



OMB No.: 0915-0285. Expiration Date: 9/30/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 3: INCOME ANALYSIS	FOR HRSA USE ONLY	
	LAL 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. The program income total on this form must match the program income total on Form 3A.

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
1. Medicaid					
2. Medicare					
3. Other Public					
4. Private					
5. Self Pay					
6. Total (Lines 1-5)	will auto-calculate in EHB	will auto-calculate in EHB	N/A	will auto-calculate in EHB	will auto-calculate in EHB

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

7. 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	will auto-calculate in EHB	will auto-calculate in EHB

Total 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 Income (Lines 6+14)	N/A	N/A	N/A	will auto-calculate in EHB	will auto-calculate in EHB
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 2.5 hours 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 for the **first year** of the proposed new designation period. 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 the health center’s 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, the 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. This includes all income from medical, dental, mental health, substance abuse, other professional, vision, and other clinical services, as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

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.

Patient service revenue associated with sites or services not in the approved scope of project, including those pending approval, must be excluded.

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

- 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): This includes all billable/reimbursable visits.¹ The value is typically based on assumptions about consolidated individual clinician time, productivity, and visits by payer. There may be other exclusions or additions, which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (See Ancillary Instructions section of the RD Instructions.)

Note: The patient service income budget is primarily based upon income per visit estimates. However, there are some forms of patient service income which do not generate reportable visits in UDS or on Form 3, such as income from laboratory or pharmacy services; capitated managed care; performance incentives; wrap payments; and cost report settlements. You may choose to include some or all of this income in the income per visit assumption, basing it on historical experience. You may also choose to separately budget for some or all of these sources of patient service income.

Income per Visit - Column (c): This value may be calculated by dividing projected income in Column (d) by billable visits in Column (b).

Projected Income - Column (d): This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the first year of the proposed designation period. Pharmacy income may be estimated by 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 in Column (d).

Prior FY Income – Column (e): This is the income data from the health center's most recent fiscal year, which will be either interim statement data or audit data. The fiscal year was specified because the interim data can eventually be compared to actual audit data.

¹ 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 than those noted above, but must report the consolidated result in Projected Income Column (d) along with the related data requested in Columns (a) through (e). Income for each service may be estimated by multiplying the projected visits by assumed income per visit. For example, capitated managed care income may be based upon member-month enrollment projections, and estimated capitation rates for each plan grouped by payer and added to the projected income. The estimated visits associated with these managed care plans are entered in Column (b).

Payer Categories (Lines 1 – 5): There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings in UDS. The [UDS Manual](#) must be used to define each payer category.

Visits are reported on the line of the primary payer (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 that 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, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown 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. In the event you do not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation 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): This includes 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 payments, incentives, and primary care case management income.

Medicare (Line 2): This includes 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, and case management fee income from the Affordable Care Act (ACA) Medicare Demonstration Program.

Other Public (Line 3): This includes income from federal, state, or local government programs earned for providing services that is not reported elsewhere. 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. Examples of these include the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and the Title X Family Planning Program.

Private (Line 4): This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, and other private contracts for service. 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 Veteran's Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans which 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): This includes 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): This is the 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. It includes other federal, state, local, and other income. It is income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients (patients of an entity with which the health center is contracting) 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. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

Other Federal (Line 7): This is income from federal funds where your organization is the recipient of a Notice of Award from a federal agency. It does not include federal funds awarded through intermediaries (see Line 9 below). It includes funds from federal sources such as the Centers for Disease Control and Prevention (CDC), Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), and others. It includes Department of

Health and Human Service (DHHS) funding under the Ryan White HIV/AIDS Program Part C, DHHS Capital Development funding, and others. The CMS Medicare and Medicaid EHR incentive program income is reported here in order to be consistent with the [UDS Manual](#).

State Government (Line 8): This is 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; Women, Infants, and Children (WIC); immunization funding; and similar awards.

Local Government (Line 9): This is 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: (1) a health center that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line, and (2) 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 would be classified as income earned from a local government and be shown on this line.

Private Grants/Contracts (Line 10): This is income from private sources, such as foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

Contributions (Line 11): This is income from private entities and individual donors that may be the result of fund raising.

Other (Line 12): This is incidental income not reported elsewhere and includes 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): This is the amount of funds needed from your organization's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources should be adequate to support normal operations.

Total Other (Line 14): This is the sum of lines 7 – 13.

Total Non-Federal (Line 15): This is the sum of Lines 6 and 14 and is the total non-federal (non-Health Center Program) income.

Note: In-kind donations are not included as income on Form 3.