

NATIONAL RESEARCH REPORT

The FQHC Benchmark Report No Margin. No Mission.

What 1,139 Health Centers Reveal About Financial Sustainability,
Revenue Realization, and the Capacity to Protect Every Dollar

**1,356**

HRSA-funded health centers

1,139

verified Form 990s

32.7M

patients served

Contents

	Executive Summary: The Financial Reality	3
01	Why Margin Matters	5
02	What the Stronger-Margin Health Centers Reveal	7
03	Financial Resilience: Margin and Cash	12
04	From Billed Charges to Cash in the Bank	16
05	What Only Claim-Level Analysis Can Reveal	20
06	The Capacity Challenge: No Claim Left Behind	23
07	What Is Your Revenue Cycle Really Worth?	27
A	Regional and State Financial Profiles	28
B	Endnotes: Data Sources, Calculations and Definitions	34
C	Executive Oversight Card and Measure Reference	38

ABOUT THE DATA

The FQHC Benchmark Report is built on a consolidated national dataset that Synergy Billing assembled for this research. It joins two public sources for each of the 1,356 health centers funded by HRSA's Health Center Program:

HRSA Uniform Data System (UDS), 2025 reporting year.

About 2,000 data elements across 30 UDS tables, including patients and payer mix, staffing and visits (Table 5), costs (Table 8A), charges, collections and adjustments by payer (Table 9D), and grant and other revenue (Table 9E).

IRS Form 990. Each organization's latest full return: more than 100 fields covering revenue (Part VIII), expenses (Part IX), the balance sheet (Part X) and supporting schedules.

Each health center was matched to its own Form 990 through IRS filer records, the IRS Business Master File and scale checks. 1,139 matches were verified. Hospitals and other organizations whose return covers more than the health center (74), and public or tribal entities that do not file a Form 990 (121), were excluded rather than estimated. Of the 1,139 verified returns, 96.2% cover fiscal years ending in 2024 or 2025; the rest end in early 2026 (36) or 2023 (7).

We report medians, so each health center counts once; we compare similar centers with each other; and we separate what public data can establish from what only a health center's own claims can show. Every figure states its population and source. Formulas, data elements and definitions are in the endnotes ([Appendix B](#)).

HOW TO USE THIS REPORT

CEOs and boards Executive Summary and Sections 1 to 3	CFOs and finance leaders Sections 3 to 5	Revenue cycle leaders Sections 5 and 6	Everyone Section 7. Regional profiles, methods and the Oversight Card are in the appendices.
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EXECUTIVE SUMMARY

The Financial Reality

A community health center can report a financial surplus while losing money on its operations. It can show a collection rate approaching 100% while individual claims still need investigation. And it can appear financially stable while holding less than a month of reported cash.

None of these measures is wrong. Each tells part of the story. The problem begins when part of the story is mistaken for the whole.

In our national analysis, nearly half of the 1,139 health centers with a verified Form 990 ran an operating loss (523, or 45.9%). Another 62 (5.4%) lost money on operations but reported a positive bottom line because of non-operating money. The median health center received \$63.52 for every \$100 it billed, while the conventional adjusted collection rate reported 99.4% collected (pooled across all dollars, so larger centers carry more weight). At the median operating margin of 0.6%, a health center with \$14 million in operating revenue keeps about \$84,000 a year; one unexpected expense, rate cut, provider vacancy or unworked denial can erase it.

FIGURE 1 • SIGNATURE FINDINGS

Thin margins and thin cash behind a collection rate that looks nearly perfect

0.6%

Median operating margin

The typical health center has little operating cushion. Form 990, n = 1,139.

45.9%

Ran an operating loss

523 of 1,139 health centers. Operating deficits are widespread.

168

Operating loss and under 30 days of reported cash

14.8% of 1,138 centers. Margin and liquidity pressure at the same time.

\$63.52

Received per \$100 billed, median center

Billed charges and payments are different measures. UDS 2025, n = 663.

5.4%

Positive total margin despite an operating loss (62 of 1,139)

73 days

Median reported days cash; middle half 33 to 139 (1,138)

99.4%

Adjusted collection rate, pooled across all dollars (659)

1.51 vs 1.26

Fiscal and billing staff per 10,000 visits: loss-making vs other (283, 306)

Source: Synergy Billing analysis of verified IRS Form 990s (latest full return per center, fiscal years ending 2023 to 2026, blended) and HRSA UDS 2025. Medians, each center counted once, unless labeled pooled. Operating margin excludes non-operating items; grants and 340B stay in. See [Appendix B](#).

The financial question for every CEO, CFO and board is not whether these numbers are right. It is whether the measures we rely on tell us what we are actually owed, and how much of it reaches the bank.

To find the answer, Synergy Billing examined 1,139 verified Form 990 filings alongside HRSA's 2025 Uniform Data System. The findings show thin operating margins, wide differences in financial resilience, and open questions about how reliably earned reimbursement becomes available cash.

THE QUESTION BEHIND THE NUMBERS

Public data shows where a health center stands. It cannot answer two of the most important financial questions for any FQHC:

1 How much of our outstanding A/R is actually collectable?

2 How much patient service revenue should we be collecting for the care we provide?

The answers live in a health center's own claims, payments, adjustments and balances. This report shows why, and where to look.

Three measures connect the sections that follow

SECTIONS 1-2

Margin

Tells us whether the operating model produces a surplus.

SECTION 3

Liquidity

Tells us how much financial flexibility exists.

SECTIONS 4-6

Billing effectiveness

Helps determine how reliably reimbursement legitimately owed becomes cash.

READING THE FIGURES

Figures are medians of eligible health centers unless labeled pooled. Populations differ by measure (1,139 for Form 990 margins; 1,138 for days cash; 663 for UDS Table 9D; 691 for staffing) and each figure states its own. Group differences show association, not cause.

01

Why Margin Matters

Why a surplus is capacity, not profit, for a mission-driven organization.

No margin, no mission. Yet there is a stubborn myth in community health: that a surplus is somehow unbecoming for a mission-driven organization. The tax code disagrees. A 501(c)(3) health center may earn a surplus. What it may not do is hand net earnings to private shareholders or individuals.

That distinction matters because margin is not profit in the Wall Street sense. Margin is capacity. It is next year's raise for the medical assistant who keeps the clinic running, the dental equipment replacement that keeps getting deferred, the cash that covers payroll while a Medicaid payment sits in someone's queue, and the ability to open a site when the community needs one.

A health center without margin still has a mission. It just has fewer resources to pay for it.

Operating Margin and Total Margin

Total margin asks whether reported revenue exceeded reported expenses, counting everything: patient revenue, grants, investment income and one-time gains. Operating margin asks whether revenue classified as operating covers those same expenses. It removes investment income, gains, fundraising, settlements and similar non-operating items, and keeps grants and pharmacy income, including 340B, because for a health center those fund operations. Line-level definitions are in [Appendix B](#).

Two cautions apply. A positive operating margin is not financial independence: it includes federal grants and 340B income a center does not control. And a positive total margin does not prove that cash grew, because both margins are accrual measures.

TABLE 1 · TOTAL MARGIN AND OPERATING MARGIN

Measure	Median	Share negative	Health centers
Total margin	1.9%	40.7%	1,139
Operating margin	0.6%	45.9%	1,139

A note on the numbers: for the typical health center, non-operating items add 0.7 percentage points of margin. That is the median of each center's own gap. The difference between the two national medians (1.9% minus 0.6%) is 1.3 points. Both are true; they answer different questions. Source: verified Form 990s, fiscal years ending 2023 to 2026, blended.

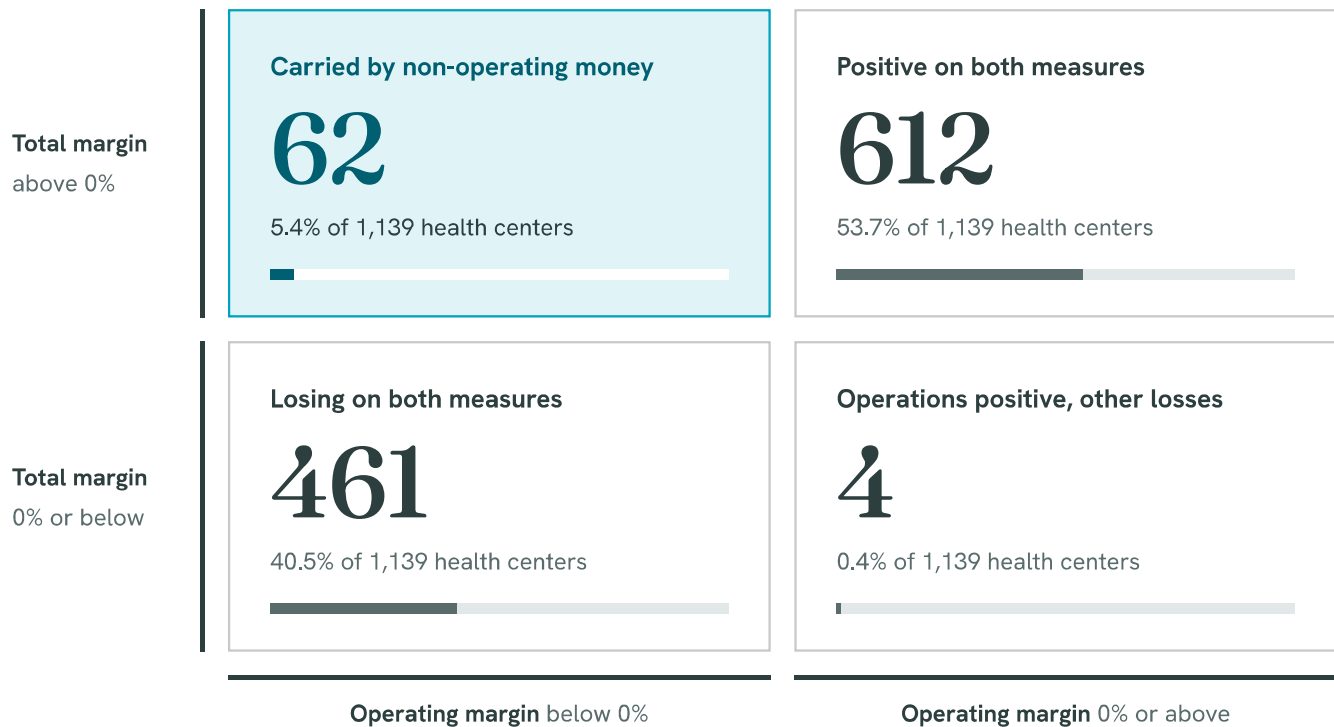
The Margin Quadrant: Four Financial Positions

Viewed through both measures at once, every health center falls into one of four financial positions.

FIGURE 2 • THE MARGIN QUADRANT

A positive bottom line does not always mean positive operations

Health centers by operating margin and total margin; n = 1,139



Highlighted: centers whose reported surplus depends on investment income, gains or other non-operating money. Boxes are equal size; the bar in each box shows its share of 1,139. Source: Synergy Billing analysis of verified Form 990s, latest full return, fiscal years ending 2023 to 2026, blended. See [Appendix B](#).

The 62 health centers in the highlighted quadrant (5.4% of 1,139) are the strategic story. Their reported surplus is real, but it depends on money that may not recur: an investment year that went well, a one-time gain, a settlement. Nothing about that money is improper, and grants are not the issue here; grants are counted as operating revenue. The question for those boards is simply whether next year's operations can stand on their own.

If so many health centers operate with little or no margin, what separates the organizations that perform better?

02 What the Stronger-Margin Health Centers Reveal

Where the pressure concentrates, and what separates the top quartile from the bottom.

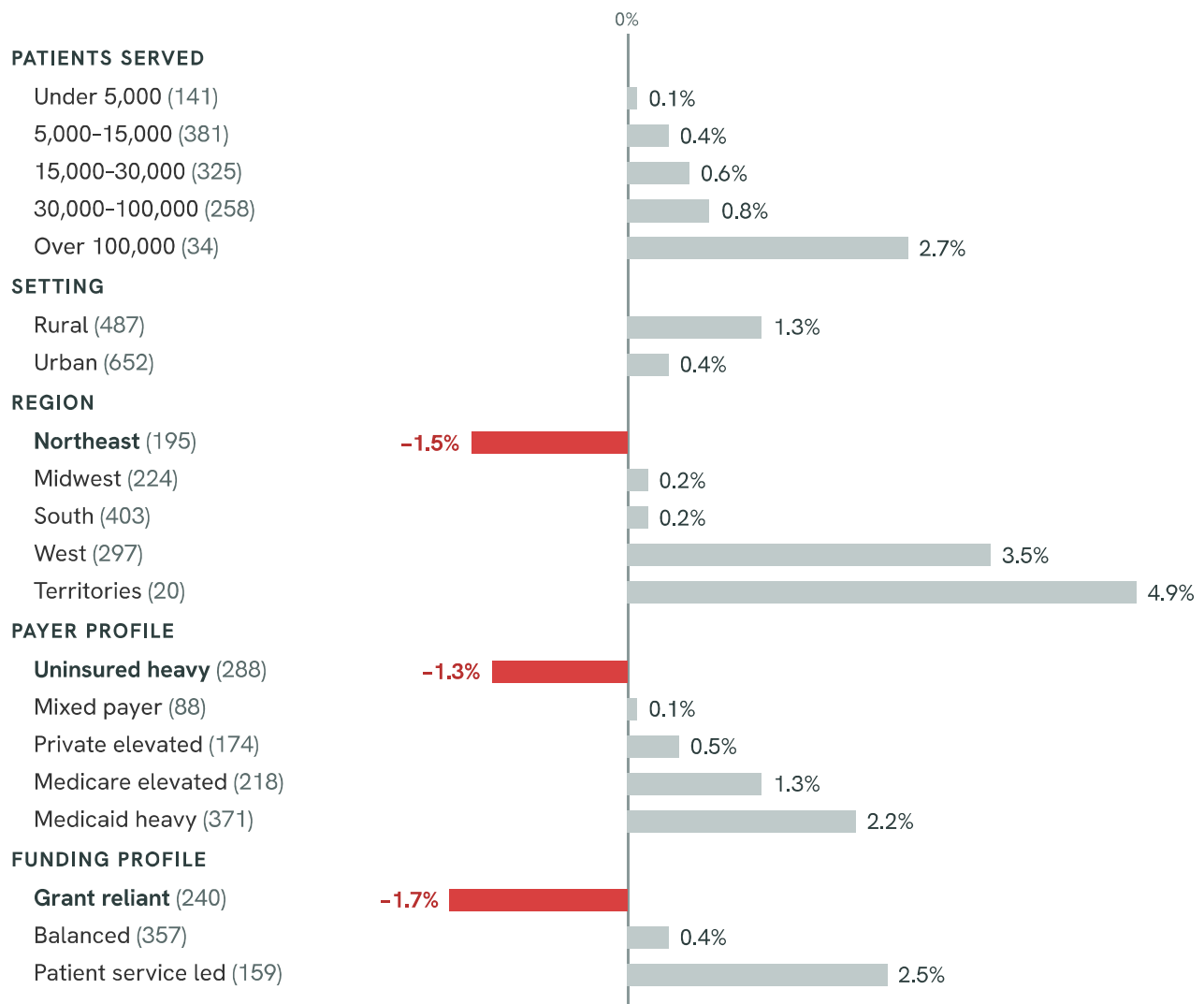
Where the Financial Pressure Concentrates

A single national median hides a lot of geography and circumstance. Slice the 1,139 health centers a few ways and the pressure points come into focus.

FIGURE 3 · MEDIAN OPERATING MARGIN BY GROUP

The Northeast stands out, alongside grant-reliant and uninsured-heavy centers

Median operating margin by group. Highlighted bars: the typical center loses money. Centers in parentheses.



Source: verified Form 990s, fiscal years ending 2023 to 2026 (blended); groups from UDS 2025. Medians, each center once. Profiles of circumstance, not grades of management. 383 centers lack a funding profile.

Three groups have a typical center in the red: grant-reliant centers, uninsured-heavy centers, and the Northeast. Scale helps, but only at the very top. Below 100,000 patients, the median barely moves with size, from 0.1% to 0.8%. Rural centers edge out urban ones, and Medicaid-heavy centers outperform the uninsured-heavy by more than three points.

AN IMPORTANT CAUTION

These are profiles of circumstance, not report cards on management. A grant-reliant center serving a largely uninsured community is doing exactly what the Health Center Program was built for. Its thin margin describes its situation; it does not grade its leadership.

Geography Matters

In 22 of 48 states and territories with at least five verified health centers, the typical center runs an operating loss; state medians range from -10.2% to 8.1%. Medicaid rates, expansion status, managed-care design and cost of living all differ, so a state median is context, not a grade. State profiles are in [Appendix A](#).

TABLE 2 · REGIONAL FINANCIAL PROFILE

Region	Health centers	Verified 990s	Typical operating margin	Share with an operating loss	Typical days cash	Centers with UDS payment data	Insurance \$ per \$100 billed
Northeast	226	195	-1.5%	57%	57	104	\$65
Midwest	268	224	0.2%	49%	72	166	\$72
South	454	403	0.2%	48%	77	211	\$65
West	376	297	3.5%	36%	79	165	\$80
Territories and Freely Associated States	32	20	4.9%	10%	126	13	\$79
United States	1,356	1,139	0.6%	46%	73	659	\$70

Margins, loss share and days cash come from verified Form 990s (fiscal years ending 2023 to 2026, blended). Insurance \$ per \$100 billed comes from UDS 2025 only. Medians, each center counted once. Green and red mark regions meaningfully better or worse than the U.S. median on margin, loss share and days cash.

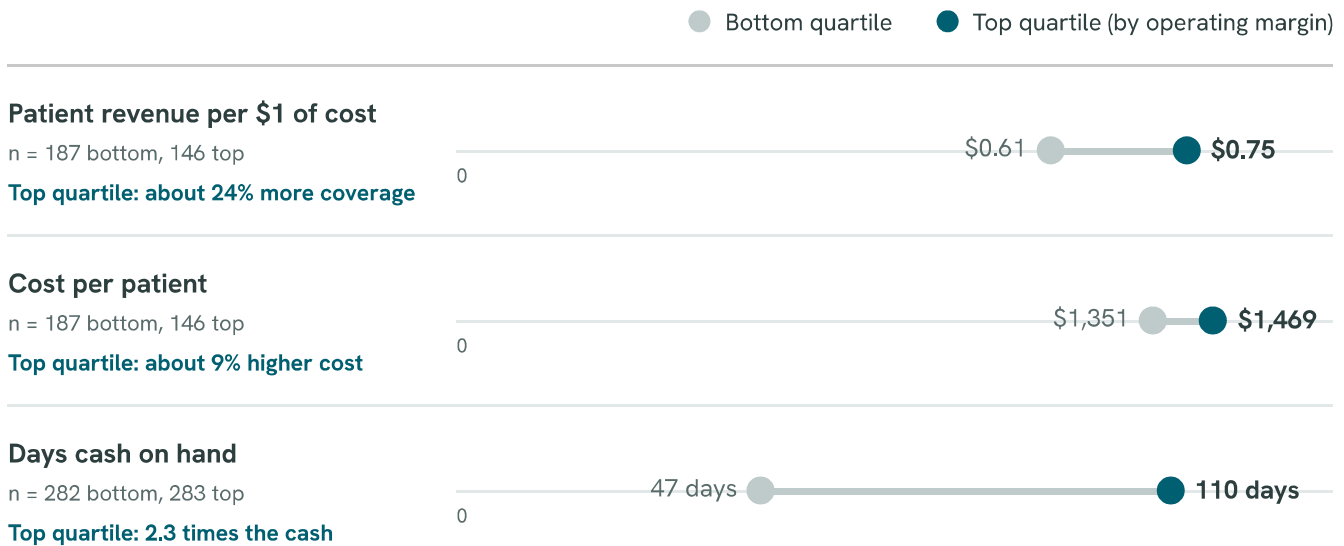
Higher Margins Do Not Necessarily Come From Lower Costs

One of the more revealing findings challenges a familiar assumption: financially stronger health centers are not the ones spending the least to serve their patients. Within each peer group (same region, size band and urban or rural setting), we compared the quarter of health centers with the highest operating margin against the quarter with the lowest: a median operating margin of 10.8% against -10.8% (283 centers each; Form 990 fiscal years ending 2023 to 2026, blended).

FIGURE 4 · TOP AND BOTTOM OPERATING-MARGIN QUANTILES WITHIN PEER GROUPS

Higher margins do not come from lower costs

They cover more of their cost with patient revenue and hold more than twice the cash.



Medians. Quartiles of operating margin within peer groups (region, size, urban or rural) of 10+ centers; 283 each. Own scale per row. Source: days cash, Form 990, fiscal years ending 2023 to 2026 (blended); revenue and cost, UDS 2023 to 2025. Association, not cause: payer mix, rates, service mix and grants also move these figures.

Stronger-margin centers reported higher costs per patient, about 9% more (\$1,469 against \$1,351; UDS cost per patient, same-year data). But they generated more patient service revenue relative to those costs: 75 cents for every dollar of cost against 61 cents, about 24% more coverage. And they held 2.3 times the cash, 110 days against 47. Financial sustainability cannot be understood through expense management alone.

AN IMPORTANT CAVEAT

This comparison shows association, not cause. Payer mix, Medicaid rates, PPS methodology, service mix, provider productivity, grant funding and pharmacy economics all move patient revenue coverage. Better billing is one plausible contributor. The public data cannot say how much.

One measure does not separate them: the public receivables-to-charges proxy, at 32 days for the top quartile and 34 for the bottom (152 and 182 centers). Part of the reason is that the 990 shows accounting A/R, usually after an allowance for bad debt, which can look healthier than what sits in the billing system. A balance-sheet snapshot cannot see what separates these groups. The claims can.

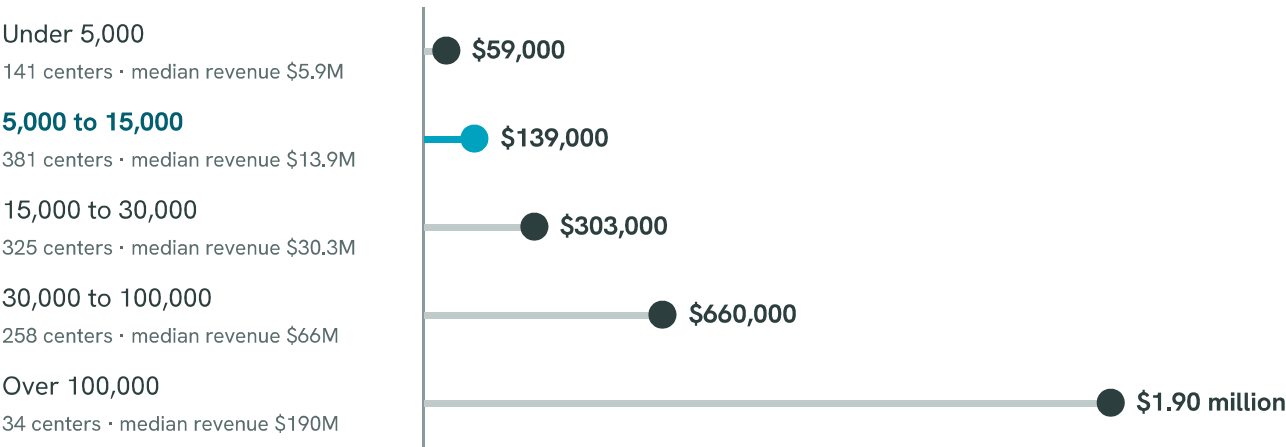
What One Point of Margin Is Worth

Translating margin into dollars makes its scale tangible. The chart shows what one point of operating margin is worth by the number of patients a health center serves; the table that follows shows how far the typical loss-making center sits from break-even.

FIGURE 5 · WHAT ONE POINT OF MARGIN IS WORTH

One point of margin is worth \$59,000 to \$1.9 million a year

One percentage point of operating margin, in dollars, by patients served. Highlighted: the most common health center size.



Source: verified Form 990s, fiscal years ending 2023 to 2026 (blended); patients, UDS 2025. Operating revenue includes grants. Scale, not an estimate of recoverable reimbursement. Over 100,000: 34 centers.

TABLE 3 · DISTANCE TO BREAK-EVEN FOR THE TYPICAL LOSS-MAKING CENTER

Patients served	Health centers	Share with an operating loss	Typical loss-making center’s gap	Gap per patient	Gap per visit
Under 5,000	141	50%	\$377,000	\$132	\$45
5,000 to 15,000	381	49%	\$840,000	\$90	\$26
15,000 to 30,000	325	44%	\$1.22M	\$59	\$20
30,000 to 100,000	258	44%	\$2.81M	\$61	\$21
Over 100,000	34	32%	\$6.21M†	\$43†	\$15†

† Based on 11 loss-making centers; read with caution. Source: verified Form 990s, fiscal years ending 2023 to 2026 (blended); patients and visits, UDS. See [Appendix B](#).

\$139,000

One point of margin, most common center (5,000 to 15,000 patients)

\$90

More per patient for the typical loss-maker to reach break-even

\$26

More per visit for the same center

Take the most common health center, serving 5,000 to 15,000 patients. One point of margin is worth about \$139,000 a year. For the typical one losing money, getting back to break-even takes about \$90 more per patient, or \$26 per visit.

The gap is a measure of financial distance, not a forecast of recoverable revenue. Some of it may be reimbursement that was earned but never recognized or was written off, such as unworked denials, unrecovered underpayments or patient balances never pursued. Much of it is cost structure, payer mix, fee schedules or reimbursement rates that no billing team can change. Only claim-level analysis can say how much is which.

Which leads to a fair question for any board before it adds a service line or chases another grant: is the health center receiving all the reimbursement its care has earned?

03 Financial Resilience: Margin and Cash

No margin, no mission, and no cash, no time.

No margin, no mission, and no cash, no time. Operating margin tells leadership whether the operating model generates a surplus. Days cash on hand shows how much financial flexibility an organization may have when reimbursement or operations are disrupted: how many days it could cover normal operating expenses if no more cash came in. Together they give a more useful view of financial resilience.

Two centers with the same margin, one holding 30 days of cash and the other 100, face very different choices when a major payer pays late.

What the National Benchmark Shows

73 days

Median reported days cash

1,138 centers; middle half 33 to 139 days

57.6%

Reported fewer than 90 days

90 days is a descriptive reference, not a standard

51 vs 95

Median days, loss-making vs break-even or better

522 and 616 centers

Across 1,138 health centers with a verified Form 990, the median was 73 days of reported cash, with the middle half between 33 and 139 days, and 57.6% reported fewer than 90 days (fiscal years ending 2023 to 2026, blended). Ninety days is a descriptive reference for this analysis, not a federal requirement or a universal standard.

Margin and cash move together. Health centers with an operating loss held a median of 51 days, against 95 days for centers at or above break-even, and 70.3% of loss-making centers held less than 90 days, against 46.8% of the rest (522 and 616 centers).

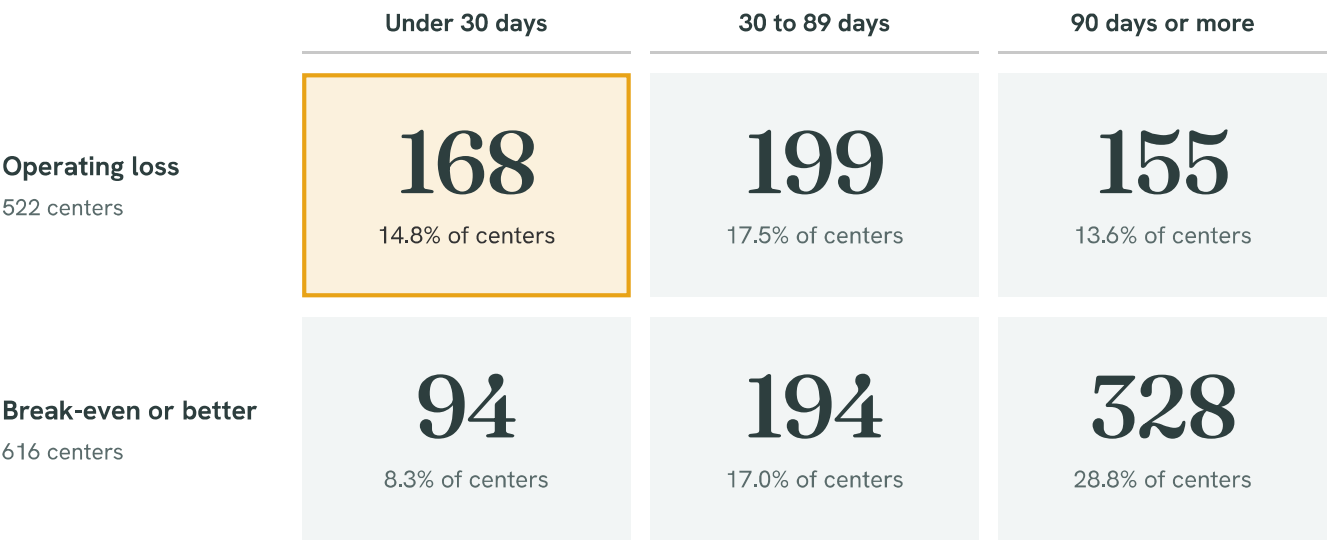
The Double Exposure: Operating Losses and Limited Cash

Among the 1,138 health centers with eligible liquidity data, 168 (14.8%) reported both an operating loss and fewer than 30 days of reported cash. These organizations carry recurring operating deficits and limited reported liquidity at the same time. That does not establish insolvency, and not all reported cash is unrestricted. It shows why operating margin and reserves should be read together.

FIGURE 6 · THE DOUBLE EXPOSURE: MARGIN AND CASH

168 centers with an operating loss and under 30 days of cash

Health centers by operating result and reported days cash on hand



Operating loss and under 30 days: **168 (14.8%)**. Under 60: **293 (25.7%)**. Under 90: **367 (32.2%)**.

Source: verified Form 990s, fiscal years ending 2023 to 2026 (blended); n = 1,138. Restricted cash not separated. Day bands are analytical categories for this report, not regulatory standards. Association, not cause.

The matrix also shows the reverse case: 94 centers broke even or better on operations but held less than 30 days of reported cash, a liquidity vulnerability despite positive operations. Day bands here are analytical categories, not regulatory standards.

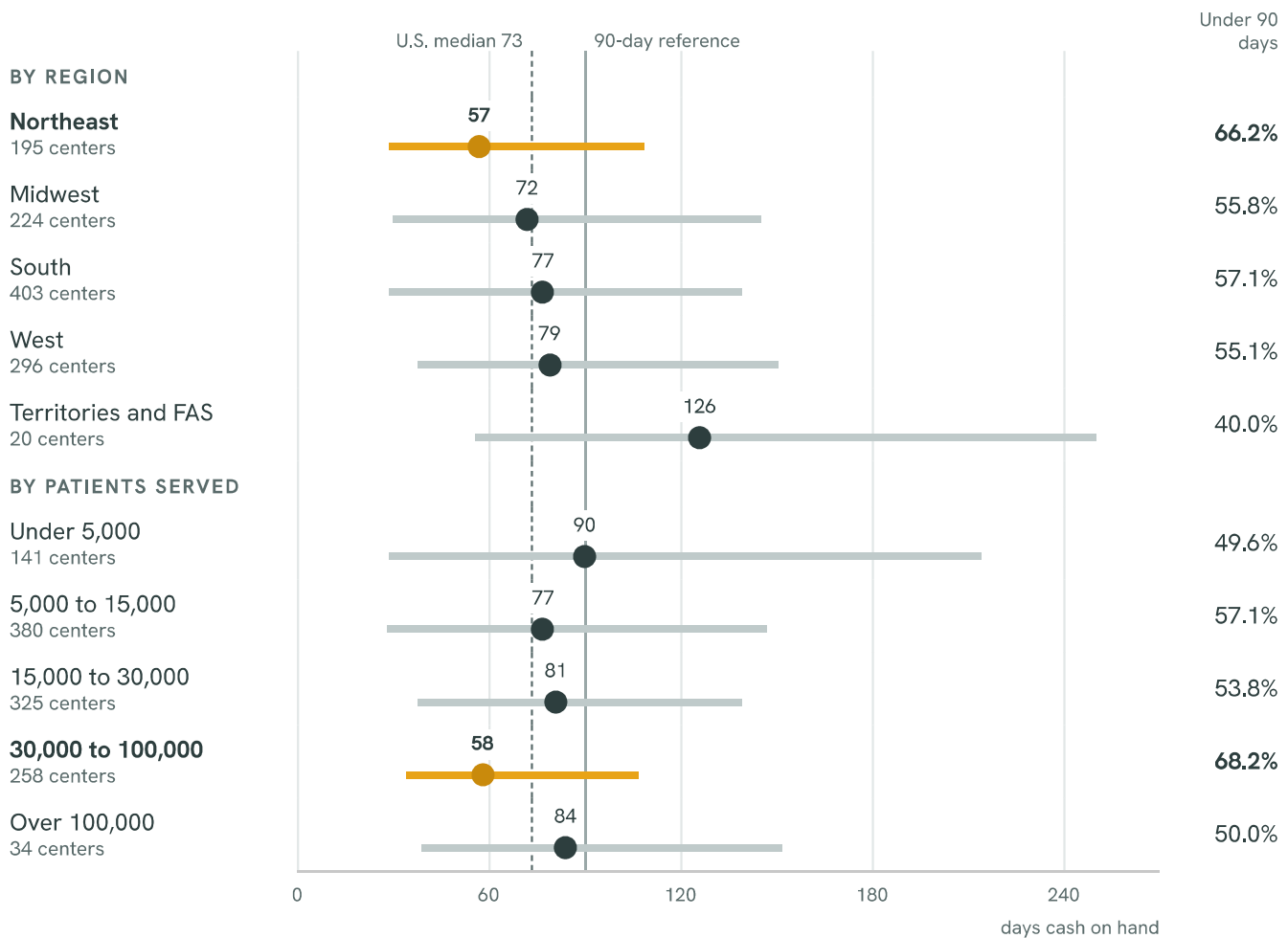
Liquidity by Region and Size

The Northeast holds the smallest regional cushion: a median of 57 days, with 66.2% of its centers under 90. Size does not move liquidity in a straight line. Centers serving 30,000 to 100,000 patients report the lowest median (58 days) and the largest share under 90 (68.2%), while the smallest centers report the highest median (90 days) and the widest spread. These differences describe the conditions health centers operate in; they do not explain them.

FIGURE 7 · REPORTED DAYS CASH BY REGION AND SIZE

Northeast centers and those serving 30,000 to 100,000 patients hold the least cash

Reported days cash on hand (Form 990). Dot and number = median center; bar = middle half of centers.



Source: verified Form 990s, fiscal years ending 2023 to 2026 (blended); patients, UDS 2025. Investments excluded; restricted cash cannot be separated. 90 days is a descriptive reference, not a standard. U.S.: 57.6% of 1,138 centers under 90 days. Territories (20) and over 100,000 (34) rest on small groups.

READING THE MEASURE

Reported days cash is Form 990 cash plus savings and temporary cash investments, divided by average daily expenses excluding depreciation. It is a consistent public-data proxy, not unrestricted operating liquidity, because Form 990 does not separate cash that is freely available from cash restricted for other purposes. HRSA lists days cash among its Financial Performance Indicators, with a different formula and no published target.

The question for leadership is not how much cash appears in a public filing. It is how much unrestricted liquidity is actually available, and how reliably legitimate reimbursement replenishes it. The full method and source differences are in [Appendix B](#).

Note: Capital Link's 2021–2024 national analysis lists more than 60 days cash on hand as a target. It is cited as a source only; see [Appendix B](#).

What Leadership Can and Cannot Control

Not every pressure in this report is equally movable. Sorting them is the first step toward a plan.

Structural factors Largely outside direct control	EXAMPLES State Medicaid rates and PPS methodology, payer mix, community need and uninsured share, local labor markets, grant levels	WHAT LEADERSHIP CAN DO Know them, plan around them, and advocate where possible
Operating decisions Within management’s reach	EXAMPLES Staffing model, provider productivity, service mix, site footprint, expense management	WHAT LEADERSHIP CAN DO Compare with relevant peers, investigate material differences, and look for improvements in staffing, productivity, service mix, expense management and reimbursement processes
Revenue cycle opportunities Where this report goes next	EXAMPLES Claim accuracy and denial prevention, underpayment recovery, A/R follow-up, credentialing, posting rules, supplemental payment reconciliation	WHAT LEADERSHIP CAN DO Measure with claim-level data and add capacity where it is short

Benchmarking does not improve performance by itself. It shows which differences deserve investigation. A peer median is context, not a target: nationally, the typical health center runs a 0.6% operating margin, and nearly half lose money. Some differences reflect conditions outside management’s control; others reflect operating decisions or revenue cycle processes it can change. The third row is where the rest of this report goes next.

If a health center has earned the reimbursement, what is preventing that money from reaching the bank?

04 From Billed Charges to Cash in the Bank

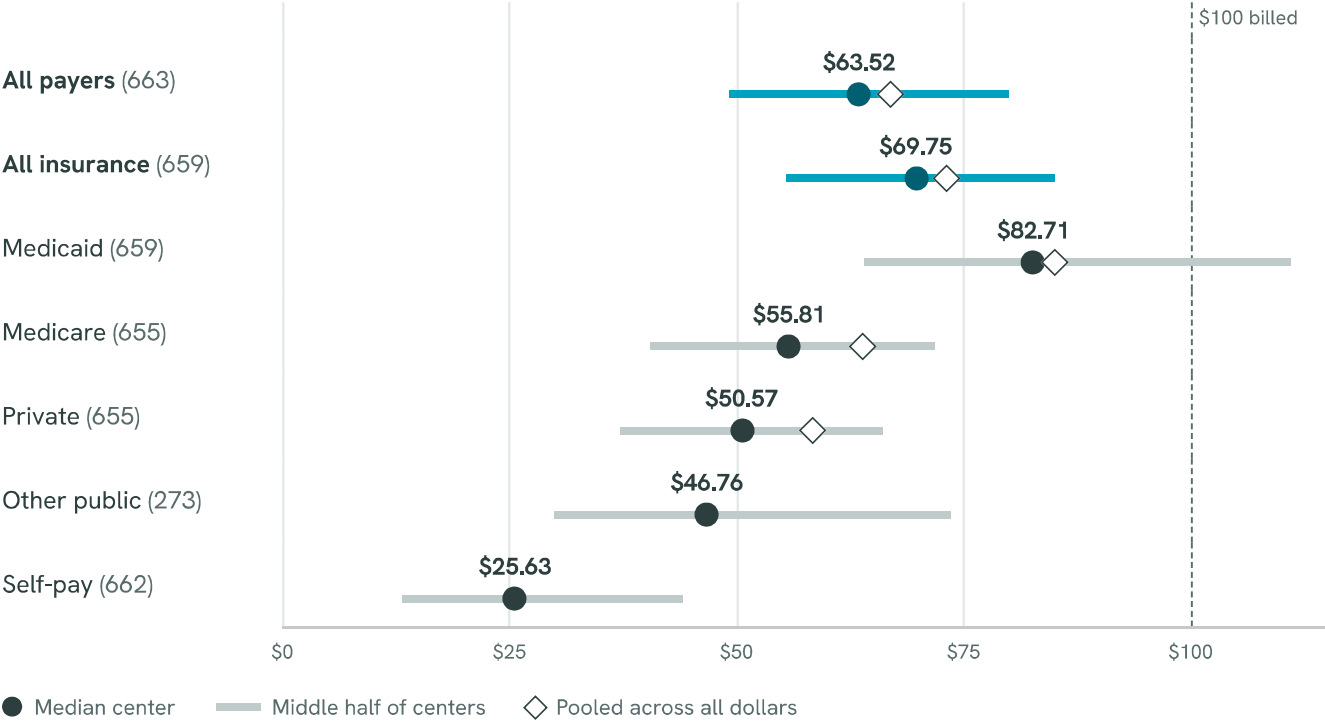
For every \$100 we billed, how much actually arrived?

Every visit starts life as a charge and, if everything goes right, ends as a deposit. So an important starting question for any board is a simple one: for every \$100 we billed, how much actually arrived? For the median health center in 2025, the answer was **\$63.52** (UDS 2025, n = 663).

FIGURE 8 · RECEIVED PER \$100 BILLED, BY PAYER

What the median health center received for every \$100 billed (UDS 2025)

\$63.52 across all payers. Centers in parentheses.



Source: HRSA UDS 2025, Table 9D. Charges and payments share a year, not a claim cohort. Payments ÷ billed charges, no adjustments; pooled figures weight larger centers more. Not what was owed.

Read with care: charges and payments here are reported in the same calendar year but do not belong to the same claim cohort. Payments include settlements and claims from earlier periods, and each health center sets its own charges.

Medicaid returns the most per \$100 billed (a typical \$82.71, and more than \$100 for a quarter of centers, because prior-year settlements and wraparound payments land in the same year). Medicare and commercial plans return roughly half. Self-pay returns about a quarter, by design: sliding-fee discounts are part of the mission, not a billing failure.

Medians and pooled figures answer different questions. The median describes the typical health center: half received more per \$100 billed, half received less. Pooling every dollar across the 663 centers gives larger centers more weight and produces higher figures: \$66.99 for all payers, \$73.09 for insurers overall, \$84.95 for Medicaid, \$63.87 for Medicare and \$58.41 for commercial plans. This report leads with medians because it benchmarks health centers, not dollars.

What Does a 99.4% Collection Rate Really Tell Us?

\$63.52

Received per \$100 billed

Median of each center's own ratio. No adjustments. 663 centers.

VS

99.4%

Adjusted collection rate

Payments ÷ (charges – adjustments), pooled across all dollars. 659 centers.

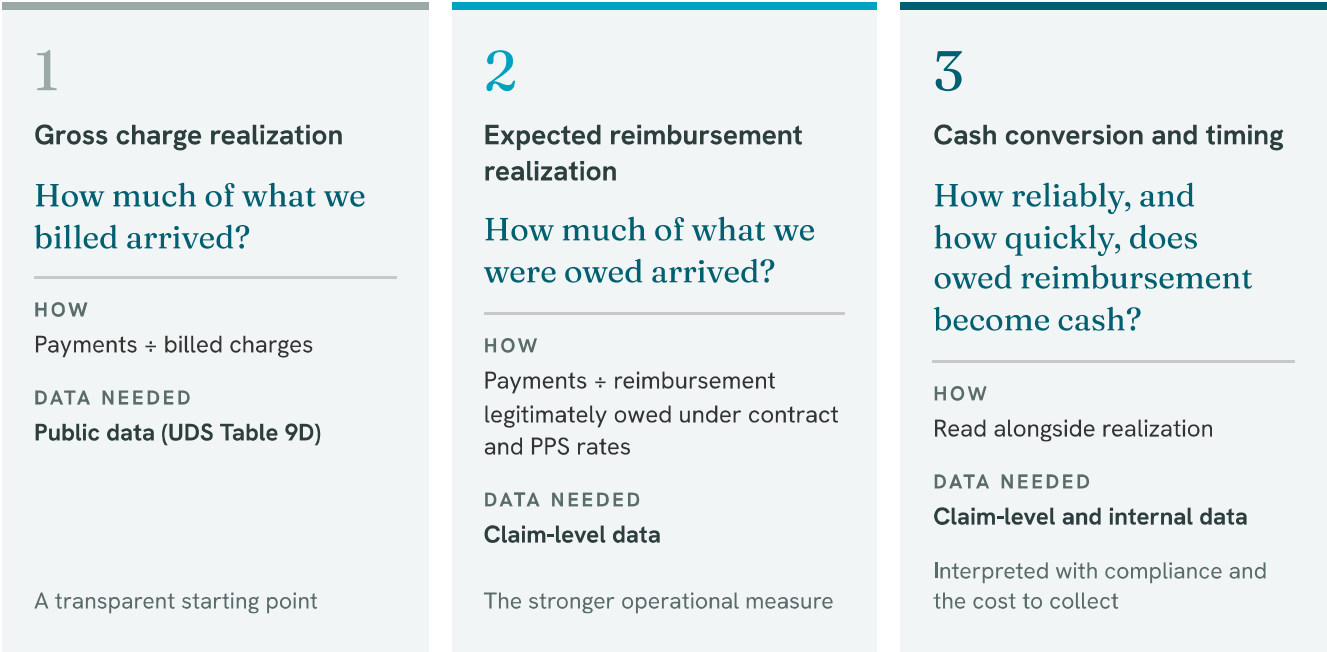
The familiar collection rate divides payments by charges after contractual adjustments. Nationally, it reports that payers paid 99.4 cents of every expected dollar (659 health centers, pooled across all dollars). A rate near 100% looks like excellent performance. But it depends on which adjustments reduce the denominator, how transactions are classified, and when payments are recorded. It cannot show that every claim was paid appropriately or that every legitimate reimbursement opportunity was pursued.

The two headline figures are built differently. \$63.52 is the median of each center's own ratio; 99.4% pools every dollar, so larger centers weigh more. They are not two views of one number, and adjustments alone do not explain the distance between them. Understanding that distance requires the claims, payments, denials and adjustments themselves.

Gross charge realization, the chart on page 16, keeps adjustments out of the math, which makes it a transparent starting point. It is not a complete measure of billing effectiveness. Charge-master pricing, payer mix, PPS and supplemental payments, settlements and payment timing all move it, and it cannot establish what was legitimately owed. A health center receiving \$55 per \$100 billed may collect a greater share of what it is owed than one receiving \$75. That is why we read three measures together.

FIGURE 9 · THREE MEASURES, THREE QUESTIONS (ILLUSTRATIVE)

Realization is read three ways, and only one is visible in public data



Illustrative. Formulas and what each measure can hide are in the Measure Reference, [Appendix C](#).

Expected reimbursement realization, read alongside cash conversion and timing and interpreted with compliance and the cost to collect, is the stronger operational measure of billing effectiveness. Public data opens the conversation; claim-level data finishes it.

Because fee schedules vary (charges per visit run from about \$220 to \$675 between the 10th and 90th percentile; UDS 2025, n = 613), received per \$100 billed means the most in three comparisons: against your own history, payer by payer, and against centers that set charges in a similar way.

Billing Effectiveness and the Path to Margin

We define billing effectiveness simply: turning properly documented, billable care into the cash the health center is legitimately owed, on time, at a reasonable cost, and in compliance. Activity measures such as claims submitted and first-pass acceptance rate tell you the machine is running. Expected reimbursement realization and cash conversion tell you whether it is producing.

Improving revenue cycle performance can strengthen cash flow, prevent avoidable losses and protect future operating margin, but those effects are not identical. Collecting an existing receivable generally converts an asset into cash rather than creating new revenue. Recovering previously written-off or unrecognized reimbursement may change reported results, depending on the accounting treatment. Preventing denials and underpayments protects future revenue. Leadership needs to know both how much reimbursement is legitimately owed and how reliably it becomes available cash.

Stronger cash flow and stronger operating margin are related goals, not identical accounting outcomes.

FIGURE 10 · WHAT THE NUMBERS CANNOT TELL US

Public benchmarks show where to look; the claims show what is there

Public data can show

Form 990 and UDS

- Whether operations produce a surplus, and where margin pressure concentrates
- Reported days cash, restricted and unrestricted combined
- Received per \$100 billed, by payer
- The adjusted collection rate, pooled
- Fiscal and billing staff per visit

Only claim-level data can show

Claims, remittances, adjustments and balances

- What reimbursement was legitimately owed
- Whether a denial was worked, or a payment matched the contract
- Whether a balance closed before anyone reviewed it
- How much outstanding A/R is actually collectable
- How much cash is unrestricted, or what the billing-system A/R holds

Synergy Billing. Based on the limitations of public data described in [Appendix B](#).

That distinction is the discipline behind this report. Many analyses treat every financial difference as lost revenue. The public data cannot support that claim, and this report does not make it. What public data can do is show leadership where to look. The claims show what is there.

What happens when a claim requiring follow-up is adjusted off before anyone investigates it?

05 What Only Claim-Level Analysis Can Reveal

The tests in this section require a health center's own claim, remittance, adjustment and A/R data.

The public measures above show where a health center stands. They cannot show what happened to an individual claim: whether a denial was worked, whether a payment matched the contract, whether a balance closed before anyone reviewed it. The tests in this section require a health center's own claim, remittance, adjustment and A/R data.

When an Adjustment Closes a Claim Before the Work Is Finished

Some revenue cycle problems are hard to detect because the billing system is working exactly as configured. Consider a \$100 visit denied for a missing modifier. The remittance reports no payment, and an automated posting rule adjusts off the entire charge. The claim leaves A/R before anyone has a chance to work it: the account shows a zero balance, drops out of routine follow-up queues, and the collection rate does not move.

FIGURE 11 · THE SAME DENIED CLAIM, TWO OUTCOMES (ILLUSTRATIVE)

One posting decision determines whether the claim is ever worked

\$100 Visit billed · denied for a missing modifier · remittance reports \$0 payment

LANE A · CLOSED BY A POSTING RULE



OUTCOME **Leaves A/R before anyone works it**

LANE B · KEPT VISIBLE AS AN EXCEPTION



OUTCOME **The applicable reimbursement, not necessarily the full \$100**

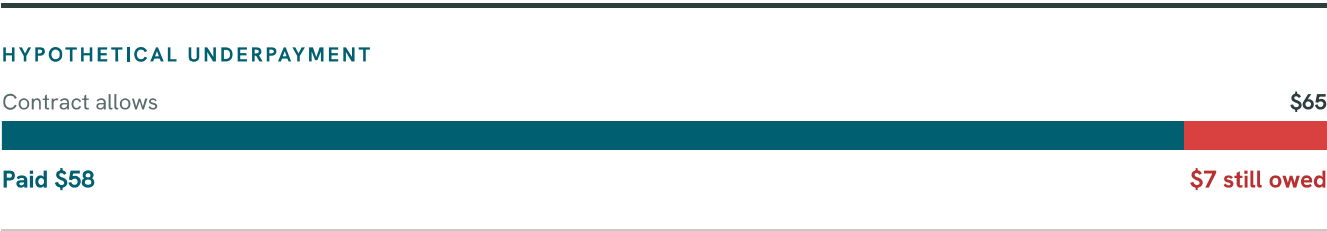
Illustrative; no claim-level data from any health center is used in this report. A zero-payment, full-charge adjustment is an exception worth reviewing, not proof of lost reimbursement.

Corrected by adding the modifier and resubmitted, that claim could have produced the applicable reimbursement amount, which is not necessarily the full \$100 billed. Some full-charge adjustments are legitimate; others are claims that need correction, appeal or further review. A zero-payment, full-charge adjustment is an exception worth reviewing, not proof of lost reimbursement.

The management question is whether unresolved claims stay visible and accountable until they are appropriately resolved.

Adjustments, Underpayments and Write-Offs

A contractual adjustment is expected and legitimate. A full-charge adjustment, an administrative write-off or an underpayment may not be. In a hypothetical example, a plan whose contract allows \$65 for a visit pays \$58: the \$7 difference is an underpayment still owed under the contract, not a contractual adjustment.



HRSA’s reporting guidance limits adjustments to contractual reductions, not non-covered services, late filings or unpaid deductibles and co-pays (HRSA Table 9D Fact Sheet). Posting systems do not always draw that line on their own, and no annual report can show where it was drawn. Definitions are in [Appendix B](#).

What Is Your Open A/R Really Worth?

How much of our outstanding A/R is actually collectable? An outstanding A/R balance is not a single pool of money waiting to be collected. Some balances will be legitimately adjusted. Others are pending with payers. Some need corrections or appeals. Still others may no longer be recoverable. The balance in a billing system therefore does not equal the amount a health center can reasonably expect to receive.

TABLE 4 · THREE CATEGORIES OF OUTSTANDING A/R

■	Legitimately adjusted or not owed	Amounts not payable under the applicable reimbursement rules
■	Pending or unresolved	Claims awaiting adjudication, payment, correction or investigation
■	Potentially collectable	Legitimate reimbursement that remains reasonably recoverable

Sorting a balance into these categories requires the accounts themselves: payer terms, claim status, age, documentation and remaining recovery rights. Multiplying gross A/R by a national payment ratio does not answer the question.

Reconciling Book A/R and Billing-System A/R

The public receivables-to-charges proxy in this report divides year-end Form 990 receivables by a day of UDS third-party charges: median 32 days, middle half 21 to 52 days (n = 678; each 990 year-end paired with UDS charges within one year). It is directional at best. The 990 reports accounting A/R, usually net of an allowance for bad debt, while the billing system often carries a different, larger balance. It is not standard net patient A/R days and should never be compared with a health center’s own A/R report as though they were the same measure.

Reconciling book A/R with billing-system A/R can surface ordinary accounting differences (contractual allowances, bad-debt estimates, timing, settlements), operational problems, and collectable balances that never appear in normal reporting.

Public benchmarks tell leadership where to look. Claim-level analysis helps determine what actually happened.

06

The Capacity Challenge:
No Claim Left Behind

Even when reimbursement opportunities are identified, does the billing department have the capacity to pursue them?

PICTURE THE WEEK

Monday’s claims have to go out. Friday’s remittances have to post. The clearinghouse rejected forty claims overnight. A payer changed its modifier rules. A provider’s credentialing file needs a signature. And underneath all of it sits the backlog: the denials from March, the underpaid managed-care visits, the secondary claims that never went out. New work arrives every day. Old work waits. **The old work is where the money quietly expires.**

Every unresolved claim carries an operational consequence. Some need routine follow-up. Others involve denials or underpayments with filing or appeal deadlines that will eventually limit recovery. When a billing department lacks the capacity to address those exceptions promptly, legitimate reimbursement becomes harder, more expensive or impossible to recover.

What the Staffing Data Shows

We expected to find that loss-making health centers run thin billing teams. The data says the opposite.

TABLE 5 · FISCAL AND BILLING STAFFING, UDS 2025, TABLE 5

Measure	Loss-making centers	Centers at or above break-even
Fiscal and billing staff per 10,000 visits (median)	1.51	1.26
Visits per fiscal and billing staff member (median)	6,628	7,917
Health centers	283	306

+20%**More fiscal and billing staff per visit at loss-making centers**

p = 0.003, Mann-Whitney

1.40**Staff per 10,000 visits, median center**

Middle half 0.96 to 2.04; n = 691

\$2.7M**Annual charges per fiscal and billing staff member**

n = 596

Health centers losing money carry about 20% more fiscal and billing staff per visit than those breaking even, a statistically significant difference (Mann-Whitney p = 0.003) that describes the gap between the groups, not its cause. Nationally, the median center reports 7.7 fiscal and billing staff, 1.40 per 10,000 visits (middle half 0.96 to 2.04; n = 691), each managing roughly \$2.7 million in annual charges (n = 596).

What does that mean? The data cannot say why performance differs. The measure includes finance and accounting staff, and outsourced billing is generally not counted as staff. More people per visit does not prove a team is stretched, and it does not prove that more specialized capacity is the answer. Staffing levels alone do not explain revenue cycle performance.

The more useful management question is whether the health center has the expertise, workflows and available capacity necessary to pursue appropriate reimbursement.

Four Ways to Add Capacity

1 Hire	Add internal billing specialists	STRENGTHS Direct control; knowledge stays in-house	WATCH-OUTS FQHC-experienced billers are hard to find; months to full productivity; turnover; payroll and management load
2 Reorganize	Create a checkpoint at payment posting where every denial, discrepancy and underpayment is caught and assigned	STRENGTHS Problems surface early; clear accountability	WATCH-OUTS Moves work rather than adding hours; the backlog can still outgrow the team
3 Augment (co-source)	Outside FQHC specialists take defined queues such as aged A/R, denials or underpayments, or clear a backlog in a short-term project	STRENGTHS Adds expert hours fast; internal team and workflows stay; scales up or down	WATCH-OUTS Needs clear handoff rules, data access and reporting
4 Partner (full revenue cycle)	A specialized FQHC partner runs billing and revenue cycle operations end to end, with defined performance reporting	STRENGTHS No recruiting or turnover risk; FQHC expertise from day one; leadership time returns to patients and growth	WATCH-OUTS Requires a clear agreement, transparent reporting and data access; less day-to-day direct control

None of these is right for everyone. A health center with a clean, current A/R and a stable team may need nothing more than a sharper checkpoint. One with a growing backlog and an open job posting that has sat for six months may need hours that hiring cannot deliver in time. And a health center that cannot recruit or keep experienced FQHC billers may find that a full revenue cycle partner is the most practical answer.

What if a health center could get the billing capacity it needs, in the form that fits, and keep its focus on patients?

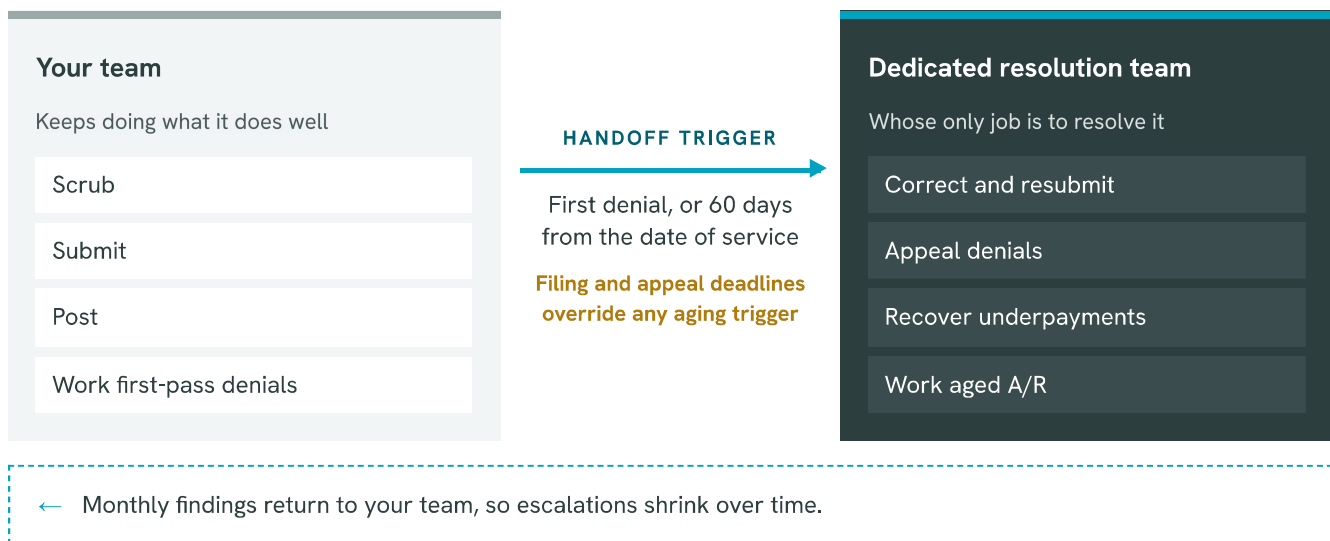
No Claim Left Behind: Capacity That Fits Your Health Center

Health centers exist to care for their communities, not to chase insurance companies. Every hour a CFO or clinic leader spends on a denied claim is an hour not spent on patients, staff or growth. Working with a specialized revenue cycle partner does not have to mean replacing your billing department. For some health centers the right answer is to augment the team they have. For others, especially those that cannot find or keep experienced billers, a full revenue cycle partnership is the logical solution.

When augmenting is the fit, your team keeps doing what it does well: scrubbing, submitting, posting and working first-pass denials. When a claim slips past a defined point, such as a first denial or 60 days from the date of service, it moves to a dedicated team whose only job is to resolve it. Filing and appeal deadlines override any aging trigger. Nothing falls through the floor, because there is a net under it.

FIGURE 12 · NO CLAIM LEFT BEHIND CO-SOURCING WORKFLOW (ILLUSTRATIVE)

Nothing falls through the floor, because there is a net under it



Illustrative. Handoff points, queues and reporting are defined with each health center.

Synergy Billing has worked exclusively with community health centers for more than 20 years, with a 100% U.S.-based team that lives inside FQHC reimbursement every day: PPS and wraparound rules, Medicare FQHC billing, managed-care contracts, credentialing, denials and appeals. We support both models with FQHC-specific expertise, defined workflows, transparent performance reporting and clear accountability. The objective is not to impose one operating model. It is to help each health center secure the reimbursement its mission depends on.

20+ Years working exclusively with community health centers	100% U.S.-based team	2 Models supported: co-sourcing and full revenue cycle partnership
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How We Help

- 1

Clear the backlog

In a focused, short-term project, we work aging A/R claim by claim to recover what is legitimately collectable. Depending on the balances and an individual assessment, Synergy may be able to advance funds against qualifying receivables while the work is done. Eligibility, amount and terms are set case by case, and this is never a guarantee. An advance changes when cash arrives and carries its own terms and costs; it does not improve recurring operating margin.
- 2

Add capacity

Through co-sourcing, Synergy takes defined work queues such as denials, underpayments and aged A/R, with follow-up discipline and monthly findings, so escalations shrink over time.
- 3

Run the revenue cycle

For health centers that want one accountable partner, Synergy manages billing and revenue cycle operations end to end, with transparent performance reporting.

Every path serves one goal: collect what has already been earned for care already delivered, and make sure preventable problems do not quietly become permanent losses.

Every dollar matters.

But not every billed dollar is owed, and not every outstanding balance is collectable. An effective revenue cycle knows the difference, pursues what is legitimately due, and lets nothing collectable expire for lack of time.

07 What Is Your Revenue Cycle Really Worth?

National benchmarks show where a health center stands. They cannot answer two of the most important financial questions for yours:

- 1 How much of our outstanding A/R is actually collectable?
- 2 How much patient service revenue should we be collecting for the care we provide?

Answering them takes your own claims, payments, adjustments, denials and balances. That is the purpose of Synergy Billing's Complimentary FQHC Revenue Cycle Analysis: our FQHC specialists review your revenue cycle data to show where appropriate reimbursement may be delayed, underpaid, unresolved or at risk of being lost, and whether additional expertise or capacity would help. The objective is a clearer financial picture and a practical basis for deciding what comes next. There is no requirement to outsource your revenue cycle to benefit from it.

COMPLIMENTARY · NO OBLIGATION

Request Your Complimentary Revenue Cycle Analysis

[Request My Complimentary Analysis →](#)

The initial request takes less than a minute. Our team will follow up to discuss the information needed for an appropriate review. No patient information is required to submit the request.

No Margin. No Mission. No Claim Left Behind.

APPENDIX A

Regional and State Financial Profiles

The national story is thin margins. The regional story is that “thin” means very different things depending on where you stand. In the West, the typical health center earns 3.5% on operations. In the Northeast, it loses 1.5%, and well over half of centers run an operating loss.

Each page in this appendix covers one region: how many HRSA health centers operate in each state, how many patients they serve, and the typical (median) value of every measure in this report. A region total and the U.S. figure sit at the bottom of each page, so any state can be read against both.

How to read the pages

- **Color** marks a state that is meaningfully better (green) or worse (red) than the U.S. median. Only measures with a clear better-or-worse reading are colored: margins, loss share, days cash and patient revenue per \$1 of cost. Counts, cost per patient, the receivables-to-charges proxy and dollars received per \$100 billed are shown as context, because a higher or lower value is not good or bad on its own.
- **A dash** means too few centers to publish safely: fewer than 5 verified 990s for margins and days cash, or fewer than 10 centers with published UDS data for the other measures. Region and U.S. rows are always shown.
- **Days in A/R** (the receivables-to-charges proxy) is the public estimate, built on accounting A/R that is usually net of a bad-debt allowance. It can mislead in either direction; read it as a prompt for questions, not a fact.
- **Insurance \$ per \$100 billed** is cash received from insurers for every \$100 billed to them, UDS 2025, no adjustments. Fee schedules differ, so read it alongside the other columns.

A state median is context for a conversation, not a grade. Medicaid rates, expansion status, managed-care design, cost of living and payer mix all differ from state to state.

FIGURE A1 · REGIONAL PROFILE

Northeast

226
health centers

195
verified 990s

104
with UDS payment data

Typical operating margin

-1.5%

U.S. 0.6%

Share with an operating loss

57%

U.S. 46%

Typical days cash

57

U.S. 73

Insurance \$ per \$100 billed

\$65

U.S. \$70

The Northeast is where the pressure is highest. The typical center loses 1.5% on operations and 57% of centers run an operating loss, the highest share of any region. New York (64 centers), New Jersey, Pennsylvania and Connecticut all sit in the red, while Massachusetts, New Hampshire and Maine are positive. Cash is thinner too: 57 typical days on hand against 73 nationally, and insurers return \$65 for every \$100 billed, against \$70 nationally.

STATE PROFILES · MEDIANS

State	Centers	Patients	Verified 990s	Operating margin	Total margin	Share with a loss	Days cash	Patient rev. per \$1 cost	Cost per patient	Days in A/R (proxy)	Insurance \$ per \$100
Connecticut	16	447K	15	-1.9%	-1.2%	73%	76	-	-	-	-
Maine	18	205K	18	2.1%	2.5%	44%	90	\$0.75	\$1,588	29	-
Massachusetts	37	885K	31	3.7%	4.6%	29%	65	\$0.58	\$2,163	39	-
New Hampshire	9	94K	7	6.3%	8.0%	14%	64	-	-	-	-
New Jersey	23	644K	20	-4.3%	-3.2%	70%	54	\$0.47	\$1,054	66	\$53
New York	64	2.31M	51	-6.3%	-4.4%	71%	51	\$0.59	\$1,502	26	\$58
Pennsylvania	40	869K	35	-3.6%	-0.8%	66%	44	\$0.73	\$1,176	32	\$69
Rhode Island	8	233K	7	-2.7%	0.0%	57%	83	-	-	-	-
Vermont	11	208K	11	-1.0%	0.8%	55%	57	-	-	-	-
Northeast region	226	5.90M	195	-1.5%	0.3%	57%	57	\$0.66	\$1,434	33	\$65
United States	1,356	32.74M	1,139	0.6%	1.9%	46%	73	\$0.68	\$1,418	32	\$70

Green or red: at least 1 point of margin, 10 points of loss share, 15 days cash or \$0.05 of patient revenue per \$1 of cost better or worse than the U.S. median. Dash: too few centers to publish. Margins, loss share and days cash: verified Form 990s, fiscal years ending 2023 to 2026, blended. Other measures: UDS. Patients and centers: UDS 2025.

FIGURE A2 · REGIONAL PROFILE

Midwest

268 health centers 224 verified 990s 166 with UDS payment data

Typical operating margin

0.2%

U.S. 0.6%

Share with an operating loss

49%

U.S. 46%

Typical days cash

72

U.S. 73

Insurance \$ per \$100 billed

\$72

U.S. \$70

The Midwest sits right at break-even: a typical operating margin of 0.2%, with half of centers in the red. It is a region of contrasts. Iowa, Minnesota and Illinois run losses, while Missouri, Wisconsin and Ohio are comfortably positive. Cash splits the same way, from more than 100 typical days in Iowa, Kansas, Missouri and Nebraska to about 45 in Minnesota and Wisconsin. Insurers here return \$72 for every \$100 billed, slightly above the U.S. figure, led by Indiana at \$99.

STATE PROFILES · MEDIAN

State	Centers	Patients	Verified 990s	Operating margin	Total margin	Share with a loss	Days cash	Patient rev. per \$1 cost	Cost per patient	Days in A/R (proxy)	Insurance \$ per \$100
Illinois	45	1.45M	30	-2.2%	-0.9%	63%	51	\$0.63	\$1,216	29	\$62
Indiana	26	715K	22	-0.1%	0.9%	50%	54	\$0.79	\$1,161	32	\$99
Iowa	14	263K	13	-4.9%	-3.8%	69%	116	\$0.74	\$1,453	29	-
Kansas	19	316K	17	1.0%	-1.6%	41%	112	\$0.62	\$1,209	27	\$67
Michigan	39	693K	34	0.5%	1.5%	41%	52	\$0.64	\$1,334	38	\$66
Minnesota	16	158K	12	-4.3%	-3.8%	67%	45	-	-	-	\$85
Missouri	27	682K	25	3.8%	5.6%	28%	117	\$0.69	\$1,349	25	\$65
Nebraska	7	122K	6	-1.6%	-1.0%	67%	107	-	-	-	-
North Dakota	4	37K	4	-	-	-	-	-	-	-	-
Ohio	51	933K	43	1.8%	2.5%	40%	65	\$0.74	\$1,122	31	\$70
South Dakota	4	124K	3	-	-	-	-	-	-	-	-
Wisconsin	16	300K	15	4.1%	4.6%	47%	45	\$0.63	\$1,423	-	-
Midwest region	268	5.79M	224	0.2%	0.8%	49%	72	\$0.68	\$1,303	30	\$72
United States	1,356	32.74M	1,139	0.6%	1.9%	46%	73	\$0.68	\$1,418	32	\$70

Green or red: at least 1 point of margin, 10 points of loss share, 15 days cash or \$0.05 of patient revenue per \$1 of cost better or worse than the U.S. median. Dash: too few centers to publish. Margins, loss share and days cash: verified Form 990s, fiscal years ending 2023 to 2026, blended. Other measures: UDS. Patients and centers: UDS 2025.

FIGURE A3 · REGIONAL PROFILE

South

454 health centers 403 verified 990s 211 with UDS payment data

Typical operating margin

0.2%

U.S. 0.6%

Share with an operating loss

48%

U.S. 46%

Typical days cash

77

U.S. 73

Insurance \$ per \$100 billed

\$65

U.S. \$70

The South is the largest region by health center count (454) and splits almost exactly down the middle. Arkansas, Kentucky, North Carolina, Oklahoma and Louisiana run healthy positive margins with deep cash reserves. The District of Columbia, Alabama, Georgia, Tennessee, Virginia and Texas run losses; Texas alone has 71 health centers. Patient revenue covers 63 cents of each dollar of cost, the lowest of any region, and insurers return \$65 for every \$100 billed. Texas, at \$51, is the lowest of any state with enough published data. Alabama is one of the states where the two margins disagree: an operating loss, rescued by non-operating income.

STATE PROFILES · MEDIANS

State	Centers	Patients	Verified 990s	Operating margin	Total margin	Share with a loss	Days cash	Patient rev. per \$1 cost	Cost per patient	Days in A/R (proxy)	Insurance \$ per \$100
Alabama	17	317K	13	-3.8%	1.3%	62%	100	-	-	-	-
Arkansas	12	385K	12	5.4%	6.3%	25%	125	-	-	57	-
Delaware	3	44K	3	-	-	-	-	-	-	-	-
District of Columbia	8	180K	7	-7.7%	-7.0%	57%	30	-	-	-	-
Florida	47	1.67M	38	0.9%	1.6%	45%	39	\$0.67	\$1,070	25	\$63
Georgia	35	766K	33	-3.4%	-2.4%	61%	33	\$0.57	\$1,004	23	\$58
Kentucky	25	676K	21	4.8%	5.9%	33%	131	\$0.73	\$1,555	32	\$73
Louisiana	35	501K	27	2.8%	5.4%	33%	87	\$0.72	\$1,252	21	\$72
Maryland	16	369K	15	-0.9%	0.2%	60%	76	-	-	-	-
Mississippi	20	306K	20	0.0%	1.3%	50%	41	\$0.58	\$1,093	23	-
North Carolina	38	732K	34	4.5%	6.1%	26%	120	\$0.62	\$1,427	39	\$75
Oklahoma	21	357K	20	3.3%	3.3%	40%	110	\$0.66	\$1,409	20	\$72
South Carolina	23	442K	23	0.2%	1.9%	48%	65	\$0.65	\$1,537	26	-
Tennessee	29	428K	22	-2.7%	-1.1%	59%	84	\$0.61	\$1,220	27	\$55
Texas	71	1.90M	62	-1.9%	-1.1%	60%	60	\$0.53	\$1,101	23	\$51
Virginia	26	410K	26	-2.3%	-0.9%	58%	87	\$0.60	\$1,389	56	\$58
West Virginia	28	593K	27	1.8%	3.0%	44%	96	\$0.69	\$1,489	39	\$72
South region	454	10.08M	403	0.2%	1.4%	48%	77	\$0.63	\$1,307	29	\$65
United States	1,356	32.74M	1,139	0.6%	1.9%	46%	73	\$0.68	\$1,418	32	\$70

Green or red: at least 1 point of margin, 10 points of loss share, 15 days cash or \$0.05 of patient revenue per \$1 of cost better or worse than the U.S. median. Dash: too few centers to publish. Margins, loss share and days cash: verified Form 990s, fiscal years ending 2023 to 2026, blended. Other measures: UDS. Patients and centers: UDS 2025.

FIGURE A4 · REGIONAL PROFILE

West

376 health centers 297 verified 990s 165 with UDS payment data

Typical operating margin

3.5%

U.S. 0.6%

Share with an operating loss

36%

U.S. 46%

Typical days cash

79

U.S. 73

Insurance \$ per \$100 billed

\$80

U.S. \$70

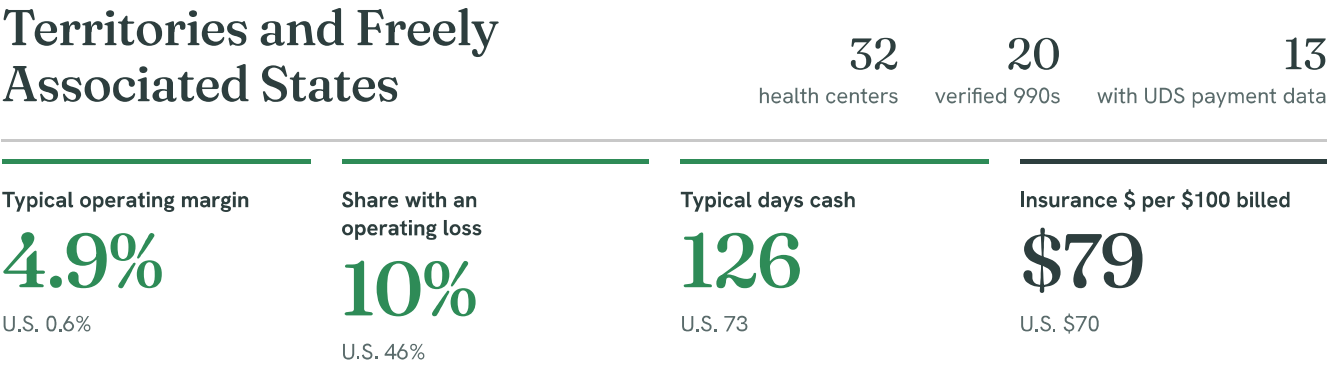
The West is the strongest region on almost every financial measure: a typical operating margin of 3.5%, the lowest share of centers with a loss among the four census regions (36%), and \$80 from insurers for every \$100 billed. California carries the region, with 170 health centers and 5.9 million patients. It is also the most expensive place to deliver care, at a typical \$1,879 per patient. Utah is the outlier in the other direction: 9 of its 10 verified centers ran an operating loss. Note the receivables-to-charges proxy here: Colorado and Oregon show 52 to 58 days, a reminder that the public measure reflects how A/R is booked as much as how fast it is collected.

STATE PROFILES · MEDIANS

State	Centers	Patients	Verified 990s	Operating margin	Total margin	Share with a loss	Days cash	Patient rev. per \$1 cost	Cost per patient	Days in A/R (proxy)	Insurance \$ per \$100
Alaska	27	114K	14	8.0%	9.3%	21%	64	–	–	–	\$79
Arizona	23	856K	18	–2.4%	–1.1%	56%	35	\$0.75	\$1,569	41	\$68
California	170	5.90M	141	6.5%	8.0%	28%	95	\$0.76	\$1,937	33	\$79
Colorado	19	638K	16	2.0%	2.1%	44%	94	\$0.60	\$1,600	58	\$94
Hawaii	13	157K	13	2.2%	3.7%	46%	64	–	–	–	–
Idaho	14	248K	10	2.9%	3.2%	30%	77	–	–	–	–
Montana	13	124K	11	3.7%	4.2%	36%	41	\$0.64	\$1,934	–	\$83
Nevada	7	136K	6	–0.5%	–0.5%	50%	47	–	–	–	–
New Mexico	16	294K	15	0.6%	1.1%	47%	64	–	–	23	–
Oregon	30	440K	18	5.4%	6.7%	28%	103	\$0.72	\$2,219	52	\$92
Utah	12	140K	10	–10.2%	–8.2%	90%	124	–	–	–	–
Washington	27	1.29M	23	0.9%	2.1%	43%	75	\$0.85	\$1,566	–	\$84
Wyoming	5	34K	2	–	–	–	–	–	–	–	–
West region	376	10.38M	297	3.5%	4.5%	36%	79	\$0.71	\$1,879	36	\$80
United States	1,356	32.74M	1,139	0.6%	1.9%	46%	73	\$0.68	\$1,418	32	\$70

Green or red: at least 1 point of margin, 10 points of loss share, 15 days cash or \$0.05 of patient revenue per \$1 of cost better or worse than the U.S. median. Dash: too few centers to publish. Margins, loss share and days cash: verified Form 990s, fiscal years ending 2023 to 2026, blended. Other measures: UDS. Patients and centers: UDS 2025.

FIGURE A5 · REGIONAL PROFILE



APPENDIX B

Endnotes: Data Sources, Calculations and Definitions

All data is accurate when properly qualified. These are the qualifications.

TABLE B1 • MEASURES, SOURCES AND CALCULATIONS

Measure	Source and data elements	Calculation	Population and years
Operating margin	Form 990 Part VIII lines 1-12 and line 11 descriptions; Part I line 18	(Operating revenue – total expenses) ÷ operating revenue; operating revenue = line 12 less lines 3-9 and line 11 items matching a published non-operating keyword list (about \$55M at 79 centers). Line 10 and grants stay in. Keeping the line 11 items moves the median to 0.8%	1,139 centers; fiscal years ending 2024-2025 for 96.2%, early 2026 for 36, 2023 for 7
Total margin	Form 990 Part VIII line 12; Part I line 18	(Line 12 – line 18) ÷ line 12; unadjusted	Same
Reported days cash	Form 990 Part X lines 1 and 2; Part I line 18; Part IX line 22	(Cash + savings and temporary cash investments) ÷ ((expenses – depreciation) ÷ 365); investments excluded; restricted cash cannot be separated	1,138 centers
Peer quartiles	990 operating margin; peer group = region, size band, urban or rural	25th and 75th percentiles within groups of 10 or more verified centers (linear interpolation, ties included)	283 + 283 centers in 31 groups
Patient revenue per \$1 of cost; cost per patient	UDS Table 9D line 14 column b; Table 8A line 17; total patients	Collections ÷ total cost; total cost ÷ patients; same UDS year	187 + 146 quartile centers; UDS 2025 (256), 2024 (42), 2023 (35)
Received per \$100 billed	UDS Table 9D column b ÷ column a, by payer (lines 1-13) and total (line 14)	Median of each center's ratio; column b already includes wraparound, reconciliation and incentive payments; blank payment fields excluded	663 centers (Medicare 655, self-pay 662); UDS 2025

TABLE B1 • CONTINUED

Measure	Source and data elements	Calculation	Population and years
Adjusted collection rate	UDS Table 9D columns a, b and d, third-party payers	Total payments ÷ (total charges – adjustments), pooled across all dollars	659 centers; UDS 2025
Receivables-to-charges proxy	Form 990 Part X line 4; UDS 9D third-party charges	A/R ÷ (charges ÷ 365); accounting A/R, usually net of a bad-debt allowance	678 centers; 990 year-end within one calendar year of the UDS year
Fiscal and billing staff per 10,000 visits	UDS Table 5 line 30b column a; line 34 columns b and b2	FTE ÷ visits × 10,000; includes finance and accounting staff	691 centers; 283 loss-making and 306 other; UDS 2025
One point of margin	990 operating revenue; UDS 2025 patients	1% of median operating revenue by size band; gap = median operating loss among loss-making centers	1,139 centers; 523 with a loss
UDS revenue/cost proxy (sensitivity only)	UDS 9D line 14 column b; 9E line 11 and line 1k; 8A line 17	(Revenue less capital grants – cost) ÷ revenue less capital grants; median –0.8%, 52.8% negative; –1.3% without COVID-19 funding; correlates 0.29 with 990 operating margin	635 centers; UDS 2025

STATISTICS AND PRIVACY

Medians, unweighted, each center counted once, unless a figure is labeled pooled. Group differences show association, not cause. No individual health center is named; state figures appear only where at least 5 verified centers report (10 for UDS-based measures). Dataset coverage and matching are described in [About the Data](#) at the front of the report.

Data Notes by Section

- **Executive Summary and Section 1** (margins and the quadrant): 1,139 health centers with a verified Form 990, latest full return, fiscal years ending 2025 (724), 2024 (372), 2026 (36) and 2023 (7), blended. Each center counts once; medians describe the typical health center, not the typical dollar. Operating margin is our analytical definition, not an audited standard.
- **Section 3** (days cash): reported days cash, n = 1,138, fiscal years ending 2023 to 2026, blended; 365-day year; restricted and unrestricted cash combined. Loss and non-loss groups: 522 and 616 centers. Day bands in the margin-and-cash matrix and the 90-day reference are analytical categories, not regulatory standards. Region and size figures are medians of the centers in each group; size bands use UDS 2025 patient counts.

Data Notes by Section, continued

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- **Section 2** (pressure, geography, peer quartiles, one point of margin): n = 1,139; each group's n is in its chart. States: 1,125 centers in 48 states and territories with n of 5 or more; the 14 others stay in national figures. 383 centers without published patient revenue have no funding profile. Territories rest on 20 centers. Peer quartiles: 283 bottom-quartile and 283 top-quartile centers, defined by the 25th and 75th percentiles of operating margin (linear interpolation, ties at the cutoff included) within peer groups that have at least 10 verified centers (31 groups, 1,087 centers); margins and days cash blend fiscal years ending 2025 (357), 2024 (192), 2026 (15) and 2023 (2); patient revenue per dollar of cost and cost per patient use UDS revenue and cost from the same year, 2025 (256), 2024 (42) or 2023 (35). One point of margin: 523 centers with an operating loss; one point = 1% of median operating revenue; gap = median operating loss among loss-making centers; per-visit figures use the 377 loss-making centers with UDS visit counts from 2025 (285), 2024 (56) or 2023 (36). Patient counts are UDS 2025.
-
- **Section 4** (billed charges to cash): HRSA UDS 2025, Table 9D, 663 health centers that consented to publish it (659 with insurance charges). Received = column b, amount collected, which already includes wraparound, reconciliation and incentive payments; billed = column a, full charges. Charts show the median center and the middle half; pooled across all dollars the figures are \$66.99 all payers, \$73.09 insurers, \$84.95 Medicaid, \$63.87 Medicare and \$58.41 private. Blank payment fields are excluded rather than treated as \$0, so Medicare rests on 655 centers and self-pay on 662. Ratios are shown to the cent as computed. The 99.4% adjusted collection rate is dollar-weighted across 659 centers. Charges per visit use Table 5 visits (n = 613). Single reporting year, no blending.
-
- **Section 5** (claims): the receivables-to-charges proxy uses 678 centers whose 990 fiscal year-end falls within one calendar year of the UDS charge year. Claim-level tests and the two-lane diagram are illustrative; no claim-level data from any health center is used in this report.
-
- **Section 6** (capacity): HRSA UDS 2025, Table 5, line 30b, fiscal and billing personnel (includes accounting and finance staff, not billing alone); visits = line 34, in-person plus virtual; centers with staff and visits above zero (n = 691). Billing vendors paid on a contingency or per-claim basis are generally not reported as FTEs, so outsourced capacity is undercounted. Loss status comes from the verified 990, matched to 589 of these centers. Association, not cause.
-

Definitions

Contractual adjustment	The difference between the charge and what the payer contract or reimbursement rule allows. Expected, legitimate, not lost.
Full-charge adjustment	The entire charge adjusted off with no payment. Sometimes legitimate; sometimes a denial closed by posting rules before anyone could work it. Each one is an exception to review.
Bad debt	A balance judged uncollectable under accounting policy. In HRSA reporting it exists only for self-pay patients (\$310 million across these centers in 2025). Third-party bad debt is not reported at all.
Administrative write-off	A balance removed for an operational reason, such as a missed filing limit or an unworked denial. This is where earned revenue quietly disappears.
Underpayment	A payment below what the contract or PPS rate actually requires.
Outstanding A/R	Still on the books. Pending, disputed, aging, or collectable.

Limitations

Financial results blend fiscal years ending 2023 to 2026, so centers are not measured over the same twelve months. Findings describe eligible populations (1,139 for Form 990 measures; 663 for UDS Table 9D; 691 for staffing), not every health center. Group comparisons show association, not cause. Public data cannot establish what reimbursement was legitimately owed, separate restricted from unrestricted cash, or reproduce a center’s billing-system A/R; those questions require claim-level and internal data. Operating margin and reported days cash are analytical definitions, not audited standards.

Sources

Sources: [HRSA Uniform Data System downloads](#) · [HRSA UDS Table 9D Fact Sheet 2025](#) · [IRS Form 990 series downloads](#) · [HRSA Financial Performance Indicators](#)

Liquidity context: [Capital Link, Financial and Operational Performance Analysis 2021-2024](#) (June 2026), National Data Summary, p. 49: “Days Cash on Hand > 60 Days” listed as a target; the report does not publish its days-cash formula. Cited as a source only; no other Capital Link figures are reproduced. HRSA days cash definition, no target value: HRSA Financial Performance Indicators (OMB 0915-0285).

HRSA program references (context; no margin, cash or collection-rate standard is set in them): [Compliance Manual, Chapter 15](#) · [Compliance Manual, Chapter 16](#) · [Site Visit Protocol, Billing and Collections](#) · [Site Visit Protocol, Financial Management](#)

APPENDIX C

Executive Oversight Card and Measure Reference

The Executive Oversight Card

Five measures management can complete monthly from internal records, with a deeper quarterly review by the finance committee. The blank column is yours to fill in; public references are context, not targets.

Executive Oversight Card		Monthly · Finance committee quarterly	
MEASURE	OUR VALUE	PUBLIC REFERENCE	QUESTION FOR THE REVENUE CYCLE TEAM
Operating margin		Median 0.6% (Form 990, fiscal years ending 2023–2026, blended; n = 1,139)	What is driving the change since last year?
Unrestricted days cash		Median 73 days of reported cash, restricted and unrestricted combined (Form 990; n = 1,138); 90 days used as a descriptive reference	What would a 60-day payer delay do to us?
Expected reimbursement realization, by payer		No public benchmark	Where are we furthest from what we are owed?
A/R over 90 days, by payer		No public benchmark	What share is still within filing and appeal limits?
Unresolved denial dollars		No public benchmark	How many full-charge adjustments with no payment were closed without review?

Public references come from verified Form 990s and UDS 2025 as described in [Appendix B](#). They are context for the conversation, not targets.

Measure Reference

What each measure in this report is, how it is calculated, and what it can hide. The first three answer different questions about revenue realization and are best read together.

TABLE C1 · MEASURE REFERENCE

Measure	How it is calculated	What it can hide
Received per \$100 billed (gross charge realization)	$\text{Payments} \div \text{billed charges} \times 100$, by payer (UDS Table 9D column b $\div$ column a)	Charge-master pricing, payer mix, PPS and supplemental payments, settlements and timing; it cannot show what was owed
Expected reimbursement realization	$\text{Payments} \div \text{reimbursement legitimately owed under contract and PPS rates}$	Errors in the expected amounts themselves
Adjusted collection rate	$\text{Payments} \div (\text{charges} - \text{adjustments})$	Whatever was adjusted out of the denominator, correctly or not
Full-charge adjustments with no payment	Claim lines where the adjustment equals the full charge and payment is \$0	Valid non-covered, duplicate or reversed claims; each is a review flag, not proof of loss
Operating margin	$(\text{Operating revenue} - \text{expenses}) \div \text{operating revenue}$	Dependence on grants and 340B income; classification and timing
Total margin	$(\text{All revenue} - \text{all expenses}) \div \text{all revenue}$	Weak operations offset by investment income or one-time gains
Days cash on hand	Cash and short-term equivalents $\div$ daily operating expense excluding depreciation	Restricted cash, debt covenants, uneven cash flow
Days in A/R	$\text{A/R} \div \text{average daily charges}$	Bad-debt allowances on the books; balances still in the billing system
Denial rate	$\text{Denied} \div \text{submitted or adjudicated claims}$; state count or dollars, first or final adjudication	Severity, repeat denials, dollars left unresolved
First-pass acceptance rate	$\text{Claims accepted without correction} \div \text{claims submitted}$	Underpayments and delays after acceptance

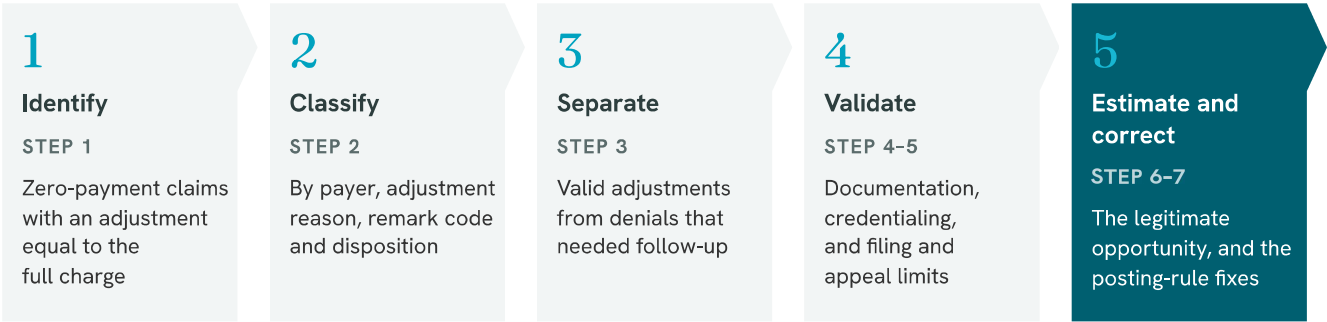
Shaded: the three realization measures, best read together (see Figure 9).

Full-Charge Adjustment Review: Detailed Steps

The seven steps behind the five-stage review in Figure C1, applied to the claim story in [Section 5](#). Each flagged claim is an exception to review, not proof of lost revenue.

FIGURE C1 · FULL-CHARGE ADJUSTMENT REVIEW (ILLUSTRATIVE)

Five stages, seven steps, from flag to fix



Illustrative. Each flagged claim is an exception to review, not proof of lost revenue.

- 1 Identify zero-payment claims with an adjustment equal to the full charge.
- 2 Classify them by payer, adjustment reason, remark code and how they were dispositioned.
- 3 Separate valid adjustments from denials that needed follow-up.
- 4 Confirm documentation and credentialing: was the service supported in the record, and was the rendering provider enrolled with the payer on the date of service?
- 5 For claims that needed follow-up, determine whether reimbursement is still recoverable within timely filing limits and appeal deadlines.
- 6 Estimate the legitimate reimbursement opportunity: the applicable reimbursement amount, not the billed charge.
- 7 Identify corrective actions, such as posting-rule changes, so the pattern does not recur.

A/R Account-Level Assessment

The six steps behind the three A/R categories in [Section 5](#). The result is an estimate grounded in claim-level evidence, not a guarantee of recovery.

TABLE C2 • FROM GROSS A/R TO COLLECTABLE OPPORTUNITY

1	Gross A/R	Outstanding charges and balances, by payer
2	Expected reimbursement	Legitimate reimbursement under payer contracts and applicable rules
3	Payment status	Pending, denied, underpaid, appealed, disputed or paid
4	Account age	Aging by payer and claim status
5	Recovery eligibility	Filing limits, appeal deadlines, documentation and credentialing
6	Collectable opportunity	Reasonably recoverable amounts, based on available claim-level evidence

NEXT STEP

To run this assessment on your own accounts, see the Complimentary FQHC Revenue Cycle Analysis on [page 27](#).

No Margin. No Mission. No Claim Left Behind.

Synergy Billing works exclusively with community health centers, with a 100% U.S.-based team, helping each one collect what it has earned so it can sustain and expand care.