Hospital: _____

Hospital Number: |_____|_____|_____|_____|

NEW JERSEY ACUTE CARE HOSPITALS

2024 COST REPORTS

PATIENT CARE VOLUMES

B

Do not change any preprinted wording on this form.

	Inpatient Volumes	A	B	C	D	E	F	G	H	I	J	K	L
		MSA	PED	OBS	PSA (5)	ICU (6)	CCU	NNI	NBN	SNF	SAC	Transfer Within Hospital	TOTAL
1	Admissions (1,2) (Incl. Same Day Medical Admissions)											( )	**0**
2	Same Day Medical Admissions											/ / / / / / / /	
3	Patient Days (1,3)											/ / / / / / / /	
4	Licensed Beds/Bassinets (4)											/ / / / / / / /	
5	Maintained Beds (7)											/ / / / / / / /	
6	Occupancy Percentage (1)											/ / / / / / / /	
7	Discharges (1)	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	/ / / / / / / /	

FOOTNOTES:

(1) Must exclude all Same Day Surgery as defined in NJAC 8:31B-3.11. Calculate occupancy percentage using Licensed Beds/Bassinets.

(2) Include patients transferred from other units within the Hospital for all services (including Newborns).

(3) Include patient days of patients transferred from other units (including Newborns) and Same Day Medical Admissions.

(4) Include licensed MSA beds used for Same Day Surgery or Same Day Medical Admissions, but not unlicensed beds.

(5) Report all Psychiatric admissions here. Provide detailed listing in Form "B" format for all inpatient Psychiatric cases utilizing specialty Psychiatric beds.

(6) Report Burn Care in ICU. Provide detailed listing.

(7) Report "Set up and Staffed Beds" on this line.

This report is required by state regulation. Failure to report as provided for within NJAC 8:31B-3.3 Uniform Reporting: Current Costs and NJAC 8:31B-4.6(c) may result in a daily penalty past the appropriate submission due date. Intentional misrepresentation of falsification of any information contained within this cost report may be punishable by fine and/or imprisonment under state law.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenues and Expenses prepared by the _____ (Provider Name) _____ (Provider Number) for the cost report period commencing on _____ and concluding on _____, 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 in accordance with the applicable instructions, except as noted.

Name and Title of Contact for these Forms	Telephone Number	Name and Title of Responsible Official	Signature	Date