New Jersey Department of Health

CY 2024 FINANCIAL REPORT
LICENSED AMBULATORY CARE FACILITIES
SUBJECT TO THE AMBULATORY ASSESSMENT

Refer to the accompanying instructions to fill out this form.

Facility Name / Facility Address 1 / Facility Address 2 / City / State / Zip / Email Address	License Number NJ Tax Identification Number

Line No.	Payer	A All Visits	B Gross Charges	C Gross Receipts *
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	**0**	**$ 0.00**	**$ 0.00**

*** If CY 2024 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 Receipts*
Reduced or No-Fee Care to Patients Based Upon Ability to Pay			

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

New Jersey Department of Health
INSTRUCTIONS FOR COMPLETING THE HFEL-5, CY2024 AMBULATORY CARE FACILITY FINANCIAL REPORT

Column A, All visits -- Report each billable visit to the licensed facility.

Column B, Gross charges -- Report the amount of the gross charges before payer allowance deductions. Includes charges from all services provided within the licensed facility.

Column C, Gross receipts -- Report the amount of collected revenue after payer allowance deductions. Includes receipts from all services provided within the licensed facility.

Payer Categories:

Line 1, Medicare -- Report amounts and visits for Medicare Fee-for-Service and HMO patients.

Line 2, Medicaid -- Report amounts and visits for Medicaid Fee-for-Service and HMO patients.

Line 3, Other Government Payer -- Report amounts and visits for other government payers, such as TriCare (Champus) patients.

Line 4, Commercial -- Report amounts and visits for patients with insurance from commercial payers, including fee-for-Service and HMO patients.

Line 5, Self Pay -- Report amounts and visits for patients with no increase coverage who were billed by the facility.

Line 6, Others -- Report amounts, visits, and/or all other gross receipts that do not fit into the above listed categories.

*** Check Off** -- Check box if: 1) the facility first opened during CY 2024, or 2) the facility transferred ownership during CY 2024 and the CY 2024 gross receipt of the previous owner are not included.

Voluntarily Submitted information for Charity Care Services - Reports amounts and visits for patients who received reduces or no-fee care based upon their ability to pay. Submission of this information is voluntary for CY 2024 financial report, and does not reduce total gross receipts in determining the SFY 2026 assessment.

If an outside consultant prepared the report, the accompanying form should be signed by the license holder in addition to the person who prepared the report. The certification section on the bottom of the report is required for submission to be considered complete.