Table	Brief Description	Checks
Costs: Table 8A		
5 & 8A	FTEs and cost in sync	◆ Ideally there should be a worksheet reconciling the FTE distributions on Table 5 with the personnel cost distributions on Table 8A. Cost with no FTEs may be explained by paid referred care contracts for lab, x-ray, and other services. ◆ Significant differences in the CY-PY are compared. Personnel cost is usually 65-70% of total cost so this could be an important cost reporting issue. Check for differences and correct or provide clear explanations. Unreasonably low or high costs per FTE may be an indication of a possible mismatch of cost and FTEs. This may also be explained by donated staff where there are FTEs on the service line but the cost is reported on the donated line.
5 & 8A	Other Programs and Services FTEs and cost	◆ The specify text box on both tables should be the same. The other category includes items and programs not classifiable elsewhere and those not exclusively tied to FQHC patients. The other line includes: WIC, pass-through cost, space leased to others, staff contracted to others, retail pharmacy, adult day health care, research, etc. ◆ Receipts related to other costs are reported on table 9E on the appropriate line. For example, pass-through receipts are reported on table 9E line 6 and are offset by an equal amount of cost on the other line of table 8A.
8A & 9E	Donation descriptions	◆ Donated drugs (table 8A) are to be valued at 340B prices and described in the specify box. Drugs donated by the pharmaceutical company directly to the patient are not reported. ◆ Other donations (non-cash donations on table 8A and cash donations on table 9E) should be described in the specify boxes. ◆ In-kind donation income is reported on table 8A, not on table 9E.
8A, 9D, 9E	Pharmacy size	◆ Reporting no pharmacy or pharmaceutical cost is unusual and should be explained. Medications administered by clinicians in-house are to be reported on the pharmaceutical line and not in medical. ◆ Report dispensing cost from community-based 340B pharmacies on the pharmacy line 8a. Contract pharmacies take their fees from sales receipts before reimbursing the FQHC which causes some to omit dispensing cost and some to understate drug replenishment cost. ◆ Review pharmacy cost if it is greater than drug cost. Nationally pharmacy cost is 64% of drug cost. ◆ Pharmacy revenue data (see Table 9D) are to be reported in the same manner as all other service revenue data but this is often a problem because of limitations of the data provided by the 340B contract pharmacies. Work with contract pharmacies to ensure the health center is getting the pharmacy, drug, and dispensing fees costs separately; and that charges are reported as of the date of service and collections are reported by payer. This is important in centers where the pharmacy cost is significant.
8A	Allocation methods	◆ There are multiple ways of which overhead may be allocated. Preparers should use the simplest method which produces a reasonably accurate and comparable result to a more complex method. Cost centers with no overhead allocation will be questioned. ◆ Allocating known direct costs first is preferable. 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 is also preferable. ◆ A lesser overhead charge should be considered for large purchased service items. ◆ 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 as the sole allocation basis will generally not produce an accurate allocation of overhead. Using total direct cost, FTEs or personnel cost is a preferable one step basis.
8A	Overhead outliers	◆ Overhead cost to total cost rates of 8% for facility and 25% for non-clinical support (administration) are stable national averages over time. There is little deviation from the mean. Outliers will be questioned to check for misclassifications of cost. Significant change in rates from the prior year should be explained. ◆ Large pharmacy programs will drive overhead rates down.
All	Subrecipients and contractors	◆ Health centers should identify the existence of subrecipient and large contractor arrangements and explain how those arrangements are reported on the UDS. ◆ Subrecipients are to report a complete set of UDS tables which are consolidated with the FQHC data. Contractors report the services delivered and the cost reported is the amount paid by the FQHC.
Table	**Brief Description**	**Checks**
Patient-Related Revenue: Table 9D		
4 & 9D	Adjustments (retros, receipts, paybacks, etc.)	◆ Report retros in columns (c1, c2, and c3) and add to column (b) and subtract out of column (d) – do the opposite for (c4) paybacks made with check. ◆ No Medicaid adjustments may mean the health center is improperly recognizing charges at the FQHC rate rather than the normal fee value. This is more likely in states where Medicaid or its MCOs pay the centers their FQHC rate rather than a market rate. The absence of wraps or settlements for managed care plans should be explained. ◆ Sliding fee adjustments are reviewed for reasonableness. Usually the change from the PY is consistent with change in self-pay charges. Indigent care fund revenue data will increase sliding fee adjustments. ◆ Bad debt reported on the UDS is currently limited to self pay. The self pay bad-debt reported is either the amount directly written-off from patient accounts or preferably the amount of change in the allowance account attributable to self pay.
4 & 9D	Insurance vs. Payer	◆Table 4 classifies patients by medical insurance and table 9D classifies revenue data by the payer from which the revenue is expected or received. ◆ Other Public should be consistent with table 4 except that other public categorical grants such as Title X and BCCCP are not insurance and the patients are usually classified as uninsured on table 4.
4 & 9D	Managed care enrollment data consistency	◆ MCOs who don't provide enrollment data are not considered managed care for UDS reporting on both tables 4 and 9D. ◆ Outlier PMPM capitation and charges PMPY amounts will be questioned as will any significant change from the PY. ◆ Unusually low capitation amounts may be due to case management being mistakenly reported as managed care; and high amounts could be due to missing enrollment data or unusually high risk coverage (e.g., HIV or prenatal). Amounts may be lower or higher but should be explainable. ◆ The absence of wraps or settlements should be explained. There will be no wraps if MCOs are paying PPS rather than market rates. Wraps and settlements are to be allocated on the three lines within each payer and in columns c1 and c2.
5 & 9D	Charge ratios	w Charges per patient, charges per visit, and charge to cost ratio outliers may be questioned. Large pharmacy operations may explain high ratios and low productivity may explain a low charge to cost ratio.

9D	Pharmacy revenue	• Contract and in-house pharmacy revenue is reported on table 9D. • Pharmacy data are to be reported on table 9D in the same manner as other services are reported. Charges are to be recorded in a uniform amount - generally the retail or UCR price - for each drug for each payer by date of service; collections are to be reported by payer upon receipt along with any corresponding adjustments. See Appendix B of the UDS Manual. • Pharmacy revenue data can be a problem because of limitations of the data provided by the 340B pharmacies. Work with contract pharmacies to ensure you get the pharmacy, drug, and dispensing fees costs separately; and that charges, collections, and adjustments are reported by payer. This may be questioned, particularly in centers where the pharmacy cost is significant, as is the case when the costs exceed $1M or more or the cost is proportionately much greater than the national average of 11% of total cost.
9D	Insufficient pharmacy data	• When pharmacy data are reported by contractors on a cash basis and when receipts by payer are unknown, report the receipts on table 9D, line 13 column B and offset those receipts with an equal amount of charges in column A. This should be corrected for future reporting.
9D	Medicare G Codes or other capitated or negotiated rates	• Charges are to be reported at the normal fee value across all payers. Charges are not to be reported at negotiated or discounted rates. • Medicare requires the G codes and CPT codes to be included on Medicare claims. The G codes should be eliminated from the charges reported on the UDS. Most practice management systems have corrected for this, and if not a manual adjustment is needed.
9D	Performance incentives	• Many managed care plans and many other insurers pay a performance bonus of some sort. This is to be reported in Column b and column c3; and not on Table 9E.
9D	Charge reclassification	• Charges less collections less adjustments = change in A/R. Nationally A/R increased in an amount equal to 0.31 months of charges. 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. • Check that a large increase isn't the result of adjustment entries being reversed. Large A/R decreases may be an error if retros are included in column b, but were not taken out of column d. • Charges are to be reclassified to secondary and subsequent payers when appropriate. Failure to do this will usually cause the change in Medicare and Private payer A/R to increase and self-pay to decrease.
9D	Patient and charge mix by payer	• The patient payer mix and charge payer mix are usually comparable with some difference expected. National Medicaid plus Medicare charge mix (65%) is seven points higher than the patient mix (58%). • A large obstetrics practice or a large pharmacy operation can cause the charge mix to be greater than the patient mix. • The failure to exclude Medicare G codes from charges will overstate the Medicare payer mix. Reporting charges at negotiated or discounted rates will undermine the validity and usefulness of the charge mix data.
Table	**Brief Description**	**Checks**
Other Revenue: Table 9E		
8A & 9E	Income	• Table 9E only includes cash receipts related to income. • Loan proceeds are not reported because they are not income. Insurance proceeds are not reported if the loss was taken as an asset reduction. In-kind donations received are not cash receipts and are not reported on 9E but in-kind donations consumed are reported on the donations line 18 on table 8A
9D & 9E	Patient service receipts	• Incentive and performance payments are to be reported on table 9D except for CMS EHR incentive receipts. • Retail pharmacy receipts are reported as other revenue on table 9E, Line 10. • Categorical grant receipts which are tied to patient services are reported on table 9D; those grants not tied directly to specific patient services and which reimburse for expenses are reported on table 9E.
9D & 9E	Indigent care	• Indigent care should be reported consistently in states and localities. • Indigent program receipts are reported on table 9E. The charges and any patient receipts and sliding fee discounts applied to the charges are to be reported in self pay on table 9D line 13.
9E	Receipts by source	• Receipts are reported by the source from whom they were received and not where they originated RW A = local government or non-profit; RW B = state and RW C = federal). •The specify boxes should identify dollars by source when amounts are material and when more than one source is included..
9E	Surplus or loss	• Surplus or Loss = Tables 9D+9E receipts less table 8A cost before donations. • Large surplus or loss for CY & PY are questioned. Check if the amount is consistent with audited net income. • Check if some receipts or costs are excluded, particularly pharmacy income or cost. • A possible reason for changes from year to year may be timing of grant or wrap receipts showing large deficit one year and surplus the next.
9E	Large change from prior year	• Review prior year reporting for comparability to check that items are not omitted. If omitted, confirm no dollars were received in the current year for that program.
9E	Other receipts	• No other revenue, line 10, are questioned. Nationally other receipts = 4% of total 9D+9E receipts.

Note: The UDS Manual instructions are to be followed when reporting on the financial tables, though they may differ from accounting principles.

Reporting questions not clearly addressed by the manual are to be discussed with the UDS support line or the reviewer who will counsel with the health center's UDS team to determine the best approach.

Last updated: November 11, 2020

Acronyms used:	
A/R	Accounts receivable
BCCCP	Breast and Cervical Cancer Control Program
CMS	Centers for Medicare & Medicaid Services
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