Hospital:_____

License Number: _____

Calendar Year:_____

NEW JERSEY REHABILITATIVE, LONG TERM ACUTE CARE, AND NON-PUBLIC PSYCHIATRIC HOSPITALS ADMISSIONS & REVENUE REPORT

Admissions		
Total Admissions*	**SNF* (Skilled Nursing Facility)**	**OTHERS***

Revenue				
Inpatient	**Outpatient**	**SNF (Skilled Nursing Facility)**	**MICU (Mobile Intensive Care Unit)**	**SNRPC** (Services Not Related to Patient Care)**

*Must exclude all Same Day Surgery as defined in NJAC 8:31B-3.11.
*Exclude patients transferred from other units within the Hospital for all services.
**Refer to Financial Elements, NJAC 8:31B-4.16, 4.64 and 4.65 for items to be included, and attached itemized schedule.

Failure to report in accordance with state law and regulation may result in a daily penalty being assessed past the submission due date. (N.J.S.A. 26:2H-18.57; N.J.A.C. 8:31B-1 et seq.; N.J.A.C. 8:43E-1 et seq.). Intentional misrepresentation or falsification of any information contained within this cost report may result in civil and criminal penalties.

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 form by the

_____ _____
(Provider Name) (License Number)

for the cost report period commencing on _____ and concluding on _____,

and that to the best of my knowledge and belief, it is 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	Telephone Number	Date
Name and Title of Responsible Official	Signature	