New Jersey Department of Health
CY2025 FINANCIAL REPORT
LICENSED AMBULATORY CARE FACILITIES
SUBJECT TO THE AMBULATORY ASSESSMENT

Refer to the accompanying instructions to fill out this form

Name and Address of Facility:	License Number:
	NJ Tax Identification Number:
Email :	

Line No.	Payer	A All Visits	B Gross Charges	C Gross reciepts*
1	Medicare (Fee-for-Service and/or HMO)			
2	Medicaid (Fee-for-Service and/or HMO)			
3	Other Government Payer			
4	Commercial			
5	Self Pay			
6	Others			
7	Totals			

*** IF CY 2018 Gross Receipts are for less than 12 months, check here:** ☐

Voluntarily Submitted Information for Charity Care Services	A All Visits	B Gross Charges	C Gross reciepts*
Reduced or No-Fee Care to Patients Based Upon Ability to Pay			

Certified By (Print Name)	Title	
Signature	Telephone Number	Date
Name of License Holder (if different from above)		
Signature	Date	

HFEL-5
Apr-19