COST & FINANCIAL REPORTING SYSTEM

FISCAL YEAR 2016-17

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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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	Mode Total
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MH 1968	Determination of SD/MC Direct Services and MAA Reimbursement
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MH 1991	Calculation of SD/MC (Hospital Administrative Days)
MH 1992	Funding Sources
MH 1995	Report of Mental Health Services Act (MHSA) – Distribution of Expenditures

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 county code, legal entity name and legal entity 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 Health Care Services 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 legal entity.
- **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 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 amounts to report for outpatient services is equal to the sum of MH 1968, Lines 9, 17, 21, 25, 29 and 42 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, 17, 21, 25, 29 and 42 of Column G 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 8, 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 MH 1968, Line 13, Columns G and K for all contract providers that reported SD/MC Enhanced (Children) units on the MH 1901 Schedule B.

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 provider numbers for those providers.

Adjust Medi-Cal 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 FFP due to Costs in Excess of CPE by Settlement Group (Used to Populate MH 1979 Column J): 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 J. 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. The form serves as a source document that will enable the 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. The published charge for Mode 05, Service Function 19, Hospital Administrative Days, should include physician and ancillary costs.

Column D, Lines 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 DHCS.

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, Senate Bill 75 beneficiaries, and Medi-Cal Administrative Activities are accounted for here. Total units reported must equal the sum of Columns E, F, H, J, L, N, P, R, T, and V. 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 lower of cost or public charges.

- **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 DHCS as actual costs to the county under the county legal entity number in Program 2 – TBS costs.

- **ASO** Administrative Services Organization (ASO) 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 (Calculation of Program Costs Non-Hospital Legal Entities).

- **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 DHCS 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 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.

- **CCR** The Continuum of Care Reform (CCR) requires mental health plans to assess children prior to placement in a Short-Term Residential Therapeutic Program (STRTP). All children who have an open child welfare case are entitled to a child and family team. Mental health plans are required to participate in the child and family team when the child needs specialty mental health services. DHCS reimburses mental health plans the non-federal share of the mental health plan's certified public expenditures to provide these services.

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, 2016– June 30, 2017)
Enter the total regular SD/MC units of service for each Medi-Cal service function for the period 07/1/16 through 06/30/17. Do not include Medicare/Medi-Cal crossover units or enhanced SD/MC units here. ***See Appendix A for SD/MC Aid Codes and program descriptions.***

Column F– Medi-Medi Crossover Units July 1, 2016 – June 30, 2017)
Enter the total regular Medicare/Medi-Cal crossover units of service for each Medi-Cal service function for the period 07/1/16 through 06/30/17.

Column G – SD/MC 3RD Party Revenue
In Column G, 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, 2016 – June 30, 2017. 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 the 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 H – Units of Service for Enhanced SD/MC – Children E2, E4, E5 (July 1, 2016 – June 30, 2017)
Enter the units of service for each service function for Enhanced SD/MC – Children for Aide Codes E2, E4, and E5 for the period July 1, 2016 – June 30, 2017. ***See Appendix A for Enhanced SD/MC Children Aid Codes and Program description.***

Column I – Third Party Revenue Enhanced SD/MC – Children E2, E4, E5 – (July 1, 2016 – June 30, 2017)
Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - Children units of service for Aide Codes E2, E4, and E5 for the period July 1, 2016– June 30, 2017. See Column G for more information.

Column J – Units of Service for Enhanced SD/MC – Children (July 1, 2016 – June 30, 2017)
Enter the units of service for each service function for Enhanced SD/MC – Children for the period July 1, 2016 – June 30, 2017. Please do not include units of service for Aide Codes E2, E4, and E5. ***See Appendix A for Enhanced SD/MC Children Aid Codes and Program description.***

Column K – Third Party Revenue Enhanced SD/MC – Children (July 1, 2016 – June 30, 2017)
Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - Children units of service for the period July 1, 2016– June 30, 2017. Please do not include third party revenues for Aide Code E2, E4, and E5. See Column G for more information.

Column L – Units of Service for Enhanced SD/MC – BCCTP (July 1, 2016 – June 30, 2017)
Enter the units of services for each service function for Enhanced SD/MC – BCCTP for the period of July 1, 2016 – June 30, 2017. ***See Appendix A for Enhanced SD/MC– BCCTP Aid Codes and program descriptions.***

Column M – 3rd Party Revenue Enhanced SD/MC – BCCTP (July 1, 2016 – June 30, 2017)
Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - BCCTP units of service for the period July 1, 2016– June 30, 2017. See Column G for more information.

Column N – Units of Service for Enhanced SD/MC – Pregnancy (July 1, 2016 – June 30, 2017)
Enter units of service for each service function for Enhanced SD/MC – Pregnancy for the period July 1, 2016 – June 30, 2017. ***See Appendix A for Enhanced SD/MC– Pregnancy Aid Codes and program descriptions.***

Column O – 3rd Party Revenue Enhanced SD/MC – Pregnancy (July 1, 2016 – June 30, 2017
Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - Pregnancy units of service for the period July 1, 2016 – June 30, 2017. See Column G for more information.

Column P – Units of Service for Enhanced SD/MC – Refugee (July 1, 2016 – June 30, 2017)
Enter units of service for each service function for Enhanced SD/MC – Refugee for the period July 1, 2016 – June 30, 2017. ***See Appendix A for Enhanced SD/MC– Refugee Aid Codes and program descriptions.***

Column Q – 3rd Party Revenue Enhanced SD/MC – Refugee (July 1, 2016 – June 30, 2017
Enter the third party revenue received by the agency and attributed to Enhanced SD/MC - Refugee units of service for the period July 1, 2016 – June 30, 2017. See Column G for more information.

Column R – Units of Service ACA SD/MC – Affordable Care Act (July 1, 2016 – December 31, 2016)
Enter units of service for each service function for ACA SD/MC – Affordable Care Act for the period July 1, 2016 – December 31, 2016 for 100% FFP reimbursement. ***See Appendix A for Affordable Care Act Aid Codes and program descriptions.***

Column S – 3rd Party Revenue ACA SD/MC – Affordable Care Act (July 1, 2016 – June 30, 2017

Enter the third party revenue received by the agency and attributed to Affordable Care Act - ACA units of service for the period July 1, 2016 – December 31, 2016. See Column G for more information.

Column T – Units of Service ACA SD/MC – Affordable Care Act (January 1, 2017 – June 30, 2017)

Enter units of service for each service function for ACA SD/MC – Affordable Care Act for the period January 1, 2017 – June 30, 2017 for 95% FFP. ***See Appendix A for Affordable Care Act Aid Codes and program descriptions.***

Column U – 3rd Party Revenue ACA SD/MC – Affordable Care Act (July 1, 2016 – June 30, 2017

Enter the third party revenue received by the agency and attributed to Affordable Care Act - ACA units of service for the period January 1, 2017 – June 30, 2017. See Column G for more information.

Column V – Units of Service Medi-Cal Access Program (MCAP) (July 1, 2016 – June 30, 2017)

Enter units of service for each service function for Medi-Cal Access Program (MCAP) for the period July 1, 2016 – June 30, 2017 for 88% FFP. ***See Appendix A for MCAP Aid Codes and program descriptions.***

Column W – 3rd Party Revenue Medi-Cal Access Program (MCAP) (July 1, 2016 –June 30, 2017

Enter the third party revenue received by the agency and attributed to Med-Cal Access Program (MCAP) units of service for the period July 1, 2016 – June 30, 2017. See Column G for more information.

Column X – Units of Service for Medical for All Children (SB75) (July 1, 2016 – June 30, 2017)

Enter units of service for each service function for Medi-Cal for All Children (SB 75) for the period of July 1, 2016 – June 30, 2017.

Column Y – 3rd Party Revenue Third Party Medical for All Children (SB75) July 1, 2016 to June 30, 2017

Enter the third party revenue received by the agency and attributed to Medical for All Children (SB75) units of service for the period July 1, 20116 – June 30, 2017. See Column G for more information.

Column Z – Non-Medi-Cal Units July 1, 2016 to June 30, 2017

No entry. This column calculates the total units less all SD/MC units. Column X equals Column D less Columns E, F, H, J, L, N, P, R, T, V and X. If the sum of columns E, F, H, J, L, N, P, R, T, V and X is greater than Column D, Column Y 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 Published Charges 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 to DHCS.

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 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. **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.
3. **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 populates from MH 1901 Schedule B, Column B.

Column C – Service Function
No entry. This column automatically populates from MH 1901 Schedule B, Column C.

Column D – Total Units
No entry. This column automatically populates from MH 1901 Schedule B, ColumnD.

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, 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 or published charge). 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 – Non-Hospital Legal Entities

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 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 below definitions.

Indirect Cost Centers – County Only
Only county legal entities are required to complete lines 1 thru 23.

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 benefited 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 benefited 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 benefited 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 one 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 – A-87 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 (Healthy Families Program), 27 (M-CHIP), 28 Non-SD/MC Administration 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 of the population served by the county
   This is the number of units of service of the beneficiaries for each program divided by total units of service for all beneficiaries of the population served by the programs for all the programs .

2. Relative values based on units and published charges
   This is the number of units for each program multiplied by the published charge for the program.

3. Gross costs of each program
   Gross cost is the total of direct cost and allocated costs

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 33. 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 automatically populates from data entered on form MH 1961.

Column E – No entry. This column automatically populates from data entered on form MH 1962.

Column F – No entry. This column automatically populates from data entered on the form MH 1963.

Column G – No entry. This column sums the data contained in Columns C, D, E, and F.

Column H – No entry. This column converts the amounts in lines 1-23 to negative numbers. Please allocate the sum of lines 1 – 23 among lines 24, 29, and 33.

Column I, Lines 1 – 23 – No entry. This Column populates from MH 1965.

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

MH 1960_HOSP_COSTS

Calculation of Cost Per Day and Cost To Charge Ratios – Hospital Legal Entities

The purpose of 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, Hospital and Hospital Health Care Complex Medicare or Medi-Cal cost report. A hospital that does not submit a CMS 2552 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.

Column 1 – Total 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 – Total 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 1 and 2.

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.

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.

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.

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 equaled to the sum of Column 24 of MH 1960_HOSP_05 and Column 24 of the MH1960_HOSP_05_Admin

Column 13 – Medi-Cal SMHS Mode 05 Physician Costs
No entry. Column 13 is equaled to the sum of Column 24 of the MH 1960_PHYS_05 and Column 24 of the MH1960_PHYS_05_ Admin.

Column 14 - Medi-Cal SMHS Mode 05 Total Costs
No entry. Column 14 is equal to the sum of columns 12 and 13.

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 Psychiatric 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 – Cost Per Day to 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 (07/01/16 – 06/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for SD/MC beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for SD/MC beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/16 – 06/30/17)
No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – Medi-Medi X-Over Days/Charges/RVU (7/01/16 – 06/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for Medi-Medi X-Over beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for SD/MC beneficiaries during the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – Medi-Medi Costs X-Over Costs (07/01/16 – 06/30/17)
No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Enhanced (Children) Days/Charges/RVU for Aid Code E2, E4, and E5 (07/01/16 – 09/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for SD/MC Enhanced (Children) beneficiaries for Aide Codes E2, E4 and E5 for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Enhanced (Children) Costs for Aid Codes E2, E4 and E5 (07/01/16 – 06/30/17)
No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – SD/MC Enhanced (Children) Days/Charges/RVU for Aid Codes other than E2, E4, and E5 (07/01/16 – 09/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for SD/MC Enhanced (Children) beneficiaries for Aide Codes E2, E4 and E5 for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – SD/MC Enhanced (Children) Costs for Aid Codes Other than E2, E4 and E5 (07/01/16 – 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – SD/MC Enhanced (BCCPT) Days/Charges/RVU (07/01/16 – 06/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for SD/MC Enhanced (BCCPT) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – SD/MC Enhanced (BCCPT) Costs (07/01/16 – 06/30/17)
No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU (07/01/16 – 06/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – SD/MC Enhanced (Pregnancy) Costs (07/01/16 – 06/30/17)
No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Refugee) Days/Charges/RVU (07/01/16 – 06/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for SD/MC Enhanced (Refugees) beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Refugee) Costs (07/01/16 – 06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – Medi-Cal Access Program (MCAP) Charges/RVU (07/01/16 – 6/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for Medi-Cal Access Program (MCAP) beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for MCAP beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – Medi-Cal Access Program (MCAP) Costs (07/01/16 – 6/30/17)
No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – Affordable Care Act (ACA) Charges/RVU (07/01/16 – 12/31/16)
For routine cost centers, please enter the total psychiatric inpatient days for Affordable Care Act (ACA) beneficiaries for the period July 1, 2016 through Decemeber 31, 2016. For all other cost centers, please enter the total charges for Affordable Care Act (ACA) beneficiaries for the period July 1, 2016 through December 31, 2016 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – Affordable Care Act (ACA) Charges/RVU (01/01/17 – 06/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for Affordable Care Act (ACA) beneficiaries for the period January 1, 2017 through June 30, 2017. For all other cost centers, please enter the total charges for Affordable Care Act (ACA) beneficiaries for the period January 1, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Medi-Cal for All (SB75) Charges/RVU (07/01/16 – 06/30/17)
For routine cost centers, please enter the total psychiatric inpatient days for Medi-Cal for all Children (SB75) beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for services provided to Medical For All Children (SB75) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Medi-Cal for All (SB75) Costs (07/01/16 – 06/30/17)
No entry. Column 23 is equal to the product of columns 1 and 22.

Column 24 – Total Medi-Cal Hospital 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 Psychiatric 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's professional costs related to acute psychiatric inpatient hospital services to the appropriate settlement groups using the cost-to-charge ratios calculated on form MH 1960_HOSP_COSTS.

Column 1 – Costs Per Day/Cost-to-Charge Ratio
No entry. The cost-to-charge ratio for all other non-routine cost centers are automatically populated with data from Column 11 of the MH 1960_HOSP_COSTS

Column 2 – SD/MC Days/Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Physician Costs (07/01/16 – 06/30/17)
No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – Medi-Medi X-Over Days/Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – Medi-Medi X-Over Physician Costs (07/01/16 – 06/30/17)
No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Enhanced (Children) Days/Charges/RVU for Aid Codes E2, E4, and E5 (07/01/16- 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Enhanced (Children) Costs for Aid Code E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – SD/MC Enhanced (Children) Days/Charges/RVU for Other Enhanced Children Aid Codes (07/01/16- 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – SD/MC Enhanced (Children) Costs Other Enhanced Childrent Aid Codes (07/01/16 – 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – SD/MC Enhanced (BCCPT) Days/Charges/RVU (07/01/16 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to SD/MC Enhanced (BCCPT) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – SD/MC Enhanced (BCCPT) Costs 07/01/16 – 06/30/17
No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – SD/MC Enhanced (Pregnancy) Physician Days/Charges/RVU (07/01/16 – 06/30/17
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – SD/MC Enhanced (Pregnancy) Costs (07/01/16 – 06/30/17)
No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Refugee) Days/Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Refugee) Costs (07/01/16 – 06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – Medi-Cal Access Program (MCAP) Days/Charges/RVU (07/01/16 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Cal Access Program (MCAP) for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – Medi-Cal Access Program (MCAP) Costs (07/01/16 – 06/30/17)
No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – Affordable Care Act (ACA) Days/Charges/RVU (07/01/16 – 12/31/16)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Affordable Care Act (ACA) beneficiaries for the period July 1, 2016 through December 31, 2016 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – Affordable Care Act (ACA) Days/Charges/RVU (01/01/17 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Affordable Care Act (ACA) beneficiaries for the period January 1, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – Affordable Care Act (ACA) costs (01/01/17 – 06/30/17)
No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Medical for All Children (SB75) Days/Charges/RVU
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medical For All Children beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23– Medi-Cal for All Children (SB75) costs 07/01/16 – 06/30/17
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 (07/01/16 – 06/30/17)
For routine cost centers, please enter the total hospital administrative days for SD/MC beneficiaries for the period July 1, 2016 through June 30, 2017 For all other cost centers, please enter the total charges for hospital administrative days for SD/MC beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/16 – 06/30/17)
No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – Medi-Medi Days/Charges/RVU (07/01/16 – 06/30/17)
No entry. Hospital administrative costs is not allowable for Medi-Medi.

Column 5 – Medi-Medi Costs (07/01/16 – 06/30/17)
No entry. Hospital administrative costs is not allowable for Medi-Medi.

Column 6 – SD/MC Enhanced (Children) Days/Charges/RVU For Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17
For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (Children) beneficiaries for Aid Codes E2, E3, and E4 for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC Enhanced (Children) beneficiaries for Aid Codes E2, E4, and E5 for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Enhanced (Children) Costs for Aid Codes E2, E4, and E5(07/01/16 - 06/30/17)
No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – SD/MC Enhanced (Children) Days/Charges/RVU For Other SD/MC Enhanced Children Aid Codes (07/01/16 – 06/30/17
For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (Children) beneficiaries for Other SD/MC Enhanced Children Aid Codes for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC Enhanced (Children) beneficiaries for other Enchanced Children Aid Codes for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – SD/MC Enhanced (Children) Costs For Other SD/MC Enhanced Children Aid Codes (07/01/16 - 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 9.

Column 10 – SD/MC Enhanced (BCCPT) Days/Charges/RVU (07/01/16 - 06/30/17)
For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (Children) beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for hospital administrative days for SD/MC Enhanced (BCCPT) beneficiaries for the period July1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – SD/MC Enhanced (BCCPT) Costs (07/01/15 - 06/30/17)
No entry. Column 11 is equal to the product of columns 1 and 10..

Column 12 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU (07/01/16 – 06/30/17)
For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2016 through June 30, 2017. 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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – SD/MC Enhanced (Pregnancy) Costs (07/01/16 – 06/30/17)
No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Refugee) Days/Charges/RVU (07/01/16 – 06/30/17)
For routine cost centers, please enter the total hospital administrative days for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2016 through June 30, 2017. 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, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Refugee) Costs (07/01/16 – 06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – Medi-Cal Access Program (MCAP) Charges/RVU (07/01/16 – 06/30/17)
For routine cost centers, please enter the total hospital administrative days for Medi-Cal Access Program (MCAP) beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for hospital administrative days for MCAP beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – Medi-Cal Access Program (MCAP) Costs (07/01/16 – 06/30/17)
No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – Affordable Care Act (ACA) Charges/RVU (07/01/16 – 12/30/16)
For routine cost centers, please enter the total hospital administrative days for Affordable Care Act (ACA) beneficiaries for the period July 1, 2016 through December 31, 2016. For all other cost centers, please enter the total charges for hospital administrative days for ACA beneficiaries for the period July 1, 2016 through December 31, 2016 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16
No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – Affordable Care Act (ACA) Charges/RVU (01/01/16 – 06/30/17)
For routine cost centers, please enter the total hospital administrative days for Affordable Care Act (ACA) beneficiaries for the period January 1, 2017 through June 30, 2017. For all other cost centers, please enter the total charges for hospital administrative days for ACA beneficiaries for the period January 1, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – MediCal for All Children (SB75) Charges/RVU (07/01/16 – 06/30/17)
For routine cost centers, please enter the total hospital administrative days for services provided to Medical For All Children beneficiaries for the period July 1, 2016 through June 30, 2017. For all other cost centers, please enter the total charges for hospital administrative days for Medi-Cal for All Children (SB75) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – MediCal for All Children (SB75) Costs (07/01/16 – 06/30/17)
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-to-charge ratios calculated for physician professional costs on form MH 1960_HOSP_COSTS.

Column 1 – Ratio of Physician Professional Costs-to-Billed Professional Charges 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 Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Physician Costs (07/01/16 – 06/30/17)
No entry. Column 3 is equal to the product of columns 1 and 2.
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Column 4 – Medi-Medi Days/Charges/RVU (07/01/16 – 06/30/17)
No entry. Hospital administrative costs is not allowable for Medi-Medi.

Column 5 – Medi-Medi Costs (07/01/16 – 06/30/17)
No entry. Hospital administrative costs is not allowable for Medi-Medi.

Column 6 – SD/MC Enhanced (Children) Physician Charges/RVU For Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
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 Aid Codes E2, E4, and E5 for hospital administrative days for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Enhanced (Children) Physician Costs For Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – SD/MC Enhanced (Children) Physician Charges/RVU For Other SD/MCEnhanced Children Aid Codes (07/01/16 – 06/30/17)
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 other SD/MC Enhanced Children Aid Codes for hospital administrative days for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – SD/MC Enhanced (Children) Physician Costs For The Other Enchanced Children Aid Codes (07/01/16 – 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – SD/MC Enhanced (BCCPT) Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – SD/MC Enhanced (BCCPT) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – SD/MC Enhanced (Pregnancy) Physician Days/Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – SD/MC Enhanced (Pregnancy) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Refugee) Physician Days/Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Refugee) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – Medi-Cal Access Program (MCAP) Physician Days/Charges/RVU (07/01/16-06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Cal Access Program (MCAP) beneficiaries for hospital administrative days for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – Medi-Cal Access Program (MCAP) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – Affordable Care Act (ACA) Physician Days/Charges/RVU (07/01/16 – 12/31/16)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Affordable Care Act (ACA) beneficiaries for hospital administrative days for the period July 1, 2016 through December 31, 2016 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – Affordable Care Act (ACA) Physician Costs (07/01/16 – 12/31/16)
No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – Affordable Care Act (ACA) Physician Days/Charges/RVU (01/01/17 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Affordable Care Act (ACA) beneficiaries for hospital administrative days for the period January 1, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – Affordable Care Act (ACA) Physician Costs (01/01/17 – 06/30/17)
No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – MediCal for All Children (SB75) Physician Days/Charges/RVU (07/01/16 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to MediCal for All Children (SB75) beneficiaries for hospital administrative days for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – MediCal for All Children (SB75) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 23 is equal to the product of columns 1 and 21.

Column 24 – Total Medi-Cal Physician Costs (07/01/16 – 06/30/17)
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-to-charge ratios calculated on form MH 1960_HOSP_COSTS.

Column 1 – Cost-to-Charge Ratio
No entry. The cost-to-charge ratio for all non-routine cost centers are automatically populated with data from Column 5 of the MH 1960_HOSP_COSTS.

Column 2 – SD/MC Days/Charges/RVU (07/01/16- 06/30/17)
Please enter the total charges for SD/MC beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/16 – 06/30/17)
No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – Medi-Medi X-Over Days Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for Medi-Medi X-over beneficiaries during the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services..

Column 5 – Medi-Medi X-Over Costs (07/01/16 – 06/30/17)
No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Enhanced (Children) Days/Charges/RVU For Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17
Please enter the total charges for SD/MC Enhanced (Children) beneficiaries for Aid Codes E2, E4 and E5 for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Enhanced (Children) Costs For Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – SD/MC Enhanced (Children) Days/Charges/RVU (07/01/16 – 06/30/17
Please enter the total charges for SD/MC Enhanced (Children) beneficiaries for other SD/MC Enhanced Aid Codes for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – SD/MC Enhanced (Children) Costs (07/01/16 – 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – SD/MC Enhanced (BCCTP) Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – SD/MC Enhanced (BCCTP) Costs (07/01/1 – 06/30/17)
No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – SD/MC Enhanced (Pregnancy) Costs (07/01/16 – 06/30/17)
No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Refugee) Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Refugee) Costs (07/01/16 – 06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – Medi-Cal Access Program (MCAP) Physician Days/Charges/RVU (07/01/16-06/30/17)
For each applicable cost center, please enter the total charges for Medi-Cal Access Program (MCAP) beneficiaries for day services for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – Medi-Cal Access Program (MCAP) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – Affordable Care Act (ACA) Days/Charges/RVU(07/01/16 – 12/31/16)
Please enter the total charges for Affordable Care Act (ACA) beneficiaries for the period July 1, 2016 through December 31, 2016 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – Affordable Care Act (ACA) Days/Charges/RVU(01/01/17 – 06/30/17)
Please enter the total charges for Affordable Care Act (ACA) beneficiaries for the period January 1, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – MediCal For All Children (SB75) Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for services provided to Medi-cal For All Children beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – MediCal for All Children (SB75) Costs (07/01/16 – 06/30/17)
No entry. Column 23 is equal to the product of columns 1 and 22.

Column 20 – Total Costs (07/01/16 – 06/30/17)
No Entry. Column 20 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-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 Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Physician Costs (07/01/16 – 06/30/17)
No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – Medi-Medi X-Over Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – Medi-Medi X-Over Physician Costs (07/01/16 – 06/30/17)
No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Enhanced (Children) Physician Charges/RVU For Aid Codes E2, E4, and E5 (07/01/16 - 06/30/17
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 Aid Codes E2, E4, and E5 for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Enhanced (Children) Physician Costs For Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – SD/MC Enhanced (Children) Physician Charges/RVU For Other SD/MC Enhanced Children Aid Codes (07/01/16 - 06/30/17
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 Other SD/MC Enhanced Children Aid Codes for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – SD/MC Enhanced (Children) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – SD/MC Enhanced (BCCTP) Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – SD/MC Enhanced (BCCTP) Costs (07/01/16 – 06/30/17)
No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – SD/MC Enhanced (Pregnancy) Physician Charges/RVU(07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – SD/MC Enhanced (Pregnancy) Physician Costs(07/01/16 – 06/30/17)
No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Refugee) Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Refugee) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – Medi-Cal Access Program (MCAP) Physician Days/Charges/RVU (07/01/16-06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Cal Access Program (MCAP) beneficiaries for day services for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – Medi-Cal Access Program (MCAP) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – Affordable Care Act (ACA) Charges/RVU (07/01/16 – 12/31/16)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Affordable Care Act (ACA) beneficiaries for the period July 1, 2016 through December 31, 2016 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – Affordable Care ACT (ACA) Costs (07/01/16 – 12/31/16)
No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – Affordable Care Act (ACA) Charges/RVU (01/01/17 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Affordable Care Act (ACA) beneficiaries for the period January 1, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – Affordable Care ACT (ACA) Costs (01/01/17 – 06/30/17)
No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – Medical for All Children (SB75) Charges/RVU (07/01/16 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to MediCal for All Children beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – MediCal for All Children (SB75) Costs (07/01/16 – 06/30/17)
No entry. Column 23 is equal to the product of columns 1 and 22.

Column 22 – Total Costs (07/01/16 – 06/30/17)
No Entry. Column 22 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-to-charge ratios calculated on form MH 1960_HOSP_COSTS.

Column 1 – Cost-to-Charge Ratio
No entry. The cost-to-charge ratios are automatically populated with data from Column 5 of the MH 1960_HOSP_COSTS.

Column 2 – SD/MC Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for SD/MC beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Costs (07/01/16 – 06/30/17)
No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – Medi-Medi X-Over Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for Medi-Medi X-over beneficiaries during the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – Medi-Medi X-Over Costs (07/01/16 – 06/30/17)
No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Enhanced (Children) Days/Charges/RVU for Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
Please enter the total charges for SD/MC Enhanced (Children) beneficiaries SD/MC Enchanced Children Aid Codes E2, E4, and E5 for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7– SD/MC Enhanced (Children) Costs For Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – SD/MC Enhanced (Children) Days/Charges/RVU For Other SD/MC Enhanced Children Aid Codes (07/01/16 – 06/30/17)
Please enter the total charges for SD/MC Enhanced (Children) beneficiaries for other SD/MC Enhanced Aid Codes for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9– SD/MC Enhanced (Children) Costs For Other Enchanced Aid Codes (07/01/16 – 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – SD/MC Enhanced (BCCTP) Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for SD/MC Enhanced (BCCTP) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – SD/MC Enhanced (BCCTP) Costs (07/01/16 – 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 10.

Column 12 – SD/MC Enhanced (Pregnancy) Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for SD/MC Enhanced (Pregnancy) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – SD/MC Enhanced (Pregnancy) Costs(07/01/16 – 06/30/17)
No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Refugee) Days/Charges/RVU (07/01/16 -06/30/17)
Please enter the total charges for SD/MC Enhanced (Refugee) beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Refugee) Costs (07/01/16 -06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – Medi-Cal Access Program (MCAP) Physician Days/Charges/RVU (07/01/16-06/30/17)
For each applicable cost center, please enter the total charges for Medi-Cal Access Program (MCAP) beneficiaries for outpatient services for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – Medi-Cal Access Program (MCAP) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 16.

Column 18 – Affordable Care Act (ACA) Days/Charges/RVU (07/01/16 – 12/31/16)
Please enter the total charges for Affordable Care Act (ACA) beneficiaries for the period July 1, 2016through December 31, 2016 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – Affordable Care Act (ACA) Days/Charges/RVU (01/01/17 – 06/30/17)
Please enter the total charges for Affordable Care Act (ACA) beneficiaries for the period January 1, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21 – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 –Medical For All Children (SB75) Days/Charges/RVU (07/01/16 – 06/30/17)
Please enter the total charges for Medical For All Children beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – Medical For All Children Costs (05/01/16 – 06/30/16)
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 Physician Charges/RVU (07/01/16 - 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 3 – SD/MC Physician Costs (07/01/16 – 06/30/17)
No entry. Column 3 is equal to the product of columns 1 and 2.

Column 4 – Medi-Medi X-Over Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 5 – Medi-Medi X-Over Physician Costs (07/01/16 – 06/30/17)
No entry. Column 5 is equal to the product of columns 1 and 4.

Column 6 – SD/MC Enhanced (Children) Physician Charges/RVU For Aid Codes E2, E4,and E5 (07/01/16 – 06/30/17)
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 Aid Codes E2, E4, and E5 for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 7 – SD/MC Enhanced (Children) Physician CostsFor Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Column 7 is equal to the product of columns 1 and 6.

Column 8 – SD/MC Enhanced (Children) Physician Charges/RVU For Other SD/MC Enhanced Aid Codes (07/01/16 – 06/30/17)
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 other Enhanced Children Aid Codes for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 9 – SD/MC Enhanced (Children) Physician Costs For Other Enchanced Aid Codes (07/01/16 – 06/30/17)
No entry. Column 9 is equal to the product of columns 1 and 8.

Column 10 – SD/MC Enhanced (BCCTP) Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 11 – SD/MC Enhanced (BCCTP) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 11 is equal to the product of columns 1 and 10.

Column 12 – SD/MC Enhanced (Pregnancy) Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 13 – SD/MC Enhanced (Pregnancy) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 13 is equal to the product of columns 1 and 12.

Column 14 – SD/MC Enhanced (Refugee) Physician Charges/RVU (07/01/16 – 06/30/17)
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, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 15 – SD/MC Enhanced (Refugee) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 15 is equal to the product of columns 1 and 14.

Column 16 – Medi-Cal Access Program (MCAP) Physician Days/Charges/RVU (07/01/16-06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medi-Cal Access Program (MCAP) beneficiaries for hospital administrative days for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 17 – Medi-Cal Access Program (MCAP) Physician Costs (07/01/16 – 06/30/17)
No entry. Column 17 is equal to the product of columns 1 and 16.

Column 18 – Affordable Care Act (ACA) Physician Charges/RVU (07/01/16 – 12/31/16)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Affordable Care Act (ACA) beneficiaries for the period July 1, 2016 through December 31, 2016 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 19 – Affordable Care Act (ACA) Physician Costs (07/01/16 – 12/31/16)
No entry. Column 19 is equal to the product of columns 1 and 18.

Column 20 – Affordable Care Act (ACA) Physician Charges/RVU (01/01/17 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Affordable Care Act (ACA) beneficiaries for the period January 1, 2017 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 21– Affordable Care Act (ACA) Physician Costs (01/01/17 – 06/30/17)
No entry. Column 21 is equal to the product of columns 1 and 20.

Column 22 – MediCal for Children (SB75) Physician Charges/RVU (07/01/16 – 06/30/17)
For each applicable cost center, please enter the total charges for physician and non-physician practitioner professional services provided to Medical For All Children beneficiaries for the period July 1, 2016 through June 30, 2017 or a relative value unit (RVU) that has been approved by the Department of Health Care Services.

Column 23 – MediCal for All Children (SB75) Physician Costs (07/01/16 – 06/30/17)
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 D 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 principle 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 debts. Please enter any adjustments to costs due to bad debts on line 2.

Line 3 – Charity Allowance

Charity allowances are not included in allowable costs. Please refer to CMS Provider Reimbursement Manual, Part I, Chapter 3 for guidance regarding how to treat charity allowance. Please enter any adjustments to costs due to charity allowance on line 3.

Line 4 – Courtesy Allowance

Courtesy allowances are not included in allowable costs. Please refer to CMS Provider Reimbursement Manual, Part I, Chapter 3 for guidance regarding how to treat courtesy allowance. Please enter any adjustments to costs due to courtesy allowance on line 4.

Line 5 – 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 5.

Line 6 – 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 6.

Line 7 – Political and Lobbying Activities
Provider political and lobbying activities are not related to the care of patients 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 7.

Line 8 – 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 8.

Line 9 – Unallowable Insurance Costs
Certain insurance costs may not be allowable. Please refer to the CMS Provider Reimbursement Manual Part I, Chapter 21, Sections 2161 and 2162 for guidance regarding unallowable insurance costs. Please enter any adjustments to costs due to unallowable insurance costs on line 9.

Line 10 – Unallowable Liability Loses
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 loses. Please enter any adjustments to costs due to unallowable liability loses on line 10.

Line 11 – 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 to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Section 1254 for a description of planning cost. Please refer to the CMS Provider Reimbursement Manual, Part I, 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 11.

Lines 12-19 – Other Adjustments to Cost
Please enter any other adjustments to costs to comply with Medi-Cal principles of reimbursement on lines 12-19. 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.

Description
No entry. Column A lists the various reasons why costs may need to be adjusted to comply with Mecdi-Cal and Medicare principals of cost reimbursement.

Column A – 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 E of the MH 1960.

Column B – 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, Column D that is entered in Column C.

Column C – MH 1960 Description
No entry. This column is automatically populated when a line number is entered in Column B.

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 E of the MH 1960.

Description

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

Column A – 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 E of the MH 1960.

Column B – 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, Column E that is entered in Column C.

Column C – MH 1960 Description

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

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 F.

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 33, 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 (07/01/16 – 06/30/17)
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 the adjusted gross costs on the legal entity's cost report, MH 1992, line 3, column J. A cost report should be submitted for each contract provider payment listed.

Column E – SD/MC Payments (07/01/16 – 06/30/17)
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 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 50%.

Column F – Enhanced SD/MC Payments – Children (07/01/16 – 06/30/17)
Please enter the total amount paid to the contract provider for the specialty mental health services that the contractor reported on its cost report in Columns 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 lines 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 lines 25, Column D of the MH 1979 minus the Medi-Cal payment entered on Column F of the MH 1963 multiplied by 88%.

Column G – Enhanced SD/MC Payments - BCCTP (07/01/16 – 06/30/17)
Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column M 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 G of the MH 1963 multiplied by 65%.

Column H – Enhanced SD/MC Payments – Pregnancy (07/01/16 – 06/30/17)
Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column O 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 H of the MH 1963 multiplied by 65%.

Column I – Enhanced SD/MC Payments – Refugee (07/01/16 – 06/30/17)
Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column O 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 I of the MH 1963 multiplied by 100%.

Column J – Medi-Cal Access Program (MCAP) Payments (07/01/16 – 06/30/17)
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 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 J of the MH 1963 multiplied by 88%.

Column K – Affordable Care Act (ACA) Payments (07/01/16 – 12/31/16) – 100% FFP
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 23, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 23, 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 23, Column D of the MH 1979 minus the Medi-Cal payment entered on Column K of the MH 1963 multiplied by 100%.

Column L – Affordable Care Act (ACA) Payments (01/01/17 – 06/30/17) – 95% FFP
Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column S 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 23A, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on line 23A, 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 23A, Column D of the MH 1979 minus the Medi-Cal payment entered on Column L of the MH 1963 multiplied by 95%.

Column M– MediCal for All Children (SB75) (07/01/16 – 06/30/17)
Please enter the amount paid to the contract provider for the specialty mental health services the contractor reported on its cost report in Column Vof 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.

Column N– Medi-Cal Administrative Activities (07/01/16 – 06/30/17)
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 13 and 14, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on lines 13 and 14, 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 lines 13 and 14, Column D of the MH 1979 minus the Medi-Cal payment entered on Column N of the MH 1963 multiplied by 50%.

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 29 must be reclassified to lines 30, 31, and 32 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, 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 select from the drop-down list 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 select from the drop-down list 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 Mode 05, Service Function 10-19

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 and published charge.

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 C, line 4 is automatically calculated as line 3 divided by line 2.

Line 5 – Published Charge per Unit
No entry. Starting in Column C, 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 6– Medi-Cal Units
No entry. Starting in Column C, Medi-Cal units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Columns E.

Lines 7 – 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 8 – Enhanced SD/MC (Children) Units – Aid Codes E2, E4, and E5
No entry. Starting in Column C, Enhanced SD/MC (Children) units (from billing records) for each Medi-Cal service functions fills in automatically from the MH 1901 Schedule B, Column H.

Lines 9 – Enhanced SD/MC (Children) Units – Other Enhanced SD/MC Children Aid Codes
No entry. Starting in Column C, Enhanced SD/MC (Children) units (from billing records) for each Medi-Cal service functions fills in automatically from the MH 1901 Schedule B, Column J.

Line 10 – Enhanced SD/MC (BCCTP) Units
No entry. Starting in Column C, Enhanced SD/MC (BCCTP) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column L.

Lines 11 – Enhanced SD/MC (Pregnancy)
No entry. Starting in Column C, Enhanced SD/MC (Pregnancy) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column N.

Line 12 – Enhanced SD/MC (Refugee)
No entry. Starting in Column B, Enhanced SD/MC (Refugee) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column P.
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Line 13 – Affordable Care Act (ACA) Units (07/01/16 – 12/31/16
No entry. Starting in Column C, Affordable Care Act units (from billing records) for each Affordable Care Act Service funtion fills in automatically from the MH 1901 Schedule B, Column R.

Line 14 – Affordable Care Act (ACA) Units (01/01/17 – 06/30/17
No entry. Starting in Column C, Affordable Care Act units (from billing records) for each Affordable Care Act Service funtion fills in automatically from the MH 1901 Schedule B, Column T.

Line 15 - Medi-Cal for all for All Children (SB75) Units
No entry. Starting in Column C, SB75 units (from billing records) for each SB75 Service function fills in automatically from the MH 1901 Schedule B, Column X.

Line 16 - Medi-Cal Access Program (MCAP) Units
No entry. Starting in Column C, MCAP units (from billing records) for each Service function fills in automatically from the MH 1901 Schedule B, Column V.

Line 17 - Non Medi-Cal Units
No entry. Non-Medi-Cal units for each service function fills in automatically by subtracting Line 6 through Line 16 (Medi-Cal Units) from Line 2 (Total Units).

Line 18 – Medi-Cal Costs
No entry. Starting in Column C, line 4 is multiplied by line 6 for each SD/MC service function. The product of all SD/MC administrative day service functions computed are summed up in Column A, Line 18 and the products of all other SD/MC service functions computed are summed up in Column B, Line 18.

Line 19 – Medi-Cal Published Charges
No entry. Starting in Column C, line 5 is multiplied by line 6 for each SD/MC service function. The product of all SD/MC administrative day service functions computed are summed up on Column A, Line 19 and the product of all other SD/MC service functions computed are summed up in Column B, Line 19.

Lines 20 – Medicare/Medi-Cal Crossover Costs
No entry. Starting in Column C, line 4 is multiplied by line 7 for SD/MC service functions 10 through 18. The product of all SD/MC acute psychiatric inpatient hospital services are summed up on Column B, Line 20. These lines do not apply to administrative day services and should be left blank. Administrative Day services cannot have crossover units because Medicare will not pay for those beds.

Line 21 – Medicare/Medi-Cal Crossover Published Charges
No entry. Starting in Column C, line 5 is multiplied by line 7 for SD/MC service functions 10 through 18. The product of all SD/MC acute psychiatric inpatient hospital services are summed up on Column B, Line 21. These lines do not apply to administrative day services and should be left blank. Administrative Day services cannot have crossover units because Medicare will not pay for those beds.

Line 22 – Enhanced SD/MC (Children) Costs – Aid Codes E2, E4, and E5
No entry. Starting in Column C, Line 4 is multiplied by line 8 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 22 and the products of all other SD/MC service functions computed are summed up in Column B, Line 22.

Lines 23 – Enhanced SD/MC (Children) Published Charges – Aid Codes E2, E4 and E5
No entry. Starting in Column B, Line 5 is multiplied by line 8 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 23 and the products of all other SD/MC service functions computed are summed up in Column B, Line 23.

Line 24 – Enhanced SD/MC (Children) Costs – Other Enhanced SD/MC (Children) Aid Codes
No entry. Starting in Column C, Line 4 is multiplied by line 9 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 24 and the products of all other SD/MC service functions computed are summed up in Column B, Line 24.

Lines 25 – Enhanced SD/MC (Children) Published Charges – Other Enhances SD/MC (Children Aid Codes
No entry. Starting in Column B, Line 5 is multiplied by line 9 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 25 and the products of all other SD/MC service functions computed are summed up in Column B, Line 25.

Line 26 – Enhanced SD/MC (BCCTP) Costs
No entry. Starting in Column C, Line 4 is multiplied by line 10 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 26 and the products of all other SD/MC service functions computed are summed up in Column B, Line 26.

Lines 27 – Enhanced SD/MC (BCCTP) Published Charges
No entry. Starting in Column C Line 5 is multiplied by line 10 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 27 and the products of all other SD/MC service functions computed are summed up in Column B, Line 27.

Line 28 – Enhanced SD/MC (Pregnancy) Costs
No entry. Starting in Column C, Line 4 is multiplied by line 11 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 28 and the products of all other SD/MC service functions computed are summed up in Column B, Line 28.

Lines 29 – Enhanced SD/MC (Pregnancy) Published Charges
No entry. Starting in Column C, Line 5 is multiplied by line 11 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 29 and the products of all other SD/MC service functions computed are summed up in Column B, Line 29.

Line 30 – Enhanced SD/MC (Refugee) Costs
No entry. Starting in Column C, Line 4 is multiplied by line 12 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 30 and the products of all other SD/MC service functions computed are summed up in Column B, Line 30

Lines 31 – Enhanced SD/MC (Refugee) Published Charges
No entry. Starting in Column C, Line 5 is multiplied by line 12 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 31 and the products of all other SD/MC service functions computed are summed up in Column B, Line 31.

Line 32 – Affordable Care Act (ACA) Program Costs (07/01/16 – 12/31/16)
No entry. Starting in Column C, Line 4 is multiplied by line 13 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 32 and the products of all other SD/MC service functions computed are summed up in Column B, Line 32.

Lines 33 – Affordable Care Act (ACA) Program Published Charges (07/01/16 – 12/31/16)
No entry. Starting in Column C, Line 5 is multiplied by line 13 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 33 and the products of all other SD/MC service functions computed are summed up in Column B, Line 33.

Line 34 – Affordable Care Act (ACA) Program Costs (01/01/17 – 06/30/17)
No entry. Starting in Column C, Line 4 is multiplied by line 14 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 34 and the products of all other SD/MC service functions computed are summed up in Column B, Line 34.

Lines 35 – Affordable Care Act (ACA) Program Published Charges (01/01/17 – 06/30/17)
No entry. Starting in Column C, Line 5 is multiplied by line 14 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 35 and the products of all other SD/MC service functions computed are summed up in Column B, Line 35.

Line 36- Medi-Cal for All Children (SB75) Cost
No entry. Starting in Column C, Line 4 is multiplied by line 15 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 36 and the products of all other SD/MC service functions computed are summed up in Column B, Line 36.

Line 37- Medi-Cal for All Children (SB75) Published Charges
No entry. Starting in Column C, Line 5 is multiplied by line 15 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 37 and the products of all other SD/MC service functions computed are summed up in Column B, Line 37.

Line 38- Medi-Cal Access Program (MCAP) Cost
No entry. Starting in Column C, Line 4 is multiplied by line 16 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 38 and the products of all other SD/MC service functions computed are summed up in Column B, Line 38.

Line 39- Medi-Cal Access Program (MCAP) Published Charges
No entry. Starting in Column C, Line 5 is multiplied by line 16 for each SD/MC service function. The products of all SD/MC administrative day service functions computed are summed up in Column A, Line 39 and the products of all other SD/MC service functions computed are summed up in Column B, Line 39.

Lines 40 – Non-Medi-Cal Costs

No entry. Starting in Column C, Line 4 is multiplied by line 17 for each service function. The products of all Non-Medi-Cal administrative day service functions computed are summed up in Column A, Line 40 and the products of all other Non-Med-Cal service functions computed are summed up in Column B, Line 40 not pay for those beds.

MH1966, Mode: 05 Other 24 Hour Services (All Other SFC)
MH1966, Mode 10 - Day Service
Please follow the instructions for Mode 05_MH1966_Hospital Inpatient Services SFC-19.

MH 1966 Mode 15, (Program 1)

Allocation of Costs to Service Functions – Mode Total

MH 1966, Program 1 distributes mode costs among Medi-Cal 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 identifies 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. Line 4 is automatically calculated as line 3 divided by line 2.

Line 5 – Published Charge per Unit
No entry. 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 6 – Med-Cal Units (07/01/16 -06/30/17)
No entry. Medi-Cal units (from billing records) for each Medi-Cal service function fill in automatically from the MH 1901 Schedule B, Column E.

Lines 7 – Medicare/Medi-Cal Crossover Units (07/01/16 – 06/30/17
No entry. Medicare/Medi-Cal crossover units (from billing records) for each Medi-Cal service function fill in automatically from the MH 1901 Schedule B, Column F.

Lines 8 – Enhanced SD/MC (Children) Units For Enhanced SD/MC Children) Aid Codes E2, E4, and E5 – (07/01/16 - 06/30/17)
No entry. Enhanced SD/MC (Children) units (from billing records) for each Medi-Cal service function fill in automatically from the MH 1901 Schedule B, Column H.

Lines 9 – Enhanced SD/MC (Children) Units For Enhanced SD/MC (Children) Other Aid Codes (07/01/16 - 06/30/17)
No entry. Enhanced SD/MC (Children) units (from billing records) for each Medi-Cal service function fill in automatically from the MH 1901 Schedule B, Column J.

Line 10 – Enhanced SD/MC (BCCTP) Units (07/01/16 – 06/30/17)
No entry. Enhanced SD/MC (BCCTP) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column L.

Lines 11 – Enhanced SD/MC (Pregnancy) Units (07/01/16 – 06/30/17)
No entry. Enhanced SD/MC (Pregnancy) units (from billing records) for each Medi-Cal service function fill in automatically from the MH 1901 Schedule B, Column N.

Line 12 – Enhanced SD/MC (Refugee) Units (07/01/16 – 06/30/17)
No entry, Enhanced SD/MC (Refugee) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column P.

Line 13 – Affordable Care Act (ACA) Units (07/01/16 – 12/31/16)
No entry. Affordable Care Act units (from billing records) for each Affordable Care Act function fills in automatically from the MH 1901 Schedule B, Column R.

Line 14 – Affordable Care Act (ACA) Units (01/01/17 – 06/30/17)
No entry. Affordable Care Act units (from billing records) for each Affordable Care Act function fills in automatically from the MH 1901 Schedule B, Column T.

Line 15 – Medi-Cal for All Children (SB75) Units
No entry. SB75 Units (from billing records) for each SB75 function fills in automatically from the MH 1901 Schedule B, ColumnX .

Line 16 – Medi-Cal Access Program (MCAP) Units
No entry. MCAP Units (from billing records) for each MCAP function fills in automatically from the MH 1901 Schedule B, Column V.

Line 17 – Non Medi-Cal Units
No entry. Non-Medi-Cal units for each service function fills in automatically by subtracting Line 6 through Line 16 (Medi-Cal Units) from Line 2 (Total Units).

Line 18 – Medi-Cal Costs (07/01/16 – 06/30/17)
No entry. Line 4 is multiplied by lines 6 for each SD/MC service function. The product of line 4 and 6 is automatically entered onLine 18. The total for all service functions is entered on Line 18, Column C for the Mode Total. Non- Hospital Mode Total, Column A, line 18 is the difference between Line 18, Column C and Line 18, Column B.

Line 19 – Medi-Cal Published Charges (07/01/16 – 06/30/17)
No entry. Line 5 is multiplied by lines 6 for each SD/MC service function. The product of line 5 and 6 is automatically entered onLine 19. The total for all service furnctions is entered on Line 19, Column C as Mode Total. Non- Hospital Mode Total, Column A, line 19 is the difference between Line 19, Column C and Line 19, Column B.

Line 20 – Medicare/Medi-Cal Crossover Costs (07/01/16 – 06/30/17)
No entry. Line 4 is multiplied by lines 7 for each SD/MC service function. The product of line 4 and 7 is automatically entered onLine 20. The total for all service functions is automatically entered on Line 20, Column C as Mode Total. Non- Hospital Mode Total, Column A, line 20 is the difference between Line 20, Column C and Line 20, Column B.

Line 21 – Medicare/Medi-Cal Crossover Published Charges (07/01/16 – 06/30/17)
No entry. Line 5 is multiplied by line 7 for each SD/MC service function. The product of line 5 and 7 is automatically entered onLine 21. The total for all service functions is automatically entered on Line 21, Column C as Mode Total. Non- Hospital Mode Total, Line 21, Column A is the difference between Line 21, ColumnC and Line 21, Column B.

Line 22 – Enhanced SD/MC (Children) Costs For Enhanced SD/MC (Children) Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Line 4 is multiplied by line 8 for each SD/MC service function. The product of line 4 and 8 is automatically entered onLine 22. The total for all service functions is automatically entered on Line 22, Column C as Mode Total. Non- Hospital Mode Total, Line 22, Column A is the difference between Line 22, ColumnC and Line 22, Column B.

Lines 23 – Enhanced SD/MC (Children) Published Charges For Enhanced SD/MC (Children) Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Line 5 is multiplied by line 8 for each SD/MC service function. The product of line 5 and 8 is automatically entered onLine 23. The total for all service functions is automatically entered on Line 23, Column C as Mode Total. Non- Hospital Mode Total, Line 23, Column A is the difference between Line 23, ColumnC and Line 23, Column B.

Line 24 – Enhanced SD/MC (Children) Costs For Other Enhanced SD/MC (Children) Aid Codes (07/01/16 – 06/30/17)
No entry. Line 4 is multiplied by line 8 for each SD/MC service function. The product of line 4 and 9 is automatically entered onLine 24. The total for all service functions is automatically entered on Line 24, Column C as Mode Total. Non- Hospital Mode Total, Line 24, Column A is the difference between Line 24, ColumnC and Line 24, Column B.

Lines 25 – Enhanced SD/MC (Children) Published Charges For Other Enhanced SD/MC Children Aid Codes (07/01/16 – 06/30/17)
No entry. Line 5 is multiplied by line 8 for each SD/MC service function. The product of line 5 and 9 is automatically entered onLine 25. The total for all service functions is automatically entered on Line 25, Column C as Mode Total. Non- Hospital Mode Total, Line 25, Column A is the difference between Line 25, ColumnC and Line 25, Column B.

Line 26 – Enhanced SD/MC (BCCTP) Costs (07/01/16 – 06/30/17)
No entry. Line 4 is multiplied by line 10 for each SD/MC service function. The product of line 4 and 10 is automatically entered onLine 26. The total for all service functions is automatically entered on Line 26, Column C as Mode Total. Non- Hospital Mode Total, Line 26, Column A is the difference between Line 26, ColumnC and Line 26, Column B.

Lines 27 – Enhanced SD/MC (BCCTP) Published Charges (07/01/16 – 06/30/17)
No entry. Line 5 is multiplied by line 10 for each SD/MC service function. The product of line 5 and 10 is automatically entered onLine 27. The total for all service functions is automatically entered on Line 27, Column C as Mode Total. Non- Hospital Mode Total, Line 27, Column A is the difference between Line 27, ColumnC and Line 27, Column B.

Line 28 – Enhanced SD/MC (Pregnancy) Costs (07/01/16 – 06/30/17)
No entry. Line 4 is multiplied by line 10 for each SD/MC service function. The product of line 4 and 11 is automatically entered onLine 28. The total for all service functions is automatically entered on Line 28, Column C as Mode Total. Non- Hospital Mode Total, Line 28, Column A is the difference between Line 28, ColumnC and Line 28, Column B.

Lines 29 – Enhanced SD/MC (Pregnancy) Published Charges (07/01/16 – 06/30/17)
No entry. Line 5 is multiplied by line 11 for each SD/MC service function. The product of line 5 and 11 is automatically entered onLine 29. The total for all service functions is automatically entered on Line 29, Column C as Mode Total. Non- Hospital Mode Total, Line 29, Column A is the difference between Line 29, ColumnC and Line 29, Column B.

Line 30 – Enhanced SD/MC (Refugee) Costs (07/01/16 – 06/30/17)
No entry. Line 4 is multiplied by line 12 for each SD/MC service function. The product of line 4 and 12 is automatically entered onLine 30. The total for all service functions is automatically entered on Line 30, Column C as Mode Total. Non- Hospital Mode Total, Line 30, Column A is the difference between Line 30, ColumnC and Line 30, Column B.

Lines 31 – Enhanced SD/MC (Refugee) Published Charges (07/01/16 – 06/30/17)
No entry. Line 5 is multiplied by line 12 for each SD/MC service function. The product of line 5 and 12 is automatically entered onLine 31. The total for all service functions is automatically entered on Line 31, Column C as Mode Total. Non- Hospital Mode Total, Line 31, Column A is the difference between Line 31, ColumnC and Line 31, Column B.

Line 32 – Affordable Care Act (ACA) Program Costs (07/01/16 – 12/31/16)
No entry. Line 4 is multiplied by line 13 for each SD/MC service function. The product of line 4 and 13 is automatically entered onLine 32. The total for all service functions is automatically entered on Line 32, Column C as Mode Total. Non- Hospital Mode Total, Line 32, Column A is the difference between Line 32, ColumnC and Line 32, Column B.

Lines 33 – Affordable Care Act (ACA) Program Published Charges (07/01/16 – 12/31/16)
No entry. Line 5 is multiplied by line 13 for each SD/MC service function. The product of line 5 and 13 is automatically entered onLine 33. The total for all service functions is automatically entered on Line 33, Column C as Mode Total. Non- Hospital Mode Total, Line 32, Column A is the difference between Line 33, ColumnC and Line 33, Column B.

Line 34 – Affordable Care Act (ACA) Program Costs (01/01/17 – 06/30/17)
No entry. Line 4 is multiplied by line 14 for each SD/MC service function. The product of line 4 and 14 is automatically entered onLine 34. The total for all service functions is automatically entered on Line 34, Column C as Mode Total. Non- Hospital Mode Total, Line 34, Column A is the difference between Line 34, ColumnC and Line 34, Column B.

Lines 35 – Affordable Care Act (ACA) Program Published Charges (01/01/17 – 06/30/17)
No entry. Line 5 is multiplied by line 14 for each SD/MC service function. The product of line 5 and 14 is automatically entered onLine 35. The total for all service functions is automatically entered on Line 35, Column C as Mode Total. Non- Hospital Mode Total, Line 35, Column A is the difference between Line 35, ColumnC and Line 35, Column B.

Line 36 – Medi-Cal for All Children (SB75) Costs (07/01/16 – 06/30/17)
No entry. Line 4 is multiplied by line 15 for each SD/MC service function. The product of line 4 and 15 is automatically entered onLine 36. The total for all service functions is automatically entered on Line 36, Column C as Mode Total. Non- Hospital Mode Total, Line 36, Column A is the difference between Line 36, ColumnC and Line 36, Column B.

Lines 37 – Medi-Cal for All Children (SB75) Published Charges (07/01/16 – 06/30/17)
No entry, Line 5 is multiplied by line 15 for each SD/MC service function. The product of line 5 and 15 is automatically entered onLine 37. The total for all service functions is automatically entered on Line 37, Column C as Mode Total. Non- Hospital Mode Total, Line 37, Column A is the difference between Line 37, ColumnC and Line 37, Column B.

Line 38 – Medi-Cal Access Program (MCAP) Cost (10/01/16 – 06/30/17)
No entry. Line 4 is multiplied by line 16 for each SD/MC service function. The product of line 4 and 16 is automatically entered onLine 38 The total for all service functions is automatically entered on Line 37, Column C as Mode Total. Non- Hospital Mode Total, Line 37, Column A is the difference between Line 37, ColumnC and Line 38, Column B.

Lines 39 – Medi-Cal Access Program (MCAP) Published Charges (10/01/16 – 06/30/17)
No entry, Line 5 is multiplied by line 16 for each SD/MC service function. The product of line 5 and 16 is automatically entered onLine 39. The total for all service functions is automatically entered on Line 38, Column C as Mode Total. Non- Hospital Mode Total, Line 38, Column A is the difference between Line 38, ColumnC and Line 39, Column B.

Line 40 – Non Medi-Cal Costs (07/01/16 – 06/30/17)
No entry. The difference between Line 3 (Gross Cost) and Line 19 (Medi-Cal Costs), Line 21 (Medicare/Medi-Cal Crossover Costs), Line 23 (Children Costs), Line 25 (BCCTP Costs), Line 27 (Pregnancy Costs) , Line 29 (Refugees Costs), Line 31 (ACA P1 Costs), Line 33 (ACA P2 Costs), Line 35 (SB75 Costs), and Line 37 (MCAP Costs) is automatically populated.

MH 1966 Mode 15 (Program 2)
Allocation of Costs to Service Functions – Mode Total

MH 1966, Program 2 distributes 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 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 – 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 6 – 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.

Lines 7 – 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, Column F.

Lines 8 – Enhanced SD/MC (Children) Units For Enchanced SD/MC (Children) Aid Codes E2, E4, and E5
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 H.

Lines 9 – Enhanced SD/MC (Children) Units For Enhanced SD/MC (Children) Other Aid Codes
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 J.
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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 L.

Lines 11 – Enhanced SD/MC (Pregnancy) Units
No entry. Starting in Column B, Enhanced SD/MC (Pregnancy) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column N.

Line 12 – Enhanced SD/MC (Refugee) Units
No entry. Starting in Column B, Enhanced SD/MC (Refugee) units (from billing records) for each Medi-Cal service function fills in automatically from the MH 1901 Schedule B, Column P.

Line 13 – Affordable Care Act (ACA) Units (07/01/16 – 12/31/16)
No entry. Starting in Column B, Affordable Care Act (ACA) units (from billing records) for each Healthy Families service function fills in automatically from the MH 1901 Schedule B, Column R.

Line 14 – Affordable Care Act (ACA) Units (01/01/17 – 06/30/17)
No entry. Starting in Column B, Affordable Care Act (ACA) units (from billing records) for each Healthy Families service function fills in automatically from the MH 1901 Schedule B, Column T.

Line 15 - Medical for All Children (SB75) Units
No entry. Starting in Column B, Affordable Care Act (ACA) units (from billing records) for each Healthy Families service function fills in automatically from the MH 1901 Schedule B, Column X.

Line 16 – Medi-Cal Access Program (MCAP) Units
No entry. MCAP Units (from billing records) for each MCAP function fills in automatically from the MH 1901 Schedule B, Column V.

Line 17 – Non Medi-Cal Units
No entry. Non-Medi-Cal units for each service function fills in automatically by subtracting Line 6 through Line 16 (Medi-Cal Units) from Line 2 (Total Units).

Line 18 – Medi-Cal Costs (07/01/16 – 06/30/17)
No entry. Starting in Column B, line 4 is multiplied by line 6 for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Line 18.

Line 19 – Medi-Cal Published Charges (07/01/16 – 06/30/17)
No entry. Starting in Column B, line 5 is multiplied by line 6 for each SD/MC service function. The product of all SD/MC service functions computed are summed up on Column A, Line 19.

Line 20 – Medicare/Medi-Cal Crossover Costs (07/01/16 – 06/30/17)
No entry. Starting in Column B, line 4 is multiplied by line 7 for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Line 20.

Line 21 – Medicare/Medi-Cal Crossover Published Charges (07/01/16 – 06/30/17)
No entry. Starting in Column B, line 5 is multiplied by lines 7 for each SD/MC service function. The product of all SD/MC service functions computed are summed up in Column A, Line 21.

Line 22 – Enhanced SD/MC (Children) Costs For Enhanced SD/MC (Children) Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 4 is multiplied by line 8 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 For Enhanced SD/MC (Children) Aid Codes E2, E4, and E5 (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 5 is multiplied by line 8 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 23.
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Line 24 – Enhanced SD/MC (Children) Costs For Enhanced SD/MC (Children) Other Aid Codes (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 4 is multiplied by line 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 24.

Lines 25 – Enhanced SD/MC (Children) Published Charges For Enhanced SD/MC (Children) Other Aid Codes (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 5 is multiplied by line 9 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 25

Line 26 – Enhanced SD/MC (BCCTP) Costs (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 4 is multiplied by line 10 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 26.

Lines 27 – Enhanced SD/MC (BCCTP) Published Charges (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 5 is multiplied by line 10 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) Costs (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 4 is multiplied by line 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 (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 5 is multiplied by line 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 (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 4 is multiplied by line 12 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 30.

Lines 31 – Enhanced SD/MC (Refugee) Published Charges (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 5 is multiplied by line 12 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 31.

Line 32 – Affordable Care Act (ACA) Program Costs (07/01/16 – 12/31/16)
No entry. Starting in Column B, Line 4 is multiplied by line 13 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 32.

Lines 33 – Affordable Care Act (ACA) Program Published Charges (07/01/16 – 12/31/16)
No entry. Starting in Column B, Line 5 is multiplied by line 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 – Affordable Care Act (ACA) Program Costs (01/01/17 – 06/30/17)
No entry. Starting in Column B, Line 4 is multiplied by line 14 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 – Affordable Care Act (ACA) Program Published Charges (01/01/17 – 06/30/17)
No entry. Starting in Column B, Line 5 is multiplied by line 14 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 35.

Line 36 – Medi-Cal for All Children (SB75) (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 4 is multiplied by line 15 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 35.

Lines 37 – Medi-Cal for All Children (SB75) Published Charges (07/01/16 – 06/30/17)
No entry. Starting in Column B, Line 5 is multiplied by line 15 for each SD/MC service function. The products of all SD/MC service functions computed are summed up in Column A, Line 37.

Line 38 – Medi-Cal Access Program (MCAP) (10/01/16 – 06/30/17)
No entry. Line 4 is multiplied by line 16 for each SD/MC service function. The product of line 4 and 16 is automatically entered onLine 38 The total for all service functions is automatically entered on Line 38, Column A as Mode Total.

Lines 39 – Medi-Cal Access Program (MCAP) Published Charges (10/01/16 – 06/30/17)
No entry, Line 5 is multiplied by line 16 for each SD/MC service function. The product of line 5 and 16 is automatically entered onLine 39. The total for all service functions is automatically entered on Line 39, Column A as Mode Total.

Line 40 – Non Medi-Cal Costs (07/01/16 – 06/30/17)
No entry. The difference between Line 3 (Gross Cost) and the Sum of Line 18 (Medi-Cal Costs), Line 20 (Medicare/Medi-Cal Crossover Costs), Line 22 (Children Costs), Line 24 (BCCTP Costs), Line 26 (Pregnancy Costs) , Line 28 (Refugees Costs), Line 30 (ACA Period1 Costs), Line 32 (ACA Period2 Costs), Line 34, (SB75 Costs), and Line 36 (MCAP Costs) Line 38 is automatically populated. On Line 40.

MH 1966 Modes 45 and 60

Outreach and Support

MH 1966 for Mode 45 (Outreach) and Mode 60 (Support) services are not 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 B, and C. Legal entities must have an approved MAA plan with DHCS 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. In Column A, this field automatically populated by subtracting MH1968 Column D, Line 55 (SD/MC Reimbursement for MAA) from Line 53 (Total Expenditures from MAA).

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 proportion 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.

Determination of Cost Settlement Process

The cost report template automatically determines the lower of cost or published charge for SD/MC inpatient and outpatient services separately. The determination is based upon the cost 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, Enhanced Refugee, Affordable Care Act, Medi-Cal Access Program) with the exception of Hospital Inpatient Administration Days (mode 05, SF 19). Reimbursement of hospital inpatient administration days is based upon the lower of cost or published charge. Cost settlement for Healthy Families is based upon the lower of cost, or published charge as determined for SD/MC beneficiaries .

Column E, Line 1 – Medi-Cal Costs
No entry. The total cost of providing mode 05,acute psychiatric inpatient hospital (hospital inpatient) services to regular 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 F, Line 1 – Medi-Cal Costs
No entry. The total cost of providing Mode 05, SF19 (hospital inpatient administrative days) services to regular (excluding enhanced and Medicare crossover) Medi-Cal beneficiaries is equal to the sum of column 3 of the MH1960_HOSP_05_ADMIN and column 3 of the MH1960_PHYS_05_ADMIN.

Column G, Line 1 – Medi-Cal Costs
No entry. Column G is equal to the sum of columns E and F.

Column H, Line 1 – 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, line 18 of the MH1966 for Mode 05 (other 24 hour) services.

Column I, Line 1 – 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 18 of the MH1966, Column 3 of the MH1960_HOSP_10 and Column 3 of the MH1960_PHYS_10.

Column J, Line 1 – 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 18 of the MH1966 for Mode 15 (Program 1), Column 3 of the MH1960_HOSP_15 and Column 3 of the MH1960_PHYS_15.

Column K, Line 1 – Medi-Cal Costs
No entry. Column K is equal to the sum of Columns H through J.

Column L, Line 1 – Medi-Cal Costs
No entry. Column L is equal to Column A, line 18 of the MH1966 for Mode 15 (Program 2).

Column M, Line 1 – Medi-Cal Costs
No entry. Column M is equal to the sum of Columns K and L.

Lines 2 – Medi-Cal SMA Upper Limits
No entry. The Medi-Cal SMA Upper Limit for Mode 05, Hospital Inpatient Administrative days (SF 19) only is automatically populated from Column H of the MH 1991.

Lines 3 – Medi-Cal Published Charges
No entry. Medi-Cal published Charges for each mode of service in Columns E, F and H through J is automatically populated from the appropriate Mode total column on, Line 19 of the MH 1966 for the applicable mode of service. Column G calculates the Sum E and F and Column K calculates the sum of Columns H through J. Column M is the total of Columns K and L.

Lines 4 – 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 published charge is selected and populates lines 4 with the exception of Mode 05, Hospital Inpatient Administrative days (SF 19). 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 or published charge is selected and populates lines 4. Inpatient and outpatient reimbursement methods are determined independently in Columns G and K. Column L consists of Program 2 costs that are to be reimbursed to the county at allowable costs. Lines 4 in Column L are automatically populated by allowable costs (line1) since SMA does not apply.

Column E, Lines 5 – 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 5 is equal to the sum of Column 5 of MH 1960_HOSP_05 and Column 5 of the MH 1960_PHYS_05.

Column F, Lines 5 – Medicare/Medi-Cal Crossover Costs
No entry. The total cost of providing Mode 05, SF19 (Hospital Inpatient Administrative Days) is not applicable to Medicare/Medi-Cal crossover costs.

Column G, Lines 5 – Medicare/Medi-Cal Crossover Costs
No entry. Column G is equal to Columns E.

Column H, Lines 5 – 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, line 20 of the MH1966 for Mode 05 (other 24 hour) services.

Column I, Lines 5 – Medicare/Medi-Cal Crossover Costs
No entry. The total cost of providing day services reported in line 5 is equal to the sum of Column A, line 20 of the MH1966 for mode 10, Column 5 of the MH1960_HOSP_10 and Column 5 of the MH1960_PHYS_10.

Column J, Lines 5 – Medicare/Medi-Cal Crossover Costs
No entry. The total cost of providing outpatient services as reported in line 5 is equal to the sum of Column A, line 20 of the MH1966 for mode 15 (program 1), Column 5 of the MH1960_HOSP_15 and Column 5 of the MH1960_PHYS_15.

Column K, Lines 5 – Medicare/Medi-Cal Crossover Costs
No entry. Column K is equal to the sum of Columns H through J.

Column L, Lines 5 – Medicare/Medi-Cal Crossover Costs
No entry. Column L is equal to Column A, line 20 of the MH1966 for mode 15 (program 2) services.

Column M, Line 5 – Medicare/Medi-Cal Crossover Costs
No entry. Column M is equal to the sum of Columns K and L.

Line 6– Medicare/Medi-Cal Crossover SMA Upper Limits
No entry. SMA upper limit applies only to hospital inpatient administrative days. Hospital inpatient administrative days are not reported to Medi-Medi crossover patients. This cell remains blank.

Line 7 – Medicare/Medi-Cal Crossover Published Charges
No entry. Medi-Cal published Charges for each mode of service in Columns E and H, through J is automatically populated from the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns K and L.

Lines 8 – 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 published charge is selected and populates lines 8 with the exception of Mode 05,SF19 Hospital Inpatient Administrative days. If a legal entity has not completed the MH1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or published charge is selected and populates line 8. Inpatient and outpatient reimbursement methods are determined independently in Columns E, F and K. Column L consists of Program 2 costs that are to be reimbursed to the county as allowable costs. Lines 8 in Column are automatically populated by allowable costs (line 5) since SMA does not apply.

Lines 9 – Total SD/MC + Crossover Gross Reimbursement
No entry. Lines 9 automatically calculate the sum of lines 4 and 8.

Column E, Lines 10 – Enhanced SD/MC (Children) Costs – Aid Codes E2, E4 and E5
No entry. The total cost of providing mode 05, SF 10-18, acute psychiatric hospital inpatient, SF 10-18) services to Enhanced SD/MC (Children) beneficiaries as reported on line 10 is equal to the sum of Column 7 of MH 1960_HOSP_05 and Column 7 of the MH 1960_PHYS_05.

Column F, Lines 10 – Enhanced SD/MC (Children) Costs- Aid Codes E2, E4, and E5
No entry. The total cost of providing Mode 05, SF 19, (Hospital Inpatient Administrative Days) services to Enhanced SD/MC (Children) beneficiaries is equal to the amount determined in Column 7 of the MH1960_HOSP_05_ADMIN and Column 7 of the MH1960_PHYS_05_ADMIN.

Column G, Lines 10 – Enhanced SD/MC (Children) Costs Aid Codes E2, E4, and E5
No entry. Column G is equal to the sum of Columns E and F.

Column H, Lines 10 – Enhanced SD/MC (Children) Costs- Aid Codes E2, E4, and E5
No entry. The total cost of providing Mode 05 (other 24 hour) services to Enhanced SD/MC (Children) beneficiaries is equal to the amount determined in Column A, line 22 of the MH1966 for Mode 05 (other 24 hour) services.

Column I, Line 10 – Enhanced SD/MC (Children) Costs – Aid Codes E2, E4, and E5
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 22 of the MH1966 for mode 10, Column 7 of the MH1960_HOSP_10 and Column 7 of the MH1960 _PHYS_10.

Column J, Lines 10 – Enhanced SD/MC (Children) Costs - Aid Codes E2, E4, and E5
No entry. The total cost of providing outpatient services to Enhanced SD/MC (Children) beneficiaries are reported in line 10 is equal to the sum of Column A, line 22 of the MH1966, Mode 15 (program 1), Column 7 of the MH1960_HOSP_15 and Column 7 of the MH1960_PHYS_15.

Column K, Lines 10 – Enhanced SD/MC (Children) Costs – Aid Codes E2, E4, and E5
No entry. Column K is equal to the sum of Columns H, I, & J.

Column L, Lines 10 – Enhanced SD/MC (Children) Costs – Aid Codes E2, E4, and E5
No entry. Column L is equal to Column A, line 22 of the MH 1966 for Mode 15 (program 2) services.

Column M, Lines 10 – Enhanced SD/MC (Children) Costs – Aid Codes E2, E4, and E5
No entry. Column M is equal to the sum of Columns K and L.

Line 11 – Enhanced SD/MC (Children) SMA Upper Limits – Aid Codes E2, E4, and E5
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 2 of the MH1991.

Line 12 – Enhanced SD/MC (Children) Published Charges – Aid Codes E2, E4, and E5
No entry. Medi-Cal published Charges for each mode of service in Columns E and H through J is automatically populated from Column A, Lines 23 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns J through L.

Line 13 – Enhanced SD/MC (Children) Gross Reimbursement – Aid Codes E2, E4, and E5
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 published charge 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 or published charges is selected and populates line 13 with the exception of Mode 05, Hospital Inpatient Administration, SF 19. Inpatient and outpatient reimbursement methods are determined independently in Columns E, F, and K. Column L consists of Program 2 costs that are to be reimbursed to the county at allowable costs. Line 13 in Column L is automatically populated with allowable costs (line 10) since SMA does not apply.

Column E, Lines 14 – Enhanced SD/MC (Children) Costs – Other Aid Codes
No entry. The total cost of providing mode 05, SF 10-18, acute psychiatric hospital inpatient, SF 10-18) services to Enhanced SD/MC (Children) beneficiaries as reported on line 14 is equal to the sum of Column 7 of MH 1960_HOSP_05 and Column 9 of the MH 1960_PHYS_05.

Column F, Lines 14 – Enhanced SD/MC (Children) Costs- Other Aid Codes
No entry. The total cost of providing Mode 05, SF 19, (Hospital Inpatient Administrative Days) services to Enhanced SD/MC (Children) beneficiaries is equal to the amount determined in Column 7 of the MH1960_HOSP_05_ADMIN and Column 9 of the MH1960_PHYS_05_ADMIN.

Column G, Lines 14 – Enhanced SD/MC (Children) Costs – Other Aid Codes
No entry. Column G is equal to the sum of Columns E and F.

Column H, Lines 14 – Enhanced SD/MC (Children) Costs- Other Aid Codes
No entry. The total cost of providing Mode 05 (other 24 hour) services to Enhanced SD/MC (Children) beneficiaries is equal to the amount determined in Column A, line 24 of the MH1966 for Mode 05 (other 24 hour) services.

Column I, Line 14 – Enhanced SD/MC (Children) Costs – Other Aid Codes
No entry. The total cost of providing day services to Enhanced SD/MC (Children) beneficiaries as reported in line 14 is equal to the sum of Column A, line 24 of the MH1966 for mode 10, Column 9 of the MH1960_HOSP_10 and Column 9 of the MH1960 _PHYS_10.

Column J, Lines 14 – Enhanced SD/MC (Children) Costs – Other Aid Codes
No entry. The total cost of providing outpatient services to Enhanced SD/MC (Children) beneficiaries are reported in line 14 is equal to the sum of Column A, line 24 of the MH1966, Mode 15 (program 1), Column 9 of the MH1960_HOSP_15 and Column 9 of the MH1960_PHYS_15.

Column K, Lines 14 – Enhanced SD/MC (Children) Costs – Other Aid Codes
No entry. Column K is equal to the sum of Columns H, I, & J.

Column L, Lines 14 – Enhanced SD/MC (Children) Costs – Other Aid Codes
No entry. Column L is equal to Column A, line 24 of the MH 1966 for Mode 15 (program 2) services.

Column M, Lines 14 – Enhanced SD/MC (Children) Costs – Other Aid Codes
No entry. Column M is equal to the sum of Columns K and L.

Line 15 – Enhanced SD/MC (Children) SMA Upper Limits – Other Aid Codes
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 3 of the MH1991.

Line 16 – Enhanced SD/MC (Children) Published Charges – Other Aid Codes
No entry. Medi-Cal published Charges for each mode of service in Columns E and H through J is automatically populated from Column A, Lines 24 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns J through L.

Line 17 – Enhanced SD/MC (Children) Gross Reimbursement – Other Aid Codes
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 published charge 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 or published charges is selected and populates line 13 with the exception of Mode 05, Hospital Inpatient Administration, SF 19. Inpatient and outpatient reimbursement methods are determined independently in Columns E, F, and K. Column L consists of Program 2 costs that are to be reimbursed to the county at allowable costs. Line 13 in Column L is automatically populated with allowable costs (line 10) since SMA does not apply.

Line 18, Column E – Enhanced SD/MC (BCCTP) Costs
No entry. The total cost of providing mode 05 (hospital inpatient, SF 10-18) services to Enhanced SD/MC (BCCTP) beneficiaries as reported on line 18 is equal to the sum of Column 11 of MH 1960_HOSP_05 and Column 11 of the MH 1960_PHYS_05.

Line 18, Column F – Enhanced SD/MC (BCCTP) Costs
No entry. The total cost of providing Mode 05 (Hospital Inpatient Administrative days, SF 19) services to Enhanced SD/MC (BCCTP) beneficiaries is equal to the sum of Column 11 of the MH1960_HOSP_05_ADMIN and Column 11 of the MH1960_PHYS_05_ADMIN.

Line 18, Column G – Enhanced SD/MC (BCCTP) Costs
No entry. Column G is equal to the sum of Columns E and F.

Line 18, Column H – Enhanced SD/MC (BCCTP) Costs
No entry. The total cost of providing Mode 05 (other 24 hour) services to Enhanced SD/MC (BCCTP) beneficiaries is equal to the amount determined in Column A, line 26 of the MH1966 Mode 05 (other 24 hour) services.

Line 18, Column I – Enhanced SD/MC (BCCTP) Costs
No entry. The total cost of providing day services to Enhanced SD/MC (BCCTP) beneficiaries as reported in line 18 is equal to the sum of Column A, line 26 of the MH1966, Mode 10, Column 11 of the MH1960_HOSP_10 and Column 11 of the MH1960_PHYS_10.

Line 18, Column J – Enhanced SD/MC (BCCTP) Costs
No entry. The total cost of providing outpatient services to Enhanced SD/MC (BCCTP) beneficiaries as reported in line 18 is equal to the sum of Column A, line 26 of the MH1966 for Mode 15 (program 1), Column 11 of the MH1960_HOSP_15 and Column 11 of the MH1960_PHYS_15.

Line 18, Column K – Enhanced SD/MC (BCCTP) Costs
No entry. Column K is equal to the sum of Columns H, I & J.

Line 18, Column L – Enhanced SD/MC (BCCTP) Costs
No entry. Column L is equal to Column A, line 26 of the MH 1966 for Mode 15 (program 2) services.

Line 18, Column M – Enhanced SD/MC (BCCTP) Costs
No entry. Column M is equal to the sum of Columns K and L.

Line 19 – Enhanced SD/MC (BCCTP) SMA Upper Limits
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 4 of the MH1991.

Line 20 – Enhanced SD/MC (BCCTP) Published Charges
No entry. Medi-Cal published Charges for each mode of service in Columns E and H through J is automatically populated from Column A, Line 27 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns J through L.

Lines 21 – 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 published charge 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 or published charges is selected and populates line 17 with the exception of Mode 05, Hospital Inpatient Administration, SF 19. Inpatient and outpatient reimbursement methods are determined independently in Columns E, F and K. Column L consists of Program 2 costs that are to be reimbursed to the county as allowable costs. Line 17 in Column L is automatically populated with allowable costs (line15) since SMA does not apply.

Line 22, Column E – Enhanced SD/MC (Pregnancy) Costs
No entry. The total cost of providing mode 05 (Hospital inpatient, SF 10-18) services to Enhanced SD/MC (Pregnancy) beneficiaries as reported on line 22 is equal to the sum of Column 13 of MH 1960_HOSP_05 and Column 13 of the MH 1960_PHYS_05..

Line 22, Column F – Enhanced SD/MC (Pregnancy) Costs
No entry. The total cost of providing Mode 05 (Hospital Inpatient Administrative Days, SF 19) services to Enhanced SD/MC (Pregnancy) beneficiaries is equal to the amount determined in Column 13 of the MH1960_HOSP_05_ADMIN and Column 13 of the MH1960_PHYS_05_ADMIN.

Line 22, Column G – Enhanced SD/MC (Pregnancy) Costs
No entry. Column G is equal to the sum of Columns E and F.

Line 22, Column H – 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 28 of the MH1966 for Mode 05 (other 24 hour) services.

Line 22, Column I – Enhanced SD/MC (Pregnancy) 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 28 of the MH 1966 for mode 10, Column 13 of the MH 1960_HOSP_10, and Column 13 of the MH 1960_PHYS_10.

Line 22, Column J – Enhanced SD/MC (Pregnancy) 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 28 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.

Line 22, Column K – Enhanced SD/MC (Pregnancy) Costs
No entry. Column K is equal to the sum of Columns H, I & J.

Line 22, Column L – Enhanced SD/MC (Pregnancy) Costs
No entry. Column L is equal to Column A, line 28 of the MH 1966 for Mode 15 (program 2) services.

Line 22, Column M – Enhanced SD/MC (Pregnancy) Costs
No entry. Column M is equal to the sum of Columns K and L.

Lines 23 – Enhanced SD/MC (Pregnancy) SMA Upper Limits
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 5 of the MH1991.

Lines 24 – Enhanced SD/MC (Pregnancy) Published Charges
No entry. Medi-Cal published Charge for each mode of service in Columns E and H through J is automatically populated from Column A, Line 29 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns K through L.

Line 25 – Enhanced SD/MC (Pregnancy) Gross Reimbursement
Legal entities fall unto 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 published charge 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 or published charge is selected and populates line 21 with the exception of Mode 05, Hospital Inpatient Administration, SF 19. Inpatient and outpatient reimbursement methods are determined independently in Columns G and K. Column L consists of Program 2 costs that are to be reimbursed to the county as allowable costs Line 21 in column L is automatically populated with allowable costs (line 18) since SMA does not apply.

Line 26, Column E – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. The total cost of providing mode 05 (hospital inpatient, SF 10-18) services to Affordable Care Act beneficiaries as reported on line 26 is equal to the sum of Column 19 of MH 1960_HOSP_05 and Column 19 of the MH 1960_PHYS_05.

Line 26, Column F – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. The total cost of providing Mode 05, SF 19 (Hospital Inpatient administrative Days) services Affordable Care Act beneficiaries is equal to the amount determined in Column 17 of the MH1960_HOSP_05_ADMIN and Column 19 of the MH1960_PHYS_05_ADMIN.

Line 26, Column G – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. Column G is equal to the sum of Columns E and F.

Line 26, Column H – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. The total cost of providing Mode 05 (other 24 hour) services to Affordable Care Act beneficiaries is equal to the amount determined in Column A, line 32 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 26, Column I – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. The total cost of providing day services to Affordable Care Act beneficiaries as reported in line 26 is equal to the sum of Column A, line 32 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 26, Column J – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. The total cost of providing outpatient services to Affordable Care Act beneficiaries as reported in line 26 is equal to the sum of Column A, line 32 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 26, Column K – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16
No entry. Column K is equal to the sum of Columns H, I & J.

Line 26, Column L – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16
No entry. Column L is equal to Column A, line 32 of the MH 1966 for Mode 15 (program 2) services.

Line 26, Column M – Affordable Care Act (ACA) Costs (07/01/16 – 12/31/16)
No entry. Column M is equal to the sum of Columns K and L.

Lines 27 – Affordable Care Act (ACA) SMA Upper Limits (07/01/16 – 12/31/16
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 6 of the MH1991.

Lines 28 – Affordable Care Act (ACA) Published Charges (07/01/16 – 12/31/16
No entry. Medi-Cal published Charge for each mode of service in Columns E through J and L is automatically populated from Column A, Line 33 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns K through L.

Line 29 – Affordable Care Act Gross Reimbursement (07/01/16 – 12/31/16)
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 published charge is selected and populates line 25. 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, or published charge is selected and populates line 29 with the exception of Hospital Inpatient Administration, SF 19. Inpatient and outpatient reimbursement methods are determined independently in Columns E, F and K. Column L consists of Program 2 costs that are to be reimbursed to the county at allowable costs. Line 25 in Column L is automatically populated with allowable costs (line 23) since SMA does not apply.

Line 30, Column E – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. The total cost of providing mode 05 (hospital inpatient, SF 10-18) services to Affordable Care Act beneficiaries as reported on line 30 is equal to the sum of Column 21 of MH 1960_HOSP_05 and Column 21 of the MH 1960_PHYS_05.

Line 30, Column F – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. The total cost of providing Mode 05, SF 19 (Hospital Inpatient administrative Days) services Affordable Care Act beneficiaries is equal to the amount determined in Column 21 of the MH1960_HOSP_05_ADMIN and Column 21 of the MH1960_PHYS_05_ADMIN.

Line 30, Column G – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. Column G is equal to the sum of Columns E and F.

Line 30, Column H – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. The total cost of providing Mode 05 (other 24 hour) services to Affordable Care Act beneficiaries is equal to the amount determined in Column A, line 34 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 30, Column I – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. The total cost of providing day services to Affordable Care Act beneficiaries as reported in line 30 is equal to the sum of Column A, line 34 of the MH 1966 for mode 10, Column 19 of the MH 1960_HOSP_10, and Column 21 of the MH 1960_PHYS_10.

Line 30, Column J – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. The total cost of providing outpatient services to Affordable Care Act beneficiaries as reported in line 30 is equal to the sum of Column A, line 34 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 30, Column K – Affordable Care Act (ACA) Costs (07/01/17 – 06/30/17
No entry. Column K is equal to the sum of Columns H, I & J.

Line 30, Column L – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. Column L is equal to Column A, line 34 of the MH 1966 for Mode 15 (program 2) services.

Line 30, Column M – Affordable Care Act (ACA) Costs (01/01/17 – 06/30/17)
No entry. Column M is equal to the sum of Columns K and L.

Lines 31 – Affordable Care Act (ACA) SMA Upper Limits (01/01/17 – 06/30/17)
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 7 of the MH1991.

Lines 32 – Affordable Care Act (ACA) Published Charges (01/01/17 – 06/30/17)
No entry. Medi-Cal published Charge for each mode of service in Columns E through J and L is automatically populated from Column A, Line 35 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns K through L.

Line 33 – Affordable Care Act Gross Reimbursement (01/01/17 – 06/30/17)
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 published charge is selected and populates line 29. 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, or published charge is selected and populates line 29 with the exception of Hospital Inpatient Administration, SF 19. Inpatient and outpatient reimbursement methods are determined independently in Columns E, F and K. Column L consists of Program 2 costs that are to be reimbursed to the county at allowable costs. Line 29 in Column L is automatically populated with allowable costs (line 27) since SMA does not apply.

Line 34, Column E – MediCal for All Children (SB75) Costs
No entry. The total cost of providing mode 05 (hospital inpatient, SF 10-18) services to SB75 beneficiaries as reported on line 34 is equal to the sum of Column 23 of MH 1960_HOSP_05 and Column 23 of the MH 1960_PHYS_05.

Line 34, Column F – Medical for All Children (SB75) Costs
No entry. The total cost of providing Mode 05, SF 19 (Hospital Inpatient administrative Days) services to SB75 beneficiaries as reported on line 34 is equal to the amount determined in Column 23 of the MH1960_HOSP_05_ADMIN and Column 23 of the MH1960_PHYS_05_ADMIN.

Line 34, Column G – Medical for All Children (SB75) Costs
No entry. Column G is equal to the sum of Columns E and F.

Line 34, Column H – MediCal for All Children (SB75) Costs
No entry. The total cost of providing Mode 05 (other 24 hour) services to MediCal for All Children (SB75) beneficiaries as reported on line 34 is equal to the amount determined in Column A, line 36 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 34, Column I – MediCal for All Children (SB75) Costs
No entry. The total cost of providing day services to MediCal for All Children (SB75) beneficiaries as reported in line 30 is equal to the sum of Column A, line 36 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 34, Column J – Medical for All Children (SB75) Costs
No entry. The total cost of providing outpatient services to MediCal for All Children beneficiaries as reported in line 34 is equal to the sum of Column A, line 36 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 34, Column K – Medical for All Children (SB75) Costs
No entry. Column K is equal to the sum of Columns H, I & J.

Line 34, Column L – Medical for All Children (SB75) Costs
No entry. Column L is equal to Column A, line 36 of the MH 1966 for Mode 15 (program 2) services.

Line 34, Column M – Medi-Cal for All Children (SB75) Costs
No entry. Column M is equal to the sum of Columns K and L.

Lines 35 – MediCal for All Children (SB75) SMA Upper Limits
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 8 of the MH1991.

Lines 36 – MediCal for All Children (SB75) Published Charges
No entry. Medi-Cal published Charge for each mode of service in Columns E through J and L is automatically populated from Column A, Line 37 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns K through L.

Line 37 – MediCal for All Children (SB75) 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 published charge is selected and populates line 33. 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, or published charge is selected and populates line 33 with the exception of Hospital Inpatient Administration, SF 19. Inpatient and outpatient reimbursement methods are determined independently in Columns E, F and K. Column L consists of Program 2 costs that are to be reimbursed to the county at allowable costs. Line 33 in Column L is automatically populated with allowable costs (line 31) since SMA does not apply.

Line 38 – Total Enhanced Medi-Cal Grosss Reimbursement (Excludes EnhancedSD/MC Refugees and Medical for All California Children)
Line 38 automatically calculates the sum of lines 9, 13, 17, 21, 25, 29 and 33 and 46.

Line 39, Column E – Enhanced SDMC (Refugee) Costs
No entry. The total cost of providing mode 05 (hospital inpatient, SF 10-18) services to Enhanced SD/MC (Refugee) beneficiaries as reported on line 39 is equal to the sum of Column 15 of MH 1960_HOSP_05 and Column 15 of the MH 1960_PHYS_05.

Line 39, Column F – Enchanced SDMC Refugee Costs
No entry. The total cost of providing Mode 05, SF 19 (Hospital Inpatient administrative Days) services to Enhanced SD/MC (Refugee) beneficiaries as reported on line 39 is equal to the amount determined in Column 15 of the MH1960_HOSP_05_ADMIN and Column 15 of the MH1960_PHYS_05_ADMIN.

Line 39, Column G – Enhanced SDMC (Refugee) Costs
No entry. Column G is equal to the sum of Columns E and F.

Line 39, Column H – Enhanced SDMC (Refugee) Costs
No entry. The total cost of providing Mode 05 (other 24 hour) services to Enhanced SD/MC (Refugee) beneficiaries as reported on line 39 is equal to the amount determined in Column A, line 30 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 39, Column I – Enhanced SDMC (Refugee) Costs
No entry. The total cost of providing day services to Enhanced SD/MC (Refugee) beneficiaries as reported in line 39 is equal to the sum of Column A, line 30 of the MH 1966 for mode 10, Column 15 of the MH 1960_HOSP_10, and Column 15 of the MH 1960_PHYS_10.

Line 39, Column J – Enhanced SDMC (Refugee) Costs
No entry. The total cost of providing outpatient services to Enhanced SD/MC (Refugee) beneficiaries as reported in line 39 is equal to the sum of Column A, line 29 of the MH 1966 for mode 15 (program 1), Column 15 of the MH 1960_HOSP_15, and Column15 of the MH 1960_PHYS_15.

Line 39, Column K – Enhanced SDMC (Refugee) Costs
No entry. Column K is equal to the sum of Columns H, I & J.

Line 39, Column L – Enhanced SDMC (Refugee) Costs
No entry. Column L is equal to Column A, line 30 of the MH 1966 for Mode 15 (program 2) services.

Line 39, Column M – Enhanced SDMC (Refuee) Costs
No entry. Column M is equal to the sum of Columns K and L.

Lines 40 – Enhanced SDMC Refugee SMA Upper Limits
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 9 of the MH1991.

Lines 41 – Enhanced SDMC Refugee Published Charges
No entry. Medi-Cal published Charge for each mode of service in Columns E through J and L is automatically populated from Column A, Line 31 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns K through L.

Line 42 – Enhanced SDMC 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 published charge is selected and populates line 42. 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, or published charge is selected and populates line 42.

Line 43 – Column E – Medi-Cal Acess Program (MCAP) Costs
No entry. The total cost of providing mode 05 (hospital inpatient, SF 10-18) services to Enhanced SD/MC (Refugee) beneficiaries as reported on line 43 is equal to the sum of Column 17 of MH 1960_HOSP_05 and Column 17 of the MH 1960_PHYS_05.

Line 43, Column F - Medi-Cal Acess Program (MCAP) Costs
No entry. The total cost of providing Mode 05, SF 19 (Hospital Inpatient administrative Days) services to Medi-Cal Access Program (MCAP) beneficiaries as reported on line 43 is equal to the amount determined in Column 17 of the MH1960_HOSP_05_ADMIN and Column 17 of the MH1960_PHYS_05_ADMIN.

Line 43, Column G - Medi-Cal Acess Program (MCAP) Costs
No entry. Column G is equal to the sum of Columns E and F.

Line 43, Column H - Medi-Cal Acess Program (MCAP) Costs
No entry. The total cost of providing Mode 05 (other 24 hour) services to Medi-Cal Access Program (MCAP) beneficiaries as reported on line 43 is equal to the amount determined in Column A, line 38 of the MH 1966 for Mode 05 (other 24 hour) services.

Line 43, Column I - Medi-Cal Acess Program (MCAP) Costs
No entry. The total cost of providing day services to Medi-Cal Access Program (MCAP) beneficiaries as reported in line 43 is equal to the sum of Column A, line 38 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 43, Column J - Medi-Cal Acess Program (MCAP) Costs
No entry. The total cost of providing outpatient services to Medi-Cal Access Program (MCAP) beneficiaries as reported in line 43 is equal to the sum of Column A, line 38 of the MH 1966 for mode 15 (program 1), Column 17 of the MH 1960_HOSP_15, and Column17 of the MH 1960_PHYS_15.

Line 43, Column K - Medi-Cal Acess Program (MCAP) Costs
No entry. Column K is equal to the sum of Columns H, I & J.

Line 43, Column L - Medi-Cal Acess Program (MCAP) Costs
No entry. Column L is equal to Column A, line 38 of the MH 1966 for Mode 15 (program 2) services.

Line 43, Column M - Medi-Cal Acess Program (MCAP) Costs
No entry. Column M is equal to the sum of Columns K and L.

Line 44 – Medi-Cal Access Program (MCAP) SMA Upper Limits
No entry. Medi-Cal SMA Upper Limits for Mode 05, Hospital Inpatient Administration, SF 19 only is automatically populated from Column H, line 10 of the MH1991.

Line 45 – Medi-Cal Access Program (MCAP) Published Charges
No entry. Medi-Cal published Charge for each mode of service in Columns E through J and L is automatically populated from Column A, Line 39 of the MH 1966 for the applicable mode of service. Column M calculates the sum of Columns K through L.

Line 46 – Medi-Cal Access Program (MCAP) 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 published charge is selected and populates line 46. 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, or published charge is selected and populates line 46.

Line 47 – Less Patient and Other Payor Revenues
No entry – gray shaded.

Line 48 – 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, Column G. 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 49 – Enhanced SD/MC (Children) Patient Revenue – Aid Codes E2, E4, and E5
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column I. See Lines 47 and for more information.

Line 50 – Enhanced SD/MC (Children) Patient Revenue – Other Aid Codes
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column K. See Lines 47 and for more information.

Line 51 – Enhanced SD/MC (BCCTP) Patient Revenue
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column M. See Lines 47 for more information.

Line 52 – Enhanced SD/MC (Pregnancy) Patient Revenue
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column O See Lines 47 for more information.

Line 53 – Enhanced SD/MC (Refugees) Patient Revenue
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column Q. See Lines 47 for more information.
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Line 54 – Affordable Care Act Revenue (07/01/16 – 12/31/16)
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column S. See Lines 47 for more information.

Line 55 – Affordable Care Act Revenue (01/01/17 – 06/30/17)
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column U. See Lines 47 for more information.

Line 56 – Medical for All Children (SB75) Revenue
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column Y. See Lines 44 for more information

Line 57 – Medi-Cal Acess Program (MCAP) Revenue
No entry. The amounts are automatically populated from MH 1901 Schedule B, Column W. See Lines 44 for more information

Line 58 – 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 59 – Medi-Cal Eligibility Factor (Average)
No entry. County Medi-Cal eligibility factor (percentage) cell references MH 1901 Schedule A, Column D, Line 36.

Line 60 –SD/MC Net Reimbursement for MAA
No entry. Column A automatically populated by the amount from Line 58. Columns B and C are equal to the product of lines 58 and 59. 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 Costs or Charges (LCC) principles. MH 1969 is an optional form and should be completed by legal entities whose charges are lower than costs. 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 DHCS) 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 revenues 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, represents amount billed to

[1] See: *Medicare and Medicaid Guide, Commerce Clearing House, ¶7585, August 1989.*

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 1, 5, 10, 14, 18, 22, 26, 30, 34, and 39 Column G and Column K.

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 not 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 services 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, are to be entered by County legal entities on appropriate forms (MH 1900_Information and MH 1960).

Line 1 – County SD/MC Other Direct Service Gross Reimbursement
No entry. In Columns B and C, the county legal entity's SD/MC direct service gross reimbursement for inpatient and outpatient services are automatically populated from MH 1968, Columns G and M, Line 38 minus Lines 13,and 17. Column D is equal to the sum of Columns B and C.

Line 2 – Contract Provider Medi-Cal Other 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 G and M, sum of Lines 9, 13, 17, 21, 25, 29, 33, 42, and 46 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 percent.

Line 5 – SD/MC Administration
No entry. SD/MC administrative costs are automatically populated from MH 1960, Column J, Line 25.

Line 6 – Continuum of Care Reform Administration (CCR)
Continuum of Care Reform administrative costs are automatically populated from MH1960, Column J, Line 29. Total Stage General Fund, column O is multiplied by 50 percent.

Line 7 – SD/MC Administrative Reimbursement
No entry. Line 7, Column D, is equal to the lower of lines 4 and 5, Column D. Line 7, Column E, is equal to line 7, Column D, multiplied by 50 percent. The result is rounded to the nearest whole dollar and entered in Column E.

Line 8 – County SD/MC Enhanced (Children) Direct Service Gross Reimbursement
No entry. Line 8, Columns B and C, are automatically populated from Line 13 and 17, Columns G and M, of the MH 1968. Column D is equal to the sum of Columns B and C.

Line 9 – 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 and 17, Columns G and M, of the MH 1968 for all contract providers. Column D is equal to the sum of Columns B and C.

Line 10 – Total SD/MC Enhanced (Children) Direct Service Gross Reimbursement
No entry. The sum of Lines 8 and 9 in Column D are automatically populated on Line 13. 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 11 – 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 10, is automatically multiplied by 15 percent to compute the SD/MC enhanced (Children) administrative limit.

Line 12 – SD/MC Enhanced (Children) Administration
No entry. The SD/MC Enhanced Children Administrative costs are automatically populated from Column J, Line 27, of the MH 1960.

Line 13 – SD/MC Enhanced (Children) Administrative Reimbursement
No entry. The lower of Lines 11 and 12 from Column D is automatically selected and populated in Column D, Line 13. The amount in Column D is automatically multiplied by 65 percent to determine the FFP for Enhanced Children administrative costs. The result is rounded to the nearest whole dollar and populated on Line 13, Column G.

Line 14 – Medi-Cal Administrative Activities Service Functions 01-09
No entry. The amount in columns A and D are automatically populated from Line 60, Column A, of the MH 1968. The result in Column D is automatically populated by 50 percent and entered in Columns E and J.

Line 15 – 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 60, Column B, of the MH 1968. The result in Column D is automatically multiplied by 50 percent and entered in Columns E and J.

Line 16 – Medi-Cal Administrative Activities Service Functions 21-29 (County Only)
No entry. The amount in Columns A and D are automatically populated from Line 60, Column C, of the MH 1968. The result in Column D is automatically multiplied by 75 percent and populated in Columns H and J.

Line 17 – 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 31, of MH 1960. The result in Column D is automatically multiplied by 75 percent to determine FFP and populated in Columns H and J.

Line 18 – Other SD/MC Utilization Review (County Only)
No entry. The other SD/MC utilization review costs are automatically populated from Column J, Line 32, of the MH 1960. The result in Column D is automatically multiplied by 50 percent to determine FFP and populated in Columns E and J.

Line 19 – 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 G and M, Line 9 minus Line 44 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by the appropriate FMAP to determine FFP for SD/MC direct services and is populated in Columns F and J. Column O calculates the State General Fund portion of payments to counties. It determines the non-federal share of the net reimbursement for services provided under CCR to beneficiaries enrolled in regular and crossover Medi-Cal aid codes. The cell is automatically populated from the MH1966's and MH1968.

Line 20 – Enhanced SD/MC Net Reimbursement (Children) E2, E4, E5
No entry. The enhanced SD/MC (Children) E2, E4, and E5 direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns G and M, Lines 13 minus Line 49 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 G and J. Column J is equal to Column G minus Column I. Column O calculates the State General Fund portion of payments to counties. It determines the non-federal share of the net reimbursement for services provided under CCR to beneficiaries enrolled in enhanced children aid codes. The cell is automatically populated from the MH1966's and MH1968.

Line 21 – 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 G and M, Lines 17 minus Line 50 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 88 percent to determine FFP for enhanced SD/MC (Children) direct services and is populated in Columns G and J. Column J is equal to Column G minus Column I. Column O calculates the State General Fund portion of payments to counties. It determines the non-federal share of the net reimbursement for services provided under CCR to beneficiaries enrolled in enhanced children aid codes. The cell is automatically populated from the MH1966's and MH1968.

Line 22 – 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 G and M,

Line 21 minus Line 51, 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 G and J. Column J is equal to Column G minus Column I. Column O calculates the State General Fund portion of payments to counties. It determines the non-federal share of the net reimbursement for services provided under CCR to beneficiaries enrolled in BCCTP aid codes. The cell is automatically populated from the MH1966's and MH1968.

Line 23 – Enhanced SD/MC Net Reimbursement (Pregnancy)
No entry. The enhanced SD/MC (Pregnancy) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns G and M, Line 25 minus Line 52 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 (Pregnancy) direct services and is populated in Columns G and J. Column J is equal to Column G minus Column I. Column O calculates the State General Fund portion of payments to counties. It determines the non-federal share of the net reimbursement for services provided under CCR to beneficiaries enrolled in pregnancy related services. The cell is automatically populated from the MH1966's and MH1968.

Line 24 – Enhanced SD/MC Net Reimbursement (Refugees)
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 G and M, Line 42 minus Line 53 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 G and J. Column J is equal to Column G minus Column I. Column O is gray shaded.

Line 25 – SD/MC Net Reimbursement (Affordable Care Act) (07/01/16 – 12/31/16)
No entry. The Affordable Care Act (ACA) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns G and M, Line 29 minus Line 54 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 SD/MC Affordable Care Act (ACA) direct services and is populated in Columns G and J. Column J is equal to Column G minus Column I. Column O is gray shaded.

Line 25A – SD/MC Net Reimbursement Affordable Care Act (01/01/17 – 06/30/17)
No entry. The Affordable Care Act (ACA) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns G and M, Line 33 minus Line 55 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 95 percent in column G to determine FFP for SD/MC Affordable Care Act (ACA) direct services and is populated in Columns G and JK. Column J is equal to Column G minus Column I. Also, the same amount in Column D divided by 95% automatically populates Column K (Total SGF)

Line 26 – Medi-Cal Access Program Net Reimbursement (10/1/16 – 06/30/17)
No entry. The Medi-cal Access Program (MCAP) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns G and M, Line 46 minus Line 57 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 88 percent to determine FFP for SD/MC Affordable Care Act (ACA) direct services and is populated in Columns G and J. Column J is equal to Column G minus Column I. Column O calculates the State General Fund portion of payments to counties. It determines the non-federal share of the net reimbursement for services provided under CCR to beneficiaries enrolled in MCAP aid codes. The cell is automatically populated from the MH1966's amd MH1968.

Line 27 – Total SD/MC Reimbursement (FFP)
No entry. The sum of Lines J7, J13, J14, J15, J16, J17, J18, J19, J20, J21, J22 J23, J24, J25, J25A and J26.

Line 28 – Medi-Cal for All Children (SB75)
No entry. The Medi-Cal for all Children (SB75) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns G and M, Line 37 minus Line 56 of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by 100 percent in column K to determine FFP for SD/MC Medi-Cal for All Children (SB75) direct services and is populated in Columns K. Column K is equal to Column D.

MH 1979B

Total Certified Public Expenditures (CPE)

The purpose of the MH 1979B is to determine total certified public expenditures for the county and its contract providers for SD/MC direct services reimbursement (FFP and State Match) for inpatient and outpatient services as well as MAA reimbursement

Line 1 – Medi-Cal Administrative Reimbursement

No entry**.** The Medi-Cal Administrative Reimbursement, Column A is populated from MH 1979 Line 7, Column D. Column C is the total of Columns A and B. Column E is the product of Column A and C.

Column D

No entry. The FMAP percentage in Column D, Line 1 Medi-Cal Administrative Reimbursement is part of the worksheet.

Line 2 – SD/MC Enhanced (Children) Administrative Reimbursement

No entry**.** The SD/MC Enhanced (Children) Administrative Reimbursement, Column A is populated from MH 1979 Line 13, Column D. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D

No entry. The FMAP percentage in Column D, Line 2, SD/MC Enhanced (Children) Administrative Reimbursement is part of the worksheet.

Line 3 – Medi-Cal Administrative Activities (Service Functions 01 – 09)

No entry**.** The Medi-Cal Administrative Activities (Functions 01 -09), Column A is populated from MH 1979 Line 14. Column B is populated from of MH1963, Column N, Line 51. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D, Line 3

No entry. The FMAP percentage in Column D, Line 3 for Medi-Cal Administrative Activities (Service Functions 01-09) is part of the worksheet.

Line 4 – Medi-Cal Administrative Activities (Service Functions 11- 19, 31-39)

No entry**.** The Medi-Cal Administrative Activities (Service Functions 11-19, 31-39), Column A is populated from MH 1979 Line 15, Column D. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D, FMAP

No entry. The FMAP percentage in Column D, Line 4 for Medi-Cal Administrative Activities (Service Functions 11-39, 31-39) is part of the worksheet.

Line 5 – Medi-Cal Administrative Activities (Service Functions (21-29)
No entry**.** The Medi-Cal Administrative Activities (Service Functions 21-29), Column A is populated from MH 1979 Line 16, Column D. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 5 for Medi-Cal Administrative Activities (Service Function 21-29) is part of the worksheet.

Line 6 – Utilization Review Skilled Professional Medical Personnel (SPMP)
No entry**.** The Utilization Review Skilled Professional Medical Personnel (SPMP), Column A is populated from MH 1979 Line 17, Column D. Column C is the total of Columns A and B. Column E is the product of Column C and D

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 6 for Utilization Review Skilled Professional Medical Personnel (SPMP) is part of the worksheet.

Line 7 – Other SD/MC Utilization Review
No entry**.** The Utilization Review Skilled Professional Medical Personnel (SPMP), Column A is populated from MH 1979 Line 18, Column D. Column C is the total of Columns A and B. Column E is the product of Column C and D

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 7 for Other SD/MC Utilization Review is part of the worksheet.

Line 8 – SD/MC Net Reimbursement for Direct Services
No entry**.** The SD/MC Net reimbursement for direct services Column A is populated from MH 1979 Line 19, Column D. Column B is populated from MH 1963 Line 51 Column E. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 8 for SD/MC Net Reimbursement for Direct Services is part of the worksheet.

Line 9 – Enhanced SD/MC Net Reimbursement (Children) E2, E4, E5
No entry**.** The Enhanced SD/MC Net reimbursement (Children) E2, E4, E5 Column A is populated from MH 1979 Line 20, Column D. Column B is populated from MH 1963 line 51, Column F. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 9 for Enhanced SD/MC Net Reimbursement (Children) E2, E4, E5 is part of the worksheet.

Line 10 – Enhanced SD/MC Net Reimbursement (Children)
No entry**.** The Enhanced SD/MC Net reimbursement (Children) Column A is populated from MH 1979 Line 21, Column D. Column B is populated from MH 1963 line 51, Column G. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 10 for Enhanced SD/MC Net Reimbursement (Children) is part of the worksheet.

Line 11 – Enhanced SD/MC Net Reimbursement (BCCTP)
No entry**.** The Enhanced SD/MC Net reimbursement (BCCTP) Column A is populated from MH 1979 Line 22, Column D. Column B is populated from MH1963, line 51 Column H. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 11 for Enhanced SD/MC Net Reimbursement (BCCTP) is part of the worksheet.

Line 12 – Enhanced SD/MC Net Reimbursement (Pregnancy)
No entry**.** The Enhanced SD/MC Net reimbursement (Pregnancy) Column A is populated from MH 1979 Line 23, Column D. Column B is populated from MH1963, line 51, Column I. Column C is the total of Columns A and B. Column E is the product of Column C and D.

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 12 for Enhanced SD/MC Net Reimbursement (Pregnancy) is part of the worksheet.

Line 13 – Enhanced SD/MC Net Reimbursement (Refugees)
No entry**.** The Enhanced SD/MC Net reimbursement (Refugees) Column A is populated from MH 1979 Line 24, Column D. Column B is populated from MH1963, line 51, Column J. Column C is the total of Columns A and B. Column E is the product of Column C and D

Column D, FMAP
No entry. The FMAP percentage in Column D, Line 13 for Enhanced SD/MC Net Reimbursement (Refugees) is part of the worksheet.

Line 14 – Affordable Care Act (Net Reimbursement (ACA)
No entry**.** The Enhanced SD/MC Net reimbursement (ACA) Column A is populated from MH 1979 Line 25, Column D. Column B is populated from MH1963, line 51, Column L . Column C is the total of Columns A and B. Column E is the product of Column C and D

Column D, No FFP
No entry. The FMAP percentage in Column D, Line 14 for Enhanced SD/MC Net reimbursement (ACA) is part of the worksheet.

Line 15 – Affordable Care Act (Net Reimbursement (ACA)
No entry**.** The Enhanced SD/MC Net reimbursement (ACA) Column A is populated from MH 1979 Line 25A, Column D. Column B is populated from MH1963, line 51, Column M . Column C is the total of Columns A and B. Column E is the product of Column C and D

Column D, No FFP
No entry. The FMAP percentage in Column D, Line 15 for Enhanced SD/MC Net reimbursement (ACA) is part of the worksheet.

Line 16 Medi-Cal Access Program (MCAP) Net Reimbursement
No entry**.** The Medi-Cal Access Program (MCAP) Net reimbursement Column A is populated from MH 1979 Line 26, Column D. Column B is populated from MH1963, line 51, Column K. Column C is the total of Columns A and B. Column E is the product of Column C and D

Line 17, Column A – Total Short/Doyle Medi-Cal Reimbursement
No entry. The sum of lines 1 through 16, Column A populates line 17.

Line 17, Column B – Total Short/Doyle Medi-Cal Reimbursement
No entry. The sum of lines 1 through 16, Column B populates line 17.

Line 17, Column C – Total Short/Doyle Medi-Cal Reimbursement
No entry. The sum of line17, Column A and B populates line 17, Column C.

Line 17, Column E – Total Short/Doyle Medi-Cal Reimbursement
No entry. The sum of lines 1 through 16, Column E populates line 17.

Line 18 Affordable Care Act (5% SGF)
No entry**.** The Affordable Care Act, Column A is populated from MH 1979 Line 25A, Column D. Column B is populated from MH1963, line 51, Column M. Column C is the total of Columns A and B. Column E is 5% of Column C.

Line 19 Continuum of Care Reform Administration
No entry**.** The Continuum of Care Reform Administration, Column A is populated from MH 1979 Line 26, Column D. Column C is the total of Columns A. Column E is 50% of Column C.

Line 20 Medi-Cal for All Chiledren (SB75)
No entry**.** The Medi-Cal for ALL Children, Column A is populated from MH 1979 Line 28, Column D. Column C is the total of Columns A and B. Column E is 100% of Column C.

Line 21, Column A Total for all State General Fund Reimbursement
No entry**.** The sum of lines 18 through 20, Column A automatically populates line 21, Columns A.

Line 21, Column B Total State General Fund Reimbursement
No entry**.** The sum of lines 18 through 20, Column B automatically populates line 21, Column B.

Line 21, Column C Total State General Fund Reimbursement
No entry. The sum of line 21, Column A and B populates line 21, Column C.

Line 21 Column E Total Healthy Families Reimbursement
No entry**.** The sum of lines 18 and 20, Column E populates line 21, Column E.

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 33, 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 I 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 – Federal IDEA Funds
Enter revenues expended from federal idea funds for appropriate modes of service.

Line 12 – 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 13 – 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 J, Lines 6 and 18. Column B is equal to the sum of MH 1979, Column J, Lines 16 and17.

Column C, Line 13 is populated from the MH1968, Column K as follows:
The difference of Affordable Care Act (ACA) Gross Cost Reimbursement 07/01/16-12/31/16) and ACA Revenue (07/01/16-12/31/16) (MH1968 K25-K49) multiplied by 100 percent plus the difference of Affordable Care Gross Reimbursement (01/01/17-06/30/17) and ACA Revenue(01/01/17-06/30/17) (MH1968 K29-K50) multiplied by 95 percent plusTotal SD/MC plus Crossover Reimbursement and Medi-Medi Crossover Revenue (MH1968 K9-K44) multiplied by 50 percent plus the sum of the difference of Enhanced SD/MC Children Gross Cost Reimbursement and SD/MC Children Revenue (MH1968 K13-K45) multiplied by 88 percent plus the difference of Enhanced SD/MC (BCCTP) Gross Reimbursement and Enhanced SD/MC (BCCTP) Revenue (MH1968 K17-K46) multiplied by 65 percent plus the difference of Enhanced SD/MC (Pregnancy) Gross Reimbursement and Enhanced SD/MC (Pregnancy) Revenue (MH1968 K21-K47) multiplied by 65 percent plus the sum of the difference of Enhanced SD/MC (Refugees) Gross Reimbursement and Enhanced SD/MC (Refugees) Revenue (K38-K48) multiplied by 100 percent plus the adjustment to FFP for Mode 05-Other Hospital Inpatient on the MH1900_Info (B59) plus the difference of MCAP Gross Reimbursement and MCAP Revenue (MH1968 K42-K52) multiplied by 88 percent.

Columns D Line 13 is populated from MH1968, Column L as follows:
The sum of the difference of Affordable Care Act (ACA) Gross Cost Reimbursement and ACA Revenue (07/01/16-12/31/16) (MH1968 L25-L49) multiplied by 100 percent plus plus the difference of Affordable Care Gross Reimbursement (01/01/17-06/30/17) and ACA Revenue(01/01/17-06/30/17) (MH1968 L29-L50 multiplied by 95 percent plus the difference of Total SD/MC plus Crossover Reimbursement and Medi-Medi Crossover Revenue (MH1968 L9-L44) multiplied by 50 percent plus the difference of Enhanced SD/MC Children Gross Cost Reimbursement first period and SD/MC Children Revenue first period (MH1968 L13-L45) multiplied by 88 percent plus the sum of the difference of Enhanced SD/MC (BCCTP) Gross

Reimbursement and Enhanced SD/MC (BCCTP) Revenue (MH1968 L17-46) multiplied by 65 percent plus the sum of the difference of Enhanced SD/MC (Pregnancy) Gross Reimbursement and Enhanced SD/MC (Pregnancy) Revenue (MH1968 L21-L47) multiplied by 65 percent plus the sum of the difference of Enhanced SD/MC (Refugees) Gross Reimbursement and Enhanced SD/MC (Refugees) Revenue (L38-L48) multiplied by the adjustment to FFP for Mode 05-Other 24 Hour Services on the MH1900_Info (B60) plus the difference of MCAP Gross Reimbursement and MCAP Revenue (MH1968 L42-L52) multiplied by 88 percent.

Column E, Line 13 is populated from the MH 1968, Column M as follows:
The difference of Affordable Care Act (ACA) Gross Cost Reimbursement and ACA Revenue (07/01/16-12/31/16) (MH1968 M25-M49) multiplied by 100 percent plus the difference of Affordable Care Act (ACA) Gross Cost Reimbursement and ACA Revenue (01/01/17-06/30/17) (MH1968 M29-M50) multiplied by 95 percent plus the sum of the difference of Total SD/MC plus Crossover Reimbursement and Medi-Medi Crossover Revenue (MH1968 M9-M44) multiplied by 50 percent plus the sum of the difference of Enhanced SD/MC Children Gross Cost Reimbursement first period and SD/MC Children Revenue E2, E4, E5 (MH1968 M13-M45) multiplied by 88 percent plus the difference of Enhanced SD/MC (BCCTP) Gross Reimbursement and Enhanced SD/MC (BCCTP) Revenue (MH1968 M17-M46) multiplied by 65 percent plus the sum of the difference of Enhanced SD/MC (Pregnancy) Gross Reimbursement and Enhanced SD/MC (Pregnancy) Revenue (MH1968 M21-M47) multiplied by 65 percent plus the sum of the difference of Enhanced SD/MC (Refugees) Gross Reimbursement and Enhanced SD/MC (Refugees) Revenue (M38-M48) multiplied by the adjustment to FFP for Mode 10 Day Services on the MH1900_Info (B61) plus the difference of MCAP Gross Reimbursement and MCAP Revenue (MH1968 M42-M52) multiplied by 88 percent.

Column F, Line 13 is populated from the MH 1968, Columns N and P as follows:
The sum of the difference of Affordable Care Act (ACA) Gross Cost Reimbursement and ACA Revenue for Mode 15 Program 1 (07/01/16-12/31/16) (MH1968 N25-N49) multiplied by 100 percent plus and the difference of ACA Gross Cost Reimbursement and ACA Revenue for Program 1 (01/01/17-06/30/17) (MH1968 N29-N50)multiplied by 95 percent plus the difference of Total SD/MC plus Crossover Reimbursement and Medi-Medi Crossover Revenue for Program 1 (MH1968 N9-N44) multiplied by 50 percent plus the difference of Enhanced SD/MC Children Gross Cost Reimbursement first period and SD/MC Children Revenue first period for Program 1 (MH1968 N13-N45) multiplied by 65 percent plus the difference of Enhanced SD/MC (BCCTP) Gross Reimbursement and Enhanced SD/MC (BCCTP) Revenue for Program 1 (MH1968 N17-N46) multiplied by 65 percent plus the difference of Enhanced SD/MC (Pregnancy) Gross Reimbursement and Enhanced SD/MC (Pregnancy) Revenue for Program 1 (MH1968 N21-47) multiplied by 65 percent plus the sum of the difference of Enhanced SD/MC (Refugees) Gross Reimbursement and Enhanced SD/MC (Refugees) Revenue for Program 1 (N38-N48)) plus the difference of MCAP Gross Reimbursement and MCAP Revenue (MH1968 N42-N52) multiplied by 88 percent plus the sum of the difference of Affordable Care Act (ACA) Gross Cost Reimbursement and ACA Revenue for Mode 15 Program 2 (07/01/16-12/31/16) (MH1968 P25-N49) multiplied by 100 percent plus and the

difference of ACA Gross Cost Reimbursement and ACA Revenue for Program 1 (01/01/17-06/30/17) (MH1968 P29-P50) multiplied by 95 percent plus the difference of Total SD/MC plus Crossover Reimbursement and Medi-Medi Crossover Revenue for Program 2 (MH1968 P9-P44) multiplied by 50 percent plus of the difference of Enhanced SD/MC Children Gross Cost Reimbursement first period and SD/MC Children Revenue first period for Program 2 (MH1968 P13-P45) multiplied by 88 percent plus the difference of Enhanced SD/MC (BCCTP) Gross Reimbursement and Enhanced SD/MC (BCCTP) Revenue for Program 2 (MH1968 P17-P46) multiplied by 65 percent plus the the difference of Enhanced SD/MC (Pregnancy) Gross Reimbursement and Enhanced SD/MC (Pregnancy) Revenue for Program 2 (MH1968 P21-P47 multiplied by 65 percent plus the difference of Enhanced SD/MC (Refugees) Gross Reimbursement and Enhanced SD/MC (Refugees) Revenue for Program 2 (MH1968 P38-P48) multiplied by 100% and the adjustment to FFP for Mode 15 Day Services on the MH1900_Info (B62) plus the difference of MCAP Gross Reimbursement and MCAP Revenue (MH1968 P42-P52) multiplied by 88 percent.

Column H is equal to the sum of Lines 13, 14, and 15, Column J, from the MH1979.

Column J is equal to the sum of Columns A through I.

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 16.

Line 16 – Other Revenue
Enter all other revenues expended including AB100 distributions for Managed Care and Educationally Related Mental Services (ERMS) that are not reported on Lines 4 through 16. AB100 funds are not subject to repayment. Please do not report AB100 funding on Line 21 as MHSA.

Line 17 – 15-16 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 18 – 2011 Realignment
Enter amount expended per realignment funding. 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 Health Care Services, and services provided through the Low Income Health Program (LIHP)

Line 19 – 1991 Realignment/MOE
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 Health Care Services, and services provided through the Low Income Health Program (LIHP).

Line 20 – Prior Years MHSA
No entry.

Line 21 – MHSA
Enter amount expended per MHSA funding, including MHSA funds used to match FFP under the SD/MC program for each applicable Mode of Services. Please exclude amount expended on services provided through the Low Income Health Program (LIHP).

Line 22 – County Overmatch
Enter county overmatch funds the county contributes over the percentage amounts prescribed by law for each applicable Mode of Service.

Line 23 – CalWORKS
Enter the county CalWORKS funds used for mental health services for each applicable Mode of Service.

Line 24 – 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 applicable Mode of Service mode of service.

Line 25 – LIHP Match (MHSA): Please enter amount expended on services provided through the Low Income Health Program (LIHP) per MHSA funding for each applicable Mode of Service

Line 26 – 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 for each applicable Mode of Service

Line 27 – State General Fund
No entries. Column A, Line 27, is the Total State General Fund (SGF) of the Continuum of Care Reform Administration on MH1979, Column O Line 18. Column F is the Total SGF of the SD/MC Net Reimbursement for Direct Services, Enhanced SD/MC Children, BCCTP, Pregnancy, ACA (First Period) and MCAP programs on MH1979, Colum O Lines 19-23 and 25A and 26.

Line 28 – SB 75 Revenue – 07/01/16- 06/30/17
Please enter the amount expended on services provided through the Medi-Cal for All Programs SB75 Revenue for each applicable Mode of Service

Line 29 – Affordable Care Act (5% SGF) – 01/01/17- 06/30/17
Please enter the amount expended on services provided through the ACA Programs for the 5% State General Fund for each applicable Mode of Service

Line 30 – Total Funding Sources
No entry. This line sums Lines 8 through 28 for Columns A through I. Amount in Column J, Line 29, should equal amount in Column J, Line 3. Any difference between the amounts should be corrected before submitting the cost report.

Line 31 – LIHP Waiver Match (Other) Description
Please enter amount expended on services provided through the Low Income Health Program (LIHP) Waiver Match (other) per MHSA funding for each applicable Mode of Service.

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 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 – SMA Rate
No entry. SMA Rate for FY 2016-17 is provided.

Column C – Period of Service
No entry. Period of services is provided.

Column D – 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 MH 1901 Schedule B for Mode 05, Service Function 19.

Column E – Subtotal Amount
No entry. This is the result of Column B multiplied by Column D.

Column F – 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 G – 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 H – Total Amount
No entry. This is the sum of Columns E, F, and G for each period and settlement group.

COST REPORT TEMPLATES AND NAMING CONVENTION

SUBMITTAL FILE TO DHCS

Introduction

The FY2016-2017 Cost Report packaging, naming conventions, automated desk edits, error correction cycle, and submittal process to DHCS are described in this section.

The cost report will be distributed to the counties via the DHCS Information Technology Web Server (ITWS). Counties are required to download the appropriate cost report template(s) from ITWS and distribute the template(s) to their contract provider legal entities by any method that will not change the electronic format of the template(s). The contract provider legal entities, after the completion of their cost reports, must return them to their county for review, verification, and approval. The counties are required to package these cost reports and submit the package" to DHCS through the ITWS electronic submission process

COST REPORT FILES

The cost report files for this year remain an Excel based spreadsheet application. There will be two sets of Cost Report spreadsheet automations:

1. A Detail Cost Report for Legal Entities (contract or county), Medi-Cal and Non-Medi-Cal; and
2. A Summary Cost Report for each county or local mental health agency linking information from all legal entities.

SUBMITTAL FILE

The county Submittal File is the "package" that the county submits to DHCS. The completed detail cost reports and the summary county cost report are combined into a single "package" called a "submittal file". This packaging is completed through an archiving process called zipping. (Zipping gets its name from a product, or multitude of products, which combine files, called PKZIP. Further description and product information can be found at http://www.pkware.com and/or your local county information technology group.)

The submittal file (zipped file) is uploaded (submitted) to DHCS ITWS. The name of the submittal file must conform to the submittal file naming conventions. See the sections on File Naming Conventions. Files not conforming to the specified naming conventions cannot be processed by DHCS.

Step 1. Logon to ITWS

- This requires enrollment to ITWS and permission to access the Cost and Financial Reporting System (CFRS). We also recommend that you request permission to access the Provider / Legal Entity System.

Step 2. Download the Cost Report Template(s)

- The Detail Cost Report Template is: CFRS_20142015_CC99999X_Detail_Template.xls
- The Summary Cost Report Template is: CFRS_20142015_CC00000X_Summary_Template.xls

NOTE: There may be additional information attached to the names of these file to describe the versions that are currently being used. Please download the most recent version of these files; i.e.,

Step 3. Rename and complete the Cost Report(s)

- RENAME and CREATE a COPY of the Detail Cost Report Template for:
  - 1 for EACH Contract Provider Legal Entity
  - 1 for the County Legal Entity
- RENAME and CREATE a COPY of the Summary Cost Report Template for:
  - 1 for The County Only
- Complete these cost reports according to the instructions in the manual.

Step 4. ZIP ALL excel.xls and create Submittal File

- ALL cost report files (.xls) must be Zipped together into a submittal file (.zip). This ZIP file is also called an archive. Use the ZIP utility (i.e., PKZIP) to accomplish this.
- Note, you must create the name of this submittal file according to the naming conventions specified in this section.

Step 5. Upload/Submit the Cost Report package to ITWS

- Logon to ITWS (ITWS.dhcs.ca.gov) and go to the CFRS system.
- Select FUNCTIONS > UPLOAD, and specify the name of the submittal file that was created from the ZIP step for submission to DHCS.
- ITWS will return a confirmation message stating a successful upload process.
- You and CRFS will also receive an email notification stating that the file has been successfully received by DHCS.
- The email will entail specific information regarding your email, and also an accompanying Upload ID number, which indicates this file in the CFRS system. Please note this Upload ID number for further notices and reports.

Step 6. Automated DHCS Desk Edits

- DHCS will automatically process the Submittal ZIP file and perform the automated desk edits on the cost reports.
- You will receive an email stating that the file has been processed through the automated desk edits. The results of the automated desk edits will be attached. The attached RESULTS FILE is a TEXT file and will be named according to the submittal file that was uploaded. The name of the RESULTS FILE will include the Upload ID number that was assigned when the submittal file was received by DHCS.
- You can also logon to ITWS to review the RESULTS text file. Use the Upload ID number assigned to the submittal file to find the appropriate RESULTS text file.

Step 7. Review the Results File

- The Results File will include any processing errors found by the automated Desk Edit for all Detail Cost Reports and the Summary Cost Report.

Step 8. Correct any errors

- The county corrects the errors listed in the Results File.
- After corrections to the cost reports are completed, ALL cost report files (.xls) must again be Zipped together into a submittal file (.zip), see Step 4. The submittal file (zipped file) is uploaded to DHCS ITWS, see Step 5.

Step 9. Repeat Step 4 through Step 8 until the Results File contains no errors.

Step 10. Finished

NOTE: After completing Step 5, the Upload/Submit step, the accompanying email that you receive specifies the Upload ID number of the submittal file. This Upload ID number must be used on the MH1940 that is sent to DHCS. It is the “binding” number, which details when your cost report is actually received by DHCS. You must submit one hard copy of the cost report (summary and county detail only) and an original signed MH 1940 certification package to DHCS within 10 (ten) business days of the first submission of your cost report.

Cost Report Template Files

The FY 2015-2016 Cost Report Templates are downloaded by the county from DHCS ITWS. Remember, there are two templates:

- A template for the Detail Cost Report. RENAME and create a COPY of the Detail Cost Report template for EACH Legal Entity (contract or county), Medi-Cal and Non-Medi-Cal. Name the files according to the naming conventions specified in this section.

- A template for the Summary Cost Report. RENAME and create a copy of the Summary Cost Report template. Name the file according to the naming conventions specified in this section. The Summary Cost Report is to be completed by the County Only.

These files are located on ITWS have the following name:

- CFRS_20152016_CC99999X.XLS_Detail_Template.XLS
  - This is the Detail Cost Report.
  - The '99999' will be replaced by the number associated with the Legal Entity.
- CFRS_20152016_CC00000X.XLS_Summary_Template.XLS
  - This is the Summary Cost Report
  - The '00000' denotes a Summary Cost Report. It must remain as '00000' as it indicates the Summary Cost Report to be complete by the County.

NOTE: These files reflect a version number that is used internally when creating the Cost Reports. These files are the templates to be used for completing the Cost Reports, and the versions and names are for identification purposes.

File Naming Conventions – Detail Cost Report(s)

All naming conventions for DETAIL Cost Reports follow this format:

CFRS_20152016_*CC99999X*.XLS

Where:

CC	County Code - Two digit code
99999	5 digit number which identifies the legal entity # of the cost report for which the file is being submitted. Check your Legal Entity file for correct Legal Entity numbers of your providers that you are using.
X	"B" for Initial Image (i.e., "B"efore settlement, so this is your initial submission to ITWS until desk edits are complete) "F"inal Settlement, (i.e., after any SD/MC adjustments) "Z" for Audits, "T" for Test files and/or DMH use.

LEGAL ENTITY NUMBERS

Legal Entity numbers are assigned by DHCS by the type of Legal Entity they represent. These are essentially encoded with the 5-character Legal Entity numbering system of the Legal Entity File. Your 5-character Legal Entity numbers will resemble the following format. These are general rules and you should contact the DHCS Statistics and Data Analysis (SDA) group if you have further questions or problems about these designations.

00000	A Legal Entity number with 5 zeroes indicates that this is a Summary County Cost Report. This is very important!!!
000##	A Legal Entity number with 3 leading zeroes indicates that this is the County Legal Entity. Example, 00087 would indicate the County Legal Entity for County 87.
00F87	A Legal Entity number with 2 leading zeroes, then an “F” and a number, indicates that this is the FFS (Fee for Service) Legal Entity for the county. Example, 00F87 would indicate the FFS Legal Entity for County 87.
AFC##	A Legal Entity number with “AFC” as the preceding 3 characters indicates that this is an Administrative Services Organization (ASO) Legal Entity. The remaining 2 characters indicates that County Code. Example, AFC87 would indicate the ASO Legal Entity for County 87.
HFP##	A Legal Entity number with “HFP” as the preceding 3 characters indicates that this is a Healthy Families (Fee-For-Service) inpatient services and is used to claim all HFP inpatient services that occur in hospitals settings that would be fee-for-service if used for Medi-Cal children.
#####	Any other number is the 5-digit number which identifies the Legal Entity number. Check your Legal Entity File for correct Legal Entity numbers of the providers that you are using.

File Naming Conventions - Summary Cost Report

All naming conventions for the SUMMARY Cost Reports follow this format:

CFRS_20152016_*CC00000X*.XLS

Where:

CC	County Code – Two digit code
00000	5-zeroes. This must be specified.
X	"B" for Initial Image (i.e., "B"efore settlement, so this is your initial submission to ITWS until desk edits are complete) "F"inal Settlement, (i.e., after any SD/MC adjustments) "Z" for Audits, "T" for Test files and/or DHCS use.

File Naming Conventions - Submittal File

All naming conventions for **SUBMITTAL** Package follow this format:

CFRS_20152016_*CC_X_SUBMITTAL*.ZIP

Where:

CC	County Code – Two digit code
X	"B" for Initial Image (i.e., "B"efore settlement, so this is your initial submission to ITWS until desk edits are complete) "F"inal Settlement, (i.e., after any SD/MC adjustments) "Z" for Audits, "T" for Test files and/or DHCS use.

NOTE: If you need help using ZIP, or more formally known as PKZIP, please see http://www.pkware.com for instructions on using this and other ZIP products.

Further, when this file is uploaded to ITWS, it will be assigned an internal Upload ID (UpID) number. This UpID number will be referenced in all documentation regarding this file. You will also receive an email describing this and its newly renamed file.

Example:

1. **CFRS_20152016_87_B_SUBMITTAL.ZIP**

   The cost reports uploaded for a sample county 87. You will receive email confirmation of this submission, and it will entail the Upload ID that was assigned when this file was uploaded. This number will now be in the name of the file in your county directory on ITWS and all reference documentation regarding this upload will be specified.

2. **CFRS_20152016_87_B_7070_SUBMITTAL.ZIP**

This is how the file will look with the Upload ID specified as part of the renamed file. This will be automatically be done by DHCS and will look this way on ITWS.

Desk Edits Results File

After you have UPLOADED your Cost Report submittal file to ITWS, you will receive the following electronic communication from DHCS:

1. An instant notification from ITWS saying your file was successfully uploaded.
2. Also, you will receive an email notification in your Inbox stating that DHCS received your file as well.

In the meantime, DHCS will be processing your uploaded submittal file and when done, the following will happen:

1. Notify you via an email notification in your Inbox stating that DHCS has processed your file and the results of this process are available for viewing (or downloading) on ITWS.
2. Next, you need to Logon to ITWS to view the file and determine if the automated desk edit processing is successful or not.
3. If NOT, then make necessary corrections on your local copies of the cost reports, re-ZIP into a new Submittal File, and re-Upload to ITWS.
4. Cost report is not considered ACCEPTED, until all errors on both the detail and summary cost reports pass the automated edits.

The attached report file returned to you in the email will be named according to the following format. It will also be on ITWS with the same name as:

CFRS_20152016_CC_X_UPID_REPORT.TXT

Where:

CC	County Code – Two digit code
X	"B" for Initial Image (i.e., "B"efore settlement, so this is your initial submission to ITWS until desk edits are complete) "F"inal Settlement, (i.e., after any SD/MC adjustments) "Z" for Audits, "T" for Test files and/or DMH use.
UPID	Upload ID that was assigned when your submittal file was uploaded to ITWS.

Example:

CFRS_20152016_87_B_123456_REPORT.TXT

NOTE: This is a text document. Use Notepad or a similar product to open and read its content.

The Cost Report submission, editing and correction cycles will produce files of different types. These files may be Notification and Return Files, or possible Error files as well. These files are created by the DHCS Cost and Financial Reporting System (CFRS) and placed on the DHCS ITWS servers so the counties may download them, examine them, and determine if any corrective or continuing action needs to be taken. Also, any errors that they may have submitted in the Cost Report submission package will be listed here as well.

After a cost report has been submitted, the CFRS will process the submission package and will create the files on the ITWS server within one day after DHCS receives a CFRS submittal file.

File Naming Conventions – Samples

The Detail and Summary Cost Reports are built and named according to the naming conventions. Reminder, the Summary Cost Report contains the list of the Legal Entities that are being submitted as part of the Cost Report package.

This example would represent a sample of names for cost reports to be submitted as part of the submittal package to DHCS ITWS:

CFRS_20152016_8700000B.XLS	Summary County Cost Report for County 87. Notice all 0's (Zeroes) in the file name and only the County Code is present
CFRS_2015201_8700087B.XLS	Detail Cost Report for County 87 Legal Entity. Notice the 3 0's (Zeroes) in the file name and then the County Code is present.
CFRS_20152016_8700877B.XLS CFRS_20152016_8700887B.XLS CFRS_20152016_8700755B.XLS CFRS_20152016_8700205B.XLS CFRS_20152016_8700223B.XLS CFRS_20152016_8700227B.XLS CFRS_20152016_8700249B.XLS CFRS_20152016_8700269B.XLS CFRS_20152016_8700277B.XLS CFRS_20152016_8700279B.XLS	Detail Cost Report for Legal Entities by #. Notice the Legal Entity number is used here. " " " " " " " "

APPENDIX A

Please see the link below for FY2016-17 Aid Codes

http://www.dhcs.ca.gov/services/MH/Documents/FMORB/Aid_Code_Master_Chart_10-18-17.pdf