.

Lines 20, 20A & 20B – Medicare/Medi-Cal Crossover Published Charges

No entry. Starting in Column B, line 6 is multiplied by lines 8, 8A and 8B for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Lines 20, 20A and 20B.

Line 21 – Enhanced SD/MC (Children) Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 21.

Line 22 – Enhanced SD/MC (Children) SMA Upper Limits

No entry. Starting in Column B, Line 5 is multiplied by lines 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 22.

Lines 23 – Enhanced SD/MC (Children) Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 23.

Line 24 – Enhanced SD/MC (BCCTP) Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 24.

Line 25 – Enhanced SD/MC (BCCTP) SMA Upper Limits

No entry. Starting in Column B, Line 5 is multiplied by lines 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 25.

Lines 26 – Enhanced SD/MC (BCCTP) Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 26.

Line 27 – Enhanced SD/MC (Pregnancy) Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 27.

Line 28 – Enhanced SD/MC (Pregnancy) SMA Upper Limits

No entry. Starting in Column B, Line 5 is multiplied by lines 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 28.

Lines 29 – Enhanced SD/MC (Pregnancy) Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 29.

Line 30 – Enhanced SD/MC (Refugee) Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 12 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 30.

Line 31 – Enhanced SD/MC (Refugee) SMA Upper Limits

No entry. Starting in Column B, Line 5 is multiplied by lines 12 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 31.

Lines 32 – Enhanced SD/MC (Refugee) Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 12 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 32.

Line 33 – Healthy Families Program Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 13 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 33.

Line 34 – Healthy Families Program SMA Upper Limits

No entry. Starting in Column B, Line 5 is multiplied by lines 13 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 34.

Lines 35 – Healthy Families Program Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 13 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 35.

Lines 36 – Non-Medi-Cal Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 14 for each service function. The products of all service functions computed are summed up in Column A, Line 36.

MH 1966 Mode 05, Service Function 19**Hospital Inpatient**

Legal entities that report Mode 05, SF 19 must complete the MH 1991. The SMA rate for Mode 05, SF 19 does not include physician and ancillary service costs. The MH 1991 is intended to capture the physician and ancillary costs related to these administrative days and add them to the SMA. The intent of this procedure is to ensure that physician and ancillary costs related to these hospital administrative days are included in the comparison of the costs, SMA, and published charge. The MH 1966 pulls the SMA costs for Mode 05, SF 19 from the MH 1991.

Upon Completion of Form MH 1991, the MH 1966 for Mode 05, SF 19 automatically populates from the MH 1901 Schedules A, B, C and MH 1991.

Line 1 – Allocation Percentage

No entry. The allocation percentage is determined by taking the Total Allocated Cost for each service function from the MH 1901 Schedule C divided by the Total Allocated Cost for the respective mode of service.

Line 2 – Total Units

No entry. This field is automatically populated from the MH 1901 Schedule C, Column D.

Line 3 – Gross Cost

No entry. This field is automatically populated from the MH 1901 Schedule C, Column I. The distribution of the amount on line 3, Column A, to the appropriate service functions is completed automatically from the MH 1901 Schedule C.

Line 4 – Cost Per Unit

No entry. Starting in Column B, line 4 is automatically calculated as line 3 divided by line 2.

Line 5 – SMA per Unit

No entry. Starting in Column B, this field is automatically populated from MH 1901 Schedule A, Column C.

Line 6 – Published Charge per Unit

No entry. Starting in Column B, this field is automatically populated from the MH 1901 Schedule A, Column D. Please see the MH 1901 Schedule A instructions for more information about the published charge.

Lines 7, 7A & 7B – Med-Cal Units

No entry. Starting in Column B, Medi-Cal units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Columns E, F and G.

Lines 8, 8A & 8B – Medicare/Medi-Cal Crossover Units

These lines do not apply to this service function and should be left blank. Administrative Days cannot have crossover units because Medicare will not pay for those beds.

Lines 9 – Enhanced SD/MC (Children) Units

No entry. Starting in Column B, Enhanced SD/MC (Children) units (from billing records) for each Medi-Cal service functions fills in automatically from the MH 1901 Schedule B, Column P.

Line 10– Enhanced SD/MC (BCCTP) Units

No entry. Starting in Column B, Enhanced SD/MC (BCCTP) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column R.

Lines 11 – Enhanced SD/MC (Pregnancy)

No entry. Starting in Column B, units for each Enhanced SD/MC (Pregnancy) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Columns T.

Line 12 – Enhanced SD/MC (Refugee)

No entry. Starting in Column B, units for each Enhanced SD/MC (Refugee) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Columns V.

Line 13 – Healthy Families (SED) Units

No entry. Starting in Column B, Healthy Families units (from billing records) for each Healthy Families service function fills in automatically from the MH 1901 Schedule B, Column X.

Line 14 – Non Medi-Cal Units

No entry. Starting in Column B, non-Medi-Cal units for each service function fills in automatically from MH 1901 Schedule B, Column Z.

Lines 15, 15A & 15B – Medi-Cal Costs

No entry. Starting in Column B, line 4 is multiplied by lines 7, 7A and 7B for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Lines 15, 15A and 15B.

Lines 16, 16A & 16B – Medi-Cal SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits are populated from Column I of the MH 1991. The product of all SD/MC service functions computed are summed up in Column A, Lines 16, 16A and 16B.

Lines 17, 17A & 17B – Medi-Cal Published Charges

No entry. Starting in Column B, line 6 is multiplied by lines 7, 7A and 7B for each SD/MC service function. The product of all SD/MC service functions computed are summed up on Column A, Lines 17, 17A and 17B.

Lines 18, 18A & 18B – Medicare/Medi-Cal Crossover Costs

These lines do not apply to this service function and should be left blank. Administrative Days cannot have crossover units because Medicare will not pay for those beds.

Lines 19, 19A & 19B – Medicare/Medi-Cal Crossover SMA Upper Limits

These lines do not apply to this service function and should be left blank. Administrative Days cannot have crossover units because Medicare will not pay for those beds.

Lines 20, 20A & 20B – Medicare/Medi-Cal Crossover Published Charges

These lines do not apply to this service function and should be left blank. Administrative Days cannot have crossover units because Medicare will not pay for those beds.

Line 21 – Enhanced SD/MC (Children) Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 21.

Line 22 – Enhanced SD/MC (Children) SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits are populated from Column I of the MH 1991. The products of all SD/MC service functions computed are summed up in Column A, Line 22.

Lines 23 – Enhanced SD/MC (Children) Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 23.

Line 24 – Enhanced SD/MC (BCCTP) Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 24.

Line 25 – Enhanced SD/MC (BCCTP) SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits are populated from Column I of the MH 1991. The products of all SD/MC service functions computed are summed up in Column A, Line 25.

Lines 26 – Enhanced SD/MC (BCCTP) Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 26.

Line 27 – Enhanced SD/MC (Pregnancy) Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 27.

Line 28 – Enhanced SD/MC (Pregnancy) SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits are populated from Column I of the MH 1991. The products of all SD/MC service functions computed are summed up in Column A, Line 28.

Lines 29 – Enhanced SD/MC (Pregnancy) Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 11 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 29.

Line 30 – Enhanced SD/MC (Refugee) Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 12 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 30.

Line 31 – Enhanced SD/MC (Refugee) SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits are populated from Column I of the MH 1991. The products of all SD/MC service functions computed are summed up in Column A, Line 31.

Lines 32 – Enhanced SD/MC (Refugee) Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 12 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 32.

Line 33 – Healthy Families Program Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 13 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 33.

Line 34 – Healthy Families Program SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits are populated from Column I of the MH 1991. The products of all SD/MC service functions computed are summed up in Column A, Line 34.

Lines 35 – Healthy Families Program Published Charges

No entry. Starting in Column B, Line 6 is multiplied by lines 13 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 35.

Lines 36 – Non-Medi-Cal Costs

No entry. Starting in Column B, Line 4 is multiplied by lines 14 for each service function. The products of all service functions computed are summed up in Column A, Line 36.

MH 1966 Modes 45 and 60**Outreach and Support**

MH 1966 for Mode 45 (Outreach) and Mode 60 (Support) services, are non-Medi-Cal reimbursable. For these modes, the format consists of only six lines. MH 1966 for Modes 45 and 60 automatically populates from the MH 1901 Schedules A, B, and C.

Lines 1 – 3

No entry. These fields populate automatically from the MH 1901 Schedules B and C.

Line 4 – Cost Per Unit

No entry. Starting from Column B, Line 3 is divided by Line 2 for each service function.

Line 5 – Non-Medi-Cal Units

No entry. Starting from Column B, non-Medi-Cal units for each service function fills in from Line 2.

Line 6

No entry. Starting from Column B, non-Medi-Cal costs for each service function fills in from Line 3.

MH 1966 Mode 55**Medi-Cal Administrative Activities (MAA)**

MH 1966 for Mode 55 is for Medi-Cal Administrative Activities and consists of five lines. MH 1966 for Mode 55 is automatically populated from the MH 1901 Schedules A, B, and C. Legal entities must have an approved MAA plan with DMH in order to report Mode 55.

Lines 1 through 3

No entry. These fields are automatically populated from the MH 1901 Schedules B and C.

Line 4 – Cost Per Unit

No entry. Starting from Column B, Line 3 is divided by line 2 for each service function to calculate the cost per unit.

Line 5 – Non-Medi-Cal Costs

No entry. Starting from Column B, non-Medi-Cal units for each service function is populated by taking line 3, Column A of this form and subtracting MH 1968, Line 40, Column D.

MH 1968**Determination of SD/MC Direct Services and MAA Reimbursement**

The purpose of the MH 1968 is to determine the net SD/MC and Healthy Families direct service reimbursement (FFP and State Match) for inpatient and outpatient services as well as MAA reimbursement. MAA service function expenditures are combined on the MH 1968.

Nominal Fee Provider

The first step in the cost report settlement process is to determine whether or not the legal entity meets the Nominal Fee provider criteria (42CFR413.13). Legal entities with a significant portion of low-income patients may complete an optional form, MH 1969 Nominal Fee Provider Determination, prior to completing the MH 1968. Nominal fee providers' reimbursement is limited to the lower of reasonable and allowable cost or SMA.

Determination of Cost Settlement Process

The cost report template automatically determines the lower of cost, SMA or published charge for SD/MC inpatient and outpatient services separately. The determination is based upon the cost, SMA, or published charge amounts for services provided to all SD/MC beneficiaries (i.e., Medi-Cal, Medicare/Medi-Cal crossover, Enhanced Children, Enhanced BCCTP, Enhanced Pregnancy, and Enhanced Refugee). Cost settlement for Healthy Families is based upon the lower of cost, SMA, or published charge as determined for SD/MC beneficiaries.

Column E, Lines 1, 1A & 1B – Medi-Cal Costs

No entry. The total cost of providing mode 05 (hospital inpatient) services to regular (excluding enhanced and Medicare crossover) Medi-Cal beneficiaries is equal to the sum of Column 3 of MH 1960_HOSP_05 and Column 3 of the MH 1960_PHYS_05; Column 5 of the MH 1960_HOSP_05 and Column 5 of the MH 1960_PHYS_05; and Column 7 of the MH 1960_HOSP_05 and Column 7 of the MH 1960_PHYS_05.

Column F, Lines 1, 1A & 1B – Medi-Cal Costs

No entry. The total cost of providing Mode 05 (other 24-hour) services to regular (excluding enhanced and Medicare crossover) Medi-Cal beneficiaries is equal to the amount determined in Column A, lines 15, 15A, and 15 B of the MH 1966 for Mode 05 (other 24 hour) services.

Column G, Lines 1, 1A & 1B – Medi-Cal Costs

No entry. The total cost of providing day services as reported in line 1 is equal to the sum of Column A, line 15 of the MH 1966 for mode 10, Column 3 of the MH 1960_HOSP_10, and Column 3 of the MH 1960_PHYS_10. The total cost of providing day services as reported on line 1A is equal to the sum of Column A, line 15A of the MH

1966 for mode 10, Column 5 of the MH 1960_HOSP_10 and Column 5 of the MH 1960_PHYS_10. The total cost of providing day services as reported on line 1B is equal to the sum of Column A, line 15B of the MH 1966 for mode 10, Column 7 of the MH 1960_HOSP_10 and Column 7 of the MH 1960_PHYS_10.

Column H, Lines 1, 1A & 1B – Medi-Cal Costs

No entry. The total cost of providing outpatient services as reported in line 1 is equal to the sum of Column A, line 15 of the MH 1966 for mode 15 (program 1), Column 3 of the MH 1960_HOSP_15, and Column 3 of the MH 1960_PHYS_15. The total cost of providing day services as reported on line 1A is equal to the sum of Column A, line 15A of the MH 1966 for mode 15 (program 1), Column 5 of the MH 1960_HOSP_15 and Column 5 of the MH 1960_PHYS_15. The total cost of providing day services as reported on line 1B is equal to the sum of Column A, line 15B of the MH 1966 for mode 15 (program 1), Column 7 of the MH 1960_HOSP_15 and Column 7 of the MH 1960_PHYS_15.

Column I, Lines 1, 1A & 1B – Medi-Cal Costs

No entry. Column I is equal to the sum of Columns F, G & H.

Column J, Lines 1, 1A & 1B – Medi-Cal Costs

No entry. Column J is equal to Column A, lines 15, 15A, and 15B of the MH 1966 for Mode 15 (program 2) services.

Column K, Lines 1, 1A & 1B – Medi-Cal Costs

No entry. Column K is equal to the sum of Columns I and J.

Lines 2, 2A & 2B – Medi-Cal SMA Upper Limits

No entry. The Medi-Cal SMA Upper Limit for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 16, 16A and 16B of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H. Column K calculates the sum of Columns I and J.

Lines 3, 3A & 3B – Medi-Cal Published Charges

No entry. Medi-Cal published Charges for each mode of service in Columns E through H is automatically populated from Column A, Lines 17, 17A, and 17B of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

Lines 4, 4A & 4B – Medi-Cal Gross Reimbursement

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or SMA is selected and populates lines 4, 4A and 4B. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charge is selected and populates lines 4, 4A and 4B. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J

consists of Program 2 costs that are to be reimbursed to the county at the lower of reasonable and allowable costs or the SMA. Lines 4, 4A and 4B in Column J are automatically populated by the lower of reasonable and allowable costs (lines 2, 2A and 2B) or SMA (lines 3, 3A and 3B).

Column E, Lines 5, 5A & 5B – Medicare/Medi-Cal Crossover Costs

No entry. The total cost of providing mode 05 (hospital inpatient) services to Medicare/Medi-Cal crossover beneficiaries as reported on line 1 is equal to the sum of Column 9 of MH 1960_HOSP_05 and Column 9 of the MH 1960_PHYS_05. The total cost of providing mode 05 (hospital inpatient) services to Medicare/Medi-Cal crossover beneficiaries as reported on line 1A is equal to the sum of Column 11 of the MH 1960_HOSP_05 and Column 11 of the MH 1960_PHYS_05. The total cost of providing mode 05 (hospital inpatient) services to Medicare/Medi-Cal crossover beneficiaries as reported on line 1B is equal to the sum of and Column 13 of the MH 1960_HOSP_05 and Column 13 of the MH 1960_PHYS_05.

Column F, Lines 5, 5A & 5B – Medicare/Medi-Cal Crossover Costs

No entry. The total cost of providing Mode 05 (other 24-hour) services to Medicare/Medi-Cal crossover beneficiaries is equal to the amount determined in Column A, lines 18, 18A, and 18 B of the MH 1966 for Mode 05 (other 24 hour) services.

Column G, Lines 5, 5A & 5B – Medicare/Medi-Cal Crossover Costs

No entry. The total cost of providing day services as reported in line 1 is equal to the sum of Column A, line 18 of the MH 1966 for mode 10, Column 9 of the MH 1960_HOSP_10, and Column 9 of the MH 1960_PHYS_10. The total cost of providing day services as reported on line 1A is equal to the sum of Column A, line 18A of the MH 1966 for mode 10, Column 11 of the MH 1960_HOSP_10 and Column 11 of the MH 1960_PHYS_10. The total cost of providing day services as reported on line 1B is equal to the sum of Column A, line 18B of the MH 1966 for mode 10, Column 13 of the MH 1960_HOSP_10 and Column 13 of the MH 1960_PHYS_10.

Column H, Lines 5, 5A & 5B – Medicare/Medi-Cal Crossover Costs

No entry. The total cost of providing outpatient services as reported in line 1 is equal to the sum of Column A, line 18 of the MH 1966 for mode 15 (program 1), Column 9 of the MH 1960_HOSP_15, and Column 9 of the MH 1960_PHYS_15. The total cost of providing day services as reported on line 1A is equal to the sum of Column A, line 18A of the MH 1966 for mode 15 (program 1), Column 11 of the MH 1960_HOSP_15 and Column 11 of the MH 1960_PHYS_15. The total cost of providing day services as reported on line 1B is equal to the sum of Column A, line 18B of the MH 1966 for mode 15 (program 1), Column 13 of the MH 1960_HOSP_15 and Column 13 of the MH 1960_PHYS_15.

Column I, Lines 5, 5A & 5B – Medicare/Medi-Cal Crossover Costs

No entry. Column I is equal to the sum of Columns F, G & H.

Column J, Lines 5, 5A & 5B – Medicare/Medi-Cal Crossover Costs

No entry. Column J is equal to Column A, lines 18, 18A, and 18B of the MH 1966 for Mode 15 (program 2) services.

Column K, Lines 5, 5A & 5B – Medicare/Medi-Cal Crossover Costs

No entry. Column K is equal to the sum of Columns I and J.

Lines 6, 6A & 6B – Medicare/Medi-Cal Crossover SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 19, 19A and 19B of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H. Column K calculates the sum of Columns I and J.

Lines 7, 7A & 7B – Medicare/Medi-Cal Crossover Published Charges

No entry. Medi-Cal published Charges for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 20, 20A and 20B of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

Lines 8, 8A & 8B – Medicare/Medi-Cal Crossover Gross Reimbursement

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or SMA is selected and populates lines 8, 8A and 8B. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charge is selected and populates lines 8, 8A and 8B. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county as the lower of reasonable and allowable costs or the SMA. Lines 8, 8A and 8B in Column J are automatically populated by the lower of reasonable and allowable costs (lines 5, 5A and 5B) or SMA (lines 6, 6A and 6B).

Lines 9, 9A & 9B – Total SD/MC + Crossover Gross Reimbursement

No entry. Lines 9, 9A & 9B automatically calculate the sum of lines 4 and 8, lines 4A and 8A, and lines 4B and 8B.

Column E, Lines 10 – Enhanced SD/MC (Children) Costs

No entry. The total cost of providing mode 05 (hospital inpatient) services to Enhanced SD/MC (Children) beneficiaries as reported on line 10 is equal to the sum of Column 15 of MH 1960_HOSP_05 and Column 15 of the MH 1960_PHYS_05.

Column F, Lines 10 – Enhanced SD/MC (Children) Costs

No entry. The total cost of providing Mode 05 (other 24-hour) services to Medicare/Medi-Cal crossover beneficiaries is equal to the amount determined in Column A, lines 21 of the MH 1966 for Mode 05 (other 24 hour) services.

Column G, Lines 10 – Enhanced SD/MC (Children) Costs

No entry. The total cost of providing day services to Enhanced SD/MC (Children) beneficiaries as reported in line 10 is equal to the sum of Column A, line 21 of the MH 1966 for mode 10, Column 15 of the MH 1960_HOSP_10, and Column 15 of the MH 1960_PHYS_10.

Column H, Lines 10 – Enhanced SD/MC (Children) Costs

No entry. The total cost of providing outpatient services to Enhanced SD/MC (Children) beneficiaries as reported in line 10 is equal to the sum of Column A, line 21 of the MH 1966 for mode 15 (program 1), Column 15 of the MH 1960_HOSP_15, and Column 15 of the MH 1960_PHYS_15.

Column I, Lines 10 – Enhanced SD/MC (Children) Costs

No entry. Column I is equal to the sum of Columns F, G & H.

Column J, Lines 10 – Enhanced SD/MC (Children) Costs

No entry. Column J is equal to Column A, line 21 of the MH 1966 for Mode 15 (program 2) services.

Column K, Lines 10 – Enhanced SD/MC (Children) Costs

No entry. Column K is equal to the sum of Columns I and J.

Line 11 – Enhanced SD/MC (Children) SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Line 22 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H. Column K calculates the sum of Columns I and J.

Line 12 – Enhanced SD/MC (Children) Published Charges

No entry. Medi-Cal published Charges for each mode of service in Columns E through H is automatically populated from Column A, Lines 23 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

Line 13 – Enhanced SD/MC (Children) Gross Reimbursement

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or SMA is selected and populates line 13. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charges is selected and populates line 13. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county at the lower of reasonable and allowable costs or the SMA. Line 13 in Column J is automatically populated with the lower of reasonable and allowable costs (line 10) or SMA (line 11).

Line 14, Column E – Enhanced SD/MC (BCCTP) Costs

No entry. The total cost of providing mode 05 (hospital inpatient) services to Enhanced SD/MC (BCCTP) beneficiaries as reported on line 14 is equal to the sum of Column 17 of MH 1960_HOSP_05 and Column 17 of the MH 1960_PHYS_05.

Line 14, Column F – Enhanced SD/MC (BCCTP) Costs

No entry. The total cost of providing Mode 05 (other 24-hour) services to Medicare/Medi-Cal crossover beneficiaries is equal to the amount determined in Column A, line 24 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 14, Column G – Enhanced SD/MC (BCCTP) Costs

No entry. The total cost of providing day services to Enhanced SD/MC (BCCTP) beneficiaries as reported in line 14 is equal to the sum of Column A, line 24 of the MH 1966 for mode 10, Column 17 of the MH 1960_HOSP_10, and Column 17 of the MH 1960_PHYS_10.

Line 14, Column H – Enhanced SD/MC (BCCTP) Costs

No entry. The total cost of providing outpatient services to Enhanced SD/MC (BCCTP) beneficiaries as reported in line 10 is equal to the sum of Column A, line 24 of the MH 1966 for mode 15 (program 1), Column 17 of the MH 1960_HOSP_15, and Column 17 of the MH 1960_PHYS_15.

Line 14, Column I – Enhanced SD/MC (BCCTP) Costs

No entry. Column I is equal to the sum of Columns F, G & H.

Line 14, Column J – Enhanced SD/MC (BCCTP) Costs

No entry. Column J is equal to Column A, line 24 of the MH 1966 for Mode 15 (program 2) services.

Line 14, Column K – Enhanced SD/MC (BCCTP) Costs

No entry. Column K is equal to the sum of Columns I and J.

Line 15 – Enhanced SD/MC (BCCTP) SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Line 25 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H. Column K calculates the sum of Columns I and J.

Line 16 – Enhanced SD/MC (BCCTP) Published Charges

No entry. Medi-Cal published Charges for each mode of service in Columns E through H is automatically populated from Column A, Line 26 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

Lines 17 – Enhanced SD/MC (BCCTP) Gross Reimbursement

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or SMA is selected and populates line 17. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charges is selected and populates line 17. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county as the lower of reasonable and allowable costs or the SMA. Line 17 in Column J is automatically populated with the lower of reasonable and allowable costs (line 14) or SMA (lines 15).

Line 18, Column E – Enhanced SD/MC (Pregnancy) Costs

No entry. The total cost of providing mode 05 (hospital inpatient) services to Enhanced SD/MC (Pregnancy) beneficiaries as reported on line 18 is equal to the sum of Column 19 of MH 1960_HOSP_05 and Column 19 of the MH 1960_PHYS_05.

Line 18, Column F – Enhanced SD/MC (Pregnancy) Costs

No entry. The total cost of providing Mode 05 (other 24-hour) services to Enhanced SD/MC (Pregnancy) beneficiaries is equal to the amount determined in Column A, line 27 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 18, Column G – Enhanced SD/MC (Pregnancy) Costs

No entry. The total cost of providing day services to Enhanced SD/MC (Pregnancy) beneficiaries as reported in line 14 is equal to the sum of Column A, line 27 of the MH 1966 for mode 10, Column 19 of the MH 1960_HOSP_10, and Column 19 of the MH 1960_PHYS_10.

Line 18, Column H – Enhanced SD/MC (Pregnancy) Costs

No entry. The total cost of providing outpatient services to Enhanced SD/MC (Pregnancy) beneficiaries as reported in line 10 is equal to the sum of Column A, line 27 of the MH 1966 for mode 15 (program 1), Column 19 of the MH 1960_HOSP_15, and Column 19 of the MH 1960_PHYS_15.

Line 18, Column I – Enhanced SD/MC (Pregnancy) Costs

No entry. Column I is equal to the sum of Columns F, G & H.

Line 18, Column J – Enhanced SD/MC (Pregnancy) Costs

No entry. Column J is equal to Column A, line 27 of the MH 1966 for Mode 15 (program 2) services.

Line 18, Column K – Enhanced SD/MC (Pregnancy) Costs

No entry. Column K is equal to the sum of Columns I and J.

Lines 19 – Enhanced SD/MC (Pregnancy) SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Line 28 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H. Column K calculates the sum of Columns I and J.

Lines 20 – Enhanced SD/MC (Refugee) Published Charges

No entry. Medi-Cal published Charge for each mode of service in Columns E through H is automatically populated from Column A, Line 29 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

Line 21 – Enhanced SD/MC (Pregnancy) Gross Reimbursement

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or SMA is selected and populates line 21. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charges is selected and populates line 21. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county as the lower of reasonable and allowable costs or the SMA. Line 21 in column J is automatically populated with the lower of reasonable and allowable costs (line 18) or SMA (line 19).

Line 22, Column E – Enhanced SD/MC (Refugee) Costs

No entry. The total cost of providing mode 05 (hospital inpatient) services to Enhanced SD/MC (Refugee) beneficiaries as reported on line 22 is equal to the sum of Column 21 of MH 1960_HOSP_05 and Column 21 of the MH 1960_PHYS_05.

Line 22, Column F – Enhanced SD/MC (Refugee) Costs

No entry. The total cost of providing Mode 05 (other 24-hour) services to Enhanced SD/MC (Refugee) beneficiaries is equal to the amount determined in Column A, line 30 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 22, Column G – Enhanced SD/MC (Refugee) Costs

No entry. The total cost of providing day services to Enhanced SD/MC (Pregnancy) beneficiaries as reported in line 22 is equal to the sum of Column A, line 30 of the MH 1966 for mode 10, Column 21 of the MH 1960_HOSP_10, and Column 21 of the MH 1960_PHYS_10.

Line 22, Column H – Enhanced SD/MC (Refugee) Costs

No entry. The total cost of providing outpatient services to Enhanced SD/MC (Pregnancy) beneficiaries as reported in line 22 is equal to the sum of Column A, line 30 of the MH 1966 for mode 15 (program 1), Column 21 of the MH 1960_HOSP_15, and Column 21 of the MH 1960_PHYS_15.

Line 22, Column I – Enhanced SD/MC (Refugee) Costs

No entry. Column I is equal to the sum of Columns F, G & H.

Line 22, Column J – Enhanced SD/MC (Refugee) Costs

No entry. Column J is equal to Column A, line 30 of the MH 1966 for Mode 15 (program 2) services.

Line 22, Column K – Enhanced SD/MC (Refugee) Costs

No entry. Column K is equal to the sum of Columns I and J.

Lines 23 – Enhanced SD/MC (Refugee) SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Line 31 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H. Column K calculates the sum of Columns I and J.

Lines 24 – Enhanced SD/MC (Refugee) Published Charges

No entry. Medi-Cal published Charge for each mode of service in Columns E through H is automatically populated from Column A, Line 32 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

Lines 25 – Total Medi-Cal Gross Reimbursement (excludes Enhanced SD/MC Refugees)

No entry. Line 25 automatically calculates the sum of lines 9, 9A, 9B, 13, 17, and 21.

Line 26 – Enhanced SD/MC (Refugee) Gross Reimbursement

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or SMA is selected and populates line 26. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charge is selected and populates line 26. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county at the lower of reasonable and allowable costs or the SMA. Line 26 in Column J is automatically populated with the lower of reasonable and allowable costs (line 22) or SMA (line 23).

Line 27, Column E – Healthy Families (SED) Costs

No entry. The total cost of providing mode 05 (hospital inpatient) services to Healthy Families (SED) beneficiaries as reported on line 27 is equal to the sum of Column 23 of MH 1960_HOSP_05 and Column 23 of the MH 1960_PHYS_05.

Line 27, Column F – Healthy Families (SED) Costs

No entry. The total cost of providing Mode 05 (other 24-hour) services to Healthy Families (SED) beneficiaries is equal to the amount determined in Column A, line 33 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 27, Column G – Healthy Families (SED) Costs

No entry. The total cost of providing day services to Healthy Families (SED) beneficiaries as reported in line 27 is equal to the sum of Column A, line 33 of the MH 1966 for mode 10, Column 23 of the MH 1960_HOSP_10, and Column 23 of the MH 1960_PHYS_10.

Line 27, Column H – Healthy Families (SED) Costs

No entry. The total cost of providing outpatient services to Healthy Families (SED) beneficiaries as reported in line 27 is equal to the sum of Column A, line 33 of the MH 1966 for mode 15 (program 1), Column 23 of the MH 1960_HOSP_15, and Column 23 of the MH 1960_PHYS_15.

Line 27, Column I – Healthy Families (SED) Costs

No entry. Column I is equal to the sum of Columns F, G & H.

Line 27, Column J – Healthy Families (SED) Costs

No entry. Column J is equal to Column A, line 33 of the MH 1966 for Mode 15 (program 2) services.

Line 27, Column K – Healthy Families (SED) Costs

No entry. Column K is equal to the sum of Columns I and J.

Lines 28 – Healthy Families SMA Upper Limits

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Line 34 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H. Column K calculates the sum of columns I and J.

Lines 29 – Healthy Families Published Charges

No entry. Medi-Cal published Charge for each mode of service in Columns E through H is automatically populated from Column A, Line 35 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

Lines 30 – Healthy Families Gross Reimbursement

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or SMA is selected and populates line 30. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charges is selected and populates line 30. Inpatient and outpatient reimbursement methods are

determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county at the lower of reasonable and allowable costs or the SMA. Line 30 in Column J is automatically populated with the lower reasonable and allowable costs (line 27) or SMA (line 28).

Line 32, 32A & 32B – SD/MC + Medi-Medi Crossover Revenue

No entry. Revenue, such as patient fees for Medi-Cal share of costs, patient insurance, Medicare, and other revenue received on behalf of Medi-Cal clients in providing Medi-Cal units reported on the MH 1901_Schedule B automatically populate from MH 1901 Schedule B, Columns M, N and O. This does not include realignment funding. Revenues should be reported on an accrual basis and should be identified as directly as possible to service function or mode level. If revenues cannot be directly identified, use a reasonable method to allocate revenues between inpatient and outpatient services.

Medicare revenues include revenues for services provided during this cost report fiscal year. Prior year Medicare revenues should not be included in the cost report.

Line 33 – Enhanced SD/MC (Children) Patient Revenue

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column Q. See Lines 32, 32A and 32B for more information.

Line 34 – Enhanced SD/MC (BCCTP) Patient Revenue

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column S. See Lines 32, 32A and 32B for more information.

Line 35 – Enhanced SD/MC (Pregnancy) Patient Revenue

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column U. See Lines 32, 32A and 32B for more information.

Line 36 – Enhanced SD/MC (Refugees) Patient Revenue

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column W. See Lines 32, 32A and 32B for more information.

Line 37 – Healthy Families Revenue

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column Y. See Lines 32, 32A and 32B for more information.

Line 38 – Total Expenditures from MAA (Mode 55)

No entry. Total expenditures identified in MH 1966, Mode 55, Line 3 for Service Functions 1 through 9 in Column A; Service Functions 11 through 19 and 31 through 39 in Column B; and Service Functions 21 through 29 in Column C automatically populate these fields. The sum of Columns A, B and C are automatically calculated in Column D.

Line 39 – Medi-Cal Eligibility Factor (Average)

No entry. County Medi-Cal eligibility factor (percentage) cell references MH 1901 Schedule A, Column E, Line 35.

Line 40 –SD/MC Net Reimbursement for MAA

No entry. Column A automatically populates the amount from Line 38. Columns B and C are equal to the product of lines 38 and 39. Column D is equal to the sum of Columns A, B and C.

MH 1969 INST**Instructions for Lower of Costs or Charges Determination**

The purpose of MH 1969 is to determine if a legal entity qualifies as a Nominal Fee Provider. Before completing the MH 1969, the following questions must be answered.

- Does the legal entity have a published schedule of its full (non-discounted) charges?
- Are the legal entity's revenues for patient care based on application of a published charge schedule?
- Does the legal entity maintain written policies for its process of making patient indigence determinations?
- Does the legal entity maintain sufficient documentation to support the amount of "indigence allowances" written off in accordance with the above procedures?

If the answer to any of the above questions is no, the legal entity DOES NOT qualify as a Nominal Fee Provider and the MH 1969 should not be completed.

MH 1969 (Optional)**Lower of Costs or Charges Determination**

The legal entity must have a published schedule of its full (non-discounted) charges. The objective of MH 1969 is to determine whether a legal entity is exempt from the Lower of Cost or Charges principles. MH 1969 is an optional form and should be completed by legal entities whose charges are lower than costs and the SMA upper limits. If a legal entity answered yes to all four questions on the MH 1969 INST and its Medi-Cal adjusted customary charges are equal to or less than 60 percent of its Medi-Cal costs, the legal entity is exempt from having to include charges in the comparison on MH 1968.

The exemption must be proved separately for Medi-Cal Inpatient Services (Mode 05 – Hospital Inpatient Services) and Medi-Cal Outpatient Services (Mode 05-Other 24 Hour Services, Mode 10 – Day Services, and Mode 15-Outpatient Services). Refer to DMH Letter No. 90-05 and attachments for a detailed explanation of how to meet these four criteria.

Medi-Cal adjusted customary charges are calculated using several different methods, all of which result in the same outcome.¹ MH 1969 employs the calculation method applicable to most legal entities. Medi-Cal adjusted customary charges are calculated by first dividing actual charges to non-Medicare and non-Medi-Cal patients by adjusted or published charges to non-Medicare and non-Medi-Cal patients. This ratio is then applied to Medi-Cal charges (i.e., amounts billed to Medi-Cal), resulting in Medi-Cal adjusted customary charges. These charges are compared to 60 percent of Medi-Cal costs and, if equal to or less, the legal entity is exempt from having to apply the LCC principle. Dollar amounts should be rounded to the nearest whole dollar.

Line 1 – Amount Billed to Medi-Cal

Enter the amount billed to Medi-Cal (through DMH) for the cost report fiscal year. The amount should be derived from the county's monthly billing records. Enter amount for each mode of service in the appropriate column. The sum of Columns B through D is automatically populated in Column E.

Line 2 – Non-Medicare/Medi-Cal Patient Revenues

Enter the total patient revenue for the cost report fiscal year billed (not necessarily collected) to non-Medicare patients and non-Medi-Cal patients based on the Uniform Method of Determining Ability to Pay (UMDAP). Billings to patients liable for payment on a charge basis (non-contractual patients) based on the UMDAP should be reported.

Billing to Health Maintenance Organizations (HMOs), County Organized Health Systems (COHSs), Preferred Provider Organizations (PPOs), or Primary Care Case Management (PCCM) should not be included. Line 2, Column A, represents amount billed to patients for mode 05-Hospital Inpatient Services and Line 2, Column E,

¹ See: *Medicare and Medicaid Guide, Commerce Clearing House, ¶7585, August 1989.*

represents amount billed to patients for Mode 05-Other 24-Hour Services, Mode 10-Day Services, and Mode 15-Outpatient Services.

Line 3 – Non-Medicare/Medi-Cal Patient Insurance

Enter the total patient insurance collected from non-Medicare patients and non-Medi-Cal patients for the cost report fiscal year. Line 3, Column A, represents patient insurance collected for Mode 05-Hospital Inpatient Services and Line 3, Column E, represents patient insurance collected for Mode 05-Other 24 Hour Services, Mode 10-Day Services, and Mode 15-Outpatient Services.

Line 4 – Subtotal

No entry. This line sums Lines 2 and 3 for Column A (Inpatient) and Column E (Outpatient).

Line 5 – Non-Medicare/Medi-Cal Published Charges

Non-Medicare/Medi-Cal Published Charges represent the amount non-Medicare and non-Medi-Cal patients would have paid had they been full-fee paying patients. On a separate worksheet maintained by the legal entity, multiply the units of service/time provided to non-Medicare and non-Medi-Cal patients by the legal entity's published charge or rate for each service function. These amounts should be aggregated by mode of service and reported in the appropriate Columns on Line 5. The sum of Columns B through D is automatically populated in Column E. Columns A and E represent the legal entity's non-Medicare/Medi-Cal published charges for inpatient and outpatient services.

Line 6 – Ratio of Actual to Published Charges

No entry. The calculation is Line 4 divided by Line 5 in Column A (Inpatient) and Column E (Outpatient).

Line 7 – Medi-Cal Adjusted Customary Charges

No entry. The calculation is Line 1 multiplied by Line 6 in Column A (Inpatient) and Column E (Outpatient).

Line 8 – Medi-Cal Costs

No entry. The legal entity's total cost for providing Medi-Cal Inpatient and Outpatient services are automatically populated in Columns A and E. These costs are derived from the sum of MH 1968, Lines 9, 9A, 13, 13A, 17, 17A, and 22, Column E and Column I.

Line 9 – 60 Percent of Medi-Cal Costs

No entry. Columns A and E are automatically calculated by multiplying Line 8 by 60 percent.

If the amount on line 9, Column A (60 percent of Medi-Cal inpatient costs) is greater than Line 7, Column A (Medi-Cal inpatient adjusted customary charges), the legal entity is exempt from having to apply the LCC principle for Mode 05-Hospital Inpatient

Services. If Line 7 Column A, is greater than Line 9, Column A, the legal entity is no exempt from having to apply the LCC principle for Mode 05-Hospital Inpatient Services on MH 1968, and must include Medi-Cal Mode 05-Hospital Inpatient charges in the comparison on MH 1968.

If the amount on Line 9, Column E (60 percent of Medi-Cal outpatient costs) is greater than Line 7, Column E (Medi-Cal outpatient adjusted customary charges), the legal entity is exempt from having to apply the LCC principle for outpatient services. If Line 7, Column E, is greater than Line 9, Column E, the legal entity is not exempt from having to apply the LCC principle for outpatient service on MH 1968, and must include the Medi-Cal outpatient charges in the comparison on MH 1968.

MH 1979**SD/MC Preliminary Desk Settlement**

The objective of the MH 1979 is to determine the preliminary net Federal Financial Participation (FFP) due the mental health plan for all SD/MC and Healthy Families services provided by the legal entity. Data for Lines 1 through 6, 7 through 12, and 13 through 18, are to be entered by County legal entities on appropriate forms (MH 1900_Information and MH 1960).

Line 1 – County SD/MC Direct Service Gross Reimbursement

No entry. In Columns B and C, the county legal entity's SD/MC Direct Services Gross Reimbursement for inpatient and outpatient services are automatically populated from MH 1968, Columns E and K, Line 25 plus Line 26 minus line 13. Column D is equal to the sum of Columns B and C.

Line 2 – Contract Provider Medi-Cal Direct Service Gross Reimbursement

No entry. In Columns B and C, Contract Providers SD/MC Direct Service Gross reimbursement for inpatient and outpatient services is automatically populated from the MH 1900 Information Sheet. These amounts are manually entered on the MH 1900 Information Sheet from the MH 1968, Columns E and K, sum of Lines 9, 9A, 9B, 14, 18, and 22 for all contract providers. This entry should also include payments to FFS/MC hospitals for psychiatric inpatient services (MH 1994, Lines 2A, 6, and 7 plus FFP) that have not been included in net costs of MH 1960 (Column J). Column D is equal to the sum of Columns B and C.

Line 3 – Total Medi-Cal Direct Service Gross Reimbursement

No entry. Line 3 is equal to the sum of Lines 1 and 2. This amount represents the total allowable SD/MC direct service costs in the county that will be used to determine the maximum allowable SD/MC administrative reimbursement for the county legal entity.

Line 4 – SD/MC Administrative Reimbursement Limit

No entry. SD/MC administrative costs are limited to 15 percent of SD/MC direct service costs. Line 4 is equal to Line 3 multiplied by 15%.

Line 5 – SD/MC Administration

No entry. SD/MC administrative costs are automatically populated from MH 1960, Column J, Line 25.

Line 6 – SD/MC Administrative Reimbursement

No entry. Line 6, Column D is equal to the lower of lines 4 and 5, Column D. Line 6, Column E is equal to line 6, Column D multiplied by 50%. The result is rounded to the nearest whole dollar and entered in Column E.

Line 7 – County Healthy Families Direct Service Gross Reimbursement

No entry. Line 7, Columns B and C is automatically populated from Line 30, Columns E and K of the MH 1968. Column D is equal to the sum of Columns B and C.

Line 8 – Contract Provider Healthy Families Direct Service Gross Reimbursement

No entry. Line 8, Columns B and C are automatically populated from the MH 1900 Information Sheet. The amount entered on the MH 1900 Information Sheet should equal the sum of Line 30, Columns E and K from all contract providers' MH 1968. Column D is equal to the sum of Columns B and C.

Line 9 – Total Healthy Families Direct Service Gross Reimbursement

No entry. Line 9, Column D is equal to the sum of Lines 7 and 8, Column D. This amount represents total allowable Healthy Families direct service costs in the county that will be used to determine the maximum allowable Healthy Families administrative reimbursement for the county legal entity.

Line 10 – Healthy Families Administrative Reimbursement Limit

No entry. Healthy Families Administrative costs are limited to 10 percent of Healthy Families direct service gross costs. Line 10, Column D is equal to Line 9, Column D multiplied by 10 percent.

Line 11 – Healthy Families Administration

No entry. Line 11, Column D is automatically populated from Column J, Line 26 of the MH 1960.

Line 12 – Healthy Families Administrative Reimbursement

No entry. Line 12, Column D is equal to the lower of Lines 10 and 11, Column D. Line 12, Column I is equal to Line 12, Column D multiplied by 65 percent.

Line 13 – County SD/MC Enhanced (Children) Direct Service Gross Reimbursement

No entry. Line 13, Columns B and C are automatically populated from Line 13, Columns E and K of the MH 1968. Column D is equal to the sum of Columns B and C.

Line 14 – Contract Providers SD/MC Enhanced (Children) Direct Service Gross Reimbursement

No entry. Columns B and C, are manually entered in the MH 1900 Information Sheet based on the sum of Line 13, Columns E and K of the MH 1968 for all contract providers. Column D is equal to the sum of Columns B and C.

Line 15 – Total SD/MC Enhanced (Children) Direct Service Gross Reimbursement

No entry. The sum of Lines 13 and 14 in Column D are automatically populated on Line 9. This amount represents total allowable SD/MC Enhanced (Children) direct service costs in the county that will be used to determine maximum allowable SD/MC Enhanced (Children) administrative reimbursement for the county legal entity.

Line 16 – SD/MC Enhanced (Children) Administrative Reimbursement Limit

No entry. SD/MC Enhanced (Children) administrative costs are limited to 15 percent of SD/MC Enhanced (Children) direct service gross costs. Column D, Line 15, is automatically multiplied by 15 percent to compute the SD/MC Enhanced (Children) administrative limit.

Line 17 – SD/MC Enhanced (Children) Administration

No entry. The Healthy Families administrative costs are automatically populated from Column J, Line 27 of the MH 1960.

Line 18 – SD/MC Enhanced (Children) Administrative Reimbursement

No entry. The lower of Lines 16 and 17 from Column D is automatically selected and populated in Column D, Line 18. The amount in Column D is automatically multiplied by 50 percent to determine the FFP for Healthy Families administrative costs. The result is rounded to the nearest whole dollar and populated on Line 18, Column E.

Line 19 – Medi-Cal Administrative Activities Service Functions 01-09

No entry. The amount in columns A and D are automatically populated from line 40, column A of the MH 1968. The result in Column D is automatically populated by 50% and entered in Columns E and L.

Line 20 – Medi-Cal Administrative Activities Service Functions 11-19 and 31-39

No entry. The amount in columns A and D are automatically populated from line 40, column B of the MH 1968. The result in Column D is automatically multiplied by 50 percent and entered in Columns E and L.

Line 21 – Medi-Cal Administrative Activities Service Functions 21-29.

No entry. The amount in columns A and D are automatically populated from line 40, column C of the MH 1968.. The result in Column D is automatically multiplied by 75 percent and populated in Columns J and L.

Line 22 – Utilization Review – Skilled Professional Medical Personnel (County Only)

No entry. The SD/MC utilization review costs for skilled professional medical personnel are populated from Column J, Line 30 of MH 1960. The result in Column D is automatically multiplied by 75 percent to determine FFP and populated in Columns J and L.

Line 23 – Other SD/MC Utilization Review (County Only)

No entry. The other SD/MC utilization review costs are automatically populated from Column J, Line 31 of the MH 1960. The result in Column D is automatically multiplied by 50 percent to determine FFP and populated in Columns E and L

Lines 24, 24A & 24B – SD/MC Net Reimbursement for Direct Services

No entry. The SD/MC direct service net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns E and K, Lines 9 & 9A minus lines 32 & 32A of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by the appropriate FMAP for the period to determine FFP for SD/MC direct services and is populated in Columns F and J.

Lines 25 – Enhanced SD/MC Net Reimbursement (Children)

No entry. The Enhanced SD/MC (Children) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns E and K, Line 13 minus Line 33 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 65 percent to determine FFP for Enhanced SD/MC (Children) direct services and is populated in Columns I and L. Column L is equal to column I minus column K.

Lines 26 – Enhanced SD/MC Net Reimbursement (BCCTP)

No entry. The Enhanced SD/MC (BCCTP) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns E and K, Line 17 minus Line 34 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 65 percent to determine FFP for Enhanced SD/MC (BCCTP) direct services and is populated in Columns I and L. Column L is equal to column I minus column K.

Line 27 – Enhanced SD/MC Net Reimbursement (Pregnancy)

No entry. The Enhanced SD/MC (Refugees) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns E and K, Line 21 minus Line 35 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 100 percent to determine FFP for Enhanced SD/MC (Refugees) direct services and is populated in Columns I and L. Column L is equal to column I minus column K.

Line 28 – Enhanced SD/MC Net Reimbursement (Refugee)

No entry. The Enhanced SD/MC (Refugees) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns E and K, Line 26 minus Line 36 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 100 percent to determine FFP for Enhanced SD/MC (Refugees) direct services and is populated in Columns I and L. Column L is equal to column I minus column K.

Line 29 – Total SD/MC Reimbursement (FFP)

No entry. The sum of lines L6, L18, L19, L20, L21, L22, L23, L24, L24A, L24B, L25, L26, L27 and L28.

Line 32 – Healthy Families Net Reimbursement

No entry. The amounts from MH 1968, Line 27 minus Line 37, Columns E and K are automatically populated in Columns B and C, respectively. The sum of Columns B and C automatically populates Column D. The amount in Column D is automatically multiplied by 65 percent to determine FFP for SD/MC Healthy Families direct services and populates Column I and L. Column L is equal to column I minus column K.

Line 31 – Total Healthy Families Reimbursement

No entry. The sum of Lines 12 and 32 automatically populates line 33, Column L.

MH 1991**Calculation of SD/MC (Hospital Administrative Days)**

The objective of the MH 1991 is to identify the amount of Physician and Ancillary costs associated with SD/MC and Healthy Families (SED) Hospital Administrative Days (Mode 05, Service Function 19) for use on the MH 1966.

Column A – Settlement Group

No entry. Settlement groups are provided.

Column B – Provider Number

Enter 4-digit Provider Number.

Column C – SMA Rate

No entry. SMA Rate for FY 2010-11 is provided for the two periods.

Column D – Period of Service

No entry. Period of services is provided.

Column E – Administrative Days

Enter the number of SD/MC administrative days according to the period during which services were provided and by the settlement group to which the services were rendered during the fiscal year. This column should match the number of Medi-Cal units reported on Schedule B for Mode 05, Service Function 19.

Column F – Subtotal Amount

No entry. This is the result of column C multiplied by Column E.

Column G – Physician Costs

Enter cost of physician services related to SD/MC Administrative Days for each period and settlement group. (Amounts should be included in total billed to Medi-Cal).

Column H – Ancillary Costs

Enter cost of ancillary services related to SD/MC Administrative Days for each period and settlement group. (Amounts should be included in total billed to Medi-Cal).

Column I – Total Amount

No entry. This is the sum of columns F, G, and H for each period and settlement group.

MH 1992**Funding Sources**

The objective of MH 1992 is to identify the types of resources used to finance specific mental health program activities for each legal entity by mode of service. Funding source identifies who is paying for programs authorized by the county mental health agency.

Line 1 – Gross Cost

No entry. Column A, Line 1, is the sum of Column J, Lines 25 through 28 of the MH 1960. Column B is the sum of Column J, Lines 30 through 32 of the MH 1960. Columns C through I, Line 1 are from Column A, Line 3 of the relevant MH 1966.

Line 2 – Adjustments

Enter in Columns C through I, the amounts needed to adjust legal entity costs to actual program funding, such as the difference between county contract rate and actual cost incurred by contract providers.

For legal entities that provide services to multiple counties, adjust gross aggregate county legal entity allowable costs on Line 2, Columns C through I to agree with the amount received from each county for which a cost report is being submitted. Report aggregate gross county legal entity costs for all county legal entities on MH 1960, and aggregate gross county legal entities units of service on MH 1901 Schedule B for the determination of cost per unit.

Line 3 – Adjusted Gross Costs

No entry. Line 1 plus Line 2 automatically populates Line 3.

Line 4 – SAMHSA Grants

Enter revenues expended from the SAMHSA community mental health block grant for appropriate modes of service.

Line 5 – Path Grants

Enter revenues expended from the PATH grant for appropriate modes of service.

Line 6 – RWJ Grants

Enter revenues expended from Robert Wood Johnson (RWJ) Foundation grants for appropriate modes of service.

Line 7 – Other Grants

Enter revenues expended from other grants not reported on Lines 4 through 6 for appropriate modes of service.

Line 8 – Total Grants Accrued

No entry. Lines 4 through 7 for Columns A through G are automatically populated in Line 8.

Line 9 – Patient Fees

Enter revenue received from patient fees for appropriate treatment program modes of service.

Line 10 – Patient Insurance

Enter revenue received from patient insurance for appropriate treatment program modes of service.

Line 11 – Low Income Health Plan (LIHP) FFP

Enter the amount of FFP the legal entity received for services provided through the Low Income Health Program which are reported on MH 1901 Schedule B.

Line 12 – Regular and Enhanced SD/MC (FFP Only)

No entry. SD/MC and Enhanced SD/MC net reimbursement (FFP portion only) are included on this line. Column A is equal to the sum of MH 1979, Column L, Lines 6 and 18. Column B is equal to the sum of MH 1979, Column L, Lines 22 and 23. Column C is equal to the sum of MH 1979, Column B, Line 24*61.59, Line 24A*.58.77, Line 24B*56.88, Line 25*.65, Line 26*.65, and Line 27*.65 and line 28*.1. Columns D, E and F are equal to the sum of lines 13 minus Line 30 multiplied by 50 percent, plus the sum of Lines 17, 13, and 30 minus Lines 32, 32A, 32B, 33 and 34 multiplied by 65 percent, plus Line 26 – Line 36 from Columns J, K and L of the MH 1968. Column H is equal to the sum of Lines 19, 20 and 21, Column J from the MH 1979. Column J is equal to sum of Columns A through F and H.

Line 13 – Healthy Families Federal Share

No entry. Column A is equal to Line 12, Column J of the MH 1979. Column C is equal to the sum of the Line 32 Column L of the MH 1979. Columns D, E and F are equal to the sum of line 30 minus line 37, Columns J, K and L of the MH 1968 multiplied by 65 percent. Column J is equal to the sum of Columns A, C, and D through F of the MH 1992.

Line 14 – Medicare – Federal Share

Enter Medicare revenue accrued/received for appropriate treatment programs modes of service.

Line 15 – Conservator Administrative Fees

Enter conservator administration fees received in Column I, Line 14.

Line 16 – State General Fund – State Share

Enter State share of State General Fund (SGF) (90 percent for large counties) in Columns A through I. These are primarily categorical funds allocated by DMH to the

counties for FY 2010-2011. Community Services-Other Treatment for Mental Health Managed Care should not be included in this line.

Line 17 – State General Fund – County Match

Enter county share (10 percent for large counties) of cost to match State General Fund in Columns A through I, if applicable.

Line 18 – State General Fund – Managed Care – Outpatient Mental Health Services

Enter expenditures by modes of service for Outpatient Mental Health Services funded by FY 2010-2011 SGF – Managed Care allocation.

Line 19 – FY 2009-10 Rollover – Managed Care – Outpatient Mental Health Services

Enter expenditures for Outpatient Mental Health Services by modes of service, funded by rollover from FY 2009-10 SGF – Managed Care allocation.

Line 20 – EPSDT SD/MC – State Share Estimate

Enter estimated SGF of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) SD/MC. Estimated amount should be based upon anticipated EPSDT expenditures and may or may not be different than EPSDT SGF Interim Funding the County received as an advance.

Line 21 – FY 2009-2010 SGF Rollover

Enter by mode of service, categorical SGF rolled over from the previous fiscal year. Please include county match for rollover that requires county share.

Line 22 – Other Revenues

Enter all other revenues expended and not reported on Lines 4 through 19.

Line 23 – Realignment Funds/Maintenance of Effort

Enter amount expended per realignment funding and county Maintenance of Effort (MOE) obligations pursuant to Welfare and Institutions Code Section 17608.05 for each mode of service. Include realignment funds used to match FFP under the SD/MC program. Exclude realignment funding for State Hospitals, county match for SGF allocated by State Department of Mental Health, and services provided through the Low Income Health Program (LIHP).

Line 24 – Prior Years MHSA

No entry.

Line 25 – MHSA

Enter amount expended per MHSA funding, including MHSA funds used to match FFP under the SD/MC program. Please exclude amount expended on services provided through the Low Income Health Program (LIHP).

Line 26 – County Overmatch

Enter county overmatch funds the county contributes over the percentage amounts prescribed by law.

Line 27 – CalWORKS

Enter the county CalWORKS funds used for mental health services.

Line 28 – LIHP Match (Realignment): Please enter amount expended on services provided through the Low Income Health Program (LIHP) per realignment funding and county maintenance of effort (MOE) obligations pursuant to Welfare and Institutions Code Section 17608.05 for each mode of service.

Line 29 – LIHP Match (MHSA): Please enter amount expended on services provided through the Low Income Health Program (LIHP) per MHSA funding.

Line 30 – LIHP Match (Other): Please enter amount expended on services provided through the Low Income Health Program from sources of funding other than realignment and county MOE, and MHSA funding.

Line 31 – Total Funding Sources

No entry. This line sums Lines 8 through for Columns A through I. Amount in Column J, Line 31, should equal amount in Column J, Line 3. Any difference between the amounts should be corrected before submitting the cost report.