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Community Health Centers, Inc.®

FINANCIAL MANAGEMENT SERIES

Recording Revenue in the General Ledger

Recording revenues and expenses is an essential component of a community health center finance department. While recording expenses is similar to other kinds of organizations, recognition and recording of revenue can be unique to health centers.

This Information Bulletin:

- Discusses three kinds of revenues generated by health centers
  - Patient services revenues,
  - Federal grant revenues, and
  - Contracts and other grants.
- Explains how the Chief Financial Officer (CFO) should record these revenues in the health center's general ledger.

PATIENT SERVICES REVENUE

Patient service revenue is revenue the health center generates from treating patients. Examples are payments from Medicaid, Medicare, and commercial insurers. Patient services revenue is also referred to by the Bureau of Primary Health Care (BPHC) as "Program Income." Patient service revenue typically represents 50 – 70% of a health center's total revenue and generates transactions on a daily basis. (The 2005 national average based on the 2005 BPHC Uniform Data System report was 58%, with another 21% from BPHC grants.) Therefore, patient service revenue demands the largest and most frequent focus from the finance department, which is complicated by different reimbursement systems.

Patient Service Revenue should be expressed as gross revenue and net revenue.

Gross revenue represents the total gross charges for all services provided by the center.

Net revenue is the amount the health center expects to receive for services, and is equal to gross charges less contractual allowances and sliding fee discounts.

Gross charge is the amount the health center charges to the patient (or the patient's insurance) for a

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particular service. This charge should approximate the health center's cost. Health centers should establish their charges by dividing their costs by relative value units (RVUs) to determine a charge for each procedure.

Contractual allowance is the difference between the amount the health center charges and the amount they have agreed to accept as payment. This may be the cost-based rate Medicare pays, the Medicaid PPS rate, or the contracted fee schedule from commercial insurers.

The basic patient service revenue equation is:
Net Revenue = Gross Revenue – Contractual Allowance

This equation may also be stated as:
Gross Revenue = Net Revenue + Contractual Allowance

Determining Charges

For instance, a health center with $14,000,000 in total expenses and 100,000 visits each year might charge $140 per encounter ($14,000,000/100,000). This is the gross charge for an encounter.

If the center's Medicaid PPS rate was $117.00 per encounter (the **net revenue**), the **contractual allowance** would be $23.00 ($140 - $117 = $23).

However, a health center should determine charges and allowances based on procedures rather than visits. Thus, the health center described above might actually record revenue as follows:

Procedure (CPT-4)	Number	Standard Fee	Gross Charges
99201	3,750	$ 82.72	$ 310,200
99204	5,000	308.36	1,541,800
99212	25,000	86.89	2,172,250
99213	37,500	123.65	4,636,875
99214	28,750	185.70	5,338,875
	100,000		$14,000,000

Each month the Finance Department should obtain a report from the Billing Department that shows the **total gross charges and contractual allowances by payor source** (*e.g.,* Medicaid, Medicare, Private Insurance, Self Pay and Medicaid Managed Care plans reimbursed on a fee-for-service basis).

Based on the report, the Finance Department should **record a monthly journal entry into the general ledger.** For a health center with a charge of $100 for a specific visit and a PPS rate of $90, the entry would be recorded in this manner:

	Debit	Credit
Patient Account Receivable - Medicaid	$90.00 (Net Revenue)	
Contractual Allowance- Medicaid	$10.00 (Contractual Allowance)	
Gross Charge Revenue - Medicaid		100.00 (Gross Revenue)

Medicare and Co-Insurance

If a patient has Medicare, his/her income is over the 200% poverty level g uidelines and the co-insurance responsibility is 20%, the entry would be as follows:

	Debit	Credit
Patient Account Receivable — Medicare	$56.00 (Net Revenue)	
Patient Account Receivable — Self Pay	$20.00 (Co-pay)	
Contractual Allowance – Medicare	$24.00 (Contractual Allowance)	
Gross Charge Revenue — Medicare		$80.00 (Gross Revenue)
Gross Charge Revenue – Self Pay		$20.00 (Co-pay)

Medicare and Sliding Fee Scale

As another example, if a patient has Medicare and is between 100% and 150% of the poverty guidelines, then the patient would be eligible for a sliding fee discount on the portion of the charge that he or she is responsible for paying. The entry would then be:

	Debit	Credit
Patient Accounts Receivable – Medicare	$ 56.00 (Net Revenue)	
Patient Accounts Receivable – Self Pay	$5.00 (Co-pay)	
Sliding Fee Discount	$15.00 (Sliding Fee Discount)	
Contractual Allowance – MCR	$24.00 (Contractual Allowance)	
Gross Charge Revenue – Medicare Revenue		$80.00 (Gross Revenue)
Gross Charge Revenue – Self Pay Revenue		$20.00 (Co-pay)

Third Party Insurance

If a patient has third party insurance (private insurance), the patient is responsible for any payment over what the insurance company pays. This is similar to Medicare:

	Debit	Credit
Patient Accounts Receivable – Third Party	$55.00 (Net Revenue)	
Patient Accounts Receivable – Self Pay	$45.00 (Co-pay)	
Gross Charge Revenue – Self Pay		$45.00 (Gross Revenue)
Gross Charge Revenue – Third Party		$55.00 (Co-pay)

Where the patient is responsible only for a co-payment, the entry would be slightly different:

	Debit	Credit
Patient Accounts Receivable – Third Party	$55.00	
Contractual Allowance – Third Party	$25.00	
Patient Accounts Receivable – Self Pay	$20.00	
Gross Charge Revenue – Third Party		$80.00
Gross Charge Revenue – Self Pay		$20.00

Patient Service Revenue – Capitated

Most health centers have agreements with managed care organizations and HMOs. Often these agreements provide for monthly payments for each patient enrolled with the organization who has selected the health center as their primary care provider. This payment is referred to as "capitation." The amount paid is referred to as the capitation rate, and is paid at a "per member per month" (pmpm) rate. The health center is required to provide certain defined primary care services for its patients.

In an example where a health center has 100 managed care members in a given month, paid at a capitated rate of $25.00 pmpm, with 40 visits in the month, the revenue would be properly recorded in the general ledger as follows (two steps).

Cash received for Month's Capitation

	Debit	Credit
Cash (100 members x $25 pmpm)	$2,500	
Contractual Allowance – Managed Care		$2,500

Book charges to gross revenue.

	Debit	Credit
Contractual Allowance – Managed Care	$4,000	
Gross Charge Revenue (40 visits x $100 average charge per visit)		$4,000

The two entries for contractual allowance net to $1,500, resulting in a net result of

	Debit	Credit
Cash	$2,500	
Contractual Allowance – Managed Care	$1,500	
Gross Charge Revenue		$4,000

Note that in this example, the health center lost money on the managed care contract in the specified month. Costs for the program, represented by charges, were $4,000, but reimbursement was only $2,500. In any case where charges are equal to cost, the contractual allowance becomes a means of quantifying profitability for each payor.

Medicaid/Medicare Wrap-Around Revenue

Federal legislation protects health centers that contract with Medicaid and/or Medicare managed care organizations by keeping the health center "whole" with respect to the Medicaid PPS and Medicare cost-based billable encounter rates. When a health center provides a visit to a patient enrolled in one of these plans, the plan pays its contracted rate, and the state (for Medicaid managed care) or CMS (for Medicare managed care) pays the difference between that payment and the PPS or encounter rate. Often, these payments are recognized as a net revenue figure based on monthly eligible visits:

	Debt	Credit
Patient Accounts Receivable – Medicaid Wrap	$55.00	
Revenue – Medicaid Wrap		$55.00

When payment is received, the receivable entry is released:

	Debit	Credit
Cash	$55.00	
Patient Accounts Receivable – Medicaid Wrap		$55.00

GRANT AND OTHER REVENUE

The third source of revenue is from direct funding – a grant between the health center and a funding agency such as the federal Bureau of Primary Health Care (BPHC), a state or local government, or a private foundation.

Other sources of revenue may include interest, rent and donations and in-kind goods and services. The finance department and the chief financial officer need to understand how to properly record these revenues in the health center's general ledger.

Federal Grant Revenue

Federal grant revenue can be recognized on a 1/12th basis if the grant program generates program income (patient service revenue) and is budgeted under the total budget concept like the Section 330 grant. Therefore, if the total federal grant funding is $1,200,000 per year, the community health center should recognize $100,000 per month as follows:

	Debit	Credit
Grant Receivable	$100,000	
Grant Revenue		$100,000

The center should also draw down these dollars on a one-twelfth basis, or $100,000 each month. In that case, the entry would be:

	Debit	Credit
Cash	$100,000	
Grant Receivable		$100,000

The two entries combined result in $100,000 increase to cash and $100,000 in revenue.

If, however, the federal grant program:

- Does not generate program income,
- Is not budgeted under the total budget concept, or
- The grant dollars are for a specific purpose (*i.e.* purchase of fixed assets),

The health center should only record the grant revenue up to the amount of expenses or items purchased. Therefore, if the health center was awarded $50,000 for the purchase of new computer equipment and spent only $25,000 of these funds, the entry would be the following:

	Debit	Credit
Grant Receivable	$25,000	
Grant Revenue		$25,000

Other Grant and Contract Service Revenue

The recognition of other grant and contract service revenue would follow this same approach, the grant dollars are drawn-down or released from restriction when spent. The recording of the revenue would be based on actual expenses incurred during the period of time (monthly or quarterly). If the health center had a contract for $500,000 to provide primary care services for a calendar year, and during the first month the center incurred $43,000 of expenses, the health center should only recognize $43,000 of contract service revenue.

PRIVATE CONTRIBUTIONS

If the health center receives contributions (commonly grants from private funders such as foundations, individuals or organizations), these revenues should be recorded in accordance with Financial Accounting Standard (FAS)116. FAS 116 explains in detail the recording of contribution revenue when a restriction has been placed on the funds by the donor. Upon receipt of the cash, these funds would be recorded as temporarily restricted revenue and then released from the temporarily restricted net assets once the restriction / condition has been satisfied. Recording of donations pledged but not yet received is a more complicated matter and each center should discuss such instances with its independent accountant.

Leaders of the health center finance department need to understand how the recognition of all revenue sources should be recorded in the center's general ledger. Doing so will ensure that the information provided in the monthly financial statements is complete and accurate and will minimize year end and audit adjustments.

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