**HUMAN SERVICES**

**DIVISION OF AGING SERVICES**

**Pediatric Medical Day Care Services**

**Proposed Readoption with Amendments: N.J.A.C. 10:166**

**Proposed Repeal and New Rules: N.J.A.C. 10:166 Appendices A and B**

Authorized By: Elizabeth Connolly, Acting Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-6b(12), 6b(17), 7, 7a, 7b, 7c and 12; Reorganization Plan No. 001-1996; 42 U.S.C. § 1396a; and 42 CFR 440.90.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2016-209.

Submit written comments by February 17, 2017, to:

Walter C. Kowalski, Regulatory Officer

Office of Legal and Regulatory Affairs

Division of Aging Services

PO Box 723

Trenton, NJ 08625-0723

or Doas.legal@dhs.state.nj.us

A copy of the notice of proposal is available for review at all offices of the Area Agencies on Aging, which are situated in all 21 counties.

The agency proposal follows:

**Summary**

The rules proposed for readoption with amendments atN.J.A.C. 10:166 establish the pediatric medical day care (PMDC) program. PMDC provides medically necessary services in an ambulatory care setting to children who reside in the community and who, because they are technology-dependent and/or have medically complex needs, require the continuous rather than part-time or intermittent care of a registered professional nurse in a developmentally appropriate environment and whose needs cannot be met in a regular day care or pre-school program for handicapped persons. The rules proposed for readoption with amendments atN.J.A.C. 10:166 establish the standards for Medicaid clinical eligibility for PMDC.

PMDC is a service for primarily technology-dependent and medically fragile children that provides alternatives to private-duty nursing, prolonged hospitalization, and institutional long-term care.

N.J.A.C. 8:87, Pediatric Medical Day Care Services was adopted as new rules effective November 16, 2009. See 41 N.J.R. 4257(a). Prior to November 16, 2009, Pediatric Medical Day Care Services was contained in N.J.A.C. 8:86 with Adult Day Health Services. 36 N.J.R. 5262(a); 37 N.J.R. 385(b), 4968(a).

In 2012, N.J.S.A. 30:1A-14 transferred to the Division of Aging Services (DoAS) the powers and duties of the Department of Health and Senior Services that relate to the provision of programs or services for senior citizens, the New Jersey State Commission on Aging, the Division on Aging and Community Services, and any other division relating to senior benefits. P.L. 2012, c. 17 reestablished the Department of Health and Senior Services as the Department of Health and established the DoAS within the Department of Human Services (Department).

N.J.A.C. 8:87, Pediatric Medical Day Care Services, was recodified as N.J.A.C. 10:166 by administrative change, effective June 16, 2014. As part of the recodification, administrative changes were made throughout concerning cross-references, agency names and addresses, and the elimination of text rendered redundant or moot by the transfer of authority. 46 N.J.R. 1643(a).

Pursuant to N.J.S.A. 52:14B-5.1.c, [N.J.A.C.](https://www.lexis.com/research/buttonTFLink?_m=c4ebc6ca567be5a1a05aafbce6fc8e65&_xfercite=%3ccite%20cc%3d%22USA%22%3e%3c%21%5bCDATA%5b35%20N.J.R.%204416%28a%29%5d%5d%3e%3c%2fcite%3e&_butType=4&_butStat=0&_butNum=7&_butInline=1&_butinfo=NJ%20ADMIN%208%3a83C&_fmtstr=FULL&docnum=4&_startdoc=1&wchp=dGLzVzz-zSkAA&_md5=7459d9dbc5e10598792522f2a2fa15bb) 10:166 was scheduled to expire on November 16, 2016. As the Department submitted this notice of proposal to the Office of Administrative Law prior to that date, the expiration date was extended 180 days to May 15, 2017, pursuant to N.J.S.A. 52:14B-5.1.c(2). The DoAS has reviewed the rules and determined them to be necessary, adequate, reasonable, proper, and responsive for the purpose for which they were originally promulgated.

N.J.A.C. 10:166-1.1 sets forth the purpose and scope of PMDC.

N.J.A.C. 10:166-1.2 sets forth the definitions of words and terms used in the chapter. The definition of Division is proposed to be amended to reflect that the Division of Aging and Community Services is now the Division of Aging Services.

N.J.A.C. 10:166-2.1 sets forth standards for provider participation in PMDC. N.J.A.C. 10:166-2.1 is proposed to be amended to reference the name of the Department’s current Medicaid fiscal agent.

N.J.A.C. 10:166-2.2 provides for evaluation of providers and quality assurance.

N.J.A.C. 10:166-2.3 provides sanctions and remedies for non-compliance with the chapter.

N.J.A.C. 10:166-2.4 allows providers to appeal decisions made by the Department pursuant to N.J.A.C. 10:166-2 or 5.

N.J.A.C. 10:166-3.1 sets standards for functional assessments of Medicaid PMDC beneficiaries.

N.J.A.C. 10:166-3.2 provides that Medicaid beneficiaries may receive PMDC services instead of private duty nursing.

N.J.A.C. 10:166-3.3 allows Medicaid beneficiaries discharged from a neonatal intensive care unit to be eligible for PMDC.

N.J.A.C. 10:166-3.4 provides the procedure for referral and authorization for PMDC services. Paragraph (d)4 is proposed to be added to provide that the reauthorization procedures shall not apply to PMDC beneficiaries enrolled in a Medicaid managed care organization (MCO), for whom reauthorization shall be conducted according to the MCO’s contract with the Department and the requirements of the Medicaid State Plan or applicable waiver.

N.J.A.C. 10:166-3.5 provides a fair hearing for a Medicaid beneficiary who is denied PMDC.

N.J.A.C. 10:166-4.1 provides for the reimbursement of PMDC providers. This section is proposed to be amended to provide that, as required by P.L. 2016, c. 10, the PMDC per diem reimbursement rate for State fiscal year 2017 is $330.81, as amended and supplemented by subsequent State appropriations acts.Proposed new paragraph (a)5 would provide that the requirements of paragraphs (a)1 through 4 shall not apply in any State fiscal year in which the PMDC rate is established in the State appropriations act.

N.J.A.C. 10:166-4.2 sets forth the billing codes for PMDC.

N.J.A.C. 10:166-5.1 provides general provisions for PMDC services.

N.J.A.C. 10:166-5.2 specifies services to be provided by a PMDC facility.

N.J.A.C. 10:166-6.1 sets forth cost report preparation and submission requirements. This section is proposed to be amended to reference the correct website for obtaining the Division’s forms.

N.J.A.C. 10:166-6.2 requires PMDC facilities to file audited financial statements. The section is proposed to be amended to correct a grammatical error.

N.J.A.C. 10:166 Appendix A continues to contain the primary health care provider report on Medicaid beneficiary. Appendix B continues to contain the pediatric medical day care facility cost report. N.J.A.C. 10:166 Appendices A and B are proposed for repeal and replacement to effect technical corrections to the forms.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar requirement pursuant to N.J.A.C. 1:30-3.3(a)5.

**Social Impact**

The rules proposed for readoption with amendments, new rules, and repeals should have a positive effect on beneficiaries since the rules will assure the continued coverage of PMDC services to the beneficiaries served by the 11 Medicaid pediatric medical day care facilities licensed by the Department of Health. N.J.A.C. 8:43J-2.3(b) allows a pediatric medical day care facility to be licensed to serve a maximum of 27 technology-dependent children.

The rules proposed for readoption with amendments, new rules, and repeals impact PMDC providers that participate in the program. These providers are subject to the program requirements described in this chapter. Pediatric medical day care services fulfill the health needs of eligible children who could benefit from a health services alternative to prolonged hospitalization or institutionalization. The PMDC program provides medically necessary services in an ambulatory care facility setting to children who reside in the community and who, because they are technology-dependent and/or have medically complex needs, require continuous, rather than part-time or intermittent, care of a registered professional nurse in a developmentally appropriate environment and whose needs cannot be met in a regular day care or pre-school handicapped program.

The rules proposed for readoption with amendments, new rules, and repeals would establish clinical eligibility criteria for children who are financially eligible for Medicaid to participate in PMDC. The requirements for licensure of health care facilities to be eligible to provide Medicaid-reimbursable PMDC services are found at N.J.A.C. 8:43J.

PMDC facilities allow children who are technology-dependent and/or have medically complex conditions to receive medical, nursing, and other services while continuing to live in their own homes. Those affected by the rules proposed for readoption with amendments, new rules, and repeals include the children who receive services at these facilities, their families and caregivers, the entities that own and operate PMDC facilities, and facility staff. Currently, there are 16 licensed PMDC facilities in the State, 11 of which are Medicaid-certified.

This rulemaking would not change the clinical eligibility criteriafor PMDCat N.J.A.C. 10:166-3.1.

The rulemaking would not change the requirements for provider participation in PMDC, including maintenance of attendance records and providing attendance reports to the Department. These requirements have assured and would continue to assure public confidence in the fiscal integrity of PMDC.

The State and the providers of PMDC services will benefit because these rules allow the Department to continue the PMDC program, thus ensuring continuation of services to beneficiaries and continued reimbursement to providers. Without these services, the long-term effects on the beneficiaries would likely require additional and potentially more costly programming and services. For all these reasons, the Department expects a beneficial social impact and a primarily positive reaction to the rules proposed for readoption with amendments, new rules, and repeals.

**Economic Impact**

The rules proposed for readoption with amendments, new rules, and repeals would not impose additional economic burdens on the regulated industry. The rules proposed for readoption with amendments, new rules, and repeals would not change the requirements for prior authorization, clinical eligibility, or discharge. The Department believes that the overall economic impact of the chapter has been beneficial.

The PMDC eligibility criteria atN.J.A.C. 10:166 ensure the appropriateness and fiscal efficiency of admissions to PMDC facilities by continuing the system of prior authorization by the Department based upon use of a functional assessment and precise eligibility criteria that provide for proper use of PMDC services.

The rules proposed for readoption with amendments, new rules, and repeals would continue the uniform requirement of prior authorization for all participants in PMDC by means of a functional assessment for clinical eligibility. The procedures for prior authorization and assessment have provided a comprehensive, fair, and consistent evaluation of potential PMDC beneficiaries. Since 2009, the application of the prior authorization process has resulted in efficient use of PMDC services and has decreased State Medicaid expenditures. At the same time, the enhanced clinical eligibility standards have decreased the pool of eligible participants, resulting in some PMDC facilities realizing a lower participation rate.

Since the inception of prior authorization for PMDC in 2009, the Department has needed two additional staff members to conduct reviews for prior authorization, at an approximate cost to the State of $140,000 annually.

The Department proposes to amend N.J.A.C. 10:166-3.4(d) to provide that the reauthorization procedures shall not apply to PMDC beneficiaries enrolled in a Medicaid managed care organization (MCO), for whom reauthorization shall be conducted according to the MCO’s contract with the Department and the requirements of the Medicaid State Plan or applicable waiver. The PMDC facility administrators would no longer be required to refer MCO beneficiaries to the Department for reauthorization. Although the Department has no way to quantify these costs, this should reduce administrative costs for the PMDC facilities.

As described in the Summary above, the readopted rules at N.J.A.C. 10:166-4.1 establish the Department's existing practice of paying one rate to all PMDC facilities. However, since 2008, the PMDC rate has been established by the State Legislature in the State fiscal year appropriations act. The 2017 State fiscal year appropriations act maintained the PMDC rate at $330.81. P.L. 2016, c. 10, p. 113. Since the rules proposed for readoption with amendments, new rules, and repeals establish the rate required in the appropriations act, the rules would not have a negative economic impact on PMDC facilities.

ExistingN.J.A.C. 10:166-6.1 requires PMDC facilities to annually prepare cost reports and N.J.A.C. 10:166-6.2 requires PMDC facilities to annually submit audited financial statements prepared by an accountant. Since these requirements would not be enhanced by the rules proposed for readoption with amendments, new rules, and repeals, the rules would not result in any additional expenditure by PMDC facilities in the preparation of these financial reports.

**Federal Standards Statement**

The New Jersey Medicaid State Plan refers to PMDC as "Medical day care" and identifies it as an independent clinic service. Independent clinic services are governed by 42 U.S.C. § 1396d(a)(9) and 42 CFR 440.90. Pursuant to 42 CFR 440.90, "clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. The proposed amendments, new rules, and repeals would meet but not exceed the Federal standards for independent clinic services at 42 U.S.C. § 1396d(a)(9) and 42 CFR 440.90. Therefore, a Federal standards analysis is not required.

**Jobs Impact**

The Department anticipates that no jobs will be generated or lost as a result of the rules proposed for readoption with amendments, new rules, and repeals. The Department has budgeted money for administrative costs. The proposed amendments, new rules, and repeals would not significantly alter the requirements governing the operation of PMDC. The Department does not anticipate that the rules proposed for readoption with amendments, new rules, and repeals would have a significant effect on the size of the PMDC facility staff.

**Agriculture Industry Impact**

The rules proposed for readoption with amendments, new rules, and repeals will have no impact on the agriculture industry in the State of New Jersey.

**Regulatory Flexibility Analysis**

The rules proposed for readoption with amendments, new rules, and repeals impose reporting, recordkeeping, and other compliance requirements on licensed PMDC facilities, of which there are currently 11 Medicaid certified facilities. All of these facilities are small businesses within the meaning of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

PMDC facilities have been and would continue to be required to maintain records necessary for submitting claims for reimbursement for services rendered. Compliance with the procedures specified in the rules proposed for readoption, new rules, and repeals would ensure that PMDC facilities are reimbursed in a timely manner for the provision of PMDC services.

N.J.A.C. 10:166-4.1(g) would retain the requirement that PMDC facility administrators verify a child's Medicaid financial eligibility for PMDC.

N.J.A.C. 10:166-3.4 would require PMDC facilities to submit written requests to the Department for prior authorization of PMDC services.

N.J.A.C. 10:166-2.1 would require PMDC facility administrators to calculate a PMDC facility's average daily census each calendar quarter.

The rules proposed for readoption with amendments, new rules, and repeals would continue the existing requirements atN.J.A.C. 10:166-6.1 and 6.2 that PMDC facilities prepare an annual cost report and financial statement and the reporting procedure is identical for all facilities, regardless of size. The proposed amendments, new rules, and repeals would require financial statements to be verified by certified public accountants. Although the use of certified public accountants adds to the cost of the preparation of the financial statements, the Department believes that any cost will be offset by the advantages of PMDC facilities providing data with a greater degree of reliability for the Department to oversee costs associated with the PMDC. Fiscal integrity is required of all programs under the New Jersey Medicaid Program regardless of size and the Department believes that financial statements and cost reports are the minimum reporting requirements necessary to assure such fiscal integrity.

The proposed amendments, new rules, and repeals would impose costs on PMDC facilities that are small businesses that are the same as costs imposed on all PMDC facilities generally and are described in the Economic Impact above.

The Department has determined that the proposed amendments, new rules, and repeals represent the minimum standards necessary to promote public confidence in the fiscal integrity of the PMDC program, to ensure the health and safety of children served in PMDC facilities, and to ensure the efficient allocation and use of PMDC services. Moreover, the existing regulated community of PMDC service providers consists entirely of entities that are small businesses and the Department expects that new providers in this industry would likewise be small businesses. Therefore, the Department proposes no lesser or differing requirements or standards based on business size.

**Housing Affordability Impact Analysis**

The rules proposed for readoption with amendments, new rules, and repeals will have an insignificant impact on the affordability of housing in New Jersey and there is an extreme unlikelihood that the rules would evoke a change in the average costs associated with housing because the rules concern PMDC program requirements. The rules proposed for readoption with amendments, new rules, and repeals would not apply to housing units, and would have no impact on the average cost of housing. The rules proposed for readoption with amendments, new rules, and repeals would establish Medicaid eligibility standards for pediatric medical day care services.

**Smart Growth Development Impact Analysis**

The rules proposed for readoption with amendments, new rules, and repeals will have no impact on smart growth and there is an extreme unlikelihood that the rules would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey because the rules proposed proposed for readoption with amendments, new rules, and repeals concern PMDC program requirements.

**Full text** of the rules proposed for readoption may be found in the New Jersey Administrative Code at [N.J.A.C. 10:16](https://www.lexis.com/research/buttonTFLink?_m=c4ebc6ca567be5a1a05aafbce6fc8e65&_xfercite=%3ccite%20cc%3d%22USA%22%3e%3c%21%5bCDATA%5b35%20N.J.R.%204416%28a%29%5d%5d%3e%3c%2fcite%3e&_butType=4&_butStat=0&_butNum=24&_butInline=1&_butinfo=NJ%20ADMIN%208%3a83C&_fmtstr=FULL&docnum=4&_startdoc=1&wchp=dGLzVzz-zSkAA&_md5=6ab6f8ba8b3d3389e2959832af7519f1)6.

**Full text** of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:166 Appendices A and B.

**Full text** of the proposed amendments and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. GENERAL PROVISIONS

10:166-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

…

"Division" means the Office of Community Choice Options in the Division of Aging [and Community] Services of the Department, for which the contact information is as follows: Office of Community Choice Options, Division of Aging Services, NJ Department of Human Services, PO Box 807, Trenton, NJ 08625-0807, telefacsimile: (609) 984-3897.

…

SUBCHAPTER 2. PROVIDER PARTICIPATION IN MEDICAID AND PROVIDER SANCTIONS AND REMEDIES

10:166-2.1 Standards for provider participation in Medicaid

(a) A PMDC facility shall meet the following requirements for Medicaid provider participation:

1. (No change.)

2. Conformance with the requirements for provider participation as set forth in the Medicaid Administration Manual.

i. (No change.)

ii. Additional information respecting provider enrollment may also be obtained on the Worldwide Web at [www.njmmis.com](http://www.njmmis.com) or by telephoning [Unisys] **Molina**, the fiscal aqent for PMDC, at (609) 588-6036;

3. – 8. (No change.)

SUBCHAPTER 3. PROCEDURES FOR DETERMINING CLINICAL ELIGIBILITY FOR PMDC

10:166-3.4 Procedure for referral to and authorization of PMDC

(a) – (c) (No change.)

(d) Continuation of Medicaid reimbursement for PMDC is contingent upon the Division's reauthorization of PMDC in accordance with the following procedures:

1. – 3. (No change.)

**4. The reauthorization procedures of this subsection shall not apply to PMDC beneficiaries enrolled in a Medicaid managed care organization (MCO), for whom reauthorization shall be conducted according to the MCO’s contract with the Department and the requirements of the Medicaid State Plan or applicable waiver.**

SUBCHAPTER 4. BASIS OF PAYMENT

10:166-4.1 Reimbursement rate

(a) [The] **In accordance with P.L. 2016, c. 10, the** per diem reimbursement rate for PMDC for fiscal year [2009] **2017** is [$307.92] **$330.81** (base reimbursement rate)**, as amended and supplemented by subsequent State appropriations acts**.

1. – 4. (No change.)

**5. The requirements of (a)1 through 4 above shall not apply in any State fiscal year for which the PMDC rate is established in the State appropriations act.**

(b) - (h) (No change.)

SUBCHAPTER 6. FINANCIAL REPORTING

10:166-6.1 Cost report preparation and timing of submission

(a) PMDC facility staff shall submit a completed cost report in the form at chapter Appendix B, incorporated herein by reference, covering a period of one calendar year, commencing January 1 and ending December 31, to the Department on or before March 31 of the year next succeeding the calendar year for which the cost report is prepared.

1. The form of cost report is available for download from the Department’s forms page at [nj.gov/health/forms] **[www.state.nj.us/humanservices/doas/home/forms.html](http://www.state.nj.us/humanservices/doas/home/forms.html)** and is available on request to the following:

Division of Aging Services

NJ Department of Human Services

PO Box 807

Trenton, NJ 08625-0807

2. (No change.)

(b) - (e) (No change.)

10:166-6.2 Financial statements

(a) (No change.)

(b) The audited financial statements of the PMDC facility shall be prepared:

1. – 3. (No change.)

4. On an organization-wide basis**,** so [that] that the audited financial statements fairly present the financial position and results of the PMDC facility’s total operations and cash flow.

(c) (No change.)

**APPENDIX A**

**New Jersey Department of Human Services**

**Pediatric Medical Day Care Services**

**PRIMARY HEALTH CARE PROVIDER REPORT**

**ON MEDICAID BENEFICIARY**

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| **Identifying Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. Sex:  Male  Female | | | | | | | | | | | | | | Age: | | | | |  | | | | | | Birthdate: | | | | |  | | | | | |
| 3. Medicaid Number: | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| 4. Social Security Number: | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | | |
| 5. Name of Parent/Guardian: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Address (if different from child’s): | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
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| **authorization for release of health Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| I hereby authorize | | | | | | |  | | | | | | | | | | | | | | | | to disclose health information and release the medical | | | | | | | | | | | | |
| records of | | | | |  | | | | | | | | | | | | | | , the applicant/beneficiary to the New Jersey Department of Human | | | | | | | | | | | | | | | | |
| Services, as may be requested, for the purpose of determining eligibility for Pediatric Medical Day Care services. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Signature: | | | | |  | | | | | | | | | | | | | | | | | Date: | | | | | |  | | | | | |  | |
| *(Parent or Other Legal Representative)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **health Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **History** *(attach additional sheet if needed)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 2. **Diagnosis** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| *(Add attachment for additional diagnoses)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. **Medications** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Name** | | | | | | | | | | | | | |  | | | **Dosage** | | | | | | |  | | **Route** | | | |  | | **Frequency** | | |
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| 4. **Treatment Procedure/Plan** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 5. Does child attend school?  Yes  No If Yes, number of days per week: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6. Does child receive other services? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Private Duty Nursing  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If Yes, number of days per week: | | | | | | | | | | | | |  | | | | | | Number of hours per day: | | | | | | | | | | |  | | | | |  |
| Home Health Care  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If Yes, number of days per week: | | | | | | | | | | | | |  | | | | | | Number of hours per day: | | | | | | | | | | |  | | | | |  |
| Early Intervention  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If Yes, attach copy of the latest IFSP. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7. Does child have special transportation needs?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, describe: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. Nursing care needs (check all appropriate on list): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Nutrition Elimination Cardiopulmonary Status Mobility** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Regular Diet Appropriate for age Monitoring Only Appropriate for age | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Special Diet Bowel Incontinence (age >3) CPAP/Bi-PAP Prosthesis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetic Shots Urine Incontinence (age >3) CP Monitor Splints | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Formula-Special Ostomy, type: Pulse Ox Non ambulatory | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| N/G tube/G-tube/J-tube  Vital signs >2/day >18 months old | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Slow Feeder Catheterization Oxygen Therapy Wheelchair | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FTT or Premature Home Dialysis Vent | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hyperalimentation Other (describe) \*\* Trach | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nebulizer Tx | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Suctioning | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chest Physical Tx | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Behavioral/Developmental Integument Neurological Status** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Appropriate for age Normal Normal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hyperactive Burn Care Deaf | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cooperative Sterile Dressings Blind | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alert Decubiti Seizures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Developmental Delay Eczema-Severe Paralysis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental Retardation Other \*\* Neurological Deficit (describe) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Behavioral Problems\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Verbal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Non-Verbal | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \* Please describe Behavioral Problems, if checked: | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \*\* Other, describe: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. Name of Physician/Provider *(Print)*: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone Number: | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Fax Number: | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Signature of Physician: | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Date Signed: | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
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**APPENDIX B**

**NEW JERSEY DEPARTMENT OF HUMAN SERVICES**

**PEDIATRIC MEDICAL DAY CARE FACILITY**

**COST REPORT**

*(Name and Address of Day Care Center)*

*(DOH License Number)*

*(Molina Number)*

**FOR THE PERIOD OF:**

**THROUGH:**

*(Number of Months)*

*(Day Care Center Telephone Number)*

*(Day Care Center Fax Number)*

*(Email Address)*

*(Website)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **STATEMENT OF REPORTED COSTS** | | | | | | **Schedule A**  *DO NOT change any preprinted*  *wording on this schedule.* | | | |
| **Cost Center** | **Sch.** | **A** | | **B** | **C** | **D** | **E** | **F** | | **G** | **H** | **I** |
| **Number of Employees** | | **Hours** | **Salaries and Fringe Benefits** | **Fees and Other Expenses** | **Recovery and Eliminations** | **Net Expenses** | | **Expenses Applicable to APDC** | **Expenses Applicable to Non-APDC** | **Allocation Basis (Per Sch. A-5)** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | GFRB | General Fringe Benefits | A-3 |  |  |  |  |  |  |  |  |  |

**RECIPIENT CARE**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2 | DNS | Director of Nursing Service |  |  |  |  |  |  |  |  |  |  |
| 3 | RNS | Nursing, RN’s - Salaried |  |  |  |  |  |  |  |  |  |  |
| 4 | RNCT | Nursing, RN’s – Contracted |  |  |  |  |  |  |  |  |  |  |
| 5 | LPNS | Nursing, LPN’s - Salaried |  |  |  |  |  |  |  |  |  |  |
| 6 | LPCT | Nursing, LPN’s - Contracted |  |  |  |  |  |  |  |  |  |  |
| 7 | UAPS | Nursing, Unlic.Assistive Personnel-Salaried |  |  |  |  |  |  |  |  |  |  |
| 8 | UAPC | Nursing, Unlic.Assistive Personnel-Contracted |  |  |  |  |  |  |  |  |  |  |
| 9 | MDDR | Medical Director |  |  |  |  |  |  |  |  |  |  |
| 10 | DS | Develop. Serv.-Child Life Specialist | A-3 |  |  |  |  |  |  |  |  |  |
| 11 | RHBT | Rehab. and Other Services (PT, OT, ST) | A-3 |  |  |  |  |  |  |  |  |  |
| 12 | PHCS | Pharmacy Consultant |  |  |  |  |  |  |  |  |  |  |
| 13 | DIET | Dietician |  |  |  |  |  |  |  |  |  |  |
| 14 | FOOD | Food |  |  |  |  |  |  |  |  |  |  |
| 15 | NLDG | Non-Legend Drugs |  |  |  |  |  |  |  |  |  |  |
| 16 | MDSP | Medical Supplies |  |  |  |  |  |  |  |  |  |  |
| 17 | SOSR | Social Services |  |  |  |  |  |  |  |  |  |  |
| 18 | LDLI | Laundry and Linen |  |  |  |  |  |  |  |  |  |  |
| 19 | HSKP | Housekeeping |  |  |  |  |  |  |  |  |  |  |
| 20 | RTNS | Recipient Transportation Services |  |  |  |  |  |  |  |  |  |  |
| 21 | OXYG | Oxygen |  |  |  |  |  |  |  |  |  |  |
| 22 |  | **Total Recipient Care** |  |  |  |  |  |  |  |  |  |  |

**GENERAL SERVICES**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 23 | ADMIN | Administration | A-1 |  |  |  |  |  |  |  |  |  |
| 24 | OADM | Other Administrative | A-2 |  |  |  |  |  |  |  |  |  |
| 25 | OBSR | Other General Services | A-3 |  |  |  |  |  |  |  |  |  |
| 26 |  | **Total General Services** |  |  |  |  |  |  |  |  |  |  |

**PROPERTY, OPERATING**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 27 |  | Maintenance |  |  |  |  |  |  |  |  |  |  |
| 28 |  | Property Taxes (Land) |  |  |  |  |  |  |  |  |  |  |
| 29 |  | Property Taxes (Building) |  |  |  |  |  |  |  |  |  |  |
| 30 |  | Utilities | A-3 |  |  |  |  |  |  |  |  |  |
| 31 |  | Property Insurance |  |  |  |  |  |  |  |  |  |  |
| 32 |  | **Total Property, Operating** |  |  |  |  |  |  |  |  |  |  |

**PROPERTY, CAPITAL**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 33 | DPAM | Depreciation and Amortization | A-6 |  |  |  |  |  |  |  |  |  |
| 34 | RTLE | Net Rentals and Leases |  |  |  |  |  |  |  |  |  |  |
| 35 | INTR | Interest |  |  |  |  |  |  |  |  |  |  |
| 36 |  | **Total Property, Capital** |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 37 | NRO | **Expenses Not Related to Center Operations** | A-4 |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 38 | TOT | **Total Expenses** |  |  |  |  |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Center Name:  DOH License Number:  Molina Number:  Cost Report F.Y.E.: | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **ADMINISTRATION** | | | | | **Schedule A-1**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
| Description | | **A** | **B** | **C** | **D** | | **E** | **F** |
| **Number of Employees** | **Hours** | **Salaries and Fringe Benefits** | **Fees and Other Expenses** | | **Recovery and Eliminations** | **Net Routine Expenses** |

**DETAILS OF ADMINISTRATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Management Fees, Provider Schedule of Explanation |  |  |  |  |  |  |
| 2 | Home Office Costs, Not in Line 1 Above |  |  |  |  |  |  |
| 3 | Director’s Fees and Expenses |  |  |  |  |  |  |
| 4 | Related Party Compensation |  |  |  |  |  |  |
| 5 | Management Auto Leasing and Depreciation |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |
| 11 | Management Out of State Travel |  |  |  |  |  |  |
| 12 | Administrator Out of State Travel |  |  |  |  |  |  |
| 13 | Assistant Administrator Out of State Travel |  |  |  |  |  |  |
| 14 | Management Salary |  |  |  |  |  |  |
| 15 | Administrator Salary |  |  |  |  |  |  |
| 16 | Assistant Administrator Salary |  |  |  |  |  |  |
| 17 | Management General Fringe Benefits |  |  |  |  |  |  |
| 18 | Administrator General Fringe Benefits |  |  |  |  |  |  |
| 19 | Assistant Administrator General Fringe Benefits |  |  |  |  |  |  |
| 20 | Management Special Fringe Benefits |  |  |  |  |  |  |
| 21 | Administrator Special Fringe Benefits |  |  |  |  |  |  |
| 22 | Assistant Administrator Special Fringe Benefits |  |  |  |  |  |  |
| 23 | Management Dues |  |  |  |  |  |  |
| 24 | Administrator Dues |  |  |  |  |  |  |
| 25 | Assistant Administrator Dues |  |  |  |  |  |  |
| 26 | Management Other (Specify): |  |  |  |  |  |  |
| 27 | Administrator Other (Specify): |  |  |  |  |  |  |
| 28 | Assistant Administrator Other (Specify): |  |  |  |  |  |  |
| 29 | **Total to Schedule A, Line 23** |  |  |  |  |  |  |

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| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **OTHER ADMINISTRATIVE** | | | | | | **Schedule A-2**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
| Description | | **Schedule A, Line Number** | | **A** | **B** | **C** | **D** | | **E** | **F** |
| **Number of Employees** | **Hours** | **Salaries and Fringe Benefits** | **Fees and Other Expenses** | | **Recovery and Eliminations** | **Net Routine Expenses** |
| 1 | Office Personnel | |  |  |  |  |  | |  |  |
| 2 | Office Supplies and Expenses | |  |  |  |  |  | |  |  |
| 3 | Telephone | |  |  |  |  |  | |  |  |
| 4 | License and Dues | |  |  |  |  |  | |  |  |
| 5 | Data Processing | |  |  |  |  |  | |  |  |
| 6 | Insurance Not Related to Property or Employees | |  |  |  |  |  | |  |  |
| 7 | Business Taxes | |  |  |  |  |  | |  |  |
| 8 | Travel | |  |  |  |  |  | |  |  |
| 9 | Accounting Fees | |  |  |  |  |  | |  |  |
| 10 | Legal Fees | |  |  |  |  |  | |  |  |
| 11 | Other Administrative Fees | |  |  |  |  |  | |  |  |
| 12 | Seminars | |  |  |  |  |  | |  |  |
| 13 | Medical Records | |  |  |  |  |  | |  |  |
| 14 | Help Wanted Ads | |  |  |  |  |  | |  |  |
| 15 | Services and Supplies Sold | |  |  |  |  |  | |  |  |
| 16 | Purchase Discounts and Rebates | |  |  |  |  |  | |  |  |
| 17 | Other OADM Recoveries | |  |  |  |  |  | |  |  |
| 18 | Amortization of Start-up Costs | |  |  |  |  |  | |  |  |
| 19 | Employee Gifts and Parties | |  |  |  |  |  | |  |  |
| 20 | Other (Specify): | |  |  |  |  |  | |  |  |
| 21 | Other (Specify): | |  |  |  |  |  | |  |  |
| 22 | Other (Specify): | |  |  |  |  |  | |  |  |
| 23 | Other (Specify): | |  |  |  |  |  | |  |  |
| 24 | Other (Specify): | |  |  |  |  |  | |  |  |
| 25 | Other (Specify): | |  |  |  |  |  | |  |  |
| 26 | Other (Specify): | |  |  |  |  |  | |  |  |
| 27 | Other (Specify): | |  |  |  |  |  | |  |  |
| 28 | Other (Specify): | |  |  |  |  |  | |  |  |
| 29 | Other (Specify): | |  |  |  |  |  | |  |  |
| 30 | Other (Specify): | |  |  |  |  |  | |  |  |
| 31 | **Total to Schedule A, Line 24** | | **A, 24** |  |  |  |  | |  |  |

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| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **OTHER COST DETAILS** | | | | | **Schedule A-3**  **Page 1 of 2**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
| Description | **Schedule A, Line Number** | **A** | **B** | **C** | **D** | | **E** | **F** |
| **Number of Employees** | **Hours** | **Salaries and Fringe Benefits** | **Fees and Other Expenses** | | **Recovery and Eliminations** | **Net Routine Expenses** |

**GFRB GENERAL FRINGE BENEFITS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | FICA - OASDI |  |  |  |  |  |  |  |
| 2 | FICA - Medicare |  |  |  |  |  |  |  |
| 3 | Workers’ Compensation |  |  |  |  |  |  |  |
| 4 | Unemployment Insurance |  |  |  |  |  |  |  |
| 5 | Disability Insurance |  |  |  |  |  |  |  |
| 6 | Medical Insurance |  |  |  |  |  |  |  |
| 7 | Life and Other Insurance |  |  |  |  |  |  |  |
| 8 | Uniform Allowance |  |  |  |  |  |  |  |
| 9 | Employee Physicians and Inoculations |  |  |  |  |  |  |  |
| 10 | Other (Specify): **Dental** |  |  |  |  |  |  |  |
| 11 | Other (Specify): **401(k)** |  |  |  |  |  |  |  |
| 12 | Other (Specify): **CPR** |  |  |  |  |  |  |  |
| 13 | Other (Specify): |  |  |  |  |  |  |  |
| 14 | Other (Specify): |  |  |  |  |  |  |  |
| 15 | General Fringe Benefit Recovery |  |  |  |  |  |  |  |
| 16 | **Total to Schedule A, Line 1** | **A, 1** |  |  |  |  |  |  |

**DS DEVELOPMENTAL SERVICES**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 17 | Other Therapy: **Daily Classroom Supplies** | |  |  |  |  |  | |  |  |
| 18 | Other Therapy: **Crafts** | |  |  |  |  |  | |  |  |
| 19 | Other Therapy: | |  |  |  |  |  | |  |  |
| 20 | Other Therapy: | |  |  |  |  |  | |  |  |
| 21 | Other Therapy: | |  |  |  |  |  | |  |  |
| 22 | Other Therapy: | |  |  |  |  |  | |  |  |
| 23 | Other Therapy: | |  |  |  |  |  | |  |  |
| 24 | **Total to Schedule A, Line 10** | | **A, 10** |  |  |  |  | |  |  |
| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **OTHER COST DETAILS** | | | | | | **Schedule A-3**  **Page 2 of 2**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
| Description | | **Schedule A, Line Number** | | **A** | **B** | **C** | **D** | | **E** | **F** |
| **Number of Employees** | **Hours** | **Salaries and Fringe Benefits** | **Fees and Other Expenses** | | **Recovery and Eliminations** | **Net Routine Expenses** |

**RHBT REHABILITATIVE AND OTHER SERVICES**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 25 | Occupational Therapy |  |  |  |  |  |  |  |
| 26 | Physical Therapy |  |  |  |  |  |  |  |
| 27 | Speech Therapy |  |  |  |  |  |  |  |
| 28 |  |  |  |  |  |  |  |  |
| 29 | Developmental Therapy |  |  |  |  |  |  |  |
| 30 |  |  |  |  |  |  |  |  |
| 31 | Other (Specify): **Social Worker PRN** |  |  |  |  |  |  |  |
| 32 | Other (Specify): |  |  |  |  |  |  |  |
| 33 | **Total to Schedule A, Line 11** | **A, 11** |  |  |  |  |  |  |

**OGSR OTHER GENERAL SERVICES**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 34 | Disposal Service |  |  |  |  |  |  |  |
| 35 | Exterminating Service |  |  |  |  |  |  |  |
| 36 | Grounds Maintenance |  |  |  |  |  |  |  |
| 37 | Medical Library |  |  |  |  |  |  |  |
| 38 | Motor Pool |  |  |  |  |  |  |  |
| 39 | Plant Security |  |  |  |  |  |  |  |
| 40 | Snow Removal |  |  |  |  |  |  |  |
| 41 | Fire Drill |  |  |  |  |  |  |  |
| 42 | Other (Specify): **IT Consultants** |  |  |  |  |  |  |  |
| 43 | Other (Specify): |  |  |  |  |  |  |  |
| 44 | **Total to Schedule A, Line 25** | **A, 25** |  |  |  |  |  |  |

**UTIL FACILITY EXPENSES**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 45 | Cable Television |  |  |  |  |  |  |  |
| 46 | Electric |  |  |  |  |  |  |  |
| 47 | Fuel Oil |  |  |  |  |  |  |  |
| 48 | Natural Gas |  |  |  |  |  |  |  |
| 49 | Water and Sewage |  |  |  |  |  |  |  |
| 50 | **Total to Schedule A, Line 30** | **A, 30** |  |  |  |  |  |  |

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| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **EXPENSES NOT RELATED TO THE**  **OPERATION OF THE CENTER** | | | | | **Schedule A-4**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
| Description | | | **A** | **B** | **C** | **D** | | **E** | **F** |
| **Number of Employees** | **Hours** | **Salaries and Fringe Benefits** | **Fees and Other Expenses** | | **Recovery and Eliminations** | **Net Routine Expenses** |
| 1 | Personal Expenses | |  |  |  |  | |  |  |
| 2 | Interest | |  |  |  |  | |  |  |
| 3 | Fines, Penalties and Non-Allowable Interest | |  |  |  |  | |  |  |
| 4 | Amortization of Organization Cost | |  |  |  |  | |  |  |
| 5 | Prescribed Drugs | |  |  |  |  | |  |  |
| 6 |  | |  |  |  |  | |  |  |
| 7 |  | |  |  |  |  | |  |  |
| 8 | Income Taxes, including N. J. Corporate Business Tax on Net Income and Subsequent Years Liability | |  |  |  |  | |  |  |
| 9 |  | |  |  |  |  | |  |  |
| 10 |  | |  |  |  |  | |  |  |
| 11 | Contributions | |  |  |  |  | |  |  |
| 12 | Collection Costs for Overdue Private Patient Accounts | |  |  |  |  | |  |  |
| 13 | Promotional and Directory Advertising Except for Bold Print Yellow Page Ads | |  |  |  |  | |  |  |
| 14 | Expenses Relating to Future Expansion, to include Architect Fees | |  |  |  |  | |  |  |
| 15 | Fund Raising Expenses | |  |  |  |  | |  |  |
| 16 | Bad Debts | |  |  |  |  | |  |  |
| 17 | Other (Specify): | |  |  |  |  | |  |  |
| 18 | Other (Specify): | |  |  |  |  | |  |  |
| 19 | Other (Specify): | |  |  |  |  | |  |  |
| 20 | Other (Specify): | |  |  |  |  | |  |  |
| 21 | Other (Specify): | |  |  |  |  | |  |  |
| 22 | Other (Specify): | |  |  |  |  | |  |  |
| 23 | Other (Specify): | |  |  |  |  | |  |  |
| 24 | Other (Specify): | |  |  |  |  | |  |  |
| 25 | Other (Specify): | |  |  |  |  | |  |  |
| 26 | Other (Specify): | |  |  |  |  | |  |  |
| 27 | **Total to Schedule A, Line 37** | |  |  |  |  | |  |  |

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| **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **BASIS OF ALLOCATION SCHEDULE** | | | | | | | |
| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | | | **Schedule A-5**  *DO NOT change any preprinted*  *wording on this schedule.* | | | |
| **Code** | **Basis** | **A** | **B** | | **C** | **D** | **E** |
| **Applicable**  **to PMDC** | **Applicable to Non-PMDC** | | **Total** | **Percent Applicable**  **to PMDC** | **Percent Applicable to Non-PMDC** |
| 1 | DEFAULT (100% Day Care) |  |  | |  |  |  |
| 2 | Recipient Days |  |  | |  |  |  |
| 3 | Accumulated Costs |  |  | |  |  |  |
| 4 | Number of Meals Served |  |  | |  |  |  |
| 5 | Square Feet |  |  | |  |  |  |
| 6 | Other: |  |  | |  |  |  |
| 7 | Other: |  |  | |  |  |  |
| 8 | Other: |  |  | |  |  |  |
| 9 | Other: |  |  | |  |  |  |
| 10 | Other: |  |  | |  |  |  |
| 11 | Other: |  |  | |  |  |  |
| 12 | Other: |  |  | |  |  |  |
| 13 | Other: |  |  | |  |  |  |
| 14 | Other: |  |  | |  |  |  |
| 15 | Other: |  |  | |  |  |  |
| 16 | Other: |  |  | |  |  |  |
| 17 | Other: |  |  | |  |  |  |
| 18 | Other: |  |  | |  |  |  |
| 19 | Other: |  |  | |  |  |  |
| 20 | Other: |  |  | |  |  |  |
| 21 | Other: |  |  | |  |  |  |
| 22 | Other: |  |  | |  |  |  |
| 23 | Other: |  |  | |  |  |  |
| 24 | Other: |  |  | |  |  |  |
| 25 | Other: |  |  | |  |  |  |
| 26 | Other: |  |  | |  |  |  |

**The following allocation bases are acceptable. Only one allocation base may be used per line. This form MUST BE completed for ALL applicable lines. Use of any other basis MUST BE accompanied by the Department’s letter approving the use of the other basis. The Department’s letter is valid for a one-year period only. Use the default (0) for all 100% Pediatric Medical Day Care Center lines.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Cost Center*** | | |  | | ***Allocation Basis*** | | | |
|  | | |  | |  | | | |
| *1. General Fringe Benefits, Administration and Other Administrative* | | |  | | *Recipient Days or Accumulated Costs* | | | |
|  | | |  | |  | | | |
| *2. Dietary, Food* | | |  | | *Recipient Days or Number of Meals Served* | | | |
|  | | |  | |  | | | |
| *3. Housekeeping, Other General Services, ALL Property Operating and Fixed Properly Cost Centers* | | |  | | *Square Feet* | | | |
|  | | |  | |  | | | |
| *4. Nursing, All Special Care Cost Centers* | | |  | | *Recipient Days or Actual Cost* | | | |
| **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **ITEMIZED DEPRECIATION SCHEDULE** | | | | | | | | | |
| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | | | | **Schedule A-6**  *DO NOT change any preprinted*  *wording on this schedule.* | | | | |
| Description | | **A** | | **B** | | **C** | **D** | **E** | |
| **Date of**  **Purchase** | | **Purchase**  **Price** | | **Length of**  **Useful Life**  **(Years\*)** | **Accumulated Depreciation \*\*** | **Current**  **Depreciation \*\*** | |
| 1 |  |  | |  | |  |  |  | |
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| 34 |  |  | |  | |  |  |  | |
| 35 |  |  | |  | |  |  |  | |
| 36 | Total to Schedule A, Line 32 |  | |  | |  |  |  | |

\* Years is NOT subject to change.

\*\* Depreciation reported must be consistent with Federal Tax reporting.

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| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **ITEMIZED SALARY SCHEDULE** | | | | | **Schedule A-7**  **Page 1 of 2**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
| **Sch.A**  **Line No.** | **Name** | Position | | **Function Code \*** | **Total Hours Per Week** | **Clinical Hours Per Week** | **Annual Salary** | | **Full Time Equivalent** | **Work Schedule**  **Days and Hours of the Day** |
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| **Page 1 Total** | | | | |  |  |  | |  |  |

\*Codes: A-Administration C-Clinical Staff D–Dietary Staff S-Support Staff T-Transportation

Note: Administrator and Assistant Administrator are reported under “A”, Administration.

|  |  |  |  |  |  |  |  |  |  |  |
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| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **ITEMIZED SALARY SCHEDULE** | | | | | **Schedule A-7**  **Page 2 of 2**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
| **Sch.A**  **Line No.** | **Name** | Position | | **Function Code \*** | **Total Hours Per Week** | **Clinical Hours Per Week** | **Annual Salary** | | **Full Time Equivalent** | **Work Schedule**  **Days and Hours of the Day** |
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\*Codes: A-Administration C-Clinical Staff D–Dietary Staff S-Support Staff T-Transportation

Note: Administrator and Assistant Administrator are reported under “A”, Administration.

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| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **NUMBER OF SLOTS UTILIZATION/**  **GROSS REVENUE FROM ROUTINE SERVICES** | | | | | **Schedule B**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
|  | | **Number of Slots** | | | | | **E** | **F** |
| **A** | **B** | **C** | **D** | | **A + B**  **Total Amortized** | **C + D**  **Total Occupied** |
| **Authorized** | | **Occupied** | | |
| **AM** | **PM** | **AM** | **PM** | |

A NUMBER OF SLOTS UTILIZATION

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Private |  |  |  |  |  |  |
| 2 | Medicaid |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 | Other (Specify): |  |  |  |  |  |  |
| 5 | Other (Specify): |  |  |  |  |  |  |
| 6 | Other (Specify): |  |  |  |  |  |  |
| 7 | Other (Specify): |  |  |  |  |  |  |
| 8 | Other (Specify): |  |  |  |  |  |  |
| 9 | ANNUAL UTILIZATION |  |  |  |  |  |  |

B GROSS REVENUES FROM ROUTINE SERVICES

|  |  |  |  |
| --- | --- | --- | --- |
| 10 | Private |  |  |
| 11 | Medicaid |  |
| 12 | ABC Program for Medically Fragile Children |  |
| 13 |  |  |
| 14 |  |  |
| 15 |  |  |
| 16 |  |  |
| 17 |  |  |
| 18 |  |  |
| 19 |  |  |
| 20 | Other (Specify): |  |
| 21 | Other (Specify): |  |
| 22 | Other (Specify): |  |
| 23 | Other (Specify): |  |
| 24 | Other (Specify): |  |
| 25 | TOTAL REVENUES FROM ROUTINE SERVICES |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **INFORMATION SHEET** | | | **Schedule C**  *DO NOT change any preprinted*  *wording on this schedule.* | | | | |
| A. **TYPE OF FACILITY** Yes No | **B. IDENTIFYING NUMBER** | | **C. TYPE OF OWNERSHIP Yes No** | | | | | | |
| 1. | 1. Federal ID **\_\_\_\_\_\_\_\_\_\_\_\_** | | 1. Proprietary | | | | | | |
| 2. | 2. Licensing Number **\_\_\_\_\_\_\_\_\_\_\_\_** | | 2. Voluntary | | | | | | |
| 3. | 3. Provider Number **\_\_\_\_\_\_\_\_\_\_\_\_** | | 3. Governmental | | | | | | |
| 4. Pediatric Medical Day Care | 4. MOLINA Number **\_\_\_\_\_\_\_\_\_\_\_\_** | | 4. Other (Specify): | | | | | | |
| 5. Other (Specify): | 5. Letter of Agreement **\_\_\_\_\_\_\_\_\_\_\_\_** | | Building Land | | | | | | |
|  | 6. Other (Specify): **\_\_\_\_\_\_\_\_\_\_\_\_** | | Owned by Operator: | | | | | | |
| **D. EMPLOYEE MEALS** |  | | Leased from Related Organization: | | | | | | |
| 1. Estimated Meals served to Employees per Year: **\_\_\_\_\_\_\_\_\_\_** | **E. LICENSED SLOTS** | | Leased from Unrelated Organization: | | | | | | |
| 2. Estimated Average Price Charged to Employees: **\_\_\_\_\_\_\_\_\_\_** | 1. Number of Slots **\_\_\_\_\_\_\_\_\_\_\_\_** | | Name of Licensee Corporation Owning Facility: | | | | | | |
|  |  | |  | | | | | | |
|  |  | | Name of Organization Operating Facility: | | | | | | |
|  |  | |  | | | | | | |
|  |  | |  | | | | | | |
| **F. CONTRACTED SERVICES Yes No** | **If Yes, Name of Contracted Vendor** | |  | **Contract Amount Reported in Sch. A** | |  | **Schedule A,**  **Line Number** |  |
| 1. Meal Preparation |  | |  |  | |  |  |  |
| 2. Recipient Transportation Service |  | |  |  | |  |  |  |
| 3. Other (Specify): |  | |  |  | |  |  |  |
| 4. Other (Specify): |  | |  |  | |  |  |  |
| 5. Other (Specify): |  | |  |  | |  |  |  |
| 6. Other (Specify): |  | |  |  | |  |  |  |
| 7. Other (Specify): |  | |  |  | |  |  |  |
|  |  | |  | | | | | | |
| **G. HOURS OF OPERATION** | | |  | | | | | | |
| 1. Days of Operation Mon Tues Wed Thurs Fri Sat Sun | | |  | | | | | | |
| 2. Hours of Operation (Indicate Times) | | | | | | | | | |
| (Example: 8:30 – 10:00) AM | | | | | | | | | |
| (Example: 1:00 – 4:30) PM | | | | | | | | | |
| 3. Hours of Structured Programming AM | | | | | | | | | |
| PM | | | | | | | | | |
|  | | | | | | | | | |

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| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **DATA REGARDING RELATED PARTIES**  **AND KEY EMPLOYEES** | | | | **Schedule D**  *DO NOT change any preprinted*  *wording on this schedule.* | | |
|  | A | B | | C | D | E | | F | G |
| **Related Party Type** | **Related Party Name** | | **Loans** | | **Equity Percent of Total** | | **Reporting Period Transactions** | |
| **Ending Balance** | **Annual Interest Rate** | **Nature of Transaction(s)** | **Schedule A**  **Costs** |
|
| 1 |  |  | |  |  |  | |  |  |
| 2 |  |  | |  |  |  | |  |  |
| 3 |  |  | |  |  |  | |  |  |

DATA REGARDING KEY EMPLOYEES INCLUDING RELATED PARTIES

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **H** | **I** | **J** | **K** | **L** | **M** | **N** | **O** |
| **Title** | **Name of Employee** |  | **Hours Worked** | **Annual Compensation** | **Special Fringe Benefits** | **Auto Expense and Other** | **Related Party?**  **Yes/No** |
| 4 | Administrator |  |  |  |  |  |  |  |
| 5 | Asst. Administrator |  |  |  |  |  |  |  |
| 6 | Nursing Director |  |  |  |  |  |  |  |
| 7 | RN Supervisor |  |  |  |  |  |  |  |
| 8 | President |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |

RELATED EMPLOYEE AND/OR WORKS IN MORE THAN ONE PEDIATRIC MEDICAL DAY CARE CENTER OR NURSING FACILITY

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Name of Employee** | **E. I. Number** | **Center’s Name** | **Position(s)** | **Hours Worked** | **Compensation** |
| 10 |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |
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| --- | --- | --- |
| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **RECONCILIATION** | **Schedule E**  *DO NOT change any preprinted*  *wording on this schedule.* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **A** | **B** | **C** | **D** |
| **SCHEDULE** | **COLUMN** | **LINE** | **AMOUNT** |

EXPENSES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 | Total Gross Salaries Reported |  |  |  |  |
| 2 | Total Gross Salaries per Form 941 |  |  |  |  |
| 3 | Difference Line (Line 1 less Line 2) |  |  |  |  |
| 4 | Explanations of Line 3 |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 | Total Expenses Reported |  |  |  |  |
| 9 | Total Expenses Per Financial Statements |  |  |  |  |
| 10 | Difference Line (Line 8 less Line 9) |  |  |  |  |
| 11 | Explanations of Line 10 |  |  |  |  |
| 12 |  |  |  |  |  |
| 13 |  |  |  |  |  |
| 14 |  |  |  |  |  |
| 15 |  |  |  |  |  |
| 16 | TOTAL |  |  |  |  |

REVENUES

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1 | Routine Revenues | B |  |  |  |
| 2 | Incidental Revenues |  |  |  |  |
| 3 | Other Operating Revenues |  |  |  |  |
| 4 | SCHEDULE |  |  |  |  |
| 5 | Total Revenues Reported |  |  |  |  |
| 6 | Total Revenues per Financial Statements |  |  |  |  |
| 7 | Difference Line (Line 5 less Line 6) |  |  |  |  |
| 8 | Explanations of Line 7 |  |  |  |  |
| 9 |  |  |  |  |  |
| 10 |  |  |  |  |  |
| 11 |  |  |  |  |  |
| 12 | TOTAL |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NEW JERSEY DEPARTMENT OF HUMAN SERVICES**  **PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**  **CERTIFICATION BY OWNER / PROVIDER** | | | | | |
| Center Name:  DHS License Number:  Molina Number:  Cost Report F.Y.E.: | | | | **Schedule F**  *DO NOT change any preprinted*  *wording on this schedule.* | |
| MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE AND/OR FEDERAL LAW.  I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report, supporting Schedules, and financial information prepared for the Pediatric Medical Day Care Facility identified and for the reporting period thereof, and to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of this Pediatric Medical Day Care Facility in accordance with applicable instructions, except as noted herein, in writing.  SIGNED: | | | | | |
|  |  |  |  | |  |
|  | Complete Name of Certifying Officer |  | Title of Certification Officer | |  |
|  |  |  |  | |  |
|  | Signature of Certifying Officer |  | Date Signed | |  |
|  |  |  |  | |  |
| If this Cost Report and Schedules were completed by other than the Administrator of the Pediatric Medical Day Care Facility, the preparer **must** sign and date the following statement:  TO THE BEST OF MY KNOWLEDGE, ALL THE COSTS CONTAINED WITHIN THIS COST REPORT AND SCHEDULES WERE PREPARED FROM THE RECORDS OF THIS PEDIATRIC MEDICAL DAY CARE FACILITY AND REASONABLY RELATE TO PATIENT CARE.  SIGNED: | | | | | |
|  | | |  | |  |
|  | |  |
|  |  |  |  | |  |
|  | Name of Preparer |  | Address of Preparer | |  |
|  |  |  |  | |  |
|  | Name of Preparer Firm |  | Telephone Number of Preparer | |  |
|  |  |  |  | |  |
|  | Signature of Preparer |  | Date Signed | |  |