

Uniform Data System Financial Tables Guidance

This resource provides guidance on common issues, key considerations, and helpful tips related to completing the UDS financial and operational tables. It is designed to support health centers in accurately reporting UDS financial data by highlighting frequent challenges and offering practical solutions to improve data quality and reporting compliance. Acronyms used throughout this file are defined on the final page.

Brief Description and Impacted Table(s)	Checks and Solutions
Accounts receivables (Table 9D)	- Charges less collections less adjustments, or the amount by which what is owed to the health center increases or decreases during the calendar year = change in accounts receivable (A/R). Formula: $T9D_L14_CA - T9D_L14_CB - T9D_L14_CD - T9D_L13_CE - T9D_L13_CF$. - Nationally, the number of months of charges that the change in A/R equals is 0.2 months. - The change in A/R is usually consistent with the change in charges - when charges increase A/R increases. Large changes in A/R are questioned. Formula: $((T9D_L14_CA - T9D_L14_CB - T9D_L14_CD - T9D_L13_CE - T9D_L13_CF) / T9D_L14_CA) * 12$ Large changes in accounts receivables - Charges are to be reclassified to secondary and subsequent payers when appropriate. Failure to do this may cause the change in Medicare and Private payer A/R to increase and self-pay to decrease. - Check that a large increase is not the result of adjustment entries being reversed. Large A/R decreases may be an error if retroactive payments are appropriately included as collections in Column B, but were not taken out as adjustments in Column D.
Charge rates (such as Medicare G-codes or other negotiated rates) and charge to cost ratios (Table 9D)	- Charges across all payers are to be reported only from the health center's schedule of fees. Charges are not to be reported at payer, negotiated, or discounted rates. - Medicare requires the G-codes and CPT codes to be included on Medicare claims. Remove the G-codes from the charges reported on the UDS. Most practice management systems correct for this, and if not, a manual adjustment is needed. - The failure to exclude Medicare G-codes from charges will overstate the Medicare payer mix. - Charges per patient, charges per visit, and charge to cost ratio outliers may be questioned (when unusually high or low). - Large pharmacy operations may explain high charge to cost ratios and low productivity may explain a low charge to cost ratio.
Donations (Tables 8A and 9E)	- Donations to the health center may be in non-monetary (services, facilities, or supplies) or monetary. - Donated drugs are to be valued at 340B prices and reported on Line 18 of Table 8A. - Drugs donated by the pharmaceutical company directly to the patient are not reported. - In-kind (non-monetary) donations made to the health center are reported on Table 8A, Line 18. - Report only cash donations on Table 9E, Line 10, Other Revenue. - All donations (non-cash donations on Table 8A and cash donations on Table 9E) must be described in the specify boxes.

FTEs (Table 5) to costs (Table 8A) must sync	• Personnel FTE classifications should be consistent with cost classifications. • If there is a reason why such a comparison would look unusual, include an explanation on Table 8A. ○ Explain FTEs with no costs. For example, volunteers may be reported on Table 5 with no cost on Table 8A. ○ Explain costs with no FTEs. This may be due to having paid referred care contracts for lab, x-ray, and other services. Cost checks • Significant differences in the current year to prior year are compared. • Unreasonably low or high costs per FTE may be an indication of a possible mismatch of cost and FTEs. • Low costs per FTE may be explained by having donated personnel where there are FTEs on the service line but the cost is reported on the donated line.
Other programs and services (Tables 5/8A)	The Other Programs and Services category includes in-scope items and programs not classifiable elsewhere and those not exclusively tied to health center patients. This line includes: ○ Adult, elderly, and youth programs, such as ADHC, child care, PACE ○ Basic needs, such as shelters/housing, food, and clothing ○ Employment, vocational, AmeriCorps or other job training programs ○ Fitness or exercise programs ○ Head Start or Healthy Start ○ Pass-through costs ○ Public/Retail pharmacies ○ Research ○ Retail pharmacy ○ Space leased to others ○ Support group services ○ WIC • Do not report these programs as Enabling services or in other service or cost categories. • The “Specify” text box in this category across both Tables 5 and 8A should contain the same programs and descriptions (e.g., if WIC is described on Table 5, Line 29, for the program FTE, the costs on Table 8A, Line 12, should also note the related WIC costs). • With the exception of ADHC and PACE, receipts related to these costs are generally reported on Table 9E on the appropriate line. For example, pass-through receipts are reported on Table 9E, Lines 1a-1e (on line for funding received), and are offset by an equal amount of cost on Table 8A, Line 12. ADHC and PACE are reported by payer (generally Medicare and/or Medicaid) on Table 9D.
Other Revenue and Receipts (Table 9E)	• Table 9E only includes cash receipts related to other, non-patient service revenue, including grant and contract dollars received during the year from HRSA’s BPHC, other federal, state, local, indigent care, private entities, foundations, and other revenue sources. • Receipts are reported by the source from whom they were received and not where they originated. For example, RW A = local government or non-profit, RW B = state, and RW C = federal. • Unrecognized gains are not reported. Only cash gains from sales on investments revenue is reported in the UDS on Line 10 of Table 9E. • Indigent program receipts are reported on Table 9E, Line 6a. • Use the specify boxes throughout the table to identify dollars by source.

	Large changes in revenue sources - Review prior year grant and contract Table 9E reporting for comparability to check that items are not omitted. - Check for accuracy when reporting significant reduction or no dollars in the current year from programs and vice versa. Other receipts - Nationally, other receipts = 4% of total 9D+9E receipts. - Do not report any patient service revenue on the Other Revenue Line 10. - Retail pharmacy receipts are reported as other revenue on Table 9E, Line 10. - Other Revenue, Line 10, are to be described. - Loan proceeds are not reported because they are not revenue. Loans are not reported as revenue anywhere in the UDS. - Insurance proceeds are not reported if the loss was taken as an asset reduction. Only proceeds issued as a cash amount during the year are reportable. - Unrecognized gains are not reported. Only cash gains from sales on investments revenue is reported in the UDS on Line 10 of Table 9E. COVID-19 receipts - COVID-19 supplemental funds through the BPHC are to be checked against the COVID-19 grant sources and activity codes. - Report on Table 9E, Lines 10+1p2, only the amount drawn down during the calendar year, not the award total. The amount should never exceed the total award amount. - Report other non-BPHC COVID-19 receipts received during the year on the Table 9E line representing the entity for which the health center received funds from, regardless of original source.
Overhead (Table 8A)	Allocation methods - There are multiple ways which overhead (facility and non-clinical support [administration]) may be allocated. Health centers should use the simplest method which produces a reasonably accurate and comparable result to a more complex method. The following method is preferable: - Allocating known direct costs first. For example, all the facility cost of a dental-only site would be charged directly to dental. - Doing an allocation of facility cost second and administration cost third. - A lesser overhead charge should be considered for large purchased-service items (e.g., lab, X-ray). - If the proportion of overhead cost to direct cost is the same for each line, it indicates that a one-step method was used. Given that managing personnel consumes most of the overhead, using square feet of space or equal proportions of overhead to cost centers as the sole allocation basis will generally not produce an accurate allocation of overhead. Overhead outliers - Overhead cost to total cost rates of 7% for facility and 24% for non-clinical support (administration) have been stable national averages. There is little deviation from the mean. - Check for misclassifications of cost when unusually high or low overhead rates are present. - Explain significant change in rates from the prior year in comments. - Large pharmacy programs will drive overhead rates down.

Patient characteristics (Table 4) and payers (Table 9D) consistency	Primary medical insurance vs. third-party payer - Table 4 classifies patients by primary medical insurance and Table 9D classifies revenue data by the payer from which the revenue is expected or received. - The patient mix and charge payer mix are usually comparable with some difference expected. - Nationally the charge mix for Medicaid plus Medicare (63%) is similar, although slightly higher than the patient mix for Medicaid plus Medicare (59%). - There are limited Other Public insurances, but commonly Other Public payers. - Categorical grants such as Title X and BCCEDP are not insurance and the patients are usually classified as uninsured on Table 4, but these grants reimburse for services provided to patients. Managed care enrollment - The determination of managed care reporting in the UDS is that the health center has a contractual agreement with a managed care organization (MCO) or managed care plan through which the health center is assigned patients and manages the comprehensive care of those patients, assuming some risk in the process. - MCOs who don't provide (assign) enrollment data to the health center are not considered managed care for UDS reporting on both Tables 4 and 9D. - Outlier (unusually high or low) PMPM capitation and charges PMPY amounts will be questioned as will any significant change from the PY. Outlier PMPM amounts should be explained. - Unusually low capitation amounts (for example between \$5-\$10 per member per month) may be due to case management being mistakenly reported as managed care. - High amounts could be due to missing enrollment data or high-risk coverage (e.g., HIV or prenatal).
Performance incentives (Tables 9D and 9E)	- Many managed care plans and many other insurers pay a performance bonus or incentives. These are to be reported in Columns B and C3 of Table 9D, and not on Table 9E. - The one exception is the receipt of incentive and performance payments received by the CMS for the adoption, implementation, upgrade, and demonstration of meaningful use of certified EHR technology and interoperability through the Promoting Interoperability Program, which are reported on Line 3a of Table 9E.
Pharmacy costs (Table 8A) and revenue (Table 9D)	Pharmacy costs, dispensing to patients - The cost for medications administered by in-house clinicians or contract pharmacy is to be reported on Table 8A on the pharmaceutical Line 8b (not on the medical line). - Contract pharmacies, which are generally using 340B purchased drugs, take their fees from sales receipts before reimbursing the health center. The dispensing cost should not be omitted, as this may result in understated drug replenishment cost. Report dispensing cost from 340B contract pharmacies on Table 8A, Line 8a, Pharmacy. - Reporting no pharmacy or pharmaceutical costs on Table 8A is unusual and should be explained in table comments. - Review pharmacy cost (Table 8A, Line 8a) if it is greater than drug cost (Table 8A, Line 8b). Nationally, pharmaceutical costs are 74% of the total pharmacy costs. - Pharmacy revenue data may be questioned, particularly in health centers where the pharmacy cost is significant (when the costs exceed \$1M or more or the cost is proportionately much greater than the national average of 14% of total cost). Pharmacy revenue, dispensing to patients

	- Pharmacy revenue data are to be reported on Table 9D in the same manner as other services are reported. - Pharmaceutical charges are to be recorded in a uniform amount – generally the retail or UCR price – for each drug, by payer, and by date of service. - Collections are to be reported by payer upon receipt, along with any corresponding adjustments. - Do not report pharmacy revenue, dispensed to health center patients, on Table 9E. Limitations - Pharmacy revenue data can be problematic if the data provided by the contract pharmacies to the health center is limited. Work with contract pharmacies to ensure the health center receives detailed reports that show: - The pharmacy, drug, and dispensing fees costs separately - The drug and dispensing fees charges by payer - Dates of service - Amounts collected and adjusted during the year by payer - In rare instances, when pharmacy revenue details are not properly tracked by contractors, receipts by payer are not always known. Report the receipts on Table 9D, Line 13 Self Pay, Column B, and offset those receipts with an equal charge amount in Column A. Steps are to be implemented to properly document and correct for this situation in future UDS reporting. - Refer to the UDS Manual Appendix B, which provides further detail on reporting in-house and contract pharmacy revenue.
Reconciliations to charges and collections (Table 9D)	- Report retroactive settlements and receipts (e.g., wraparounds, incentives) on Table 9D in Columns C1, C2, and C3 (as appropriate), and add to Column B as collections. Also, subtract retros out of Column D as adjustments. Do the opposite mathematical steps for Column C4, for paybacks made with a check. - No Medicaid reconciliations is more likely in states where Medicaid or its MCOs pay the centers their FQHC rate rather than a market rate. It could also be that the health center is improperly recognizing charges at the FQHC rate rather than their set fee schedule charge rate. Explain the absence of wraparounds or settlements for managed care plans. - Sliding fee discounts are reviewed for reasonableness. Usually, the direction of change in sliding fee from the PY is consistent with the change in self-pay charges. - Bad debt reported on the UDS currently only includes self-pay patient debt. The reported debt can be either the amount directly written off during the calendar year from patient accounts or, ideally, the change in the A/R account for self-pay patients at the end of the year.
Subawardees and contractors (multiple tables)	- Health centers should identify the existence of subawardee and contractor arrangements and the arrangements should be clearly documented and the services, patients, costs, and revenue under these arrangements are to be included on the UDS. - Subawardees are to report a complete set of UDS tables and forms to the awarded health center, which consolidates the subawardee data with the health center's data. - Contractors report the services delivered and the costs for providing services to the health center. The health center reports in the UDS the amount they paid to the contractor for the purchased services.
Surplus or deficit (Tables 8A, 9D, and 9E)	- Surplus or Deficit = Tables 9D+9E receipts less Table 8A cost before donations. Formula: $T9D_L14_CB + T9E_L11_CA - T8A_L17_CC$ - A possible reason for changes from year to year may be timing of grant or wrap receipts showing deficit one year and surplus the next.

	• Large surplus or deficit for CY and PY are questioned. Check if the amount is consistent with audited net revenue. • Check if some receipts or costs are missing, particularly pharmacy revenue or cost.
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Note: Follow the UDS Manual instructions when reporting on the financial and operational tables, though they may differ from accounting principles. Discuss reporting questions not clearly addressed by the UDS Manual with the UDS Support Line or the UDS Reviewer who will counsel with the health center's UDS team on proper reporting.

ACRONYMS USED:

- A/R - Accounts receivable
- BCCEDP - Breast and Cervical Cancer Early Detection Program
- CMS - Centers for Medicare & Medicaid Services
- COVID-19 - Coronavirus disease
- CY - Current or calendar year
- EHR - Electronic health record
- FQHC – Federally-qualified health center
- FTE - Full-time equivalent
- HIV - Human immunodeficiency virus
- MCO - Managed care organization
- PMPM - Per member per month
- PMPY - Per member per year
- PPS - Prospective payment system
- PY - Prior year
- RW - Ryan White
- UCR - Usual, customary, and reasonable
- WIC - Women, infants, and children

TABLE FORMULA REFERENCES:

- T – Table
- L – Line
- C – Column

Example: T9D_L14_CA refers to Table 9D, Line 14, Column A