HRSA Health Center Program

Form 3: Income Analysis

OMB No.: 0915-0285. Expiration Date: 4/30/2026

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 section. 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)	*will auto-calculate in EHBs*	*will auto-calculate in EHBs*	N/A	*will auto-calculate in EHBs*	*will auto-calculate in EHBs*
Part 2: Other Income – Other Federal, State, Local, and Other Income					
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	*will auto-calculate in EHBs*	*will auto-calculate in EHBs*

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	*will auto-calculate in EHBs*	*will auto-calculate in EHBs*
Comments/Explanatory Notes (if applicable)					

Public Burden Statement: Health centers (section 330 grant funded and Federally Qualified Health Center look-alikes) deliver comprehensive, high quality, cost-effective primary health care to patients regardless of their ability to pay. The Health Center Program application forms provide essential information to HRSA staff and objective review committee panels for application evaluation; funding recommendation and approval; designation; and monitoring. The OMB control number for this information collection is 0915-0285 and it is valid until 4/30/2026. This information collection is mandatory under the Health Center Program authorized by section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b). 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 the HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

Instructions

Form 3 collects the projected income from all sources other than this Health Center Program funding request for the **upcoming budget period.** Form 3 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 services provided to health center patients. This includes services reimbursed by health insurance plans, managed care organizations, categorical grant programs (e.g., breast and cervical cancer screening), employers, and health provider organizations. Reimbursements may be based upon visits, procedures, member months, enrollees, achievement of performance goals, or other service-related measures.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations 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 cost reimbursement rate from Medicaid and Medicare, contact your Primary Care Association (PCA) for help with your application.

The program income section groups billable visits and income into the same five payer groupings used in the UDS Manual. Each payer (lines 1-5) is described below. All patient service revenue is reported in this section of the form. Only include patient service revenue associated with sites and services proposed in your application.

Patients by Primary Medical Insurance - Column (a): Includes the projected number of unduplicated patients categorized by payer based on the patient's primary medical insurance (payer billed first) as of their last visit. Patients are categorized in the same way as in the UDS Manual, Table 4, lines 7 – 12.

For example:

- Categorize a patient with both Medicare and Medicaid coverage as a Medicare patient on line 2.

- Categorize a Medicaid patient with no dental coverage who is only seen for dental services as a Medicaid patient on line 1 with a self-pay visit on line 5.

Billable Visits – Column (b): Includes all billable/reimbursable visits.[1] 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 visits which are only for 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 section at the bottom of the form.

Note: The patient service revenue budget is primarily based on income per visit estimates. However, some forms of patient service income do not result in reportable visits, such as income from laboratory or pharmacy services, capitated-managed care, performance incentives, wrap payments, and cost report settlements. Based on past 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 from all patient services for each pay grouping, including an allowance for bad debt. Pharmacy income may be estimated using historical data to determine the number of prescriptions per medical visit and the average income per prescription. Combine all separate projections of income and report them here.

Prior FY Income – Column (e): The income data from your health center's most recently completed fiscal year, which will be either interim statement data or audit data for the entire scope of project. New applicants who are not operational can enter 0.

Alternative Instructions for Capitated Managed Care:

You may use your own methods for budgeting patient service income other than those noted above. However, you must report the consolidated result in the 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

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

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 (payer billed first). When a single visit involves more than one payer, assign each portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments that the patient pays, 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. If you cannot accurately associate the income to secondary and subsequent sources, you may include that income on the primary payer line.

Ancillary Revenue Instructions: All service revenue is to be categorized by payer, including pharmacy and other ancillary service revenue. If you do not normally categorize the projected ancillary or other service revenue by payer, assign 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 Medicaid agency or by a fiscal intermediary. It includes all projected revenue from managed care capitation, settlements from FQHC cost reimbursement reconciliations, wrap-around payments, performance incentives, pharmaceutical reimbursements, and primary care case management.

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 reconciliations, 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 for providing services or pharmaceuticals that is unearned or based upon meeting the plan's eligibility criteria. For example:

- Income from CHIP operated independently from Medicaid.
- Other Public income also includes income from categorical grant programs when the grant income is earned by providing services (e.g., Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program).

Private (Line 4): Income earned from private insurance plans, managed care plans, and other private contracts for services or pharmaceuticals. This includes plans such as commercial insurance

(e.g., Blue Cross Blue Shield), 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. Also categorize as private insurance: revenue 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.

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. It includes other federal, state, local, and other income. It is revenue that is not directly tied to visits, procedures, or other specific services. It includes income from services provided to non-health center patients. For example, income from in-house retail pharmacy sales to individuals who are not health center patients. Categorize income based on the source you receive it from and not the source it originates from.

Other Federal (Line 7): Income from direct federal funds, where your organization is the recipient of a notice of award (NOA) directly from a federal agency. It includes funds from federal sources such as the CDC, Housing and Urban Development (HUD), Centers for Medicare & Medicaid Services (CMS), Health Center Program capital awards, and others. The CMS EHR incentive program income is reported here to be consistent with the UDS Manual. Exclude this Health Center Program operational (H80) funding request.

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, federal funding awarded through intermediaries, and similar awards. For example, include: (1) income earned under a contract with the local Department of Health to provide services to the Department's patients, and (2) grants that are awarded through municipalities.

Private Grants/Contracts (Line 10): Income from private sources, such as foundations, non-profits, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, if you operate a 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 health center contract on this line.

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

Other (Line 12): Income not reported elsewhere, including items such as interest income, retail pharmacy 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 this is necessary. Amounts from non-federal sources, combined with this Health Center Program funding request, should typically be able to cover 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 funding request).

Note: Do not include in-kind donations on Form 3. You may discuss in-kind donations in the SUPPORT REQUESTED section of the Project Narrative. You may also include in-kind donations on the SF-424A: Budget Information Form.