

HRSA

Health Resources & Services Administration

OMB No.: 0915-0285. Expiration Date: 1/31/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration Form 3: Income Analysis	FOR HRSA USE ONLY	
	Grant Number	Application Tracking Number

Note: The value in the Projected Income (d) column should equal the value in the Billable Visits (b) column multiplied by the value in the Income per Visit (c) column. If not, explain in the Comments/Explanatory Notes box. In the Prior FY Income (e) column, enter the income data from the health center's most recent fiscal year audit or interim financial statement.

Part 1: Patient Service Revenue – Program Income

Payer Category	Patients by Primary Medical Insurance (a)	Billable Visits (b)	Income per Visit (c)	Projected Income (d)	Prior FY Income (e)
1. Medicaid					
2. Medicare					
3. Other Public					
4. Private					
5. Self Pay					
6. Total (Lines 1-5)	<i>will auto-calculate in EHB</i>	<i>will auto-calculate in EHB</i>	N/A	<i>will auto-calculate in EHB</i>	<i>will auto-calculate in EHB</i>

Part 2: Other Income – Other Federal, State, Local and Other Income

Payer Category	Patients by Primary Medical Insurance (a)	Billable Visits (b)	Income per Visit (c)	Projected Income (d)	Prior FY Income (e)
7. Other Federal	N/A	N/A	N/A		
8. State Government	N/A	N/A	N/A		
9. Local Government	N/A	N/A	N/A		
10. Private Grants/Contracts	N/A	N/A	N/A		
11. Contributions	N/A	N/A	N/A		
12. Other	N/A	N/A	N/A		
13. Applicant (Retained Earnings)	N/A	N/A	N/A		
14. Total Other: (Lines 7-13)	N/A	N/A	N/A	<i>will auto-calculate in EHB</i>	<i>will auto-calculate in EHB</i>



Total Non-Federal (Non-Health Center Program) Income (Program Income Plus Other)					
Payer Category	Patients by Primary Medical Insurance (a)	Billable Visits (b)	Income per Visit (c)	Projected Income (d)	Prior FY Income (e)
15. Total Non-Federal (Lines 6+14)	N/A	N/A	N/A	<i>will auto-calculate in EHB</i>	<i>will auto-calculate in EHB</i>
Comments/Explanatory Notes (if applicable)					

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0285. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N-39, Rockville, Maryland, 20857.

Instructions for Form 3: Income Analysis

Form 3 collects the projected patient services and other income from all sources (other than the Health Center Program grant funds) for the **first year** of the proposed project. Base Form 3 income on the proposed NAP site(s) only (i.e., do not include income from sites outside the proposed scope of project). Form 3 income is divided into two parts: (1) Patient Service Revenue - Program Income and (2) Other Income - Other Federal, State, Local, and Other Income.

Part 1: Patient Service Revenue – Program Income

Patient service revenue is income directly tied to the provision of services to health center patients. Services to patients that are reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., breast and cervical cancer screening), employers, and health provider organizations are classified as patient service revenue. Reimbursements may be based upon visits, procedures, member months, enrollees, achievement of performance goals, or other service related measures.

The program income section groups billable visits and income into the same five payer groupings used in the [UDS Manual](#). All patient service revenue is reported in this section of the form.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations that are designed to make up the difference between the approved FQHC rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees. If you do not have an FQHC reimbursement rate for services provided to Medicaid and Medicare beneficiaries, you may contact your PCA to inquire about FQHC rates for service delivery programs that are similar in size.¹

¹ For a listing of HRSA-supported PCAs, refer to HRSA's [Strategic Partnerships website](#).



Only include patient service revenue associated with sites or services proposed in this application.

Patients by Primary Medical Insurance - Column (a): The projected number of unduplicated patients classified by payer based upon the patient's primary medical insurance (payer billed first). The patients are classified in the same way as in the [UDS Manual](#), Table 4, lines 7 – 12. Do not include patients who are only seen for non-billable or enabling service visits. To determine where to count patients, note these examples:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Billable Visits – Column (b): All billable/reimbursable visits.² The value is typically based on assumptions about the amount of available clinician time, clinician productivity (visits per unit of time), and mix of billable visits by payer. Do not include billable services related to laboratory, pharmacy, imaging, and other ancillary services in this column. (See Ancillary Instructions under Payer Categories below.) Note other significant exclusions or additions in the Comment/Explanatory Notes box at the bottom of the form.

Note: The patient service income budget is primarily based on income per visit estimates. However, some forms of patient service income do not generate reportable visits, such as income from laboratory or pharmacy services, capitated-managed care, performance incentives, wrap payments, and cost report settlements. Based on historical experience, you may choose to include some or all of this income in the income per visit assumption. You may also choose to separately budget for some or all of these sources of patient service income.

Income per Visit – Column (c): Calculated by dividing projected income in Column (d) by billable visits in Column (b).

Projected Income – Column (d): Projected accrued net revenue, including an allowance for bad debt, from all patient services for each pay grouping. Pharmacy income may be estimated using historical data to determine the number of prescriptions per medical visit and the average income per prescription. All separate projections of income are consolidated and reported here.

Prior FY Income – Column (e): The income data from the health center's most recent fiscal year, which will be either interim statement data or audit data, when available.

² These visits will correspond closely with the visits reported on the [UDS Manual](#) Table 5, excluding enabling service visits.



Alternative Instructions for Capitated Managed Care:

Health centers may use their own methods for budgeting patient service income other than those noted above, but must report the consolidated result in the Projected Income Column (d), along with the related data requested in Columns (a) through (e). You may estimate income for each service by multiplying the projected visits by assumed income per visit. For example, capitated managed care income may be based on member-month enrollment projections and estimated capitation rates for each plan, grouped by payer and added to the projected income. Enter the estimated visits associated with these managed care plans in Column (b).

Payer Categories (Lines 1 – 5): The five payer categories (Medicaid, Medicare, Other Public, Private, and Self-Pay) reflect the five payer groupings in UDS. The [UDS Manual](#) includes definitions for each payer category.

Visits are reported on the line of the primary payer, which is the payer billed first. Income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute each portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, report that income on the self-pay line. If the co-payment is to be paid by another payer, report that income on the other payer's line. It is acceptable if you cannot accurately associate the income to secondary and subsequent sources.

Ancillary Instructions: All service income is to be classified by payer, including pharmacy and other ancillary service revenue. If you do not normally classify the projected ancillary or other service revenue by payer category, allocate the projected income by payer group using a reasonable method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

Medicaid (Line 1): Income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap-around payments, incentives, pharmaceutical reimbursements, and primary care case management income.

Medicare (Line 2): Income from the FQHC cost reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from the FQHC cost reimbursement, risk pool distributions, performance incentives, pharmaceutical reimbursements, and case management fee income.

Other Public (Line 3): Income not reported elsewhere from federal, state, or local government programs earned for providing services or pharmaceuticals. A CHIP operated independently from the Medicaid program is an example of other public insurance. Other Public income also includes income from categorical grant programs when the grant income is earned by providing services. An example of this includes the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program.



Private (Line 4): Income from private insurance plans, managed care plans, and other private contracts for services or pharmaceuticals. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, service contracts with employers, and Veterans Health Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans that are earned by government employees, veterans, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

Self-Pay (Line 5): Income from patients, including full-pay, self-pay, and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

Total (Line 6): Sum of lines 1-5.

Part 2: Other Income – Other Federal, State, Local, and Other Income

This section includes all income other than the patient service revenue shown in Part 1 (not including the NAP funding request). It includes other federal, state, local, and other income. It is income that is earned but not directly tied to visits, procedures, or other specific services. Income is to be classified based on the source of the revenue. Income from services provided to non-health center patients either in-house or under contract with another entity such as a hospital, nursing home, or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to individuals who are not patients of the health center.

Other Federal (Line 7): Income from direct federal funds, where your organization is the recipient of an NoA from a federal agency. It does not include this NAP funding request or federal funds awarded through intermediaries (see Line 9 below). It includes funds from federal sources such as the CDC, Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), and Department of Health and Human Service funding under the Ryan White HIV/AIDS Program Part C, Facility Investment Program grants and others. The CMS EHR incentive program income is reported here in order to be consistent with the [UDS Manual](#).

State Government (Line 8): Income from state government funding, contracts, and programs, including uncompensated care funding; state indigent care income; emergency preparedness funding; mortgage assistance; capital improvement funding; school health funding; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); immunization funding; and similar awards.

Local Government (Line 9): Income from local government grants, contracts, and programs, including local indigent care income, community development block grants, capital improvement project funding, and similar awards. For example:

- If you contract with the local Department of Health to provide services to the Department's patients, report all income earned under this contract on this line.



- Ryan White Part A funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A funding received directly from the municipality would be shown on this line.

Private Grants/Contracts (Line 10): Income from private sources, such as foundations, nonprofits, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, if you operate a 340B pharmacy in part for your own patients and in part as a contractor to another health center, report the pharmacy income for your own patients in Part 1 under the appropriate payer categories and the income from the contracted health center on this line.

Contributions (Line 11): Income from private entities and individual donors that may be the result of fundraising.

Other (Line 12): Incidental income not reported elsewhere, including items such as interest income, patient record fees, vending machine income, dues, and rental income. Applicants typically have at least some “other” income to report on Line 12.

Applicant (Retained Earnings) (Line 13): The amount of funds needed from your retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why your organization’s funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the Health Center Program funds, should typically be adequate to support operations.

Total Other (Line 14): The sum of lines 7 – 13.

Total Non-Federal (Line 15): The sum of Lines 6 and 14 (the total income aside from this Health Center Program grant).

Note: In-kind donations are not included on Form 3. You may discuss in-kind donations in the SUPPORT REQUESTED section of the Project Narrative. Additionally, such donations may be included on the SF-424A (Section A: Budget Summary—Non-Federal Resources under New or Revised Budget).