

CHAPTER 87**PEDIATRIC MEDICAL DAY CARE SERVICES****Authority**

N.J.S.A. 30:4D-6b(12), 6b(17), 7, 7a, 7b, 7c and 12; Reorganization Plan 001-1996; 42 U.S.C. §1396a; and 42 CFR 440.90.

Source and Effective Date

R.2009 d.346, effective November 16, 2009 (operative April 1, 2010).
See: 40 N.J.R. 6328(a), 41 N.J.R. 4257(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 87, Pediatric Medical Day Care Services, expires on November 16, 2016. See: 43 N.J.R. 1203(a).

Chapter Historical Note

Chapter 87, Pediatric Medical Day Care Services, was adopted as new rules by R.2009 d.346, effective November 16, 2009 (operative April 1, 2010). See: Source and Effective Date.

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(a) The purpose of this chapter is to provide standards for Medicaid reimbursement and Medicaid clinical eligibility for pediatric medical day care (PMDC) services.

1. PMDC is a program that 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 medically complex, 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.

(b) This chapter applies to children who are Medicaid beneficiaries applying for authorization or reauthorization to participate in PMDC.

(c) This chapter applies to PMDC facilities that seek to participate in and receive reimbursement for providing PMDC services and to maintain their active Medicaid provider status.

8:87-1.2 Definitions

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

“Administrator” means a PMDC facility administrator appointed pursuant to N.J.A.C. 8:43J-3.1.

“Advanced practice nurse” means “advanced practice nurse” pursuant to N.J.A.C. 8:43J-1.2.

“Asthma Guidelines” means the Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma, Full Report 2007 of the National Heart, Lung, and Blood Institute of the National Institutes of Health, US Department of Health and Human Services, 2007 edition, incorporated herein by reference, as amended and supplemented, available at <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>.

“Average daily census” means the total units of service billed by a PMDC facility per calendar quarter divided by the total number of days during the same calendar quarter in which a PMDC facility was open for operation.

“Business day” means any day other than a Saturday or a Sunday, and any day other than a day designated as a holiday by the Federal government or the State of New Jersey.

“Calendar quarter” means a period of three consecutive months within a calendar year, beginning on January 1 and ending on March 31; beginning on April 1 and ending on June 30; beginning on July 1 and ending on September 30; or beginning on October 1 and ending on December 31.

“Child” means an individual aged birth through the last day prior to his or her sixth birthday.

“Class III medical device” means a medical device that the Food and Drug Administration has categorized as “class III” pursuant to 21 CFR 860.3.

“CMS” means the Centers for Medicare and Medicaid Services, a United States Federal agency within the Department of Health and Human Services, which administers Medicare, Medicaid and the State Children’s Health Insurance Program.

“Cost report” means a document that contains PMDC facility information, such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicaid) and financial statement data prepared in accordance with N.J.A.C. 8:87-6.1.

“Department” means the New Jersey Department of Health and Senior Services.

“Device” means a device as that term is defined at Section 201(h) of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §321(h).

“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 and Community Services, NJ Department of Health and Senior Services, PO Box 807, Trenton, NJ 08625-0807, telefacsimile: (609) 984-3897.

“Facility” means a pediatric medical day care facility.

“Family” means individuals who are related by blood, marriage, civil union, domestic partnership or a legal process.

“Financial statement” means a formal statement of the financial status and net worth of a PMDC facility, setting forth and classifying assets, liabilities, revenue, expenses, sources and uses of funds, statement of changes in fund balance or net worth and notes as of a specified date prepared in accordance with N.J.A.C. 8:87-6.2.

“Fiscal agent” means an entity that processes and adjudicates provider claims on behalf of programs administered in whole or part pursuant to N.J.A.C. 10:49.

“Fiscal year” means the New Jersey State government’s accounting year, which begins July 1 and ends June 30.

“Functional assessment” means an evaluation of a Medicaid beneficiary’s health status performed by professional staff designated by the Department in accordance with N.J.A.C. 8:87-3.1.

“Inflation adjustment factor” means a figure used to adjust for inflation between the establishment date of the base reimbursement rate and the prospective rate period.

“Initial plan of care” means an “initial plan of care” pursuant to N.J.A.C. 8:43J-1.2.

“Interdisciplinary plan of care” means an “interdisciplinary plan of care” pursuant to N.J.A.C. 8:43J-1.2.

“Interdisciplinary team” means “interdisciplinary team” pursuant to N.J.A.C. 8:43J.

“Licensed nursing staff member” means a registered professional nurse and/or a licensed practical nurse under the employ of a facility.

“Licensed practical nurse” or “LPN” means a “licensed practical nurse” or “LPN” pursuant to N.J.A.C. 8:43J-1.2.

“Medicaid” means medical assistance provided under a State plan approved under Title XIX of the Social Security Act or otherwise authorized under Title XIX or Title XXI of the Social Security Act, including Medicaid Waiver programs authorized under sections 1115 and/or 1915 of the Social Security Act.

“Medicaid Administration Manual” means N.J.A.C. 10:49.

“Medicaid beneficiary” means a child whom the county board of social services has determined to be financially eligible to participate in Medicaid.

“Medical director” means “medical director” pursuant to N.J.A.C. 8:43J-1.2.

“Medically complex child” means a child who exhibits a severity of illness that requires ongoing skilled nursing intervention.

“Medication administration” means “medication administration” pursuant to N.J.A.C. 8:43J-1.2.

“Neonatal intensive care unit” or “NICU” means “neonatal intensive care unit” pursuant to N.J.A.C. 8:43J-1.2.

“Nursing director” means a “nursing director” pursuant to N.J.A.C. 8:43J-7.

“Ongoing” means 24-hours per day, seven days per week.

“Parent” means a “parent” pursuant to N.J.A.C. 8:43J-1.2.

“Pediatric medical day care” or “PMDC” means a health care service designed to meet the medical, developmental, educational, nutritional and psycho-social needs of medically complex and/or technology-dependent children whose medical condition requires treatment and services beyond the scope provided to children with special health care needs by day care centers or preschool programs.

“Pediatric medical day care facility” or “PMDC facility” means a facility licensed by the Department in accordance with the Standards for Licensure of Pediatric Medical Day Care Facilities, N.J.A.C. 8:43J and that possesses a valid and current Medicaid provider agreement with the Department.

“Physician” means “physician” pursuant to N.J.A.C. 8:43J-1.2.

“PMDC beneficiary” means a child who is a Medicaid beneficiary and meets clinical eligibility criteria for PMDC pursuant to N.J.A.C. 8:87-3.1 and has obtained prior authorization to receive PMDC services pursuant to N.J.A.C. 8:87-3.4.

“Prescribed therapies” mean PMDC facility services as described at N.J.A.C. 8:87-5.1.

“Primary health care provider” means “primary health care provider” pursuant to N.J.A.C. 8:43J-1.2.

“Prior authorization” means the process set forth at N.J.A.C. 8:87-3 by which professional staff designated by the Department determine whether a Medicaid beneficiary is clinically eligible to receive PMDC services.

“Private-duty nursing” means individual and continuous nursing care, provided by licensed nursing staff pursuant to N.J.A.C. 10:60-5.

“Registered professional nurse” or “RN” means “‘registered professional nurse’ or ‘R.N.’” pursuant to N.J.A.C. 8:43J-1.2.

“Skilled nursing intervention” means care that requires the knowledge and experience of licensed nursing staff or a specially trained primary caregiver able to meet the specific needs of the child in the child’s home.

“Technology-dependent child” means a child who requires a specific class III medical device to compensate for the loss of a vital body function to avert death or further disability and ongoing skilled nursing intervention in the use of the device.

“Transportation services” means the conveying of PMDC participants who require transportation between a PMDC facility and the child’s home, either directly or through contractual arrangements, in accordance with N.J.A.C. 8:43J-16.

“Unit of service” means a minimum of six consecutive hours of service provided daily to a PMDC beneficiary at a PMDC facility.

“Week” means seven calendar days, starting on Sunday and continuing through Saturday.

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

8:87-2.1 Standards for provider participation in Medicaid

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

1. Licensure and approval by the Department in accordance with the Standards for Licensure of Pediatric Medical Day Care Facilities at N.J.A.C. 8:43J.

i. Participation as a provider is contingent upon continued licensure of the PMDC facility pursuant to and in compliance with N.J.A.C. 8:43J and compliance with any applicable Federal or State laws of the Medicaid program respecting provider participation in Medicaid;

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

i. The Administrator or other corporate officer of the PMDC facility shall complete any documentation required pursuant to the foregoing.

ii. Additional information respecting provider enrollment may also be obtained on the Worldwide Web at www.njmmis.com or by telephoning Unisys, the fiscal agent for PMDC, at (609) 588-6036;

3. Maintenance of an on-site average daily census of 27 or fewer children and an on-site daily census of no more than 30 children.

i. The average daily census shall be calculated each calendar quarter beginning on January 1 of the calendar year.

ii. The facility administrator shall calculate the average daily census and shall attest in writing to the accuracy thereof;

4. Maintenance of a daily attendance record that includes the printed name and the arrival and departure times of each child attending on that day, signed by the parent or recorded by PMDC staff designated by the Administrator.

i. The facility administrator shall submit the daily attendance record to the Department upon the Department’s request.

ii. If a child’s parent is unable to sign the daily attendance record, the facility administrator or his or her designee shall attest in writing to the accuracy of the

indicated arrival and departure times of the child and shall include the signed attestation as part of the daily attendance record the PMDC facility maintains;

5. Preparation and submission of a cost report pursuant to N.J.A.C. 8:87-6.1;

6. Submission of a financial statement pursuant to N.J.A.C. 8:87-6.2;

7. Acceptance of the amounts paid by the Department in the form of per diem reimbursement for PMDC beneficiaries as payment in full plus any deductible, coinsurance or co-payment required to be paid by the PMDC beneficiary, pursuant to N.J.A.C. 10:49-9.8(b)6; and

8. Retention, as part of each PMDC beneficiary's permanent record, of the signed acknowledgement of the PMDC beneficiary's parent that a determination of a Medicaid beneficiary's clinical eligibility to receive services is not permanent and that redeterminations of clinical eligibility will be made on the basis of subsequent functional assessments pursuant to N.J.A.C. 8:87-3.1 and prior authorization of service pursuant to N.J.A.C. 8:87-3.4.

8:87-2.2 Evaluation of provider and quality assurance

(a) The Department shall conduct an evaluation of the quality and effectiveness of the services a PMDC facility provides to a PMDC beneficiary at the time professional staff designated by the Department conduct a review for reauthorization of service on-site at the PMDC facility pursuant to N.J.A.C. 8:87-3.4(c).

(b) As part of the process of reauthorization of service for a PMDC beneficiary, professional staff designated by the Department shall review:

1. The PMDC beneficiary's most current interdisciplinary plan of care for conformance with N.J.A.C. 8:43J-5;

2. The services being provided to the PMDC beneficiary and their conformity with a PMDC beneficiary's interdisciplinary plan of care and N.J.A.C. 8:87-5.1;

3. The most current interdisciplinary team's assessment of the PMDC beneficiary's progress or lack of progress in meeting the objectives prescribed by the PMDC beneficiary's interdisciplinary plan of care and any documentation by the PMDC facility staff of reasons, if any, for the PMDC beneficiary's lack of progress; and

4. The PMDC beneficiary's attendance record and reasons for absences, if any, with particular attention to an intervening hospitalization or illness.

(c) Professional staff designated by the Department performing a review for reauthorization of service for a PMDC beneficiary may contact parents of PMDC beneficiaries and, as appropriate, PMDC beneficiaries themselves

to inquire as to appropriateness of care and satisfaction with services provided.

(d) Professional staff designated by the Department performing an on-site evaluation in connection with the reauthorization of service for a PMDC beneficiary shall notify the Division of Health Facilities Evaluation and Licensing of the Department if the on-site evaluation reveals that the PMDC facility is providing substandard services and/or inadequate documentation of these services, not complying with N.J.A.C. 8:43J or otherwise violating any law or regulation applicable to the provision of PMDC.

1. Upon such notification, the Division of Health Facilities Evaluation and Licensing shall undertake enforcement action pursuant to N.J.A.C. 8:43J and 8:43E, as appropriate.

8:87-2.3 Sanctions and remedies

Non-compliance with N.J.A.C. 8:43J or 8:87 may result in sanctions and remedies being imposed as provided in the Medicaid Administration Manual, N.J.A.C. 8:43E and/or any other applicable law or regulation.

8:87-2.4 PMDC facility fair hearings and informed dispute resolution

A PMDC facility wishing to contest decisions made by the Department pursuant to N.J.A.C. 8:87-2 or 5 may request a fair hearing by submitting a request therefor, pursuant to the Medicaid Administration Manual and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

SUBCHAPTER 3. PROCEDURES FOR DETERMINING CLINICAL ELIGIBILITY FOR PMDC

8:87-3.1 Functional assessment of Medicaid beneficiaries

(a) PMDC admission and Medicaid reimbursement for PMDC shall be contingent upon a Medicaid beneficiary's receipt of authorization from the Department pursuant to N.J.A.C. 8:87-3.4 and the performance of an initial functional assessment of the Medicaid beneficiary by professional staff designated by the Department that results in a determination that the Medicaid beneficiary is a medically complex and/or technology-dependent child who requires PMDC facility services pursuant to N.J.A.C. 8:87-5.

(b) The initial functional assessment shall consist of:

1. An interview with the Medicaid beneficiary's parent(s);

2. Observation of the Medicaid beneficiary;

3. A review of the Medicaid beneficiary's medical status in the past six months with attention to changes in

symptoms, feeding, medications or activity and to intervening events, such as hospitalization or acute illness;

4. A detailed review of the skilled nursing needs of the Medicaid beneficiary during a typical 24-hour period, including, but not limited to:

- i. Dependence on mechanical ventilation;
- ii. The presence of a tracheostomy requiring frequent suctioning;
- iii. The presence of pulmonary insufficiency requiring positioning, suctioning and/or chest physical therapy;
- iv. The need for enteric feeding complicated by either gastroesophageal reflux and risk of aspiration or by a need for frequent venting of the tube, or both;
- v. The presence of diabetes requiring frequent blood sugar testing and medication adjustment;
- vi. The presence of a seizure disorder manifested by frequent and prolonged seizures requiring emergency medication administration;
- vii. The presence of moderate persistent or severe persistent asthma requiring nebulizer treatments more than twice a day and frequent medication adjustment in accordance with the Asthma Guidelines; and/or

viii. The need for intermittent bladder catheterization;

5. A detailed review of all other elements of the Medicaid beneficiary's care needs during a typical 24-hour period, including a review of:

- i. Who provides care to the beneficiary;
- ii. The types of care the beneficiary receives;
- iii. The locations at which the beneficiary receives each type of care; and
- iv. If the beneficiary receives private-duty nursing, the quantity of time (that is, the number of hours) during which, and the times and locations at which, the beneficiary receives private-duty nursing;

6. An evaluation and consideration of information about the Medicaid beneficiary's medical, rehabilitative, developmental and psychosocial needs received from the nursing director, the child's primary health care provider and/or other healthcare professionals who have current and relevant knowledge of the Medicaid beneficiary; and

7. A review of the family composition, ages of any siblings residing with the Medicaid beneficiary and the available community support.

(c) Based on the results of the functional assessment performed pursuant to (b) above, professional staff designated by the Department shall make a determination whether the Medicaid beneficiary is a technology-dependent child and/or

a medically complex child and therefore is clinically eligible to receive PMDC services.

(d) Professional staff designated by the Department performing the functional assessment shall document, in writing, the results of the functional assessment, which writing shall contain, at a minimum, the following:

1. Medicaid beneficiary identification information, including name, date of birth, sex, address, telephone number and Medicaid identification number;

2. A narrative of the Medicaid beneficiary's current medical status, past medical history and any additional considerations;

3. A determination that the Medicaid beneficiary is or is not a technology-dependent child and/or a medically complex child and a written summary of findings supporting that determination; and

4. The name and title of the professional staff designated by the Department who performed the functional assessment and the date the functional assessment was completed.

(e) Professional staff designated by the Department shall perform a functional assessment:

1. Prior to initial provision of services to a Medicaid beneficiary;

2. When the interdisciplinary plan of care reflects a change in status that may alter a PMDC beneficiary's eligibility to receive PMDC; and

3. At least every 180 days after the initial and each subsequent assessment.

8:87-3.2 PMDC clinical eligibility for Medicaid beneficiaries receiving private-duty nursing

(a) A Medicaid beneficiary who receives private-duty nursing authorized by the New Jersey Department of Human Services pursuant to N.J.A.C. 10:60 may elect to receive PMDC services instead of, but not in addition to, the authorized daytime hours of private-duty nursing, if professional staff designated by the Department determine that the Medicaid beneficiary is a medically complex child and/or a technology-dependent child pursuant to N.J.A.C. 8:87-3.1.

1. PMDC hours shall supplant, not supplement, authorized private-duty nursing hours, on an hour-for-hour basis.

2. A Medicaid beneficiary may elect to replace some or all of the authorized private-duty nursing hours for PMDC hours, but not concurrently; that is, a Medicaid beneficiary shall not receive authorized private-duty nursing during the same hours the beneficiary receives replacement PMDC.

8:87-3.3 PMDC clinical eligibility for Medicaid beneficiaries being discharged from a neonatal intensive care unit

(a) The Department shall waive the requirement at N.J.A.C. 8:87-3.4(a) that professional staff designated by the Department perform a functional assessment prior to admission to a PMDC facility for a Medicaid beneficiary being discharged from a NICU if:

1. The PMDC facility nursing director, with input from the nursing director of the NICU, performs an assessment and determines that the child is medically complex and/or technology-dependent and documents, in writing, the results of the assessment, which writing shall contain, at a minimum, a summary of findings supporting that determination;

2. Based on the PMDC nursing director's determination, the PMDC facility administrator notifies the Division, in writing, of the facility's intention to admit the Medicaid beneficiary by following the requirements for notification contained in, and submitting the documentation required at N.J.A.C. 8:87-3.4(b)1i and provides a copy of the PMDC nursing director's written assessment; and

3. Within 20 business days following the Medicaid beneficiary's admission to the PMDC facility, the facility administrator transmits by regular mail a copy of the Medicaid beneficiary's discharge summary from the NICU to the Division.

(b) Upon the Division's receipt of the notice required by (a)2 above and the discharge summary required by (a)3 above, the Department shall transmit a written notice to the PMDC facility administrator that the Department has approved Medicaid beneficiary's receipt of PMDC and shall mail a copy of the written notice to the Medicaid beneficiary's parent and to the fiscal agent.

(c) The written approval the Department issues pursuant to (b) above shall be effective for 90 days following the date of the Medicaid beneficiary's admission to the PMDC facility.

(d) Reauthorization of PMDC services for a PMDC beneficiary who was discharged from a NICU and admitted to a PMDC facility in accordance with (a) above shall be in accordance with N.J.A.C. 8:87-3.4(c).

8:87-3.4 Procedure for referral to and authorization of PMDC

(a) Medicaid reimbursement for PMDC is contingent upon the Department's issuance of authorization of PMDC to a Medicaid beneficiary.

(b) To request initial authorization a PMDC administrator shall submit the following to the Division by regular mail:

1. A completed prior authorization request form, which requires provision of information identifying the Medicaid beneficiary, the primary health care provider's report on the Medicaid beneficiary and a statement of the PMDC facility's reasons for requesting approval, which form may be obtained by telephoning the Fiscal Agent at (800) 776-6334; and

2. A completed report of the Medicaid beneficiary's primary health care provider in the form at chapter Appendix A, incorporated herein by reference.

(c) Upon receipt of the fully completed documentation required pursuant to (b) above, professional staff designated by the Department shall:

1. Review the submitted documentation;

2. Schedule a visit with the child's parent at the Medicaid beneficiary's home or at an alternate location at which the Medicaid beneficiary is present;

3. Conduct an initial functional assessment pursuant to N.J.A.C. 8:87-3.1;

4. Prepare a written evaluation and make a determination, documented in writing, that the Medicaid beneficiary is either clinically eligible or clinically ineligible to receive PMDC based on the results of the functional assessment; and

5. If, as a result of the functional assessment, professional staff designated by the Department determine that the Medicaid beneficiary is:

i. Clinically eligible for PMDC, the Division shall issue a written notice of authorization to receive PMDC to the Administrator, with a notification to the Medicaid beneficiary's parent and the fiscal agent, which authorization shall be valid for a period not to exceed 180 days from the date of the initial authorization approval; or

ii. Clinically ineligible for PMDC, the Division shall mail, to the Administrator and the Medicaid beneficiary's parent, a written notice of denial of authorization for PMDC that contains a summary of the procedures at N.J.A.C. 8:87-3.5 to which the Medicaid beneficiary's parent must adhere to appeal the determination.

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

1. The administrator shall submit a prior authorization request form to the Division no fewer than 20 business days before the expiration of the authorization for PMDC in effect at the time of request for reauthorization.

2. Upon receipt of the request, the Division shall schedule a visit to the facility during which professional staff designated by the Department shall:

- i. Review the PMDC beneficiary's medical record and current interdisciplinary plan of care;
 - ii. Observe the PMDC beneficiary;
 - iii. Interview, as appropriate, facility staff providing prescribed therapies to the PMDC beneficiary; and
 - iv. Based on information obtained pursuant to (d)2i through iii above, prepare a written determination as to whether the PMDC beneficiary continues to be medically complex and/or technology dependent.
3. If professional staff designated by the Department determine that the PMDC beneficiary is:
- i. Clinically eligible for PMDC, the Division shall issue a written notice of authorization to receive PMDC to the Administrator, with a notification to the Medicaid beneficiary's parent and the fiscal agent, which authorization shall be valid for a period not to exceed 180 days; or
 - ii. Clinically ineligible for PMDC, the Division shall mail, to the Administrator and the Medicaid beneficiary's parent, a written notice of denial of authorization for PMDC that contains a summary of the procedures at N.J.A.C. 8:87-3.5 to which the Medicaid beneficiary's parent must adhere to appeal the determination.

8:87-3.5 Fair hearing for Medicaid beneficiaries who are denied PMDC

- (a) A Medicaid beneficiary may appeal a determination of clinical ineligibility made by the Division pursuant to N.J.A.C. 8:87-3.4.
- (b) To initiate an appeal, the Medicaid beneficiary must submit a request for a fair hearing pursuant to N.J.A.C. 10:49-10 and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.
- (c) A request for an administrative hearing shall be considered timely filed if it is submitted within 20 days of the date of issuance to the beneficiary's parent of notice of the determination by professional staff designated by the Department of the child's clinical ineligibility for PMDC.
- (d) At the administrative hearing, the burden is upon the Medicaid beneficiary to demonstrate clinical eligibility for PMDC.

SUBCHAPTER 4. BASIS OF PAYMENT

8:87-4.1 Reimbursement rate

- (a) The per diem reimbursement rate for PMDC for fiscal year 2009 is \$307.92 (base reimbursement rate).

1. The Department shall rebase the base reimbursement rate every three years using data regarding median allowable costs the Department collects in PMDC facility cost reports and financial statements.

2. In years during which the Department does not rebase the base reimbursement rate, the Department shall calculate the per diem reimbursement rate payable to all PMDC facilities by multiplying the base reimbursement rate by the inflation adjustment factor.

3. The Department shall develop the inflation adjustment factor upon consideration of:

- i. The average hourly earnings of manufacturing employees in New Jersey as published by the United States Department of Labor, Bureau of Labor Statistics;
- ii. The Consumer Price Index as published by the United States Department of Labor, Bureau of Labor Statistics; and
- iii. Other standards imposed by law or regulation governing rate-setting methodology in Medicaid programs.

4. The Department shall publish a notice of revisions to the PMDC base reimbursement rate, per diem reimbursement rate, and/or inflation adjustment factor in the New Jersey Register by no later than February 1 of the fiscal year immediately preceding the fiscal year for which the revision is to be in effect.

(b) Pursuant to the Medicaid Administration Manual at N.J.A.C. 10:49-9.8(b)6, a PMDC facility shall accept the Medicaid reimbursement rates the Department establishes, and shall accept payments the Department makes on behalf of PMDC beneficiaries to PMDC facilities as payment in full for services so provided, subject to any applicable deductible, coinsurance or co-payment for which a Medicaid beneficiary may be responsible.

(c) A medical director may bill the New Jersey Medicaid Program using the Health Insurance Claim Form, CMS-1500, only for services provided to a PMDC beneficiary for whom the medical director is a designated primary health care provider.

1. A medical director shall not bill the New Jersey Medicaid Program separately for any service performed for any PMDC beneficiary in a PMDC facility while serving solely in the role of a medical director.

(d) Transportation services a PMDC facility provides are included in the per diem reimbursement rate for PMDC and are not reimbursable as a separate service.

(e) All prescribed therapies identified in the PMDC beneficiary's initial and/or interdisciplinary plan of care are included in the per diem reimbursement rate and neither the PMDC facility nor the individuals providing the prescribed

therapies shall bill the New Jersey Medicaid Program separately for these therapies.

(f) The PMDC facility administrator shall make inquiry of the child's parent respecting the existence of any private health insurance plan that provides a payment benefit for PMDC on behalf of the child and shall ensure that the PMDC facility bills any such private health insurance plan for covered services provided to the child prior to the facility submitting claims for Medicaid reimbursement to the fiscal agent.

(g) The PMDC facility administrator shall verify each child's Medicaid financial eligibility, prior to submitting a prior authorization request form, and monthly thereafter, using the Recipient Eligibility Verification System pursuant to N.J.A.C. 10:49-2.11.

(h) The Department shall reimburse PMDC facilities for no more than a combined total of five units of service per week per PMDC beneficiary, even if the PMDC beneficiary receives services from multiple PMDC facilities during the same week.

8:87-4.2 Billing codes

(a) The New Jersey Medicaid Program uses the CMS Healthcare Common Procedure Coding System (HCPCS).

1. The HCPCS codes for PMDC are as follows:

- Z1863 Pediatric medical day care facility visit for a technology-dependent child
- Z1864 Pediatric medical day care facility visit for a medically complex child

SUBCHAPTER 5. PMDC SERVICES

8:87-5.1 General provisions

(a) A PMDC beneficiary attending a PMDC facility shall receive one unit of service per day, excluding transportation time, not to exceed five units of service per week, in accordance with a primary health care provider's written order and authorization by professional staff designated by the Department pursuant to N.J.A.C. 8:87-3.4.

(b) A PMDC facility shall be equipped and staffed to accommodate no fewer than six medically complex children and/or technology-dependent children in accordance with N.J.A.C. 8:43J.

(c) All prescribed therapies shall be included in the interdisciplinary plan of care and shall be provided according to the written, dated and signed orders of the PMDC beneficiary's primary health care provider.

8:87-5.2 PMDC facility services

(a) To receive Medicaid reimbursement for PMDC, a PMDC facility shall provide services pursuant to N.J.A.C. 8:43J.

(b) In addition to the services PMDC facilities must provide pursuant to (a) above, to receive Medicaid reimbursement for PMDC, PMDC facilities shall provide, on-site, medical equipment and supplies in accordance with N.J.A.C. 8:43J-8.5, provided that Medicaid per diem reimbursement for PMDC excludes durable medical equipment and medical supplies that are provided to the PMDC beneficiary as specified in the Medicaid Supplier Manual at N.J.A.C. 10:59.

SUBCHAPTER 6. FINANCIAL REPORTING

8:87-6.1 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 and is available on request to the following:

Division of Senior Benefits and Utilization
Management
NJ Department of Health and Senior Services
PO Box 715
Trenton, NJ 08625-0715

2. The PMDC facility administrator and a corporate officer of the PMDC facility shall sign and certify the cost report.

i. If the cost report is prepared by someone other than the administrator or corporate officer of the PMDC facility, the preparer also shall sign and certify the cost report.

(b) If the Department does not receive a PMDC facility's cost report by March 31 of the calendar year next succeeding the calendar year for which the cost report is prepared, the Department shall send the PMDC facility a notice, by certified mail, return receipt requested, advising the PMDC facility that its failure to timely submit an acceptable cost report shall result in a suspension of payment of any increase based upon the application of the inflation adjustment factor to the base reimbursement rate in effect on that March 31.

1. The Department shall not implement the application of an inflation adjustment factor until the first day of the month following submission by the PMDC facility of a cost report to the Department, in a form acceptable to the Department.

(c) The Department shall review the cost report as filed by the PMDC facility and may contact PMDC facility staff either by writing or telephonically, to request additional information from PMDC facility staff if the cost report is incomplete or does not otherwise conform to the requirements of (a)1 above.

1. If PMDC facility staff fails to provide such additional information to the Department, the Department shall deem the cost report to be not filed until the PMDC facility files a cost report that is complete and conforms to the requirements of (a)1 above.

2. The Department shall provide written notice to the PMDC administrator that the PMDC facility has not filed an acceptable form of cost report and that the Department shall suspend any available increase in payment based upon the application of an available inflation adjustment factor to the then-effective base reimbursement rate for the month that the notice is so provided and until the first day of the month following submission by the PMDC facility of a cost report to the Department that is complete and conforms to (a)1 above.

(d) The Administrator or his or her designee shall submit completed cost reports bearing the original signatures of the administrator, a corporate officer of the PMDC facility and, if applicable, the preparer of the cost report, to the address specified in (a)1 above.

(e) The PMDC facility administrator or corporate officer of the PMDC facility shall certify that all financial information contained in a PMDC facility's cost report is reconciled with the PMDC facility's audited financial statements, submitted by the PMDC facility in accordance with N.J.A.C. 8:87-6.2.

8:87-6.2 Financial statements

(a) A PMDC facility shall complete and provide audited financial statements covering a period of one calendar year to the Department no later than March 31 of the year next succeeding the calendar year for which the financial statement is prepared by the PMDC facility.

1. The reporting period covered by a PMDC facility's audited financial statements shall be 12 consecutive calendar months commencing January 1 and ending December 31.

2. If the Department does not receive a PMDC facility's audited financial statements by March 31 of the calendar year next succeeding the calendar year for which the audited financial statements are prepared, the Department shall send the PMDC facility a notice, by certified

mail, return receipt requested, advising the PMDC facility that its failure to timely submit acceptable audited financial statements shall result in a suspension of payment of any inflation adjustment factor over the base rate in effect on that March 31.

i. The Department shall not implement an inflation adjustment factor until the first day of the month following submission by the PMDC facility of its audited financial statements to the Department, in a form acceptable to the Department.

3. The Department shall review the audited financial statements as filed by the PMDC facility.

i. The Department may contact PMDC facility staff, either by writing or telephonically, to request additional information from PMDC facility staff if the audited financial statements are incomplete or do not otherwise conform to the requirements of this section.

ii. If PMDC facility staff fails to provide such additional information to the Department, the audited financial statements shall be deemed by the Department as not filed until audited financial statements are filed with and accepted by the Department.

iii. The Department shall provide written notice to the Administrator that an acceptable form of the audited financial statements have not been filed and that the Department shall suspend payment of any inflation adjustment factor over the then effective base rate for the month that the notice is so provided and until the first day of the month following submission by the PMDC facility of audited financial statements to the Department, in a form acceptable to the Department.

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

1. By a certified public accountant licensed pursuant to N.J.A.C. 13:29;

2. In accordance with generally accepted auditing standards established by the American Institute of Certified Public Accountants.

3. Annually based on a calendar year beginning on January 1 and ending on the next following December 31 and submitted to the Department by PMDC facility staff at the time the PMDC facility staff submit the cost report; and

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) The audited financial statements shall include the following:

1. An opinion prepared by the certified public accountant on the audited financial statements taken as a whole;

2. A balance sheet, income statement, sources and uses of funds and any notes for the PMDC facility for the reporting period covered by the audited financial statements;

3. If the PMDC facility is a subsidiary of a corporate parent, the balance sheet, income statement, sources and uses of funds and any notes for the corporate parent and a detailed cost allocation worksheet for the corporate parent and each of its subsidiaries, including the PMDC facility, containing an explanation of the cost allocation methodologies used by the corporate parent for the PMDC facility and all of its subsidiaries; and

4. A specific statement that all required tax returns have been filed by the PMDC facility and all applicable taxes (including, but not limited to, payroll taxes) have been paid.

8:87-6.3 Audit

(a) The Department, subject to providing prior notice to the PMDC facility, may perform an on-site review at the Department's discretion of all financial information and statistics maintained by the PMDC facility to verify consistent reporting of data and/or extraordinary variations in data relating to the development of cost reports and/or financial statements by the PMDC facility.

1. Upon completion of an audit, the Department shall review its draft findings and adjustments with the PMDC facility staff and shall issue a written summary of such findings.

APPENDIX A

New Jersey Department of Health and Senior Services
Pediatric Medical Day Care Services

PRIMARY HEALTH CARE PROVIDER REPORT
ON MEDICAID BENEFICIARY

IDENTIFYING INFORMATION

- 1. Name of Beneficiary (Last, First, MI): _____
Address: _____

- Telephone Number: _____
- 2. Sex: Male Female Age: _____ Birthdate: _____
- 3. Medicaid Number: _____
- 4. Social Security Number: _____
- 5. Name of Parent/Guardian: _____
Address (if different from child's): _____

- Telephone Number: _____
- Cell Phone Number: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize _____ to disclose health information and release the medical records of _____, the applicant/beneficiary to the New Jersey Department of Health and Senior Services, as may be requested, for the purpose of determining eligibility for Pediatric Medical Day Care services.

Signature: _____ Date: _____
(Parent or Other Legal Representative)

HEALTH INFORMATION

- 1. **History** *(attach additional sheet if needed)*

PRIMARY HEALTH CARE PROVIDER REPORT ON MEDICAID BENEFICIARY
(Continued)

2. Diagnosis

- 1. _____
- 2. _____
- 3. _____

(Add attachment for additional diagnoses)

3. Medications

Name	Dosage	Route	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Treatment Procedure/Plan

Type	Frequency
_____	_____
_____	_____
_____	_____
_____	_____

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:

PRIMARY HEALTH CARE PROVIDER REPORT ON MEDICAID BENEFICIARY (Continued)

8. Nursing care needs (check all appropriate on list):

Nutrition

- Regular Diet, Special Diet, Diabetic Shots, Formula-Special, N/G tube/G-tube/J-tube, Slow Feeder, FTT or Premature, Hyperalimentation

Elimination

- Appropriate for age, Bowel Incontinence (age >3), Urine Incontinence (age >3), Ostomy, type, Catheterization, Home Dialysis, Other (describe) **

Cardiopulmonary Status

- Monitoring Only, CPAP/Bi-PAP, CP Monitor, Pulse Ox, Vital signs >2/day, Oxygen Therapy, Vent, Trach, Nebulizer Tx, Suctioning, Chest Physical Tx

Mobility

- Appropriate for age, Prosthesis, Splints, Non ambulatory >18 months old, Wheelchair

Behavioral/Developmental

- Appropriate for age, Hyperactive, Cooperative, Alert, Developmental Delay, Mental Retardation, Behavioral Problems*, Verbal, Non-Verbal

Integument

- Normal, Burn Care, Sterile Dressings, Decubiti, Eczema-Severe, Other **

Neurological Status

- Normal, Deaf, Blind, Seizures, Paralysis, Neurological Deficit (describe)

* Please describe Behavioral Problems, if checked:

Blank lines for describing behavioral problems.

** Other, describe:

Blank lines for describing other conditions.

9. Name of Physician/Provider (Print):

Address:

Telephone Number:

Fax Number:

Signature of Physician:

Date Signed:

APPENDIX B

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

**PEDIATRIC MEDICAL DAY CARE FACILITY
COST REPORT**

(Name and Address of Day Care Center)

(DHSS License Number)

(UNISYS Number)

FOR THE PERIOD OF:

THROUGH:

(Number of Months)

(Day Care Center Telephone Number)

(Day Care Center Fax Number)

(Email Address)

(Website)

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Center Name:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
 PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT

Schedule A

DO NOT change any preprinted wording on this schedule.

STATEMENT OF REPORTED COSTS

	Cost Center	Sch.	A Number of Employees	B Hours	C Salaries and Fringe Benefits	D Fees and Other Expenses	E Recovery and Eliminations	F Net Expenses	G Expenses Applicable to APDC	H Expenses Applicable to Non-APDC	I 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:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

**NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR 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						

Center Name:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
 PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT

Schedule A-2

DO NOT change any preprinted wording on this schedule.

OTHER ADMINISTRATIVE

Schedule A, Line Number	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	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:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
 PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT

Schedule A-3
 Page 1 of 2

DO NOT change any preprinted
 wording on this schedule.

OTHER COST DETAILS

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:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
 PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT

Schedule A-3
 Page 2 of 2

DO NOT change any preprinted
 wording on this schedule.

OTHER COST DETAILS

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:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

**NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
 PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT**

Schedule A-4

*DO NOT change any preprinted
 wording on this schedule.*

**EXPENSES NOT RELATED TO THE
 OPERATION OF THE CENTER**

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						

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
 PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT
 BASIS OF ALLOCATION SCHEDULE

Center Name:
 DHSS Number:
 UNISYS 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 Property Cost Centers | Square Feet |
| 4. Nursing, All Special Care Cost Centers | Recipient Days or Actual Cost |

**NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT
ITEMIZED DEPRECIATION SCHEDULE**

Center Name:
DHSS License Number:
UNISYS 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						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36	Total to Schedule A, Line 32					

* Years is NOT subject to change.

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

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
 PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT

Schedule B

DO NOT change any preprinted wording on this schedule.

Center Name:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

**NUMBER OF SLOTS UTILIZATION/
 GROSS REVENUE FROM ROUTINE SERVICES**

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:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

**NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
 PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT
 INFORMATION SHEET**

Schedule C

DO NOT change any preprinted wording on this schedule.

<p>A. TYPE OF FACILITY</p> <p>1. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Pediatric Medical Day Care <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Other (Specify): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. EMPLOYEE MEALS</p> <p>1. Estimated Meals served to Employees per Year: _____</p> <p>2. Estimated Average Price Charged to Employees: _____</p>	<p>B. IDENTIFYING NUMBER</p> <p>1. Federal ID _____</p> <p>2. Licensing Number _____</p> <p>3. Provider Number _____</p> <p>4. UNISYS Number _____</p> <p>5. Letter of Agreement _____</p> <p>6. Other (Specify): _____</p> <p>E. LICENSED SLOTS</p> <p>1. Number of Slots _____</p>	<p>C. TYPE OF OWNERSHIP</p> <p>1. Proprietary <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Voluntary <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Governmental <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Other (Specify): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><u>Building</u> <u>Land</u></p> <p>Owned by Operator: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leased from Related Organization: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leased from Unrelated Organization: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name of Licensee Corporation Owning Facility: _____</p> <p>Name of Organization Operating Facility: _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

F. CONTRACTED SERVICES	Yes	No	If Yes, Name of Contracted Vendor	Contract Amount Reported in Sch. A	Schedule A, Line Number
1. Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
2. Recipient Transportation Service	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
3. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
4. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
5. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
6. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
7. Other (Specify):	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

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

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT

Schedule D

Center Name:
DHSS License Number:
UNISYS Number:
Cost Report F.Y.E.:

DATA REGARDING RELATED PARTIES
AND KEY EMPLOYEES

DO NOT change any preprinted
wording on this schedule.

	A Related Party Type	B Related Party Name	C Loans		E Equity Percent of Total	F Reporting Period Transactions		G Schedule A Costs
			Ending Balance	Annual Interest Rate		Nature of Transaction(s)		
2								
3								

DATA REGARDING KEY EMPLOYEES INCLUDING RELATED PARTIES

	H Title	I Name of Employee	J	K Hours Worked	L Annual Compensation	M Special Fringe Benefits	N Auto Expense and Other	O 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						
14						

Center Name:
 DHSS License Number:
 UNISYS Number:
 Cost Report F.Y.E.:

**NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR 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 HEALTH AND SENIOR SERVICES
PEDIATRIC MEDICAL DAY CARE CENTER COST REPORT
CERTIFICATION BY OWNER / PROVIDER

Center Name:
DHSS License Number:
UNISYS 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