STATE OF NEW JERSEY

Department of Health and Senior Services

Nursing Facility Rate Setting and Reimbursement Cost Report
Input Data

2008 NF Cost Report

Facility Name	**Sussex County Homestead**
Period Beginning:	**January 1, 2008**
Period Ending:	**December 31, 2008**
D.H.S.S. Number:	**19510**
Unisys Number:	**4503902**
Facility Telephone:	**(973) 948-5400**
FAX Number:	**(973) 948-5810**
Email Address:	

Number of Months: 12

Please type in the green cells ONLY.

Website:

General Administrative Information

(Check all applicable blocks with an "**X**")

A. Type of Facility

- ____ Hospital
- **x** Nursing Facility
- ____ Residential Unit
- ____ Medical Day Care
- ____ Special Care: UNISYS #
- ____ Special Care: UNISYS #
- ____ Special Care: UNISYS #
- ____ Other-Specify: UNISYS #

B. Type of Ownership

- ____ Proprietary
- ____ Voluntary
- **x** Governmental
- ____ Other * **SCNF**- Specify:

	Building	Land
Owned by Operator	x	x
Leased from Related Organization		
Leased from Unrelated Organization		

Name of Licensee Corporation Owning Facility:
Sussex County

Name of Organization Operating Facility:
Sussex County

EXPENSES

SCHEDULE A

FACILITY NAME: **Sussex County Homestead**

D. H. S. S. NUMBER: **19510**

UNISYS NUMBER: **4503902**

COST REPORT F.Y.E.: **Dec 31, 2008**

The Blue Highlighted Cells have calculations. DO NOT ERASE!

DO NOT CHANGE PRE-PRINTED WORDING ON THIS SCHEDULE

Line #	Abbrev	Cost Center	(A) Hours	(B) Salaries and Fringes	(C) Fees and Other Expenses	(D) Recovery and Eliminations	(E) Net Total Expenses	(F) Expenses Applicable to NF	(G) Expenses Applicable to Non-NF [10]	(H) Allocation Basis Sch A-2
		General Fringe Benefits								
1		FICA		342,922			342,922			
2		Workers' Compensation Insurance		135,376			135,376			
3		Unemployment Insurance		22,413			22,413			
4		Disability Insurance		22,413			22,413			
5		Medical Insurance		1,285,622			1,285,622			
6		Dental Insurance					0			
7		Union Welfare					0			
8		Vision Insurance					0			
9		Uniforms					0			
10		Tuition Assistance					0			
11		Pension		325,888			325,888			
12		Employee's Physicals and Inoculations					0			
13		*Other:*					0			
14		*Other:*					0			
15		*Other:*					0			
16		General Fringe Benefit Recovery (Sch. A-1)					0			
17	GFRB	*Total General Fringe Benefits:*		2,134,634		0	2,134,634	2,134,634	0	
		Management and Administration								
18		Management Fees and Related Expenses					0			
19		Home Office Costs, Not in Line 18 above					0			
20		Director's Fees and Expenses (Limit $1,000)					0			
21		Related Party Compensation [4]					0			
22		Auto Leasing and Depreciation					0			
23		Other Auto Expenses					0			
24		Out of State Travel					0			
25		General Fringe Benefits [3]					0			
26		Special Fringe Benefits					0			
27		Dues					0			

EXPENSES

SCHEDULE A

FACILITY NAME: **Sussex County Homestead**

D. H. S. S. NUMBER: **19510**

UNISYS NUMBER: **4503902**

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28		*Other:*					0			
29	MGMT	*Total Management:* [5] [6]	0	0	0	0	0	0	0	
		Administrator								
30		Salary	2,080	104,840			104,840			
31		General Fringe Benefits [3]					0			
32		Special Fringe Benefits					0			
33		Out of State Travel					0			
34		Dues					0			
35		Auto Depreciation and Leasing					0			
36		Other Auto Expenses					0			
37		*Other:*					0			
38	ADM	*Total Administrator:* [6]	2,080	104,840	0	0	104,840	104,840	0	
		Assistant Administrator								
39		Salary	2,080	70,601			70,601			
40		General Fringe Benefits [3]					0			
41		Special Fringe Benefits					0			
42		Out of State Travel					0			
43		Dues					0			
44		Auto Depreciation and Leasing					0			
45		Other Auto Expenses					0			
46		*Other:*					0			
47	ASAD	*Total Assistant Administrator:* [6]	2,080	70,601	0	0	70,601	70,601	0	
		Other Administrative								
48		Home Office/Management Fees					0			
49		Office Personnel	13,397	356,096			356,096			
50		Office Supplies and Expenses			12,148		12,148			
51		Telephone			21,762		21,762			

EXPENSES

SCHEDULE A

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UNISYS NUMBER: **4503902**

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Line #	Abbrev	Cost Center	(A) Hours	(B) Salaries and Fringes	(C) Fees and Other Expenses	(D) Recovery and Eliminations	(E) Net Total Expenses	(F) Expenses Applicable to NF	(G) Expenses Applicable to Non-NF (10)	(H) Allocation Basis Sch A-2
52		License and Dues (8)			6,884		6,884			
53		Data Processing			27,880		27,880			
54		Insurance not related to property or employees			84,001		84,001			
55		Business Taxes					0			
56		Travel			3,082		3,082			
57		Accounting Fees					0			
58		Legal Fees					0			
59		Other Administrative Fees			29,624		29,624			
60		Seminars			9,611		9,611			
61		Medical Records / Medical Library					0			
62		Allowable Contributions					0			
63		Help Wanted Ads			6,292		6,292			
64		Services and Supplies Sold, Sch A-1, Line 4					0			
65		Purchase Discounts and Rebates, Sch A-1, Line 6					0			
66		Other OADM Recoveries, Sch A-1, Lines 15 - 17					0			
67		Amortization of Start-up Costs (7)					0			
68		MDS Coordinator	1,427	65,865			65,865			
69		Inservice Coordinator	1,772	72,428			72,428			
70		Quality Assurance					0			
71		Ward Clerk	3,725	32,337			32,337			
72		*Other:* **Orientation**	376	6,385			6,385			
73		*Total Nursing Administration:*	7,300	177,015	0	0	177,015			
74		Allowable Employee Gifts and Party					0			
75		*Other:* County Allocations			615,059		615,059			
76		*Other:* **Please See Note Below (12)**	0	0	0	0	0			
77	OADM	*Total Other Administrative:*	20,697	533,111	816,343	0	1,349,454	1,349,454	0	
		General Services								
78	FOOD	Food			233,003		233,003	233,003	0	

EXPENSES

SCHEDULE A

FACILITY NAME: **Sussex County Homestead**

D. H. S. S. NUMBER: **19510**

UNISYS NUMBER: **4503902**

COST REPORT F.Y.E.: **Dec 31, 2008**

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Line #	Abbrev	Cost Center	(A) Hours	(B) Salaries and Fringes	(C) Fees and Other Expenses	(D) Recovery and Eliminations	(E) Net Total Expenses	(F) Expenses Applicable to NF	(G) Expenses Applicable to Non-NF [10]	(H) Allocation Basis Sch A-2
		Total Food:			233,003	0	233,003	233,003	0	
		Dietary, Laundry, and Housekeeping								
79	DIET	Dietary [1]	31,811	548,214	-25,631		522,583	522,583	0	
80	LDLI	Laundry and Linen	4,043	67,822	91,352		159,174	159,174	0	
81	HSKP	Housekeeping	13,565	382,564	67,749		450,313	450,313	0	
82		*Total Dietary, Laundry, and Housekeeping:*	49,419	998,600	133,470	0	1,132,070	1,132,070	0	
		Other General Services								
83		Disposal Service			15,669		15,669			
84		Exterminating Service			22,960		22,960			
85		Grounds Maintenance			4,617		4,617			
86		Motor Pool					0			
87		Plant Security					0			
88		Snow Removal			21,091		21,091			
89		Fire Drill					0			
90		*Other:*					0			
91		*Other:*					0			
92	OGSR	*Total Other General Services:*	0	0	64,337	0	64,337	64,337	0	
		Property Operating [2]								
93	MAIN	Maintenance (exclude auto)			336,286		336,286	336,286	0	
94	PTXL	Property Taxes (Land)					0	0	0	
95	PTXB	Property Taxes (Building)					0	0	0	
96		Electric			189,869		189,869			
97		Cable Television/Satellite TV			7,711		7,711			
98		Fuel Oil			10,799		10,799			
99		Natural Gas					0			
100		Water & Sewerage			24,002		24,002			
101	UTIL	*Total Utilities:*			232,381	0	232,381	232,381	0	

EXPENSES

SCHEDULE A

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UNISYS NUMBER: **4503902**

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Line #	Abbrev	Cost Center	(A) Hours	(B) Salaries and Fringes	(C) Fees and Other Expenses	(D) Recovery and Eliminations	(E) Net Total Expenses	(F) Expenses Applicable to NF	(G) Expenses Applicable to Non-NF (10)	(H) Allocation Basis Sch A-2
102	PRIN	Property Insurance			15,574		15,574	15,574	0	
103		*Other:*					0	0	0	
104		*Total Property Operating:*	0	0	584,241	0	584,241	584,241	0	
		Property Capital (2)								
105	DPAM	Depreciation and Amortization			126,327		126,327	126,327	0	
106	RTLE	Net Rentals and Leases			10,088		10,088	10,088	0	
107	INTR	Allowable Interest					0	0	0	
108		*Total Property Capital:*			136,415	0	136,415	136,415	0	
		Nursing								
109	RNS	Nursing, RNs-Salaried	14,243	522,717			522,717	522,717	0	
110	RNCT	Nursing, RNs-Contracted					0	0	0	
111	LPNS	Nursing, LPNs-Salaried	23,729	549,201			549,201	549,201	0	
112	LPCT	Nursing, LPNs-Contracted					0	0	0	
113	OSAL	Nursing, Other-Salaried	84,647	1,471,600			1,471,600	1,471,600	0	
114	OSCT	Nursing, Other-Contracted					0	0	0	
115		*Total Nursing:*	122,619	2,543,518	0	0	2,543,518	2,543,518	0	
		Other Patient Care								
116	MDDR	Medical Director			15,669		15,669	15,669	0	
117	PTAC	Patient Activities	14,604	186,493	8,669		195,162	195,162	0	
118	PHCS	Pharmaceutical Consultant			14,936		14,936	14,936	0	
119	NLDG	Non-Legend Drugs			26,665		26,665	26,665	0	
120	MDSP	Medical Supplies			85,494		85,494	85,494	0	
121	SOSR	Social Services	1,388	45,481			45,481	45,481	0	
122	OXYG	Oxygen (13)			549		549	549	0	
123		*Total Other Patient Care:*	15,992	231,974	151,982	0	383,956	383,956	0	

EXPENSES

SCHEDULE A

FACILITY NAME: **Sussex County Homestead**

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Line #	Abbrev	Cost Center	(A) Hours	(B) Salaries and Fringes	(C) Fees and Other Expenses	(D) Recovery and Eliminations	(E) Net Total Expenses	(F) Expenses Applicable to NF	(G) Expenses Applicable to Non-NF (10)	(H) Allocation Basis Sch A-2
		Non-Routine/Non-Allowable								
127		Personal Expenses				0				
128		Interest assessed by DHSS				0				
129		Fines, Penalties and Non-Allowable Interest				0				
130		Amortization of Organization Cost				0				
131		Prescribed Drugs			86,318	-86,318				
132		Laboratory and X-Ray			9,578	-9,578				
133		Payments to Physicians (exclude Medical Director)				0				
134		Physical, Speech, Hearing and Occupational Therapy			356,138	-356,138				
135		Income Taxes, including NJ Corporate Business Tax on Net Income and subsequent years liability				0				
136		Gift Shop and Snack Bar				0				
137		Barber and Beauty Shop				0				
138		Contributions, except for Voluntary Fire and First Aid Companies in the vicinity of the Nursing Home				0				
139		Collection cost for overdue private patient accounts. (9				0				
140		Promotional and Directory advertising except for bold print yellow page ads				0				
141		Expenses relating to future expansion, including Architect Fees				0				
142		Fund Raising Expenses				0				
143		Utilization Review				0				
144		Dental Services				0				
145		Employee Gifts and Party (including Christmas Party)				0				

EXPENSES

SCHEDULE A

FACILITY NAME: **Sussex County Homestead**

D. H. S. S. NUMBER: **19510**

UNISYS NUMBER: **4503902**

COST REPORT F.Y.E.: **Dec 31, 2008**

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Line #	Abbrev	Cost Center	(A) Hours	(B) Salaries and Fringes	(C) Fees and Other Expenses	(D) Recovery and Eliminations	(E) Net Total Expenses	(F) Expenses Applicable to NF	(G) Expenses Applicable to Non-NF (10)	(H) Allocation Basis Sch A-2
146		Ambulance Services				0				
147		Home Office / Management Fees				0				
148		Bad Debts				0				
149		**PROVIDER TAX EXPENSE**				0				
150		Other: Ancillary				0				
151		Other: Misc				0				
152		Other: Respiratory Therapy				0				
153		Other: Special Care Nursing Facility				0				
154		Other: Medical Day Care				0				
155		Other: Other Patient Services				0				
156		Other:				0				
157		Other:				0				
158		Other:				0				
159		Other:				0				
160	NRNA	*Total Non-Routine/Non-Allowable Expenses:*	0	0	452,034	-452,034				
161	XXXX	**Total Expenses**	212,887	6,617,278	2,571,825	452,034	8,737,069	8,737,069	0	

NOTES:

(1) Place an "**X**" in this block if Dietary is 100% Contracted.

(2) Amounts paid by lessor for property operating should be netted from line 105 and reported on line(s) 93, 94, 95, 96 and 101 as applicable. For related lease, report depreciation and interest on lines 105 and 106.

(3) If General Fringe Benefits are not reported on lines 1 through 16.

(4) The cost of related parties should be reported in the Management Cost Center, except for those specifically working as the Administrator or Assistant Administrator.

EXPENSES

SCHEDULE A

FACILITY NAME: **Sussex County Homestead**

D. H. S. S. NUMBER: **19510**

UNISYS NUMBER: **4503902**

COST REPORT F.Y.E.: **Dec 31, 2008**

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Line #	Abbrev	Cost Center	(A) Hours	(B) Salaries and Fringes	(C) Fees and Other Expenses	(D) Recovery and Eliminations	(E) Net Total Expenses	(F) Expenses Applicable to NF	(G) Expenses Applicable to Non-NF (10)	(H) Allocation Basis Sch A-2

(5) Place an "**X**" in block if Management Costs include Home Office Costs. A separate Schedule of Home Office Costs must be attached.

(6) Place an "**X**" in block if Fringe Benefits are reported on Management, Administrator, and/or Assistant Administrator Salary.

Salary and Actual Fringe Benefits must be reported in Column C, Fees and Other Expense.

(7) Amount not reported in other cost centers.

(8) Exclude Lines 27, 34, and 43.

(9) Collection Agency costs or others doing work only.

(10) Defined as "Expenses Applicable to Residential, Sheltered, Medical Day Care, Other or Special Care Programs."

(11) **DO NOT** use Allocation Basis Number **2**, ***Accumulated Costs***, below Line 77.

(12) Detail for "Other" on Line 76 needs to be described here and the total will link to the appropriate cells.

(13) Includes all routine costs of providing Oxygen.

Other:	**Description**	**Hours**	**Salaries**	**Other Expense**	**Recovery**
OADM					
OADM					
OADM					
OADM					
OADM					
OADM					
OADM					
OADM					
OADM					
OADM					
OADM					
OADM					
OADM					
	Total of "Other" items:	0	0	0	0

Recoveries and Other Revenues

SCHEDULE A-1

FACILITY NAME: **Sussex County Homestead**

D. H. S. S. NUMBER: **19510**

UNISYS NUMBER: **4503902**

COST REPORT F.Y.E.: **Dec 31, 2008**

DO NOT CHANGE PRE-PRINTED WORDING ON THIS SCHEDULE

A.	INCIDENTAL REVENUES	(1) AMOUNT	(2) COST CENTER
1	Meals Sold to Guests or Employees		FOOD
2	Rooms Rented to Employees		RTLE
3	Equipment Rentals Excluding Routine Care		RTLE
4	Services And Supplies Sold		OADM
5	Telephone and Vending Machine Commissions		OADM
6	Purchase Discounts and Rebates		OADM
7	Laundry Services to Employees		LDLI
8	Private Nursing Services		RNS (3)
9	Medical Supplies sold to other than patients		MDSP
10	Cable Television		UTIL
11	Property Rentals		RTLE
12	Interest		INTR
13	General Fringe Benefits		GFRB
14	General Fringe Benefits		GFRB
15	*Other:* (Specify)		OADM
16	*Other:* (Specify)		OADM
17	*Other:* (Specify)		OADM
18	*Other:* (Specify)		DIET
19	*Other:* (Specify)		
20	*Other:* (Specify)		
21	*Other:* (Specify)		
22	*Other:* (Specify)		
23	*Other:* (Specify)		
24	**Total Revenues/Recoveries:**	-	

(1) Enter the line item amounts on Schedule A, Column G for the appropriate cost centers

(2) Enter the cost center syntax (i.e.; ADM, DIET, HSKP) from Schedule A where the line items for eliminations and recoveries appear on Schedule A, Column D. Cost Center abbreviations which may be used include: DIET, DPAM, HSKP, LDLI, MAIN, MDDR, MDSP, NLDG, OGSR, OSCT, OXYG, PHCS, PRIN, PTAC, PTXB, PTXL, AND SOSR.

(3) Indicate the center that the majority of cost are credited, for this center and all others.

B:	RESTRICTED FUNDS EXPENSED FOR OPERATING COSTS		(1) AMOUNT	(2) COST CENTER
25	Other:			
26	Other:			
27	Other:			
28	Other:			
29	Other:			
30	**Total Restricted Funds Expensed:**		-	

C:	Other Revenues	
	Item	**Revenue**
31	Investment Income	537
32	Trust Income	
33	Gifts and Bequests	
34	Gains/(Losses) On Sale Of Investments	
35	Permanent Declines In Market Value Of Investments	
36	*Other:* Medical Day Care	
37	*Other:* (Specify)	
38	*Other:* (Specify)	
39	*Other:* (Specify)	
40	*Other:* (Specify)	
41	*Other:* (Specify)	
42	*Other:* (Specify)	
43	*Other:* (Specify)	
44	***Total Other Revenues:***	**537**

45	**Total of Section A,B, and C:**	537

(NOTE: All income items that have not been reported on Schedule B-2 are to be reported on this schedule.)

BASIS OF ALLOCATION SCHEDULE

SCHEDULE A-2

FACILITY NAME: **Sussex County Homestead**
D. H. S. S. NUMBER: **19510**
UNISYS NUMBER: **4503902**
COST REPORT F.Y.E.: **Dec 31, 2008**

[X] **100% Nursing Facility**

[ ] **Special Care Program(s)**

Code	Basis	(A) Applicable To NF	(B) Applicable To Non-NF	(C) Total	(D) Percent Applicable To NF
0	**DEFAULT** (100% Nursing Facility)	1		1	100.0000%
1	Patient Days			0	#DIV/0!
2	Accumulated Costs			0	#DIV/0!
3	Number of Meals Served			0	#DIV/0!
4	Pounds of Laundry			0	#DIV/0!
5	Square Feet			0	#DIV/0!
6	Other:			0	#DIV/0!
7	Other:			0	#DIV/0!
8	Other:			0	#DIV/0!
9	Other:			0	#DIV/0!
10	Other:			0	#DIV/0!
11	Other:			0	#DIV/0!
12	Other:			0	#DIV/0!
13	Other:			0	#DIV/0!
14	Other:			0	#DIV/0!
15	Other:			0	#DIV/0!
16	Other:			0	#DIV/0!
17	Other:			0	#DIV/0!
18	Other:			0	#DIV/0!
19	Other:			0	#DIV/0!
20	Other:			0	#DIV/0!
21	Other:			0	#DIV/0!
22	Other:			0	#DIV/0!
23	Other:			0	#DIV/0!
24	Other:			0	#DIV/0!
25	Other:			0	#DIV/0!
26	Other:			0	#DIV/0!

Accumulated Costs, Schedule A 5,529,574

PATIENT DAYS AND BEDS

SCHEDULE B

FACILITY NAME: Sussex County Homestead
D. H. S. S. NUMBER: 19510
UNISYS NUMBER: 4503902
COST REPORT F.Y.E.: Dec 31, 2008

DO NOT CHANGE ANY PRE-PRINTED WORDING ON THIS SCHEDULE.

From: Jan 1, 2008 To: Dec 31, 2008

ACTUAL BASE PERIOD PATIENT DAYS

A. PATIENT DAYS

	(A) Nursing Facility	(B) Residential/ Shelter	(C) Special Program # 1 0	(D) Special Program # 2 0	(E) Special Program # 3 0	(F) Hospital **	(G) Total
1. Private	6,676						6,676
2. Medicaid	25,336						25,336
3. Medicare	3,282						3,282
4. Therapeutic Leave	13						13
5. Other:	621						621
6. Sub Total	35,928	0	0	0	0	0	35,928
7. Medicaid Bed Hold Days	184						184
8. "Other" Bed Hold Days	71						71
9. Total Patient Days	36,183	0	0	0	0	0	36,183
10. Percent Occupancy	96.92%	0.00%	0.00%	0.00%	0.00%	0.00%	96.92%
11. Medical Day Care Days							

B. LICENSED LONG TERM CARE BEDS *

Hospital Beds / Slots:
Sheltered/Residential Beds:

PERIOD FROM		TO	DAYS	BEDS	MAXIMUM BED DAYS
Jan 1, 2008	To:	Dec 31, 2008	366	102	37,332
	To:				
	To:				
	To:				
	To:				
	To:				
	To:				
	To:				
	To:				
		Total:	366	102	37,332

Maximum Available Bed Days: 37,332

Licensed Beds At Period End: 102

Weighted NF Licensed Beds: 102

C. MAINTAINED LONG TERM CARE BEDS *

PERIOD FROM		TO	DAYS	BEDS	AVAILABLE BED DAYS
Jan 1, 2008	To:	Dec 31, 2008	366	102	37,332
	To:				
	To:				
	To:				
	To:				
	To:				
	To:				
	To:				
	To:				
		Total:	366	102	37,332

Total Days In Period: 366

Maximum Available Bed Days: 37,332

Weighted NF Maintained Beds: 102

A copy of the Department of Health Licensing letter(s) acknowledging any bed changes during the reporting period must be submitted with this Cost Report.

*** Use these sections ONLY if Hospital Costs are reported on Schedule A.*

PATIENT DAYS AND BEDS

SCHEDULE B

FACILITY NAME: Sussex County Homestead
D. H. S. S. NUMBER: 19510
UNISYS NUMBER: 4503902
COST REPORT F.Y.E.: Dec 31, 2008

DO NOT CHANGE ANY PRE-PRINTED WORDING ON THIS SCHEDULE.

From: Jan 1, 2008 To: Dec 31, 2008

D. SPECIAL CARE PROGRAM(S)

Special Program # 1 Beds 0

PERIOD FROM		TO	DAYS	BEDS	AVAILABLE BED DAYS
	To:				
	To:				
	To:				
		Total:	0	0	0

Program # 1 Weighted Beds
Licensed Beds At Period End

Special Program # 2 Beds 0

PERIOD FROM		TO	DAYS	BEDS	AVAILABLE BED DAYS
	To:				
	To:				
	To:				
		Total:	0	0	0

Program # 2 Weighted Beds
Licensed Beds At Period End

Special Program # 3 Beds 0

PERIOD FROM		TO	DAYS	BEDS	AVAILABLE BED DAYS
	To:				
	To:				
	To:				
		Total:	0	0	0

Program # 3 Weighted Beds
Licensed Beds At Period End

NURSING SERVICES CLASSIFICATION

SCHEDULE B-1

Facility Name: Sussex County Homestead
D.H.S.S. Number: 19510

DO NOT CHANGE PRE-PRINTED WORDING ON THIS SCHEDULE

Report Period From: Jan 1, 2008 Through: Dec 31, 2008

The Blue Highligted Cells have calculations
DO NOT ERASE!

Note: *Completion of this Schedule will be used in setting of facility rate and is subject to Clinical Audit.*

Additional Nursing Services

Medicare	*Jan 2008*	*Feb 2008*	*Mar 2008*	*Apr 2008*	*May 2008*	*Jun 2008*	*Jul 2008*	*Aug 2008*	*Sep 2008*	*Oct 2008*	*Nov 2008*	*Dec 2008*	*Totals*
1. Tracheotomy Care													0
2. Use of Respirator													0
3. Head Trauma													0
4. Intravenous Therapy													0
5. Wound Care	1		1	6	3	3	3	1			2		20
6. Oxygen Therapy			5	6	4	4	4	1					24
7. N/G Tube Feeding	1	1	1	1	1	2	1	1		1	2	1	13
Totals	2	1	7	13	8	9	8	3	0	1	4	1	57

Medicaid	*Jan 2008*	*Feb 2008*	*Mar 2008*	*Apr 2008*	*May 2008*	*Jun 2008*	*Jul 2008*	*Aug 2008*	*Sep 2008*	*Oct 2008*	*Nov 2008*	*Dec 2008*	*Totals*
1. Tracheotomy Care													0
2. Use of Respirator													0
3. Head Trauma													0
4. Intravenous Therapy													0
5. Wound Care	1	2	1	1			3	2		1	4	1	16
6. Oxygen Therapy		3	7	3	2	3	1	4	3	3	4	4	37
7. N/G Tube Feeding	2								1		1	1	5
Totals	3	5	8	4	2	3	4	6	4	4	9	6	58

Private	*Jan 2008*	*Feb 2008*	*Mar 2008*	*Apr 2008*	*May 2008*	*Jun 2008*	*Jul 2008*	*Aug 2008*	*Sep 2008*	*Oct 2008*	*Nov 2008*	*Dec 2008*	*Totals*
1. Tracheotomy Care													0
2. Use of Respirator													0
3. Head Trauma													0
4. Intravenous Therapy													0
5. Wound Care		1	2	1	1					1			6
6. Oxygen Therapy		1	2	1	1					1			6
7. N/G Tube Feeding	2	1	1	1	1	1	1	1	1	2	1	1	14
Totals	2	3	5	3	3	1	1	1	1	4	1	1	26

Other	*Jan 2008*	*Feb 2008*	*Mar 2008*	*Apr 2008*	*May 2008*	*Jun 2008*	*Jul 2008*	*Aug 2008*	*Sep 2008*	*Oct 2008*	*Nov 2008*	*Dec 2008*	*Totals*
1. Tracheotomy Care													0
2. Use of Respirator													0
3. Head Trauma													0
4. Intravenous Therapy													0
5. Wound Care					1	1	1						3
6. Oxygen Therapy									1	1	6	2	10
7. N/G Tube Feeding		1											1
Totals	0	1	0	0	1	1	1	0	1	1	6	2	14

ACUITY OF CARE	*Jan 2008*	*Feb 2008*	*Mar 2008*	*Apr 2008*	*May 2008*	*Jun 2008*	*Jul 2008*	*Aug 2008*	*Sep 2008*	*Oct 2008*	*Nov 2008*	*Dec 2008*	*Totals*
1. Tracheotomy Care	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Use of Respirator	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Head Trauma	0	0	0	0	0	0	0	0	0	0	0	0	0
4. Intravenous Therapy	0	0	0	0	0	0	0	0	0	0	0	0	0
5. Wound Care	2	3	4	8	5	4	7	3	0	2	6	1	45
6. Oxygen Therapy	0	4	14	10	7	7	5	5	4	5	10	6	77
7. N/G Tube Feeding	5	3	2	2	2	3	2	2	2	3	4	3	33
Totals	7	10	20	20	14	14	14	10	6	10	20	10	155

Sum of Total Acuities Reported

PATIENT REVENUES

SCHEDULE B-2

Facility Name: **Sussex County Homestead**

Period Ending: **Dec-08**

Unisys Number: **4503902**

DHSS Number: **19510**

The Blue Highlighted Cells have calculations
DO NOT ERASE!

DO NOT CHANGE PRE-PRINTED WORDING ON THIS SCHEDULE

	(A) Nursing Facility NF	(B) Residential / Shelter	(C) Special Program # 1	(D) Special Program # 2	(E) Special Program # 3	(F) Hospital	(G) Other Patient Revenue	(H) Total
1. Gross Private Revenues	1,397,966							1,397,966
2. Contractual Allowances								0
3. Net Private Revenues	1,397,966	0	0	0	0	0	0	1,397,966
4. Gross Medicaid Revenues	5,545,048							5,545,048
5. Contractual Allowances								0
6. Net Medicaid Revenues	5,545,048	0	0	0	0	0	0	5,545,048
7. Gross Medicare Revenues	1,464,829							1,464,829
8. Contractual Allowances								0
9. Net Medicare Revenues	1,464,829	0	0	0	0	0	0	1,464,829
10. Other Gross Revenues 1*								0
11. Contractual Allowances								0
12. Other Net Revenues 1	0	0	0	0	0	0	0	0
13. Other Gross Revenues 2*	145,023							145,023
14. Contractual Allowances								0
15. Other Net Revenues 2	145,023	0	0	0	0	0	0	145,023
16. Other Gross Revenues 3*								0
17. Contractual Allowances								0
18. Other Net Revenues 3	0	0	0	0	0	0	0	0
19. Sum of Gross Revenues	8,552,866	0	0	0	0	0	0	8,552,866
20. Sum of Contractual Allowances	0	0	0	0	0	0	0	0
21. Sum of Net Revenues	8,552,866	0	0	0	0	0	0	8,552,866

*** Specify:**

Other Provider 1:

Other Provider 2: Therapies, Drugs, Lab, X-ray, etc.

Other Provider 3:

NOTES:

A. All Patient Revenue and Related deductions from Revenue are to be Recorded on this Schedule.

B. DO NOT include Bad Debts as a part of Allowances. Bad Debts are listed on Schedule A Line 148.

C. Report Allowances as an Absolute Value.

D. Revenue received or accrued means the amount received or receivable, whether in cash or in kind, from patients, third party payors, and others for nursing home services furnished by the nursing home provider, including retroactive adjustments under reimbursement agreements with third party payors without any deduction for expenses of any kind.

MISCELLANEOUS DATA

SCHEDULE B-3

FACILITY NAME: **Sussex County Homestead**

D. H. S. S. NUMBER: **19510**

UNISYS NUMBER: **4503902**

COST REPORT F.Y.E.: **Dec 31, 2008**

DO NOT CHANGE PRE-PRINTED WORDING ON THIS SCHEDULE

Indicate the number of patient therapy sessions for Medicaid patients which were unreimbursed by Medicare or other payers:

Physical Therapy	
Occupational Therapy	
Speech Therapy	
Total Patient Therapy Sessions:	0

Indicate the following Medicare information:

Medicare Intermediary	Highmark
Medicare Provider Number	315378
Effective date of Medicare Rate	10/1/2008

Note : **A Patient Therapy Session is one time period during which any number of physical, occupational and / or speech therapies treatment have been performed**

SELECTED DATA

SCHEDULE C

Facility Name: **Sussex County Homestead**
D. H. S. S. NUMBER: **19510**
Unisys Number: **4503902**
Period Ending: **Dec 31, 2008**

DO NOT CHANGE PRE-PRINTED WORDING ON THIS SCHEDULE

A. NURSING HOURS REQUIREMENT:

	Total Hours Paid	Total Hours Worked	Percent Worked
1. Nursing RNs Salaried, Schedule A, Line 109	14,243	12,590	
2. Nursing LPNs Salaried, Schedule A, Line 111	23,729	20,608	
3. Nursing Other Salaried, Schedule A, Line 113	84,647	72,487	
4. **Total Nursing Salaried Hours**	122,619	105,685	86%

B. CURRENT PROPERTY DATA:

	A Capitalized Maintenance & Replacement	B Additions	C Net Rental & Leases
5. Land			
6. Land Improvements			
7. Buildings including Additions	62,132		
8. Building Equipment			
9. Reimbursable Moveable Equipment	59,379		10,088
10. Non-Reimbursable Moveable Equipment			
11. Motor Vehicle (Other than for Administrator, Assistant Administrator or Management)			
12. Leasehold improvements & Other Amortization Item			
13. Special Program:			
14. Special Program:			
15. Special Program:			
16. TOTAL EXPENDITURES	121,511	-	10,088

RELATED PARTIES AND SELECTED EMPLOYEES

SCHEDULE D

Facility Name: **Sussex County Homestead**
D. H. S. S. NUMBER: **19510**
Unisys Number: **4503902**
Period Ending: **Dec 31, 2008**

DO NOT CHANGE PRE-PRINTED WORDING ON THIS SCHEDULE

Data Concerning Related Parties Other Than Employees

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	
			Loans		Equity	Reporting Period Transactions [3]	Schedule A	
	Related Party Type [2]	Related Party Name	Ending Balance	Annual Interest Rate	Percent of Total	Nature of Transaction(s)	Amount	Line Number
1								
2								
3								
4								
5								

Data Regarding Selected Employees Including Related Parties

		(H)	(I)	(J)	(K)	(L)	(M)	(N)
		Name of Employee	Live on Premises?	Hours Worked	Annual Compensation	Special Fringe Benefits	Auto Expense and Other	Related Party (Yes/No)
☐ (1)	6 Administrator	Jake Lighten	No	2,080	104,840	0	0	No
☐ (1)	7 Asst. Administrator	Barbara Wendland	No	2,080	70,601	0	0	No
☐ (1)	8 Nursing Director	Sandra O'Brien	No	2,080	95,702		0	No
☐ (1)	9 Controller		No					No
☐ (1)	10 Chief Financial Officer		No					No
☐ (1)	11							
☐ (1)	12							
☐ (1)	13							
☐ (1)	14							

Name of Employee [1]	Facility Name	Position	Hours Worked

(1) Check if Employee works in another Facility. The bottom section MUST be completed for any employee listed on Lines 6-14.

(2) Type Owner or Related to Owner.

(3) Include compensation, purchases, interest expense, leases and any other transaction affecting data reported on Schedule A.

RECONCILIATION

SCHEDULE E

FACILITY NAME: **Sussex County Homestead**
D. H. S. S. NUMBER: **19510**
UNISYS NUMBER: **4503902**
COST REPORT F.Y.E.: **Dec 31, 2008**

EXPENSES

		SCHEDULE	COLUMN	LINE	AMOUNT
1	Total Gross Salaries Reported	A	B	161	4,482,644
2	Total Gross Salaries per Form 941				4,482,644
3	Difference (Line 1 less Line 2)				0
4	Explanations of Line 3:				
5	County Consolidated				
6					
7					
8					
9					
10	Total Expenses Reported:	A	B & C	161	9,189,103
11	Total Expenses per Financial Statements				9,189,101
12	Difference Line (Line 10 less Line 11)				2
13	Explanations for Line 12				
14	Rounding				2
15					
16					
17					

REVENUES

		SCHEDULE	COLUMN	LINE	AMOUNT
1	Patient Revenues	B-2	H	21	8,552,866
2	Recoveries & Other Revenues	A-1	"AMOUNT"	24+44	537
3	Restricted Funds Recovery	A-1	"AMOUNT"	30	
4	Unrestricted Income				
5	Total Revenues Reported				8,553,403
6	Total Revenues per Financial Statements				8,553,403
7	Difference (Line 5 less Line 6)				0
8	Explanations for Line 8:				
9					
10					
11					
12					
13					
14					
15					
16					
17					

Certification

SCHEDULE F

CERTIFICATION BY TRUSTEE, OWNER, OFFICER, PARTNER OR ADMINISTRATOR OF PROVIDER

Jake Lighten (Name) **Administrator** (Title)

of the **Sussex County Homestead**
(Facility Name)

129 Morris Turnpike
(Street Address)

Newton (City) **NJ** (State) **07860-0000** (Zip Code)

19510 *DHSS Number:*

4503902 *Unisys Number:*

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE 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 facilty with a Cost Report period beginning on Jan 1, 2008 and ending on Dec 31, 2008 , and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted, and relate to patient care.

Signature (Please sign in blue ink)

(Date Signed)

(Phone Number)

(E-Mail address)

Details of Legal, Other Professional, and Contracted Services

SCHEDULE G

FACILITY NAME: **Sussex County Homestead**
D. H. S. S. NUMBER: **19510**
UNISYS NUMBER: **4503902**
COST REPORT F.Y.E.: **Dec 31, 2008**

Any expense that exceeds an annual amount of $15,000 to any consultant or firm must be reported on this schedule, and a copy of the contract must be submitted with the cost report. If the contract was filed in a prior year, there is no need to resubmit the contract unless it has been revised.

DO NOT CHANGE PRE-PRINTED WORDING ON THIS SCHEDULE

Please type in the green cells for this page.

*Legal Fees**

Name of Firm	Description of Services	Amount on Cost Report	Does a Related Party Exist?	Name of Related Party & Relationship		
	N/A					

Other Professional / Consultant Fees

Payee	Description of Services	Amount on Cost Report	Does a Related Party Exist?	Name of Related Party & Relationship	Have these services been provided by this firm or another firm in the past?	If Yes, indicate the Provider and Year
Endura Care	Therapy	397929	No		Yes	Same
Dr. Anthony DePaola	Medical Director	20904	No		Yes	Same
Pharma Care	Pharmacy Consultant	16246	No		Yes	Same

* All reported amounts for legal fees, regardless of amount, must be listed and acompanied by a letter from the law firm that includes a full discription of the services provided and the dollar amount billed for each service.

Details of Legal, Other Professional, and Contracted Services

SCHEDULE G

Contracted Services / Equipment Leases

Payee	Description of Services	Amount on Cost Report	Does a Related Party Exist?	Name of Related Party & Relationship	Have these services been provided by this firm or another firm in the past?	If Yes, indicate the Provider and Year	Terms of Contract
	N/A						

Debt Service / Interest Expense

Name of Creditor	Purpose of Loan	Original Loan Amount	Principal Amort. Period	Interest Rate / Term	Is there an Interest Swap Agreement?	If Yes, Who is the Contract With?	Terms of Agreement	Is there any related party relationship ?	Was the agreement competitive bid or was it negotiated?
	N/A								

Any expense that exceeds an annual amount of $15,000 to any consultant or firm must be reported on this schedule, and a copy of the contract must be submitted with the cost report. If the contract was filed in prior year, there is no need to resubmit unless it has been revised.

Patient Days and Revenue Details

Schedule B Supplement

FACILITY NAME: ıty Homestead
D. H. S. S. NUMBER: 19510
UNISYS NUMBER: 4503902
COST REPORT F.Y.E.: Dec 31, 2008

		Total Patient Days				Total Revenue			
		Patient Days As Reported in Sch B	Days Reported NHA 100	Diff		Revenue Reported in Sch B-2	Revenue Reported NHA 100	Diff
1	**Medicaid**	25,336	25,520	-184	**Medicaid**	5,545,048	4,554,731	990,317
2	**New Jersey**	25,336	25,520	-184	**New Jersey**	5,545,048	4,554,731	990,317
3	Routine	25,336	25,520	-184	Routine	5,545,048	4,554,731	990,317
4	Hospice	0	0	0	Hospice			0
5	Managed Care:	0	0	0	Managed Care:			0
6	Respite (State Waiver Program)	0	0	0	Respite (State Waiver Program)			0
7								0
8	**Out of State**	0	0	0	**Out of State**	0	0	0
9	Routine	0	0	0	Routine			0
10	Hospice	0	0	0	Hospice			0
11	Managed Care:	0	0	0	Managed Care:			0
12	Respite (State Waiver Program)	0	0	0	Respite (State Waiver Program)			0
13								0
14	**Private Pay**	6,676	6,741	-65	**Private Pay**	1,397,966	1,184,588	213,378
15	Private Self Pay	6,676	6,741	-65	Private Self Pay	1,397,966	1,184,588	213,378
16	Private Insurance	0	0	0	Private Insurance			0
17	Pending Medicaid Days	0	0	0				
18								0
19	**Medicare**	3,282	3,282	0	**Medicare**	1,464,829	1,536,534	-71,705
20	Part A Fee for Service (Full Payment & Co Ins Days)	3,282	3,282	0	Part A Fee for Service (Full Payment & Co Ins Days)	1,464,829	1,536,534	-71,705
21	Part C (Medicare Managed Care)	0	0	0	Part C (Medicare Managed Care)			0
22								0
23	**Other Governmental**	0	0	0	**Other Governmental**	0	0	0
24	Veteran's Administration	0	0	0	Veteran's Administration			0
25	Tricare	0	0	0	Tricare			0
26	County Respite	0	0	0	County Respite			0

Patient Days and Revenue Details

Schedule B Supplement

27	Other	0	0	0	Other			0
28	Other	0	0	0	Other			0
29								0
30	**Therapeutic Leave**	13	13	0	**Therapeutic Leave**		2,987	-2,987
31	**All Other Days not listed above**	621	627	-6	**All Other Days not listed above**		1,192,294	######
32								0
33	**Bed Holds**	255	0	255	**Bed Holds**	0	0	0
34	Medicaid NJ Bed Hold (reimbursable)	184	0	184	Medicaid NJ Bed Hold (reimbursable)			
35	Medicaid NJ Bed Hold (mandated but not reimbursable)	0	0	0	Medicaid NJ Bed Hold (mandated but not reimbursable)			0
36	Medicaid Out of State Bed Hold (reimbursable)	0	0	0	Medicaid Out of State Bed Hold (reimbursable)			0
37	Medicaid Out of State Bed Hold (mandated but not reimbursable)	0	0	0	Medicaid Out of State Bed Hold (mandated but not reimbursable)			0
38	Private Pay Bed Holds	65	0	65	Private Pay Bed Holds			0
39	Pending Medicaid Bed Holds	0	0	0				
40	All Other Bed Holds	6	0	6	All Other Bed Holds			0

Explanation

1	Bed hold day reported with payor class on NHA 100
14	Bed hold day reported with payor class on NHA 100
31	Bed hold day reported with payor class on NHA 100

Patient Days and NHA 100 Information

Reconciliation to Schedule B Supplement

FACILITY NAME: Sussex County Homestead
D. H. S. S. NUMBER: 19510
UNISYS NUMBER: 4503902
COST REPORT F.Y.E.: December 31, 2008

		Patient Days As Reported in Sch B	1	2	3	4	Adjusted Patient Days	Days Reported NHA 100	Check
1	**Medicaid**	**25,336**	**184**	**0**	**0**	**0**	**25,520**	**25,520**	0
2	**New Jersey**	**25,336**	**184**	**0**	**0**	**0**	**25,520**	**25,520**	0
3	Routine	25,336	184				**25,520**	25,520	0
4	Hospice						**0**		0
5	Managed Care:						**0**		0
6	Respite (State Waiver Program)						**0**		0
7									
8	**Out of State**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
9	Routine						**0**		0
10	Hospice						**0**		0
11	Managed Care:						**0**		0
12	Respite (State Waiver Program)						**0**		0
13									
14	**Private Pay**	**6,676**	**65**	**0**	**0**	**0**	**6,741**	**6,741**	0
15	Private Self Pay	6,676	65				**6,741**	6,741	0
16	Private Insurance						**0**		0
17	Pending Medicaid Days						**0**		
18									
19	**Medicare**	**3,282**	**0**	**0**	**0**	**0**	**3,282**	**3,282**	0
20	Part A Fee for Service (Full Payment & Co Ins Days)	3,282					**3,282**	3,282	0
21	Part C (Medicare Managed Care)						**0**		0
22									
23	**Other Governmental**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0
24	Veteran's Administration						**0**		0
25	Tricare						**0**		0
26	County Respite						**0**		0
27	Other						**0**		0
28	Other						**0**		0
29									

Patient Days and NHA 100 Information

Reconciliation to Schedule B Supplement

30	**Therapeutic Leave**	13					**13**	13	0
31	**All Other Days not listed above**	621	6				**627**	627	0
32									
33	**Bed Holds**	**255**	**-255**	**0**	**0**	**0**	**0**	**0**	0
34	Medicaid NJ Bed Hold (reimbursable)	**184**	**-184**				**0**		0
35	Medicaid NJ Bed Hold (mandated but not reimbursable)						**0**		0
36	Medicaid Out of State Bed Hold (reimbursable)						**0**		0
37	Medicaid Out of State Bed Hold (mandated but not reimbursable)						**0**		0
38	Private Pay Bed Holds	65	-65				**0**		0
39	Pending Medicaid Bed Holds						**0**		0
40	All Other Bed Holds	6	-6				**0**		0
		36,183	0	0	0	0	**36,183**	36,183	0

Column

1 Bed holds included with payor class

2

3

4

5

6

7

8

9

10