

**MH 1900****Information Worksheet**

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

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

**Section I: All Legal Entities**

Legal entities that provided SD/MC units of service during the reporting period should select the "Y" option to the question, "Are you reporting SD/MC?" Select option "N" if you are not reporting SD/MC units of services

**Section II: County Legal Entities Only**

Each county legal entity is required to respond to the question whether its population is more or less than 125,000. If the county's population is more than 125,000, select option "Y". Select option "N" if the county's population is less than or equal to 125,000.

County legal entities should report "Contract Provider Medi-Cal Direct Service Gross Reimbursement." The amounts reported here are used to populate the MH 1979, Line 2, Columns B and C, which are used to determine the Medi-Cal Administrative Reimbursement Limit. The amount to report is equal to the sum of MH 1968, Lines 9, 9A, 17, 17A, and 22, Columns E & K for all contract providers that reported Medi-Cal units on the MH 1901 Schedule B.

County legal entities should report "Contract provider enhanced (Children) Direct Service Gross Reimbursement." The amounts reported here are used to populate MH 1979, Line 14, Columns B and C, which are used to determine the Enhanced (Children) administrative reimbursement limit. The amount reported on these lines should equal the sum of MH 1968, lines 13 and 13A, Columns E & K for all contract providers that reported Medi-Cal units on the MH 1901 Schedule B.

County legal entities should report "Contract Provider Healthy Families Direct Service Gross Reimbursement." The amounts reported here are used to populate MH 1979, Line 8, Columns B and C, which are used to determine the Health Families Program administrative reimbursement limit. The amount reported on these lines should equal the sum of MH 1968, lines 27 and 27A, Columns E and K for all contract providers that reported Healthy Families units on the MH 1901 Schedule B.

In addition, county legal entities are required to enter the provider numbers for Fee-For-Service Mental Health Specialty individual and group providers.

Finally, county legal entities are required to make adjustments to Medi-Cal FFP for contract provider costs that have not been incurred by the county. To be eligible for FFP, the county mental health plan must first pay the contract provider one hundred percent of the cost of providing the service. Total payments for Medi-Cal reimbursable services are reported on the MH 1963 of the county's detail cost report. If the total county payments to a contract provider for Medi-Cal services as reported on the MH 1963, is not equal to or greater than the sum of lines 19, 20, 21, 24, 24A, 25, 25A, 26, and 26A, Column D of the contract providers MH 1979, the county mental health plan must enter an appropriate adjustment to FFP. The adjustment to FFP must equal the county's payments for Medi-Cal services less than the sum of lines 19, 20, 21, 24, 24A, 25, 25A, 26, and 26A, Column D of the contract provider's MH 1979 multiplied by the appropriate reimbursement percentage. The appropriate reimbursement percentage is equal to the sum of lines 19, 20, 21, 24, 24A, 25, 25A, 26, and 26A, Column J divided by the sum of lines 19, 20, 21, 24, 24A, 25, 25A, 26, and 26A, Column D of the contract provider's MH 1979.

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

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

**Column D – Published Charge (PC)**

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

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

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

**Column E, County Non-Medi-Cal Contract Rate**

Enter the non-Medi-Cal contract rates agreed to between the county and its service provider for Modes 45 and 60. 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 1966, MH 1968, and MH 1979. This worksheet identifies services according to “settlement type”, modes and service functions and the period of service. You should complete the MH 1991 if you report units of service for Mode 15, Service Function 19.

Total units of service and units allocated to SD/MC, Medicare/Medi-Cal Crossovers, Enhanced Medi-Cal, Medi-Cal Administrative Activities, and Healthy Families are accounted for here. Total units reported must equal the sum of Columns G, J, M, N, P, Q, S, U 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, ISA, CAW, and HOSP) in Column A. Settlement type identifies the method used to determine reimbursement limits due to the application of each program’s rules.

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

- match the invoiced units. Please contact your MAA Coordinator for additional participation requirements.
- **MHS** Mental Health Specialty (MHS) method of reimbursement is actual cost to the county. Counties are allowed to claim actual costs for payments made to Fee-For-Service individual or group providers for mental health specialty services.
  - **ISA** Integrated Service Agency (ISA) method of reimbursement is based on actual costs to the county for payments made to the providers of ISA services.
  - **CAW** California Work Opportunity and Responsibility to Kids (CalWORKS) program is to prepare clients for work and assist them to obtain and maintain employment so they can effectively support their families. Under CalWORKS, case aid to families is time-limited and able-bodied adults in the families must meet certain work requirements to remain eligible. County welfare departments under the supervision of California Department of Social Services administer this program.
  - **HOSP** Hospital (HOSP) services include mode 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 form MH 1960\_1. Please use this settlement type to separately identify units of service associated with costs reported on the form MH 1960\_1 for hospital providers.

Column B – Mode

Enter the mode of service.

Column C – Service Function

Enter the service function.

Column D – Total Units of Service

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

Column E – SD/MC Units (July 1, 2010 – September 30, 2010)

Enter the total regular SD/MC units of service for each Medi-Cal service function for the period 07/1/10 through 09/30/10. Do not include Medicare/Medi-Cal crossover units or enhanced SD/MC units here.

Column F – SD/MC Units (October 1, 2010 – June 30, 2011)

Enter the total regular SD/MC units of service for each Medi-Cal service function for the period 10/1/10 through 06/30/11. Do not include Medicare/Medi-Cal crossover units or enhanced SD/MC units here.

Column G – Total SD/MC Units

No entry. This column sums Columns E and F.

Column H – Medicare/Medi-Cal Crossover Units (July 1, 2010 – September 30, 2010)

Enter the Medicare/Medi-Cal Crossover units by service function for the period 07/01/10 – 09/30/10.

Column I – Medicare/Medi-Cal Crossover Units (October 1, 2010 – June 30, 2010)

Enter the Medicare/Medi-Cal Crossover units by service function for the period 10/01/10 – 06/30/11.

Column J – Total Medicare/Medi-Cal Crossover Units

No entry. This column sums Columns H and I.

Columns K & L – Medi-Cal Patient and Other Payor Revenue (July 1, 2010 – September 30, 2010)

In Column K, enter the third party revenue received by the agency and attributed to regular SD/MC and Medicare/Medi-Cal crossover units of service for the period July 1, 2010 – September 30, 2010. In Column L, 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 October 1, 2010 – June 30, 2011.

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

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

Column M – Units of Service for Enhanced SD/MC – Children (July 1, 2010 – September 30, 2010)

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

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

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

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

Enter 3<sup>rd</sup> party revenue for enhanced SD/MC – Children services for the entire year. See Columns K & L for more information.

Column P – Units of Service for Enhanced SD/MC – BCCTP (July 1, 2010 – September 30, 2010)

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

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

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

Column R – 3<sup>rd</sup> Party Revenue Enhanced SD/MC – BCCTP

Enter 3<sup>rd</sup> party revenue collections for Enhanced SD/MC – BCCTP services for the entire year. See Columns K & L for more information.

Column S – Units of Service for Enhanced SD/MC – Refugees

Enter units of service for each service function for Enhanced SD/MC – refugees for the entire year.

Column T – 3<sup>rd</sup> Party Revenue Enhanced SD/MC – Refugees

Enter 3<sup>rd</sup> party revenue collections for refugees for the entire year. See Columns K & L for more information.

Column U – Units of Service for Healthy Families – SED (July 1, 2010 – September 30, 2010)

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

Column V – Units of Service for Health Families – SED (October 1, 2010 – June 30, 2011)

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

Column W – 3<sup>rd</sup> Party Revenue Healthy Families – SED

Enter 3<sup>rd</sup> party revenue collections for Health Families – SED for the entire year. See Columns K & L for more information.

Column X – Non-Medi-Cal Units

No entry. This column calculates the total units less all SD/MC and Healthy Families units. Column X equals Column D less Columns G, J, M, N, P, Q, S, U, and V. If the sum of columns G, J, M, N, P, Q, S, U, and V is greater than Column D, Column X 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 32, Column J of the MH 1960. The Settlement Type, Mode, Service Function, and Total Units are automatically populated from MH 1901 Schedule B. 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 above will allow the distribution of mode costs to modes and service functions. For example, if the user selects SMA Rate as an allocation option from the Allocation Box, this worksheet will perform a relative value calculation using information from MH 1901 Schedule A to allocate mode costs to modes and service functions on MH 1966, Program 1 or 2.

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

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

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

**2. Time Study**

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

**3. Relative Value**

Units of service/time multiplied by the legal entity's charge for each service function determines the relative value assigned to each service function. A legal entity's charge for each service function is: 1) the legal entity's published charge; 2) the legal entity's usual and customary charge; or 3) the legal entity's charge to the general public for providing services. The SMA rate for each service function may be substituted for the legal entity's charge. The relative value for each service function is divided by the sum of all relative values to determine the percentage of the total for each service function. This method should be used by legal entities whose charges are established and updated annually based on the

costs of providing the service. The relative value method may not be used to allocate Mode 05, Service Functions 10 through 19, service costs according to the Department's Fiscal Audits Unit.

**Allocation Method Option Box – Select an Allocation Method**

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

**Column A – Settlement Type**

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

**Column B – Mode**

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

**Column C – Service Function**

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

**Column D – Total Units**

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

**Column E – Eligible Direct Cost**

Enter costs associated with TBS, ASO, MHS, ISA, 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, ISA, MHS AND CAW.

**Column G – Relative Value**

No entry. This column computes the relative value using the selected allocation base. Relative value is the product of multiplying the rate for allocation, SMA, or published charge by the service function total units of service. For example, if published charges

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.

**Column H – Allocation Percentage**

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

**Column I – Allocated Costs**

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

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

The purpose of the form MH 1960 is to determine the legal entity's allowable costs applicable to the following cost objectives: 1) administration, utilization review, research and evaluation, and modes of service. The purpose of lines 1 – 27 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 cost objective, and costs that are not readily assignable to the cost objective specifically benefitted without effort disproportionate to the results achieved. The purpose of lines 22 – 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. Counties should enter cost data in Columns A and B directly from their Trial Balance. The designation of costs as direct and indirect should be consistent with the county's indirect cost rate plan (ICRP) as approved by the Federal government. Report costs on the line that is most appropriate given the definitions below

**Indirect Cost Centers**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Line 21 - 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**

**Lines 22 – 26 – Administrative Costs (County Only):** County legal entities should report administrative costs on lines 23, 24, 25, and 26. 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 Information Notice 10-xy for guidance regarding costs that may be directly allocated to administration. Administrative costs should be apportioned between line 23 (Short-Doyle Medi-Cal – Other), line 24 (Health Families Program), line 25 (M-CHIP), and line 26 (non-Medi-Cal) using one of the following three methods:

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

**Lines 27 - 30 – Utilization Review Costs (County Only):** County legal entities should report utilization review costs on lines 28 – 30. Skilled Professional Medical Personnel costs should be reported on line 28, Other SD/MC Utilization Review on line 29, and non-SD/MC Utilization Review on line 30. The amount reported on line 28 is reimbursed at the enhanced rate of 75%. Documentation supporting the amount on line 28 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 31 – Research and Evaluation (County Only):** County legal entities should enter research and evaluation costs on line 31. Research includes costs for centralized activities under the direction of the Local Mental Health Director designed to increase the scientific knowledge and understanding of the nature, cause, prevention, and treatment of mental, emotional, or behavioral disorders. Evaluation includes the cost of scientific studies regarding the effectiveness and efficiency of specific mental health programs in which goals are clearly defined and achieved in measurable terms. Line 31 should not include Medi-Cal reimbursable costs. Costs of studies, analyses, surveys, and related activities aimed at improving and making provider administration and operation more efficient are not considered research costs and should not be reported on line 31.

**Line 32 – Mode Costs (Direct Service and MAA):** All legal entities must enter the direct service and MAA costs on line 30. Direct service and MAA costs include all direct costs of providing mental health services and Medi-Cal Administrative Activities.

**Line 33 – Total Costs:** Line 33 sums the costs entered in lines 23-26, 28-30, 31, and 32.

**Column A –** Please enter the salary and benefit costs accumulated in each indirect cost center and direct cost center listed in lines 1-30.

**Column B –** Please enter all costs other than salary and benefit costs accumulated in each indirect cost center and direct cost center listed in lines 1-30.

**Column C –** No entry. This column calculates the sum of Columns A and B for each cost center listed in lines 1-30.

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

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

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

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

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

**Column I, Lines 1 – 21** – No entry. This column converts the amount in Column H to a negative number.

**Column I, Lines 23 – 30** – Please enter the amount allocated to each direct cost center from the indirect cost centers.

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

**MH 1960\_1****Calculation of Program Costs – Hospital Legal Entities**

The purpose of the form MH 1960\_1 is to determine the hospital legal entity's reasonable and allowable costs applicable for providing psychiatric inpatient hospital services (mode 05), day services (mode 10), and/or outpatient services (mode 15). A hospital legal entity must first complete the CMS 2552-96, Hospital and Hospital Health Care Complex Medicare or Medi-Cal cost report. A hospital that does not submit a CMS 2552-96 to CMS and/or DHCS must at least complete worksheets A, A6, A7, A8, A8-2, A8-4, and worksheet B, Part I of the CMS 2552-96.

**Column A – Costs per W/S B, Part I**

Please enter the costs from the CMS-2552-96, Worksheet B, Part I, Column 27 for all cost centers.

**Column B – Physician Costs per W/S A-8, Line 12**

Please enter the hospitals costs for physician services that were reclassified on line 12 of the CMS 2552-6, Worksheet A-8 or the mental plan enters specialty mental health physician costs from its own record since SMHS reimbursement is an all inclusive per diem rate.

**Column C – 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 2552-96.

**Column D – Total Costs**

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

**Column E – Total Days/Charges**

Please enter total inpatient days (acute and administrative) for each routine cost center and total charges for each ancillary cost center and each outpatient cost center from the hospital's records.

**Columns F – 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 and outpatient cost center to calculate the cost to charge ratio.

**Column G – Mode 05 SMHS Days/Charges/RVU**

Please enter total acute psychiatric inpatient hospital days and associated administrative days for each routine cost center and total acute psychiatric inpatient hospital charges, including charges for associated administrative days, for each ancillary and outpatient cost center. The hospital may enter an RVU for each ancillary and outpatient cost center if the RVU has been approved by CMS and DHCS.

**Column H – Mode 05 SMHS Costs**

No entry. This column calculates the product of Columns F and G.

**Column I – Mode 10 SMHS Charges/RVU**

Please enter total charges for specialty mental health day services for each ancillary and outpatient cost center. The hospital may enter an RVU for each ancillary and outpatient cost center if the RVU has been approved by CMS and DHCS.

**Column J – Mode 10 SMHS Costs**

No Entry. This column calculates the product of Columns F and I.

**Column K – Mode 15 SMHS Charges/RVU**

Please enter total charges for specialty mental health outpatient services for each ancillary and outpatient cost center. The hospital may enter an RVU for each ancillary and outpatient cost center if the RVU has been approved by CMS and DHCS.

**Column L – Mode 15 Costs**

No entry. This column calculates the product of Columns F and K.

**MH 1960\_2****Supporting Documentation for the Allocation of Medi-Cal Mental Health Hospital Costs to Modes and Service Functions**

The purpose of the form MH 1960\_2 is to determine a hospital legal entity's reasonable and allowable costs for providing acute psychiatric inpatient hospital services (mode 05), day services (mode 10), and/or outpatient services (mode 15) when that hospital reported only Medi-Cal costs on the form MH 1960\_1.

**Column A – Settlement Type**

Please enter the settlement type for the particular mode and service function as it appears on the MH 1901 Schedule B.

**Column B – Mode**

Please enter the mode of service.

**Column C – Service Function**

Please enter the service function.

**Column D – Medi-Cal Units**

Please enter the total Medi-Cal units of service from the MH 1901 Schedule B for the particular settlement type, mode, and service function.

**Column E – Cost Per Unit/RVU**

Please enter the cost per unit or relative value unit for each particular mode and service function.

**Column F – Medi-Cal Charges**

No entry. This column calculates the product of Columns D and E.

**Column G – Allocation Percentage**

No entry. This column divides the Medi-Cal charges (Column F) for each service function by the total charges for the appropriate mode of service.

**Column H – Allocated Medi-Cal Costs**

No entry. This column multiplies the allocation percentage (Column G) for each service function by the total charges for the appropriate mode of service.

**Column I – Cost Per Medi-Cal Unit**

No entry. This column divides the allocated Medi-Cal costs (Column H) by the Medi-Cal units (Column D) to calculate the Medi-Cal cost per unit for each mode and service function.

**Column J – Total Units**

Please enter the total units of service for each mode and service function.

**Column K – Total Costs**

No entry. This column multiplies the cost per Medi-Cal unit (Column I) by the total units (Column J) to calculate the total cost for each mode and service function.

**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 on the MH 1960. Refer to the Centers for Medicare and Medicaid Services (CMS) Publication 15, Provider Reimbursement Manual for further explanation of Medi-Cal allowable and non-allowable costs.

**Line 1 – Depreciation Adjustment**

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

**Line 2 – Bad Debt**

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

**Line 3 – Charity Allowances**

Charity allowances 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 charity allowances. Please enter any adjustments to costs due to charity allowances on line 3.

**Line 4 – Courtesy Allowances**

Courtesy allowances 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 courtesy allowances. Please enter any adjustments to costs due to courtesy allowances 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 patient and are therefore not allowable costs. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Sections 2139 through 2139.3 for guidance regarding unallowable political and lobbying activities. Please enter any adjustments to costs due to political and lobbying activities on line 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 Liability Losses**

Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Section 2160.2 for guidance regarding allowable liability losses. Please enter any adjustments to costs due to unallowable liability losses on line 9.

**Line 10 – Abandonment of Construction in Progress**

Where a provider begins construction of a new facility to expand, rebuild, or relocate its present certified facility and then later abandons the partially completed asset. The cost of this abandoned asset, excluding planning costs, is an investment loss and is not allowable. If a provider abandons a partially constructed asset which would have become a newly certified facility, the loss, including abandoned planning costs, is not allowable. Please refer the CMS Provider Reimbursement Manual, Part I, Chapter 12, Section 12154ff for a description of planning costs. Please refer to the CMS Provider Reimbursement Manual, Part I, Chapter 21, Section 2155 for more information about how to treat costs of abandoned construction in progress. Please enter any adjustments to costs due to abandonment of construction in process on line 10.

**Lines 11-19 – Other Adjustments to Cost**

Please enter any other adjustments to costs to comply with Medi-Cal principles of reimbursement on lines 11-19. Please refer to the CMS Provider Reimbursement Manual, Part I, for guidance regarding allowable and unallowable costs.

**MH 1962****Other Adjustment**

The purpose of the MH 1962 is to provide detail information of other adjustments for each activity. Add or subtract any other adjustments to costs the legal entity might have on this form. For example, if the amount reported on the MH 1960 includes costs of the county substance abuse division, the costs of the substance abuse division would be deducted. Information entered here will automatically populate the appropriate line in Column F of the MH 1960.

**Column A – Description**

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

**Column B – Amount**

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

**Column C – MH 1960 Line Number**

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

**Column D – MH 1960 Description**

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

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

The purpose of the MH 1963 is to capture the payments to contract providers. Information entered here will automatically populated MH 1960, Line 3, Columns B and C.

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 30**, 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 – Amount Paid**

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

**Column E – Medi-Cal Payments**

Please enter the amount paid to the contract provider all specialty mental health services provided to Medi-Cal beneficiaries in the cost report fiscal year. This amount should be equal to or greater than the contract provider's total costs subject to reimbursement on lines 19, 20, 24, 24A, 25, 25A, 26, and 26A, Column D, of the MH 1979. If this amount is less than the contract provider's total costs subject to reimbursement on lines 19, 20, 24, 24A, 25, 25A, 26, and 26A, 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 detail cost report. The adjustment to FFP must be equal to the Medi-Cal payment entered on Column E of the MH 1963 less the sum of lines 19, 20, 24, 24A, 25, 25A, 26, and 26A, Column D, of the MH 1979 multiplied by the appropriate FMAP.

**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 line 30, Column J of the MH 1960.

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

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

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

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

**Line 1 – Allocation Percentage**

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

**Line 2 – Total Units**

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

**Line 3 – Gross Cost**

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

**Line 4 – Cost Per Unit**

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

**Line 5 – SMA per Unit**

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

**Line 6 – Published Charge per Unit**

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

**Lines 7 & 7a – 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 and F.

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

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

**Lines 9 & 9A – Enhanced SD/MC (Children) Units**

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

**Line 9B– Enhanced SD/MC (Refugees) Units**

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

**Lines 10 & 10A - Breast & Cervical Cancer Treatment & Prevention**

No entry. Starting in Column B, units for each Breast & Cervical Cancer Treatment & Prevention service function fills in automatically from the MH 1901 Schedule B, Columns P & Q.

**Line 11 & 11B – Healthy Families (SED) Units**

No entry. Starting in Column B, Healthy Families units for each Healthy Families service function fills in automatically from the MH 1901 Schedule B, Column R.

**Line 12 – Non Medi-Cal Units**

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

**Lines 13 & 13A – Medi-Cal Costs**

No entry. Starting in Column B, line 4 is multiplied by lines 7 and 7A for each SD/MC service function. The product of all SD/MC service functions computed are summed up on Column A, Lines 13 & 13A.

**Lines 14 & 14A – Medi-Cal SMA Upper Limits**

No entry. Starting in Column B, this field is populated automatically from the MH 1901, Column I. The products of all SD/MC service functions computed are summed up automatically.

**Lines 15 & 15A – Medi-Cal Published Charges**

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

**Lines 16 & 16A – Medicare/Medi-Cal Crossover Costs**

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

**Lines 17 & 17A – Medicare/Medi-Cal Crossover SMA Upper Limits**

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

**Lines 18 & 18A – Medicare/Medi-Cal Crossover Published Charges**

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

**Lines 19 & 19A – Enhanced SD/MC (Children) Costs**

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

**Lines 20 & 20A – Enhanced SD/MC (Children) SMA Upper Limits**

No entry. Starting in Column B, this field is populated automatically from the MH 1901, Column I. The products of all SD/MC service functions computed are summed up automatically.

**Lines 21 & 21A – Enhanced SD/MC (Children) Published Charges**

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

**Line 22 – Enhanced SD/MC (Refugees) Costs**

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 23 – Enhanced SD/MC (Refugees) SMA Upper Limits**

No entry. Starting in Column B, this field is populated automatically from the MH 1901, Column I. The products of all SD/MC service functions computed are summed up automatically.

**Line 24 – Enhanced SD/MC (Refugees) Published Charges**

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.

**Lines 25 & 25A – BCCTP Costs**

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

**Lines 26 & 26A – BCCTP SMA Upper Limits**

No entry. Starting in Column B, this field is populated automatically from the MH 1901, Column I. The products of all SD/MC service functions computed are summed up automatically.

**Lines 27 & 27A – BCCTP Published Charges**

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

**Lines 28 & 28A – Healthy Families Costs**

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

**Lines 29 & 29A – Healthy Families SMA Upper Limits**

No entry. Starting in Column B, this field is populated automatically from the MH 1901, Column I. The products of all SD/MC service functions computed are summed up automatically.

**Lines 30 & 30A – Healthy Families Published Charges**

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

**Line 31 – Non-Medi-Cal Costs**

No entry. Starting in Column B, line 4 is multiplied by line 12 for each service function. The amounts for all service functions are summed up in Column A.

**MH 1966 Mode 05, Service Function 19****Hospital Administrative Days**

The SMA rate for this service function does not include Physician and Ancillary service costs. The intent of this procedure is to ensure that physician and ancillary costs related to these hospital administrative days are included in the comparison of the costs, SMA and published charges. Legal entities with hospital administrative days should complete the MH 1991 for the purpose of grossing up the SMA to include Physician and Ancillary costs.

**Note:** You will need to complete the MH 1991 even if you do not have any Physician and Ancillary costs. The SMA costs are pulled directly from the MH 1901.

**Line 1 – Allocation Percentage**

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

**Line 2 – Total Units**

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

**Line 3 – Gross Cost**

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

**Line 4 – Cost Per Unit**

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

**Line 5 – SMA per Unit**

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

**Line 6 – Published Charge per Unit**

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

**Lines 7 & 7a – 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 and F.

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

No entry. Starting in Column B, Medicare/Medi-Cal Crossover units for each Medi-Cal service functions fills in automatically from the MH 1901 Schedule B, Columns H and I.

**Lines 9 & 9A – Enhanced SD/MC (Children) Units**

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

**Line 9B– Enhanced SD/MC (Refugees) Units**

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

**Lines 10 & 10A - Breast & Cervical Cancer Treatment & Prevention**

No entry. Starting in Column B, units for each Breast & Cervical Cancer Treatment & Prevention service function fills in automatically from the MH 1901 Schedule B, Columns P & Q.

**Line 11 & 11B – Healthy Families (SED) Units**

No entry. Starting in Column B, Healthy Families units for each Healthy Families service function fills in automatically from the MH 1901 Schedule B, Column R.

**Line 12 – Non Medi-Cal Units**

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

**Lines 13 & 13A – Medi-Cal Costs**

No entry. Starting in Column B, line 4 is multiplied by lines 7 and 7A for each SD/MC service function. The product of all SD/MC service functions computed are summed up on Column A, Lines 13 & 13A.

**Lines 14 & 14A – Medi-Cal SMA Upper Limits**

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

**Lines 15 & 15A – Medi-Cal Published Charges**

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

**Lines 16 & 16A – Medicare/Medi-Cal Crossover Costs**

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

**Lines 17 & 17A – Medicare/Medi-Cal Crossover SMA Upper Limits**

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

**Lines 18 & 18A – Medicare/Medi-Cal Crossover Published Charges**

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

**Lines 19 & 19A – Enhanced SD/MC (Children) Costs**

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

**Lines 20 & 20A – Enhanced SD/MC (Children) SMA Upper Limits**

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

**Lines 21 & 21A – Enhanced SD/MC (Children) Published Charges**

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

**Line 22 – Enhanced SD/MC (Refugees) Costs**

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 23 – Enhanced SD/MC (Refugees) SMA Upper Limits**

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 24 – Enhanced SD/MC (Refugees) Published Charges**

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.

**Lines 25 & 25A – BCCTP Costs**

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

**Lines 26 & 26A – BCCTP SMA Upper Limits**

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

**Lines 27 & 27A – BCCTP Published Charges**

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

**Lines 28 & 28A – Healthy Families Costs**

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

**Lines 29 & 29A – Healthy Families SMA Upper Limits**

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

**Lines 30 & 30A – Healthy Families Published Charges**

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

**Line 31 – Non-Medi-Cal Costs**

No entry. Starting in Column B, line 4 is multiplied by line 12 for each service function. The amounts for all service functions are summed up in Column A.

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

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

**Lines 1 – 3**

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

**Line 4 – Cost Per Unit**

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

**Line 5 – Non-Medi-Cal Units**

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

**Line 6**

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

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

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

**Lines 1 through 3**

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

**Line 4 – Cost Per Unit**

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

**Line 5 – Non-Medi-Cal Costs**

No entry. Starting from Column B, non-Medi-Cal units for each service function is populated by taking line 3, Column A of this form and subtracting MH 1968, Line 35, Column D.

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

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

**Nominal Fee Provider**

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

**Determination of Cost Settlement Process**

Cost settlement process is based on the application of Lower of Cost or Charges (LCC) cost reimbursement principles. Pursuant to cost reimbursement rules, the application of LCC will be based on the aggregate cost of all outpatient services. Healthy Families follows SD/MC settlement technique and process.

**Column K – Total Outpatient**

No entry. This column sums Column I – Total Outpatient excluding Program 2 and Column J (Mode 15, Program 2).

**Lines 1 & 1A – Medi-Cal Costs**

No entry. The total cost of providing services to regular (excluding enhanced and Medicare crossover) Medi-Cal patients for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 13 and 13A of the MH 1966 for the applicable mode of service. Costs reported on lines 1 & 1A are for services provided to Medi-Cal patients only and are not gross costs from line 3 of MH 1966.

**Lines 2 & 2A – Medi-Cal SMA Upper Limits**

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 14 and 14A of the MH 1966 for the applicable mode of service. Column I, calculates the sum of Columns F through H.

**Lines 3 & 3A – Medi-Cal Published Charges**

No entry. Medi-Cal published Charges for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 15 and 15A of the MH 1966

for the applicable mode of service. Column I calculates the sum of Columns F through H.

**Lines 4 & 4A – Medi-Cal Gross Reimbursement**

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost or SMA is selected and populates lines 4 and 4A. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charges is selected and populates lines 4 and 4A. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county as the lower of reasonable and allowable costs or the SMA. Lines 4 and 4A in Column J are automatically computed by taking the lower reasonable and allowable costs (lines 2 and 2A) or SMA (lines 3 and 3A).

**Lines 5 & 5A – Medicare/Medi-Cal Crossover Costs**

No entry. The total cost of providing services to Medicare/Med-Cal crossover patients for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 16 and 16A of the MH 1966 for the applicable mode of service. Column I, calculates the sum of Columns F through H.

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

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

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

No entry. Medi-Cal published Charges for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 18 and 18A of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

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

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

automatically computed by taking the lower reasonable and allowable costs (lines 5 and 5A) or SMA (lines 6 and 6A).

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

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

**Lines 10 & 10A – Enhanced SD/MC (Children) Costs**

No entry. The total cost of providing services to Medicare/Med-Cal crossover patients for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 19 and 19A of the MH 1966 for the applicable mode of service.

Column I, calculates the sum of Columns F through H.

**Lines 11 & 11A – Enhanced SD/MC (Children) SMA Upper Limits**

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

**Lines 12 & 12A – Enhanced SD/MC (Children) Published Charges**

No entry. Medi-Cal published Charges for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 21 and 21A of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

**Lines 13 & 13A – Enhanced SD/MC (Children) Gross Reimbursement**

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

**Lines 14 & 14A – BCCTP Costs**

No entry. The total cost of providing services to Medicare/Med-Cal crossover patients for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 25 and 25A of the MH 1966 for the applicable mode of service.

Column I, calculates the sum of Columns F through H.

**Lines 15 & 15A – BCCTP SMA Upper Limits**

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 26 and 26A of the MH 1966 for the applicable mode of service. Column I, calculates the sum of Columns F through H.

**Lines 16 & 16A – BCCTP Published Charges**

No entry. Medi-Cal published Charges for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 27 and 27A of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

**Lines 17 & 17A – BCCTP Gross Reimbursement**

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

**Lines 18 – Enhanced SD/MC (Refugee) Costs**

No entry. The total cost of providing services to Medicare/Med-Cal crossover patients for each mode of service in Columns E through H and J is automatically populated from Column A, Line 22 of the MH 1966 for the applicable mode of service. Column I, calculates the sum of Columns F through H.

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

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Line 23 of the MH 1966 for the applicable mode of service. Column I, calculates the sum of Columns F through H.

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

No entry. Medi-Cal published Charges for each mode of service in Columns E through H and J is automatically populated from Column A, 24 of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

**Lines 21 and 21A – Total Medi-Cal Gross Reimbursement (excludes Enhanced SD/MC Refugees)**

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable

cost or SMA is selected and populates lines 8 and 8A. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charges is selected and populates lines 8 and 8A. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county as the lower of reasonable and allowable costs or the SMA. Lines 8 and 8A in Column J are automatically computed by taking the lower reasonable and allowable costs (lines 5 and 5A) or SMA (lines 6 and 6A).

### **Line 22 – Enhanced SD/MC (Refugee) Gross Reimbursement**

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

### **Lines 23 & 23A – Healthy Families Costs**

No entry. The total cost of providing services to Medicare/Med-Cal crossover patients for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 25 and 25A of the MH 1966 for the applicable mode of service. Column I, calculates the sum of Columns F through H.

### **Lines 24 & 24A – Healthy Families SMA Upper Limits**

No entry. Medi-Cal SMA Upper Limits for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 26 and 26A of the MH 1966 for the applicable mode of service. Column I, calculates the sum of Columns F through H.

### **Lines 25 & 25A – Healthy Families Published Charges**

No entry. Medi-Cal published Charges for each mode of service in Columns E through H and J is automatically populated from Column A, Lines 27 and 27A of the MH 1966 for the applicable mode of service. Column I calculates the sum of Columns F through H.

### **Lines 26 & 26A – Healthy Families Gross Reimbursement**

Legal entities fall into one of two categories based upon qualification as nominal fee provider. If a legal entity has completed the MH 1969 and qualifies as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable

cost or SMA is selected and populates lines 8 and 8A. If a legal entity has not completed the MH 1969 or does not qualify as a nominal fee provider for inpatient and/or outpatient services, the lower of reasonable and allowable cost, SMA, or published charges is selected and populates lines 8 and 8A. Inpatient and outpatient reimbursement methods are determined independently in Columns E and I. Column J consists of Program 2 costs that are to be reimbursed to the county as the lower of reasonable and allowable costs or the SMA. Lines 8 and 8A in Column J are automatically computed by taking the lower reasonable and allowable costs (lines 5 and 5A) or SMA (lines 6 and 6A).

#### **Line 27 & 27A – SD/MC + 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 MH 1966 automatically populate from MH 1901 Schedule B, Columns K and L. 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 28 – Enhanced SD/MC (Children) Patient Revenue**

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column O. See Lines 27 and 27A for more information.

#### **Line 29 – Enhanced SD/MC (Refugees) Patient Revenue**

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column T. See Lines 27 and 27A for more information.

#### **Line 30 – Enhanced SD/MC (BCCTP) Patient Revenue**

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column R. See Lines 27 and 27A for more information.

#### **Line 31 – Healthy Families Revenue**

No entry. The amounts are automatically populated from MH 1901 Schedule B, Column W. See Lines 27 and 27A for more information.

#### **Line 32 – 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 33 – Medi-Cal Eligibility Factor (Average)**

No entry. County Medi-Cal eligibility factor (percentage) cell references MH 1901 Schedule A, Column E, Line 35.

**Line 34 – Revenue MAA**

No entry. Does not apply.

**Line 35 – Net Due for SD/MC for Direct Services (7/1/10 – 9/30/10)**

No entry. Column A automatically populates the amount from Line 32. Columns B and C are filled by the result of the product of Lines 32 and 33. The sum of Columns A, B and C, Line 35 is automatically populated in Column D, Line 35.

For Columns E, I, J, and K, the result of Line 21 minus the sum of Lines 27, 28 and 30 is automatically populated.

**Line 35A – Net Due for SD/MC for Direct Services (10/1/10 – 6/30/11)**

No entry. For Columns E, I, J, and K, Line 21A minus Line 27A.

**Line 36 – Net Due for Enhanced SD/MC (Refugees)**

No entry. Columns E, I, J, and K are automatically populated with the result of Line 22 minus Line 29.

**Line 37 – Net Due for Healthy Families (7/1/10 – 9/30/10)**

No entry. Columns E, I, J, and K are automatically populated with the result of Line 26 minus Line 31.

**Line 37A – Net Due for Healthy Families (10/1/10 – 6/30/11)**

No entry. Columns E, I, J, and K are automatically populated with Line 26A.

**MH 1969 INST****Instructions for Lower of Costs or Charges Determination**

The purpose of MH 1969 is to determine if a legal entity qualifies as a Nominal Fee Provider. Before completing the MH 1969, the following questions must be answered.

- Does the legal entity have a published schedule of its full (non-discounted) charges?
- Are the legal entity's revenues for patient care based on application of a published charge schedule?
- Does the legal entity maintain written policies for its process of making patient indigence determinations?
- Does the legal entity maintain sufficient documentation to support the amount of "indigence allowances" written off in accordance with the above procedures?

If the answer to any of the above questions is no, the legal entity DOES NOT qualify as a Nominal Fee Provider and the MH 1969 should not be completed.

**MH 1969 (Optional)****Lower of Costs or Charges Determination**

The legal entity must have a published schedule of its full (non-discounted) charges. The objective of MH 1969 is to determine whether a legal entity is exempt from the Lower of Cost or Charges principles. MH 1969 is an optional form and should be completed by legal entities whose charges are lower than costs and the SMA upper limits. If a legal entity answered yes to all four questions on the MH 1969 INST and its Medi-Cal adjusted customary charges are equal to or less than 60 percent of its Medi-Cal costs, the legal entity is exempt from having to include charges in the comparison on MH 1968.

The exemption must be proved separately for Medi-Cal Inpatient Services (Mode 05 – Hospital Inpatient Services) and Medi-Cal Outpatient Services (Mode 05-Other 24 Hour Services, Mode 10 – Day Services, and Mode 15-Outpatient Services). Refer to DMH Letter No. 90-05 and attachments for a detailed explanation of how to meet these four criteria.

Medi-Cal adjusted customary charges are calculated using several different methods, all of which result in the same outcome.<sup>1</sup> MH 1969 employs the calculation method applicable to most legal entities. Medi-Cal adjusted customary charges are calculated by first dividing actual charges to non-Medicare and non-Medi-Cal patients by adjusted or published charges to non-Medicare and non-Medi-Cal patients. This ratio is then applied to Medi-Cal charges (i.e., amounts billed to Medi-Cal), resulting in Medi-Cal adjusted customary charges. These charges are compared to 60 percent of Medi-Cal costs and, if equal to or less, the legal entity is exempt from having to apply the LCC principle. Dollar amounts should be rounded to the nearest whole dollar.

**Line 1 – Amount Billed to Medi-Cal**

Enter the amount billed to Medi-Cal (through DMH) for the cost report fiscal year. The amount should be derived from the county's monthly billing records. Enter amount for each mode of service in the appropriate column. The sum of Columns B through D is automatically populated in Column E.

**Line 2 – Non-Medicare/Medi-Cal Patient Revenues**

Enter the total patient revenue for the cost report fiscal year billed (not necessarily collected) to non-Medicare patients and non-Medi-Cal patients based on the Uniform Method of Determining Ability to Pay (UMDAP). Billings to patients liable for payment on a charge basis (non-contractual patients) based on the UMDAP should be reported.

Billing to Health Maintenance Organizations (HMOs), County Organized Health Systems (COHSs), Preferred Provider Organizations (PPOs), or Primary Care Case Management (PCCM) should not be included. Line 2, Column A, represents amount billed to patients for mode 05-Hospital Inpatient Services and Line 2, Column E,

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<sup>1</sup> See: *Medicare and Medicaid Guide, Commerce Clearing House, ¶7585, August 1989.*

represents amount billed to patients for Mode 05-Other 24-Hour Services, Mode 10-Day Services, and Mode 15-Outpatient Services.

**Line 3 – Non-Medicare/Medi-Cal Patient Insurance**

Enter the total patient insurance collected from non-Medicare patients and non-Medi-Cal patients for the cost report fiscal year. Line 3, Column A, represents patient insurance collected for Mode 05-Hospital Inpatient Services and Line 3, Column E, represents patient insurance collected for Mode 05-Other 24 Hour Services, Mode 10-Day Services, and Mode 15-Outpatient Services.

**Line 4 – Subtotal**

No entry. This line sums Lin3s 2 and 3 for Column A (Inpatient) and Column E (Outpatient).

**Line 5 – Non-Medicare/Medi-Cal Published Charges**

Non-Medicare/Medi-Cal Published Charges represent the amount non-Medicare and non-Medi-Cal patients would have paid had they been full-fee paying patients. On a separate worksheet maintained by the legal entity, multiply the units of service/time provided to non-Medicare and non-Medi-Cal patients by the legal entity's published charge or rate for each service function. These amounts should be aggregated by mode of service and reported in the appropriate Columns on Line 5. The sum of Columns B through D is automatically populated in Column E. Columns A and E represent the legal entity's non-Medicare/Medi-Cal published charges for inpatient and outpatient services.

**Line 6 – Ratio of Actual to Published Charges**

No entry. The calculation is Line 4 divided by Line 5 in Column A (Inpatient) and Column E (Outpatient).

**Line 7 – Medi-Cal Adjusted Customary Charges**

No entry. The calculation is Line 1 multiplied by Line 6 in Column A (Inpatient) and Column E (Outpatient).

**Line 8 – Medi-Cal Costs**

No entry. The legal entity's total cost for providing Medi-Cal Inpatient and Outpatient services are automatically populated in Columns A and E. These costs are derived from the sum of MH 1968, Lines 9, 9A, 13, 13A, 17, 17A, and 22, Column E and Column I.

**Line 9 – 60 Percent of Medi-Cal Costs**

No entry. Columns A and E are automatically calculated by multiplying Line 8 by 60 percent.

If the amount on line 9, Column A (60 percent of Medi-Cal inpatient costs) is greater than Line 7, Column A (Medi-Cal inpatient adjusted customary charges), the legal entity is exempt from having to apply the LCC principle for Mode 05-Hospital Inpatient

Services. If Line 7 Column A, is greater than Line 9, Column A, the legal entity is no exempt from having to apply the LCC principle for Mode 05-Hospital Inpatient Services on MH 1968, and must include Medi-Cal Mode 05-Hospital Inpatient charges in the comparison on MH 1968.

If the amount on Line 9, Column E (60 percent of Medi-Cal outpatient costs) is greater than Line 7, Column E (Medi-Cal outpatient adjusted customary charges), the legal entity is exempt from having to apply the LCC principle for outpatient services. If Line 7, Column E, is greater than Line 9, Column E, the legal entity is not exempt from having to apply the LCC principle for outpatient service on MH 1968, and must include the Medi-Cal outpatient charges in the comparison on MH 1968.

**MH 1979****SD/MC Preliminary Desk Settlement**

The objective of MH 1979 is to determine the preliminary net Federal Financial Participation (FFP) due the legal entity for all SD/MC and Healthy Families services. Data for Lines 1 through 10 and 13 through 15 are to be entered by County legal entities on appropriate forms (MH 1900\_Information and MH 1960).

**Line 1 – County SD/MC Direct Service Gross Reimbursement**

No entry. In Columns B and C, County's legal entity SD/MC Direct Services Gross Reimbursement for inpatient and outpatient services are automatically populated from MH 1968, Columns E and K, sum of Lines 9, 9A, 17, 17A, and 22. The sum of Columns B and C is automatically populated in Column D.

**Line 2 – Contract Provider Medi-Cal Direct Service Gross Reimbursement**

No entry. In Columns B and C, Contract Providers SD/MC Direct Service Gross reimbursement for inpatient and outpatient services is automatically populated from the MH 1900 Information Sheet. These services are manually entered on the MH 1900 Information Sheet from the MH 1968, Columns E and K, sum of Lines 9, 9A, 17, 17A, and 22 for all legal entities that contract for SD/MC services with the County Mental Health Plan. This entry should 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). The sum of Columns B and C automatically populates in Column D.

**Line 3 – Total Medi-Cal Direct Service Gross Reimbursement**

No entry. The sum of Lines 1 and 2 in Column D are automatically populated on Line 3. This amount represents total allowable SD/MC direct service costs in the county that will be used to determine 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. Column D, Line 3 is automatically multiplied by .15 to compute the maximum SD/MC reimbursement for administrative services.

**Line 5 – SD/MC Administration**

No entry. SD/MC administrative costs are automatically populated from MH 1960, Column J, Line 22.

**Line 6 – SD/MC Administrative Reimbursement**

No entry. The lower of Lines 4 and 5 is automatically populated in Column D, Line 6. The amount in Column D is automatically multiplied by 50% to determine FFP for SD/MC administration. The result is rounded to the nearest whole dollar and entered in Column E.

**Line 7 – County Healthy Families Direct Service Gross Reimbursement**

No entry. Columns B and C are automatically populated from the sum of Lines 27 and 27A, Columns E and K of the MH 1968. The sum of Columns B and C automatically populates Column D.

**Line 8 – Contract Provider Healthy Families Direct Service Gross Reimbursement**

No entry. Columns B and C, are manually entered in the MH 1900 Information Sheet based on the sum of Lines 27 and 27A, Columns E and K of the MH 1968 for all legal entities that contract with the County Mental Health Plan. The sum of Columns B and C automatically populates in Column D.

**Line 9 – Total Health Families Direct Service Gross Reimbursement**

No entry. The sum of Lines 7 and 8 in Column D are automatically populated on Line 9. This amount represents total allowable Healthy Families direct service costs in the county that will be used to determine maximum allowable Healthy Families administrative reimbursement for the county legal entity.

**Line 10 – Healthy Families Administrative Reimbursement Limit**

No entry. Healthy Families Administrative costs are limited to 10 percent of Healthy Families direct service gross costs. Column D, Line 9, is automatically multiplied by 10 percent to compute the Healthy Families administrative limit.

**Line 11 – Healthy Families Administration**

No entry. The Healthy Families administrative costs are automatically populated from Column J, Line 23 of the MH 1960.

**Line 12 – Healthy Families Administrative Reimbursement**

No entry. The lower of Lines 8 and 9 from Column D is automatically selected and populated in Column D, Line 10. The amount in Column D is automatically multiplied by 65 percent to determine the FFP for Healthy Families administrative costs. The result is rounded to the nearest whole dollar and populated on Line 10, Column H.

**Line 13 – County SD/MC Enhanced (Children) Direct Service Gross Reimbursement**

No entry. Columns B and C are automatically populated from the sum of Lines 13 and 13A, Columns E and K of the MH 1968. The sum of Columns B and C automatically populates Column D.

**Line 14 – Contract Providers SD/MC Enhanced (Children) Direct Service Gross Reimbursement**

No entry. Columns B and C, are manually entered in the MH 1900 Information Sheet based on the sum of Lines 13 and 13A, Columns E and K of the MH 1968 for all legal entities that contract with the County Mental Health Plan. The sum of Columns B and C automatically populates in Column D.

**Line 15 – Total SD/MC Enhanced (Children) Direct Service Gross Reimbursement**

No entry. The sum of Lines 13 and 14 in Column D are automatically populated on Line 9. This amount represents total allowable SD/MC Enhanced (Children) direct service costs in the county that will be used to determine maximum allowable SD/MC Enhanced (Children) administrative reimbursement for the county legal entity.

**Line 16 – SD/MC Enhanced (Children) Administrative Reimbursement Limit**

No entry. SD/MC Enhanced (Children) administrative costs are limited to 15 percent of SD/MC Enhanced (Children) direct service gross costs. Column D, Line 15, is automatically multiplied by 15 percent to compute the SD/MC Enhanced (Children) administrative limit.

**Line 17 – SD/MC Enhanced (Children) Administration**

No entry. The Healthy Families administrative costs are automatically populated from Column J, Line 24 of the MH 1960.

**Line 18 – SD/MC Enhanced (Children) Administrative Reimbursement**

No entry. The lower of Lines 16 and 17 from Column D is automatically selected and populated in Column D, Line 18. The amount in Column D is automatically multiplied by 50 percent to determine the FFP for Healthy Families administrative costs. The result is rounded to the nearest whole dollar and populated on Line 18, Column H.

**Line 19 – Medi-Cal Administrative Activities Service Functions 01-09**

No entry. The Net Due from Medi-Cal for MAA for Service Functions 01 through 09 is automatically populated from Line 35, Column A, or MH 1968 in Columns A and D. The result in Column D is automatically populated by 50% and entered in Columns E and J. Verify that Line 11 equals or agrees with MH 1979, Line 21, Column J (FFP).

**Line 20 – Medi-Cal Administrative Activities Service Functions 11-19 and 31-39**

No entry. The net due from Medi-Cal for MAA for service functions 11 through 10 and 31 through 39 is automatically populated from Line 35, Column B of the MH 1968 in Columns A and D. The result in Column D is automatically multiplied by 50 percent and entered in Columns E and J.

**Line 21 – Medi-Cal Administrative Activities Service Functions 21-29.**

No entry. The net due from Medi-Cal for MAA for service functions 21 through 29 is automatically populated from Line 35, Column C of the MH 1968 in Columns A and D. The result in Column D is automatically multiplied by 75 percent and populated in Columns I and J.

**Line 22 – Utilization Review – Skilled Professional Medical Personnel (County Only)**

No entry. The SD/MC utilization review costs for skilled professional medical personnel are populated from Column J, Line 26 of MH 1960. The result in Column D is automatically multiplied by 75 percent to determine FFP and populated in Columns I and J.

**Line 23 – Other SD/MC Utilization Review (County Only)**

No entry. The other SD/MC utilization review costs are automatically populated from Column J, Line 27 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.

**Lines 24 and 24A – SD/MC Net Reimbursement for Direct Services**

No entry. The SD/MC direct service net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns E and K, Lines 9 & 9A minus lines 27 & 27A of the MH 1968. Column D automatically sums Columns B and C. The amount in Column D is automatically multiplied by the appropriate FMAP for the period to determine FFP for SD/MC direct services and is populated in Columns F and J.

**Lines 25 & 25A – Enhanced SD/MC Net Reimbursement (Children)**

No entry. The Enhanced SD/MC (Children) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns E and K, Line 13 minus Line 28 and Line 13A 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 H and J.

**Lines 26 & 26A – Enhanced SD/MC Net Reimbursement (BCCTP)**

No entry. The Enhanced SD/MC (BCCTP) direct services net reimbursement for inpatient and outpatient services (Columns B and C) are automatically populated from Columns E and K, Line 17 minus Line 30 and Line 17A 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 H and J.

**Line 27 – 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 E and K, Line 22 minus Line 29 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 H and J.

**Line 28 – Total SD/MC Reimbursement Before Excess FFP**

No entry. The sum of Column J, Lines 6, and 18 through 27 is automatically populated in Column J.

**Line 29 – Contract Limitation Adjustment**

No entry. This line automatically populates from the MH 1900 Information Sheet when the county enters and adjustment to Medi-Cal FFP due to contract limitations. County legal entities are required to make adjustments to Medi-Cal FFP for contract provider

costs that have not been incurred by the county. To be eligible for FFP, the county mental health plan must first pay the contract provider one hundred percent of the cost of providing the service. Total payments for Medi-Cal reimbursable services are reported on the MH 1963 of the county's detail cost report. If the total county payments to a contract provider for Medi-Cal services as reported on the MH 1963, is not equal to or greater than the sum of lines 19, 20, 21, 24, 24A, 25, 25A, 26, and 26A, Column D of the contract providers MH 1979, the county mental health plan must enter an appropriate adjustment to FFP. The adjustment to FFP must equal the county's payments for Medi-Cal services less than the sum of lines 19, 20, 21, 24, 24A, 25, 25A, 26, and 26A, Column D of the contract provider's MH 1979 multiplied by the appropriate reimbursement percentage. The appropriate reimbursement percentage is equal to the sum of lines 19, 20, 21, 24, 24A, 25, 25A, 26, and 26A, Column J divided by the sum of lines 19, 20, 21, 24, 24A, 25, 25A, 26, and 26A, Column D of the contract provider's MH 1979.

**Line 30 – Adjusted Total SD/MC Reimbursement (FFP)**

No entry. The result of Line 28 minus Line 29 is automatically populated on Line 30.

**Line 31 & 31A – Healthy Families Net Reimbursement**

No entry. The amounts from MH 1968, Line 26 minus Line 31 and Line 26A, Columns E and K are automatically populated in Columns B and C, respectively. The sum of Columns B and C automatically populates Column D. The amount in Column D is automatically multiplied by 65 percent to determine FFP for SD/MC Healthy Families direct services and populates Column H and J.

**Line 32 – Total Healthy Families Reimbursement**

No entry. The sum of Lines 12, 31 and 31A automatically populates line 32, Column J.

**MH 1991****Calculation of SD/MC (Hospital Administrative Days)**

The objective of the MH 1991 is to identify the amount of Physician and Ancillary costs associated with SD/MC and Healthy Families (SED) Hospital Administrative Days (Mode 05, Service Function 19) for use on the MH 1966.

**Column A – Settlement Group**

No entry. Settlement groups are provided.

**Column B – Provider Number**

Enter 4-digit Provider Number.

**Column C – SMA Rate**

No entry. SMA Rate for FY 2010-11 is provided for the two periods.

**Column D – Period of Service**

No entry. Period of services is provided.

**Column E – Administrative Days**

Enter the number of SD/MC administrative days according to the period during which services were provided and by the settlement group to which the services were rendered during the fiscal year. This column should match the number of Medi-Cal units reported on Schedule B for Mode 05, Service Function 19.

**Column F – Subtotal Amount**

No entry. This is the result of column C multiplied by Column E.

**Column G – Physician Costs**

Enter cost of physician services related to SD/MC Administrative Days for each period and settlement group. (Amounts should be included in total billed to Medi-Cal).

**Column H – Ancillary Costs**

Enter cost of ancillary services related to SD/MC Administrative Days for each period and settlement group. (Amounts should be included in total billed to Medi-Cal).

**Column I – Total Amount**

No entry. This is the sum of columns F, G, and H for each period and settlement group.

**MH 1992****Funding Sources**

The objective of MH 1992 is to identify the types of resources used to finance specific mental health program activities for each legal entity by mode of service. Funding source identifies who is paying for programs authorized by the county mental health agency.

**Column J – Total Legal Entity**

No entry. This column sums Columns A through I for each Line

**Line 1 – Gross Cost**

No entry. Column A, Line 1, is the sum of Column J, Lines 22 through 25 and 29 of the MH 1960. Column B is the sum of Column J, Lines 26 through 28 of the MH 1960. Columns C through I, Line 1 are from Column A, Line 3 of the relevant MH 1966.

**Line 2 – Adjustments**

Enter in Columns C through I, the amounts needed to adjust legal entity costs to actual program funding, such as the difference between county contract rate and actual cost incurred by contract providers.

For legal entities that provide services to multiple counties, adjust gross aggregate county legal entity allowable costs on Line 2, Columns C through I to agree with the amount received from each county for which a cost report is being submitted. Report aggregate gross county legal entity costs for all county legal entities on MH 1960, and aggregate gross county legal entities units of service on MH 1901 Schedule B for the determination of cost per unit.

**Line 3 – Adjusted Gross Costs**

No entry. Line 1 plus Line 2 automatically populates Line 3.

**Line 4 – SAMHSA Grants**

Enter revenues expended from the SAMHSA community mental health block grant for appropriate modes of service.

**Line 5 – Path Grants**

Enter revenues expended from the PATH grant for appropriate modes of service.

**Line 6 – RWJ Grants**

Enter revenues expended from Robert Wood Johnson (RWJ) Foundation grants for appropriate modes of service.

**Line 7 – Other Grants**

Enter revenues expended from other grants not reported on Lines 4 through 6 for appropriate modes of service.

**Line 8 – Total Grants Accrued**

No entry. Lines 4 through 7 for Columns A through G are automatically populated in Line 8.

**Line 9 – Patient Fees**

Enter revenue received from patient fees for appropriate treatment program modes of service.

**Line 10 – Patient Insurance**

Enter revenue received from patient insurance for appropriate treatment program modes of service.

**Line 11 – 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 22 and 23. Column C is equal to the sum of MH 1979, Column B, Line 24\*.5, Line 24A\*.5, Line 25\*.65, Line 25A\*.65, Line 26\*.65, Line 26A\*.65, and Line 27\*1. Columns D, E and F are equal to the sum of lines 13 and 13A minus Line 26 multiplied by 50 percent, plus the sum of Lines 17, 17A, 13, 13A, 26, and 26A minus Lines 27, 27A, 28, and 30 multiplied by 65 percent, plus Line 22 – Line 29 from Columns J, K and L of the MH 1968. Column H is equal to the sum of Lines 19, 20 and 21, Column J from the MH 1979. Column J is equal to sum of Columns A through F and H.

**Line 12 – Healthy Families Federal Share**

No entry. Column A is equal to Line 12, Column J of the MH 1979. Column C is equal to the sum of the Lines 31 and 31A, Column J of the MH 1979. Columns D, E and F are equal to the sum of lines 31 and 31A minus line 31, Columns J, K and L of the MH 1968 multiplied by 65 percent. Column J is equal to the sum of Columns A, C, and D through F of the MH 1992.

**Line 13 – Medicare – Federal Share**

Enter Medicare revenue accrued/received for appropriate treatment programs modes of service.

**Conservator Administrative Fees**

Enter conservator administration fees received in Column I, Line 14.

**Line 15 – State General Fund – State Share**

Enter State share of State General Fund (SGF) (90 percent for large counties) in Columns A through I. These are primarily categorical funds allocated by DMH to the counties for FY 2010-2011. Community Services-Other Treatment for Mental Health Managed Care should not be included in this line.

**Line 16 – State General Fund – County Match**

Enter county share (10 percent for large counties) of cost to match State General Fund in Columns A through I, if applicable.

**Line 17 – State General Fund – Managed Care – Outpatient Mental Health Services**

Enter expenditures by modes of service for Outpatient Mental Health Services funded by FY 2010-2011 SGF – Managed Care allocation.

**Line 18 – FY 2009-10 Rollover – Managed Care – Outpatient Mental Health Services**

Enter expenditures for Outpatient Mental Health Services by modes of service, funded by rollover from FY 2009-10 SGF – Managed Care allocation.

**Line 19 – EPSDT SD/MC – State Share Estimate**

Enter estimated SGF of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) SD/MC. Estimated amount should be based upon anticipated EPSDT expenditures and may or may not be different than EPSDT SGF Interim Funding the County received as an advance.

**Line 20A – FY 2006-2007 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 20B – Other Revenues**

Enter all other revenues expended and not reported on Lines 4 through 19.

**Line 21 – Realignment Funds/Maintenance of Effort**

Enter amount expended per realignment funding and county Maintenance of Effort (MOE) obligations pursuant to Welfare and Institutions Code Section 17608.05 for each mode of service. Include realignment funds used to match FFP under the SD/MC program. Exclude realignment funding for State Hospitals and county match for SGF allocated by State Department of Mental Health.

**Line 22 – Prior Years MHSA**

No entry.

**Line 23 – MHSA**

Enter amount expended per MHSA funding, including MHSA funds used to match FFP under the SD/MC program.

**Line 24 – County Overmatch**

Enter county overmatch funds the county contributes over the percentage amounts prescribed by law.

**Line 25 – CalWORKS**

Enter the county CalWORKS funds used for mental health services.

**Line 26 – Total Funding Sources**

No entry. This line sums Lines 8 through 25 for Columns A through I. Amount in Column JI, Line 26, should equal amount in Column J, Line 3. Any difference between the amounts should be corrected before submitting the cost report.