California Community Clinics

A Cohort Analysis Report, 2005–2008

Prepared by Capital Link
in collaboration with the California HealthCare Foundation

California HealthCare Foundation

Capital Link
Connecting Health Centers to Capital Resources

ACKNOWLEDGEMENT

Capital Link is pleased to provide this report, prepared for the California HealthCare Foundation, to evaluate the financial health of California clinics and to highlight their historical growth patterns, capital financing opportunities and other trends that may influence their future financial performance and growth prospects. This study was supported by a grant from the California HealthCare Foundation, based in Oakland, California.

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, the Foundation's goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

Capital Link, established in 1998, is a non-profit organization dedicated to assisting community health centers in accessing capital for building and equipment projects. From market feasibility and program, staff and facility plans to comprehensive financing assistance, Capital Link provides extensive technical assistance to health centers to assist in strengthening their abilities to plan and carry out successful capital projects. Additionally, Capital Link works in partnership with primary care associations, consultants and other entities interested in improving access to capital for health centers.

Capital Link was founded by the National Association of Community Health Centers, Community Health Center Capital Fund, Massachusetts League of Community Health Centers, and Primary Care Associations in Illinois, North Carolina and Texas. Capital Link receives funding from governmental agencies, private foundations and fees charged to clients for services. For more information, visit www.caplink.org.

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EXECUTIVE SUMMARY

THIS REPORT, prepared for the California HealthCare Foundation by Capital Link, examines the major factors and characteristics that contribute to the financial success or duress of California community clinics. The following report is a continuation of the analysis presented in the updated *Financial Profile of the California Community Clinics 2005 – 2008* that was also conducted by Capital Link.

Using Form 990 data, each clinic's financial performance over the four year period was assessed from 2005 to 2008 using a financial performance evaluation system developed by Capital Link. Each clinic was evaluated based on a combination of certain profitability and liquidity ratios and assigned an overall score for the period. The community clinics were ranked according to their score and tiered into five groups (quintiles) based on overall financial performance. The highest and lowest cohorts were then compared and analyzed to examine factors that may affect the financial performance and financial condition of these cohorts.

The key findings of this study include:

1. **The organizational type of the clinic seems to have little bearing on its financial performance.** Both the clinics in the highest and lowest cohorts had similar proportions of FQHC, FQHC Look-Alike and Neither clinics. In addition, the distribution by clinic type between the two groups remained stable over the analysis period.

2. **Clinics in the highest cohort are more likely to be larger than clinics in the lowest cohort.** Clinics in the highest cohort are more likely to have revenues greater than $5 million while clinics in the lowest cohort have a greater percentage of clinics with revenues below $5 million.

KEY FINDINGS

1. The organizational type of the clinic seems to have little bearing on its financial performance.
2. Clinics in the highest cohort are more likely to be larger than clinics in the lowest cohort.
3. Clinics in the highest cohort have higher percentages of Grants and Contracts Revenues than clinics in the lowest cohort.
4. Medi-Cal Fee-for-Service is an important driver for successful financial performance.
5. Clinics within the highest cohorts with high self-pay / sliding fee/ free care visits have revenue from other sources to compensate.
6. Clinics in the highest cohort earn significantly more revenue on a per encounter basis.
7. There has been some overall fiscal improvement in the operations of community clinics.
8. The federal Health Center Growth Initiative significantly increased the proportion of FQHC Section 330 clinics in the state.
9. Staffing levels are growing rapidly.
10. The growth in the community clinics is occurring at the site level.

3. **In terms of revenue mix, clinics in the highest cohort have higher percentages of Grants and Contracts Revenues than clinics in the lowest cohort.** For clinics within the highest cohort, Grants and Contracts Revenues comprised 26% of total revenue compared to 17% for clinics in the lowest cohort. The clinics in the highest cohort also had a slightly higher percentage of revenue attributable to contributions and fundraising. Clinics in the lowest cohort were more reliant on Net Patient Service Revenue than the clinics in the highest cohort.

4. **Medi-Cal Fee-for-Service is an important driver for successful financial performance.** However, a clinic needs to have both high volume and good reimbursement rates to achieve a strong financial performance.

5. **Clinics within the highest cohort with high self-pay/sliding fee/free care visits have revenue from other sources to compensate.** Across size and type groups, clinics with larger self-pay/sliding fee/free care visits derive a significantly higher percentage of revenue from grants and contributions and fundraising income.

6. **While both clinics in the highest and lowest cohort have similar expense levels per encounter ($137 versus $135), Clinics in the highest cohort earn significantly more revenue on a per encounter basis.** Median Revenue per Encounter for clinics in the highest cohort was $148 compared to $137 for clinics in the lowest cohort, an $11 difference compared to the $2 difference in expenses. Revenue and expense levels per encounters were based on the median four-year average for each clinic cohort.

7. **The average Salary and Related Expenses over the four-year period of analysis was significantly higher for the clinics in the lowest cohort than the clinics in the highest cohort.** The four-year average Salary and Related Expenses as a Percentage of Total Operating Revenue was 6% higher for the clinics in the lowest cohort than the clinics in the highest cohort.

8. **Productivity based on Encounters per Primary Care Providers is virtually the same for both the clinics in the highest and lowest cohorts.**

9. **Community Clinics within the highest cohort serve a significantly higher and growing percentage of patients with incomes of less than 100% of the Federal Poverty Level (FPL).** Seventy-three percent of the patients seen by clinics within the highest cohort had income below 100% of the FPL, compared to 60% seen at clinics in the lowest cohort. The percentage of patients below 100% of the FPL also increased over time for the clinics in the highest cohort. For clinics in the lowest cohort, the patient income distribution remained the same over the four-year analysis period.

10. **Community Clinics within the highest cohort provide care to a younger patient base characterized by women of child-bearing age and children.** Clinics in the lowest cohort have a higher percentage of patients aged 45 and above.

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DEFINITIONS OF HEALTH CENTER SUB-GROUPS

Definition of Cohort Designations

FOR THE PURPOSES of this report, the analysis compares the Highest Cohort and Lowest Cohort of clinics, as divided based upon financial performance. As stated above, using Form 990 data, each health center's financial performance over the four year period was assessed using a financial performance evaluation system developed by Capital Link. Each health center was evaluated based on a combination of certain profitability and liquidity ratios and assigned an overall score for the period. See the Methodology section in Chapter 6 for additional information.

The community clinics were ranked according to their score and tiered into five groups (quintiles) based on overall financial performance. The Highest and Lowest Cohorts represent the highest and lowest quintiles that are then compared and analyzed to examine factors that may affect the financial performance and financial condition of these cohorts.

Definition of Clinics by Size

Clinics were classified by size based upon revenue level using data from IRS Form 990. The clinics were divided into three groups by total annual revenue size as follows:

Small: Under $5 million in annual revenues
Medium: Between $5 and $15 million in annual revenue
Large: Over $15 million in annual revenue

Definition of Clinic by Types

In this study, California Community Clinics were grouped into three categories by type:

- Federally Qualified Health Centers (Section 330 centers);
- Federally Qualified Health Center Look-Alikes; and
- Neither (which includes Rural Health Centers, reproductive health clinics that provide significant primary care services, and Free Clinics);

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

A significant portion of the safety net providers in California are Federally Qualified Health Centers (FQHCs). Sometimes called "community health centers," FQHCs include not only community health centers, but also migrant health centers, health care for the homeless health centers, public housing health centers and in certain instances, centers that are affiliated with counties or hospital systems.

All FQHCs are non-profit, community-based organizations or public entities that provide comprehensive primary and preventive health care and related social services to Medi-Cally underserved individuals and families regardless of their abilities to pay. FQHCs are governed by a community board of directors, at least 51% of whom must be users of the health center's services. Most FQHCs operate independently (that is, not under a hospital's license) and serve a variety of patients

including children, families, the elderly, Medicaid and Medicare recipients, low-income uninsured and underinsured individuals, high-risk populations, farm workers, and the homeless. FQHCs provide a wide range of cost-effective primary and preventive Medi-Cal services as well as other services including mental health, dental, nutrition counseling, translation and community outreach.

THERE ARE TWO SUB-CATEGORIES OF FQHCS:

- **Section 330 health centers:** Health centers are authorized under Section 330 of the U.S. Public Health Service Act, 42 USC, 254b. "Section 330s" receive a substantial annual operating grant from the federal Bureau of Primary Health Care (BPHC) to help cover the costs of providing care to those who cannot afford to pay. Until recently, Section 330 included separate subcategories of funding for community and migrant health centers, health care for the homeless programs and public housing primary care programs. Currently, these subcategories of funding have been consolidated and are now known collectively as "Section 330 health centers."
- **Look-Alike health centers:** These health centers operate much like "330s" but do not receive an annual operating grant from the BPHC.

NEITHER CLINICS:

In this study, Neither clinics were defined as all clinics that were not either an FQHC or a Look-like. This category included Rural Health Centers, Indian Health Service Clinics, Free Clinics, and Other Safety Net providers.

- **A Rural Health Center** is an outpatient facility that meets federal requirements designed to ensure the health and safety of patients. To qualify as a Rural Health Center, the clinic must be located in a rural area designated by the Health Resources and Services Administration as having a shortage of personal health care services or primary care Medi-Cal services (Medi-Cally Underserved Area (MUA) or Health Professional Shortage Area (HPSA)). RHCs may be for-profit or non-profit.
- **An Indian Health Service Clinic** is part of a health care system for American and Alaskan Natives that is supported by an agency within the US Department of Health and Human Services, the Indian Health Service (IHS). IHS clinics receive Medicaid and Medicare reimbursement through an "all inclusive rate" negotiated with the Centers for Medicare and Medicaid services. In addition, federally-recognized tribes can also establish and operate health clinics on their own or through the IHS system. The Urban Indian Health Program (UIHP) provides outpatient services to Native Americans living in urban areas. All UIHP facilities are automatically qualified to receive FQHC designation. Other programs and facilities operated by federally-recognized tribes may apply for designation as an FQHC or RHC and if approved, receive reimbursement through FQHC or RHC guidelines rather than the IHS negotiated rates. Tribal clinics that

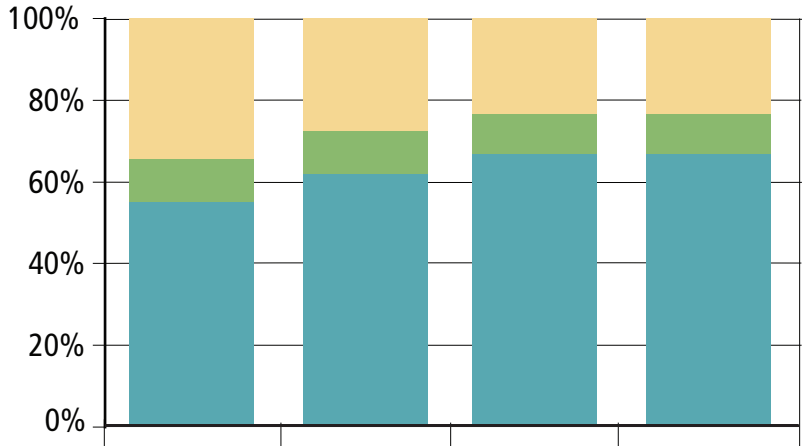
are not located on tribal lands are licensed by OSHPD and are included in this study.

- **Free clinic** is specifically defined in California statute as "a clinic operated by a tax-exempt, non-profit organization supported in whole or part by voluntary donations, gifts, grants, or government funds or contributions." Free clinics rely on volunteer providers to deliver care services and on private donations to support clinic operations.
- **Other Safety Net Providers** are other community-based, outpatient primary care providers that do not entirely meet these federal definitions but are nevertheless considered to be safety net providers. These providers include stand-alone community clinics that share many of the characteristics of FQHCs, RHCs, or Free Clinics but are not formally designated as such. Examples of other community-based health providers that are generally considered part of the health care safety net include family planning and women's health clinics, such as Planned Parenthood clinics, and school-based clinics operated by community organizations, which provide comprehensive primary health care services to certain categories of "underserved" populations.

In California, FQHCs and other types of clinics are commonly referred to as "community clinics" or sometimes just "clinics". Accordingly, for the purposes of this study, when we are referring to the broader group of primary care safety net providers, we have used the terms "community clinics" or "clinics". When we are referring to a specific type of clinic (FQHC, FQHC Look-Alike, RHC, etc.) we will so designate.

COMPARATIVE ANALYSIS OF HIGHEST AND LOWEST COHORTS

CA Community Clinics Distribution by Clinic Types, %, 2005 and 2008



	Lowest, 2005	Lowest, 2008	Highest, 2005	Highest, 2008
Neither	34%	28%	23%	23%
FQHC-LA	10%	10%	10%	10%
FQHC	55%	62%	67%	67%

THIS SECTION profiles the organizational trends, characteristics and revenue profiles that distinguish the performance of the two clinic cohorts used for this report, clinics in the lowest cohort and clinics in the highest cohort.

Distribution by Clinic Type by Cohort

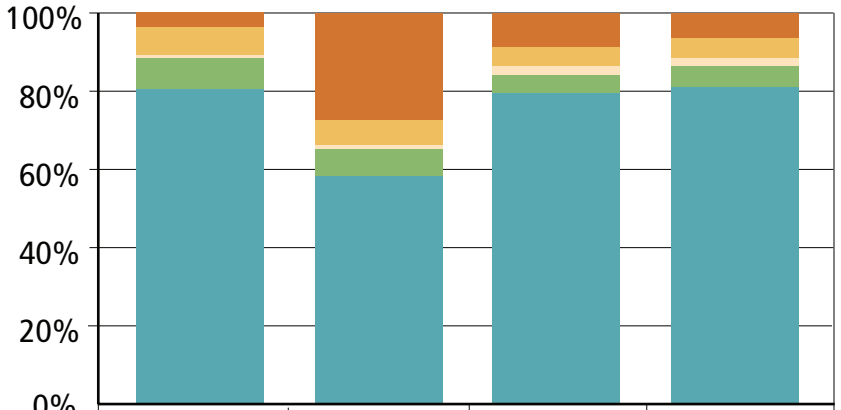
While some variance exists between the cohorts in regards to composition by clinic types, the organizational type of clinic does not affect the overall financial performance of the health center. There was also little change in the complement of clinic types within in the two years compared.

- The clinics in the highest cohort have a higher proportion of FQHCs, 67% as opposed to 62% in the clinics in the lowest cohort in 2008.
- The clinics in the highest cohort also had less Neither clinics, 23% as opposed to 28%.
- Both groups had the same percentage of FQHC Look-Alikes (10%).

Patient Race by Cohort

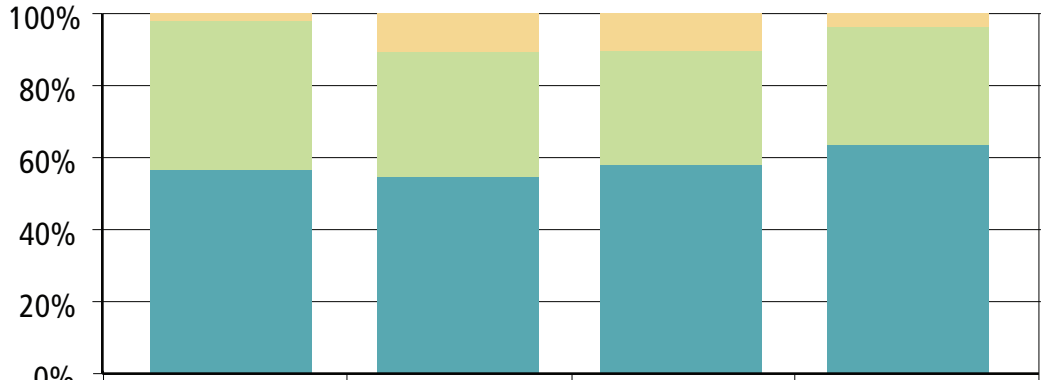
- Both groups of health centers have patient populations with similar racial distribution. The majority of patients are identified as white (80-81%), followed by Black, and Other/Unknown.
- In 2008, the distribution of patients by race for the clinics in the lowest cohort was affected by a relatively high proportion of Other/Unknown and low proportion of White reported by two health centers who served a large patient base.

CA Community Clinics Patient Race, 2005 and 2008



	Lowest 2005	Lowest 2008	Highest 2005	Highest 2008
Other / Unknown	4%	27%	9%	6%
Asian / Pacific Islander	7%	7%	5%	5%
Native American / Alaskan Native	1%	1%	2%	2%
Black	8%	7%	5%	5%
White (incl. Hispanic)	81%	58%	80%	81%

CA Community Clinics Patient Ethnicity, 2005 and 2008



	Lowest, 2005	Lowest, 2008	Highest, 2005	Highest, 2008
Unknown	2%	11%	10%	4%
Non-Hispanic	41%	35%	32%	33%
Hispanic	57%	55%	58%	64%

Patient Ethnicity by Cohort

In terms of the underlying ethnicity of the patients, both cohorts see a similar mix of Hispanic, Non-Hispanic and Unknown patients.

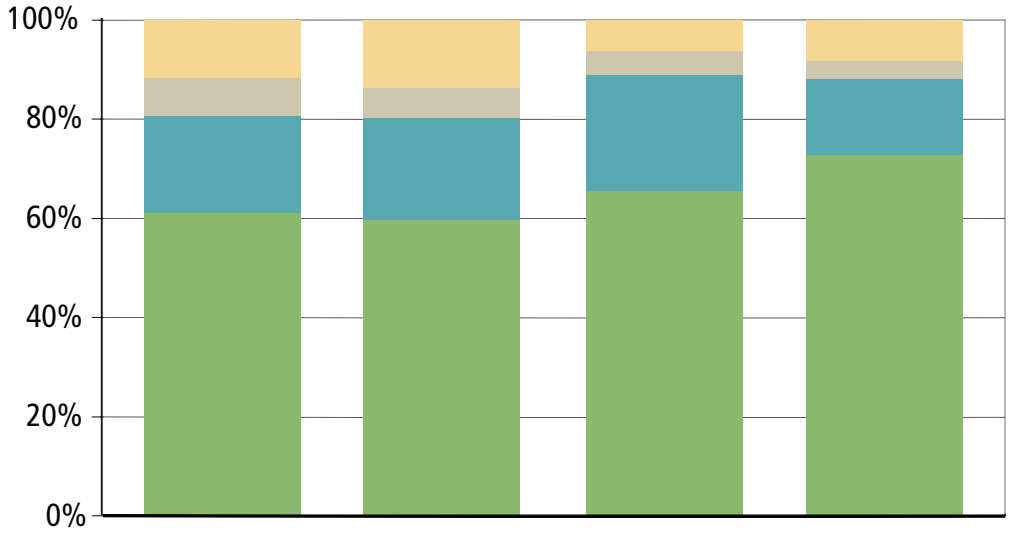
- In 2008, Hispanic patients made up 64% of the clinics in the highest cohort's patients and 55% of the clinics in the lowest cohort's patients.
- The Hispanic population has been growing as a percentage of the clinics in the highest cohort's population. This growth has corresponded to a decline in the Unknown population, indicating that the clinics in the highest cohort are getting better at reporting this data.
- Clinics in the lowest cohort reported a decline in the Non-Hispanic population between 2005 and 2008, but it also corresponded to an increase in the Unknown population.

Distribution of Patients by Level of Income by Cohort

The mix of lowest income patients, defined as those at or below 100% of the Federal Poverty Level, varies significantly among the cohorts.

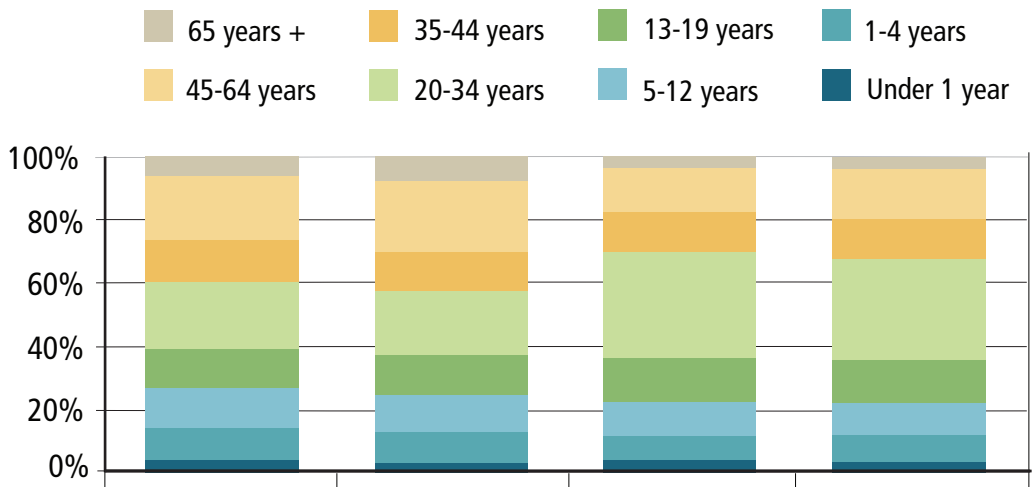
- Clinics in the highest cohort have an appreciably higher percentage of patients below 100% of the FPL, 73% in FY2008 compared to 60% for clinics in the lowest cohort.
- The number of patients with income below 100% of the FPL increased 34% and 27% respectively for clinics in the highest cohort and clinics in the lowest cohort. However as a percentage, clinics in the highest cohort are seeing a greater percentage of lowest income patients while that level is staying flat for clinics in the lowest cohort.
- The clinics in the highest cohort have seen a declining percentage of patients with incomes between 100% and 200% of the Federal Poverty Level which corresponds to the increase in the lowest income patients.

CA Community Clinics Patient Federal Poverty Level, 2005 and 2008



	Lowest, 2005	Lowest, 2008	Highest, 2005	Highest, 2008
Unknown	12%	14%	6%	8%
Above 200% FPL	8%	6%	5%	4%
100-200% FPL	20%	20%	23%	15%
Under 100% FPL	61%	60%	66%	73%

CA Community Clinics Patient Age, 2005 and 2008



	Lowest, 2005	Lowest, 2008	Highest, 2005	Highest, 2008
65 years +	6%	8%	4%	4%
45-64 years	21%	22%	14%	16%
35-44 years	13%	13%	13%	13%
20-34 years	21%	20%	33%	32%
13-19 years	12%	13%	14%	14%
5-12 years	13%	12%	11%	10%
1-4 years	10%	10%	8%	8%
Under 1 year	4%	3%	4%	3%

Comparison of Patient Distribution by Age by Cohort in 2005 and 2008

The clinics in the highest cohort have a younger age distribution across its patient base when compared to the clinics in the lowest cohort.

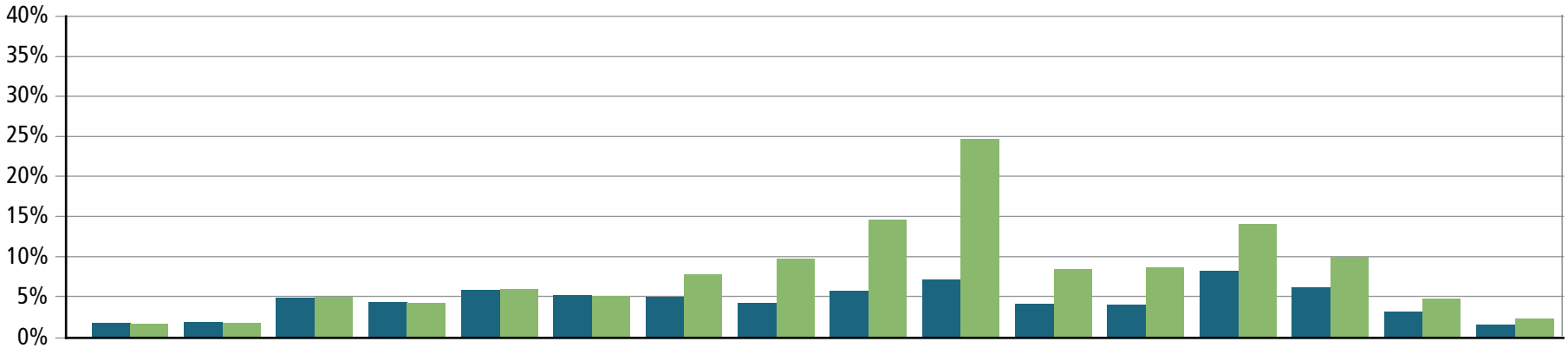
- Clinics in the highest cohort had a greater percentage of patients (32%) between 20 to 34 years of age compared to clinics in the lowest cohort (20%).
- Clinics in the lowest cohort have greater percentages of older patients aged 45 – 64 years (22%) and 65+ years (8%) when compared to the clinics in the highest cohort (16% and 4% respectively).
- The age distributions for both cohorts have not noticeably changed since 2005.

Distribution of Patients by Age and Gender by Cohort

When comparing by age and gender, the clinics in the highest cohort provide care to a greater number of women of child-bearing age (13 – 44 years) compared to the clinics in the lowest cohort.

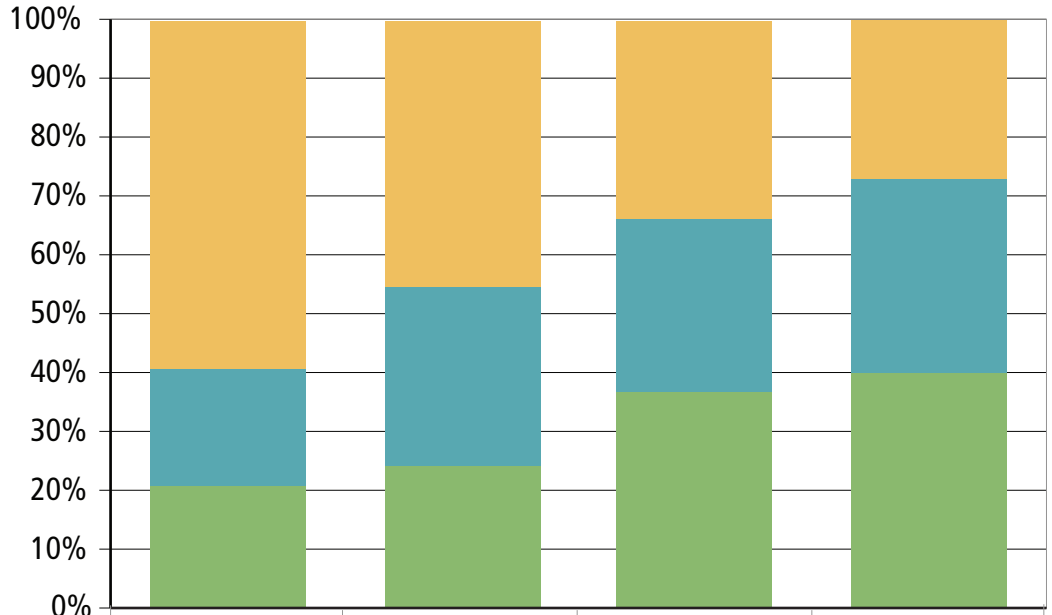
- Of the clinics in the highest cohort, 25% of patients are women between 20 and 34 years compared to 15% at clinics in the lowest cohort.
- The clinics in the lowest cohort, however, see a larger percentage of women ages 44 – 65+ years (19%), compared to the clinics in the highest cohort (12%). This may be due to these centers either maintaining their OB/GYN patients as they age, or they may be seeing a higher percentage of chronic care patients.

CA Community Clinics Patient Age Distribution, Lowest and Highest Cohorts, 2008



	<1 year, Lowest	<1 year, Highest	1-4 years, Lowest	1-4 years, Highest	5-12 years, Lowest	5-12 years, Highest	13-19 years, Lowest	13-19 years, Highest	20-34 years, Lowest	20-34 years, Highest	35-44 years, Lowest	35-44 years, Highest	45-64 years, Lowest	45-64 years, Highest	=>65 years, Lowest	=>65 years, Highest
Male	2%	2%	5%	4%	6%	5%	5%	4%	6%	7%	4%	4%	8%	6%	3%	1%
Female	2%	2%	5%	4%	6%	5%	8%	10%	15%	25%	8%	9%	14%	10%	5%	2%

CA Community Clinics Distribution by Total Revenue (form 990), 2005 and 2008



	Lowest, 2005	Lowest, 2008	Highest, 2005	Highest, 2008
< $5 M	59%	45%	33%	27%
$5–$15 M	21%	31%	30%	33%
> $15 M	21%	24%	37%	40%

Distribution of Clinics by Size for Two Cohorts

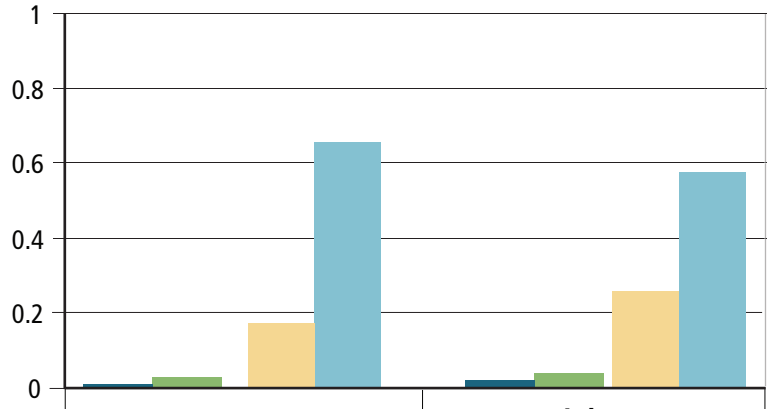
The cohorts differ significantly by distribution of clinic size as determined by the level of Total Revenue.

- The Clinics in the highest cohort have a greater percentage of the large clinics; 40% have revenues greater than $15 million and 33% have revenues from $5 to $15 million. Of the clinics in the highest cohort, 73% have revenues above $5 million compared to 55% for the lowest cohort.
- The Clinics in the lowest cohort have a greater percentage of the smaller clinics. In total, 45% of clinics in the lowest cohort have revenue below $5 million compared to 27% for the highest cohort.
- Both groups show a progression of clinics moving from smaller to larger revenue groups from 2005 to 2008.

Operating Revenue Mix by Cohort

The mix of Operating Revenues differs significantly depending on the cohort. Clinics in the highest cohort have a higher median percentage of Grants and Contract Revenue (26%) compared to 17% for the clinics in the lowest cohort in 2008. Clinics in the lowest cohort, however, have a higher median percentage of Net Patient Service Revenue (66%) when compared to the clinics in the highest cohort (58%). Clinics in the highest cohort have a slightly higher percentage (4% compared to 3%) of Contributions and Fundraising.

CA Community Clinics Operating Revenue Mix, Median %, 2008



	Lowest	Highest
Net Patient Service Revenue	66%	58%
Grants & Contract Revenue	17%	26%
Contributions / Fundraising Income	3%	4%
Other Operating Revenue	1%	2%

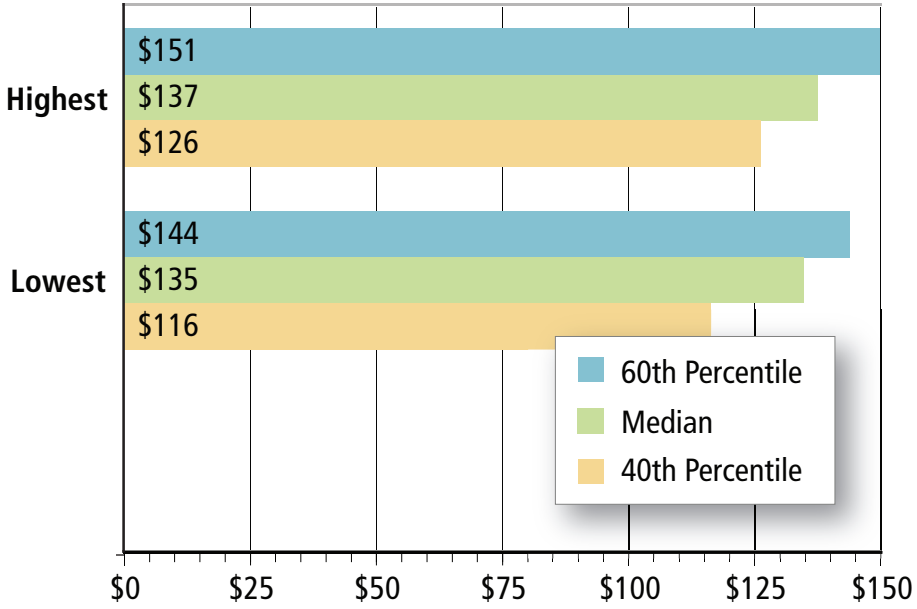
Note: Totals may not equal 100% since median values for various revenue sources may derive from different health centers.

Expense and Revenue per Encounter by Cohort

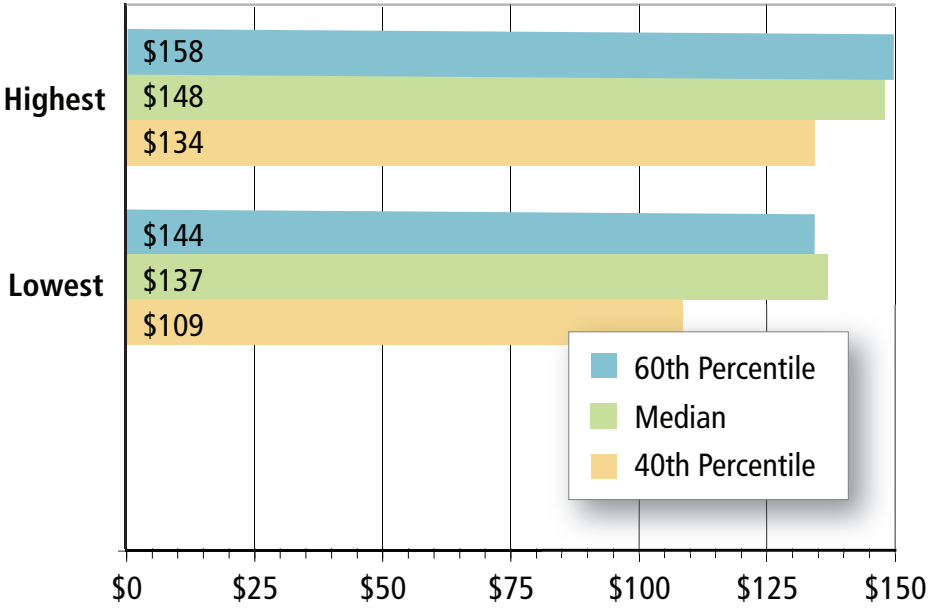
Median Expense per Encounter was similar for clinics in the highest and lowest cohorts, at $137 and $135 respectively.

- The upper and lower percentiles (60th and 40th percentiles) exhibit a greater variance between the two groups than when comparing the medians.
- When comparing median Revenue per Encounter across the cohorts, there are significant differences in the revenue received by clinics in the highest cohort clinics when compared to the clinics in the lowest cohort.
- Median Revenue per Encounter in the highest cohort was $148 compared to $137 for clinics in the lowest cohort, an $11 difference in Revenue per Encounter compared to the $2 difference in Expense per Encounter.
- At the 60th percentile, clinics in the highest cohort earn $14 per encounter more compared to a $7 difference in expenses.
- At the 40th percentile, clinics in the highest cohort earn $25 more per encounter compared to a $10 difference in expenses.
- The charts below show the median value of individual clinic averages over 4 years.

CA Community Clinics Expense / Encounter, 2005 – 2008 Average



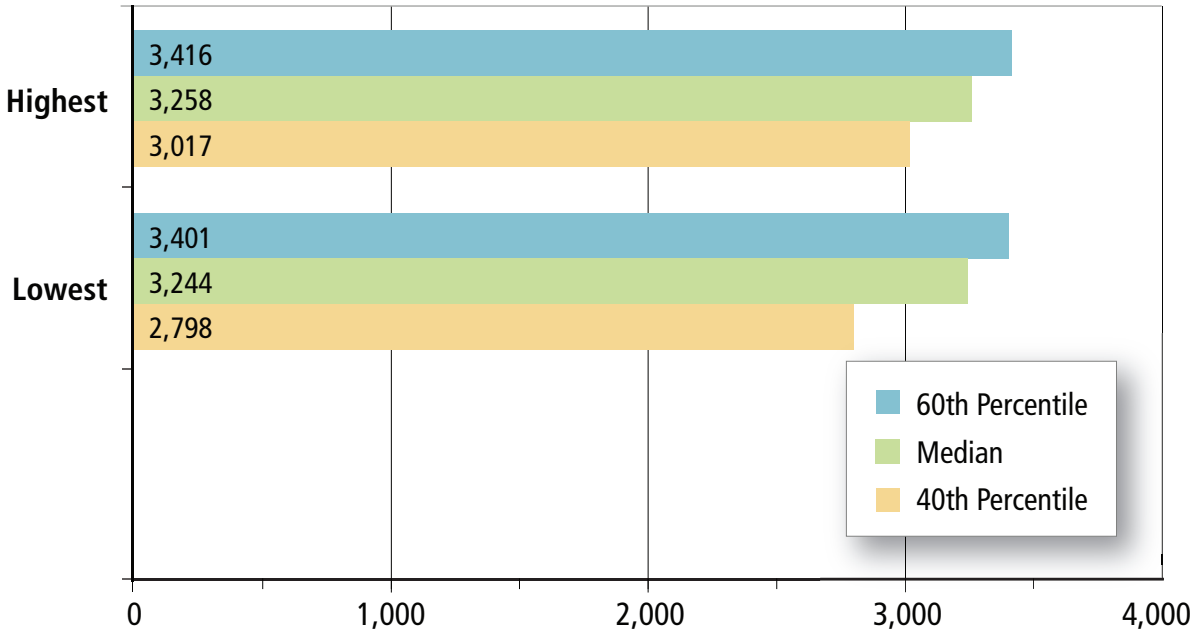
CA Community Clinics Total Operating Revenue / Encounter, 2005 – 2008 Average



Productivity by Cohort

The productivity or encounters per Primary Care Provider is virtually the same for both clinics in the highest and lowest cohorts at the median and the 60th Percentile. At the 40th percentile, providers in the lowest cohort are slightly less productive than those in the highest cohort.

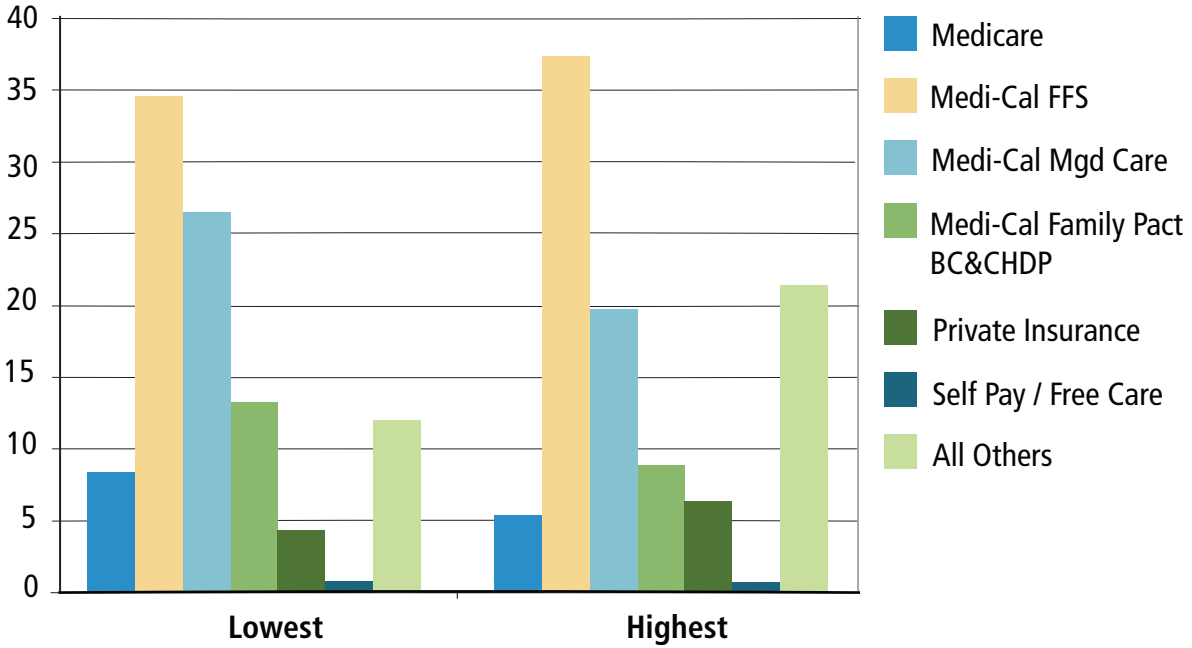
CA Community Clinics Encounters Per Primary Care Provider, 2005 – 2008 Average



This chart shows the median value of individual clinic averages over 4 years.

Please see Methodology for further details.

CA Community Clinics Percentage of Net Patient Service Revenue by Payor, by Cohort, 2008



Net Patient Service Revenue by Payor by Cohort

While both cohorts receive the majority of their NPSR from Medi-Cal Fee-for-Service, the overall mix for the two cohorts varies.

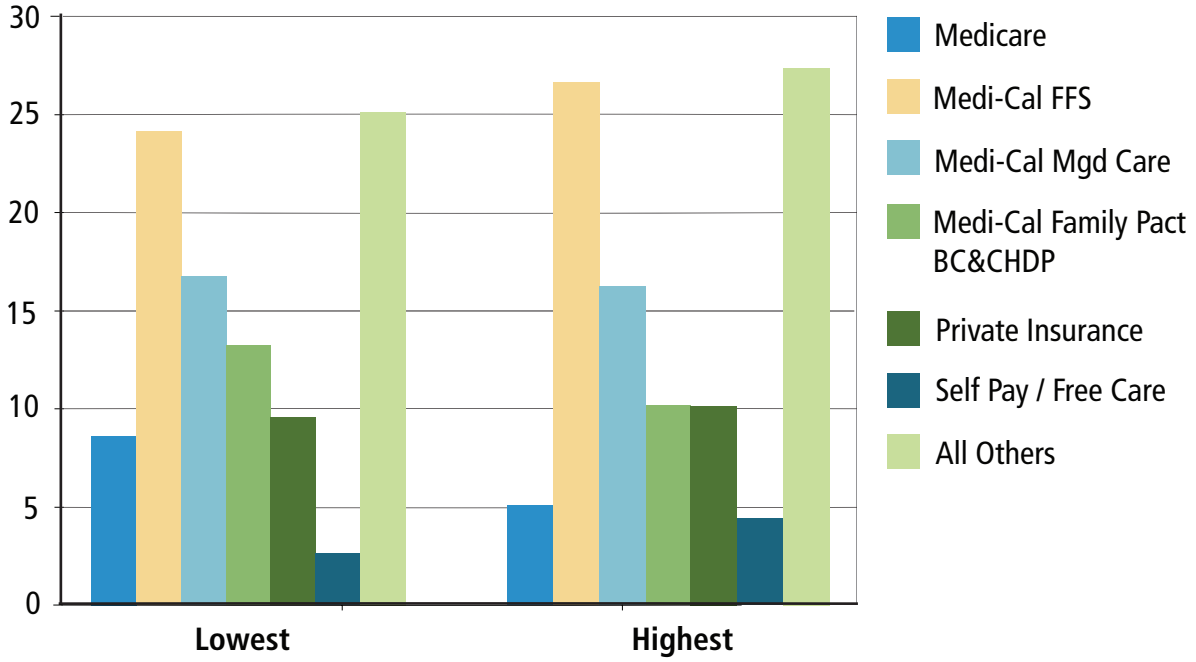
- Both the clinics in the highest and lowest cohorts derive about 53-54% of their encounters from Medi-Cal (combined Medi-Cal FFS, Managed care, and Episodic programs). However, NPSR from the combined Medi-Cal programs represents a significantly higher proportion of overall NPSR for clinics in the highest cohort (74%) versus clinics in the lowest cohort (66%).
- Clinics in the highest cohort have 37% of their NPSR from Medi-Cal FFS while clinics in the lowest cohort have 35%.
- Clinics in the lowest cohort have higher percentages of NPSR from Medi-Cal Managed Care (27%), other Medi-Cal providers (37%).
- Clinics in the lowest cohort have 8% of their NPSR from Medicare versus 5% for clinics in the highest cohort.
- Clinics in the highest cohort have 21% of NPSR from All Other payors compared to 12% at clinics in the lowest cohort.

Visits by Payor by Cohort

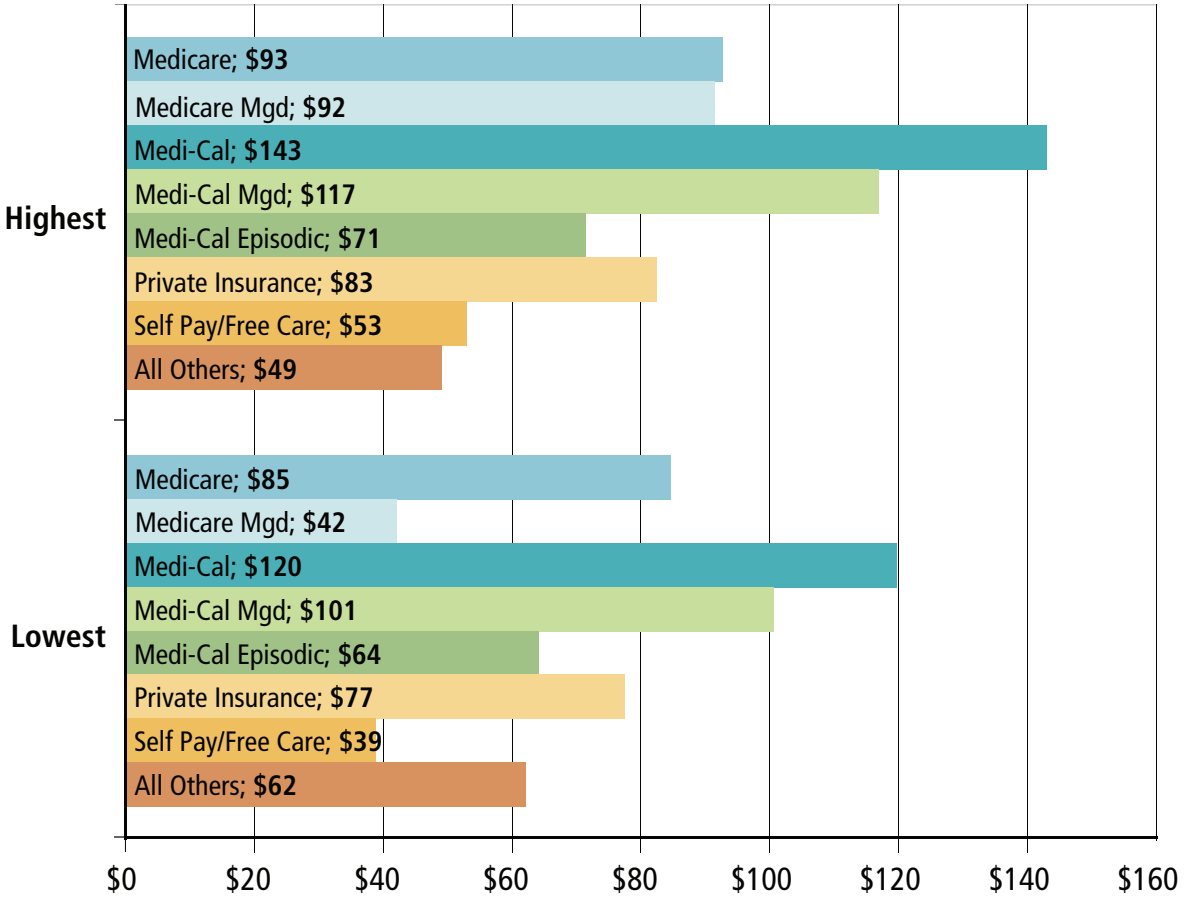
The distribution of visits by payor for the different cohorts noticeably differs from the distribution of NPSR for certain payors. Both clinics in the highest and lowest cohorts generate a significant amount of visits from All Other payors, with 25% and 27% of visits respectively. While All Other payors generate the greatest percentage of visits, they do not represent an equal percentage of patient revenue for both cohorts. The gap between the percentages of visits in comparison to the percentages of revenues is greater for the clinics in the lowest cohort.

- For both cohorts, Medi-Cal FFS, Medi-Cal Managed Care, and Other Medi-Cal payors generates a greater percentage of revenue in relation to the percentage of visits.

CA Community Clinics Percentage of Visits by Payor, by Cohort, 2008



CA Community Clinics Median Net Patient Service Revenue / Encounter, by Payor, 2005 – 2008 Average



NPSR per Encounter by Payor by Cohort

Clinics in the highest cohort earn more revenue per encounter for almost all the payors, with the exception of All Others.

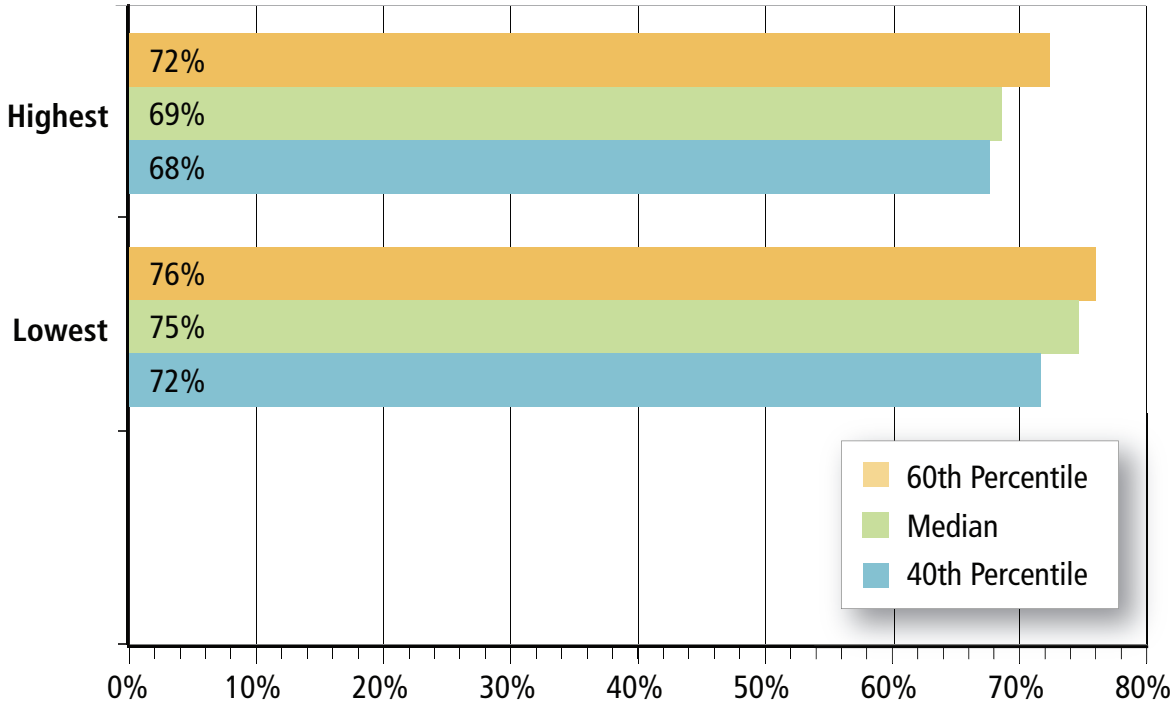
- Medi-Cal fee for service is the highest payor for both cohorts, providing $143 per visit for clinics in the highest cohort and $120 per visit for the clinics in the lowest cohort.
- Medicare Managed Care per encounter had the greatest difference ($50 per encounter) between the two cohorts, providing $92 for clinics in the highest cohort but only $42 for clinics in the lowest cohort.
- For All Others, clinics in the lowest cohort earned $62 per encounter compared to $49 for clinics in the highest cohort.

Salary and Related Expenses by Cohort

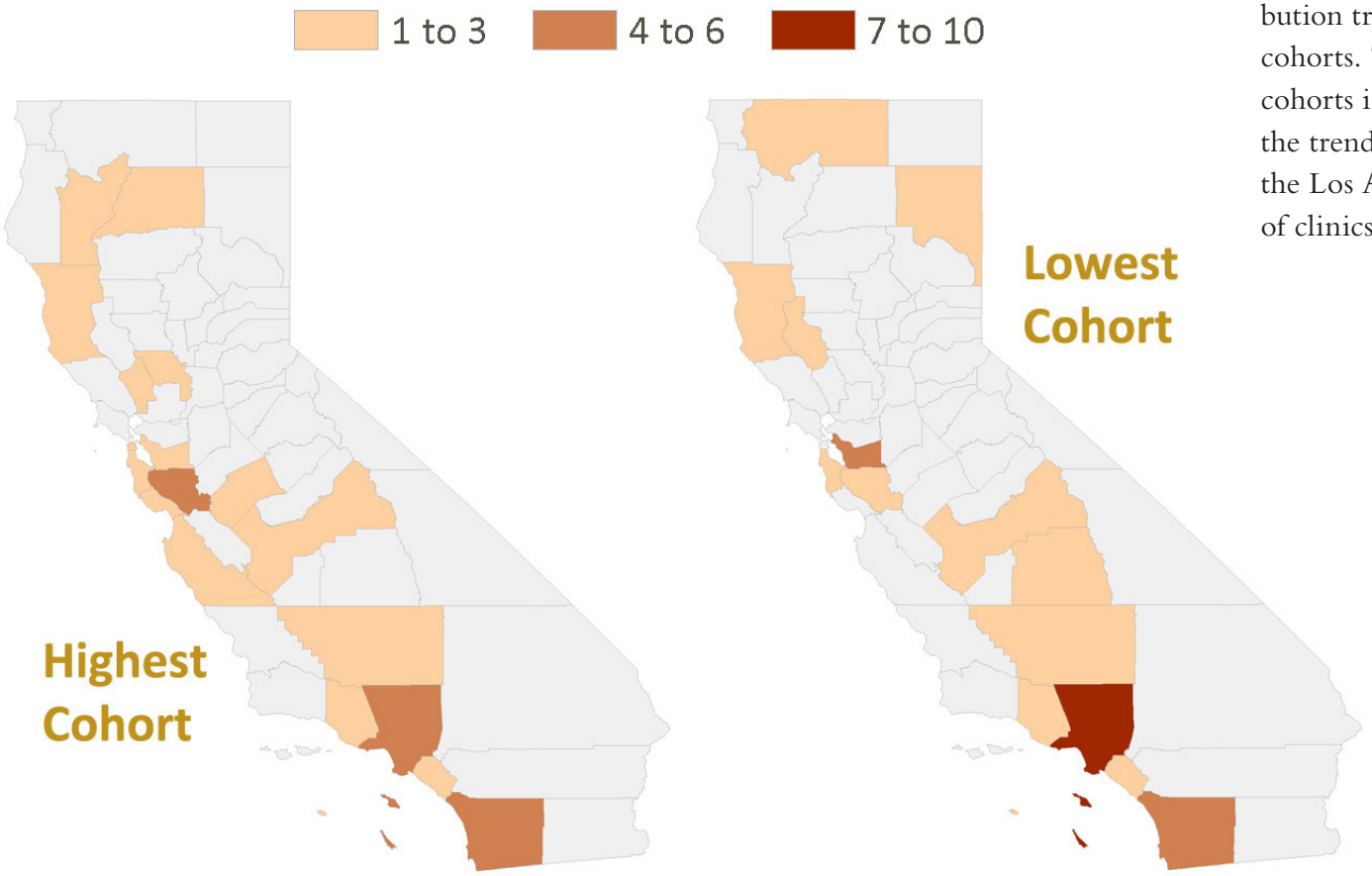
Salary & Related Expenses are the highest expense category for all community clinics. However, the average salary and related expenses over the four-year period of analysis was significantly higher for the clinics in the lowest cohort than the clinics in the highest cohort. The higher the percentage of salary related expenses are in relation to operating revenues, the more strain there is on a health center's operating performance.

- The four-year average Salary and Related Expenses as a Percentage of Total Operating Revenue was 6% higher for the clinics in the lowest cohort than the clinics in the highest cohort.
- The Salary percentage of the clinics in the higher 60th percentile for the clinics in the highest cohort matched the Salary percentage of the lowest cohort clinics in the lower 40% percentile. This shows that even the high end of the Salary expenses for clinics in the highest cohort just meets the low-end of Salary Expense for the clinics in the lowest cohort.

CA Community Clinics Salaries & Related Expenses as % of Total Operating Revenue, 2005 – 2008 Average



Geographic Concentration of Clinics by Cohort



Geographic Distribution of Highest and Lowest Cohorts

There are some interesting geographic distribution trends between the highest and lowest cohorts. There are higher percentages of both cohorts in the urban areas, consistent with the trends for clinics state-wide. However, the Los Angeles area has a greater percentage of clinics that are part of the lowest cohort.

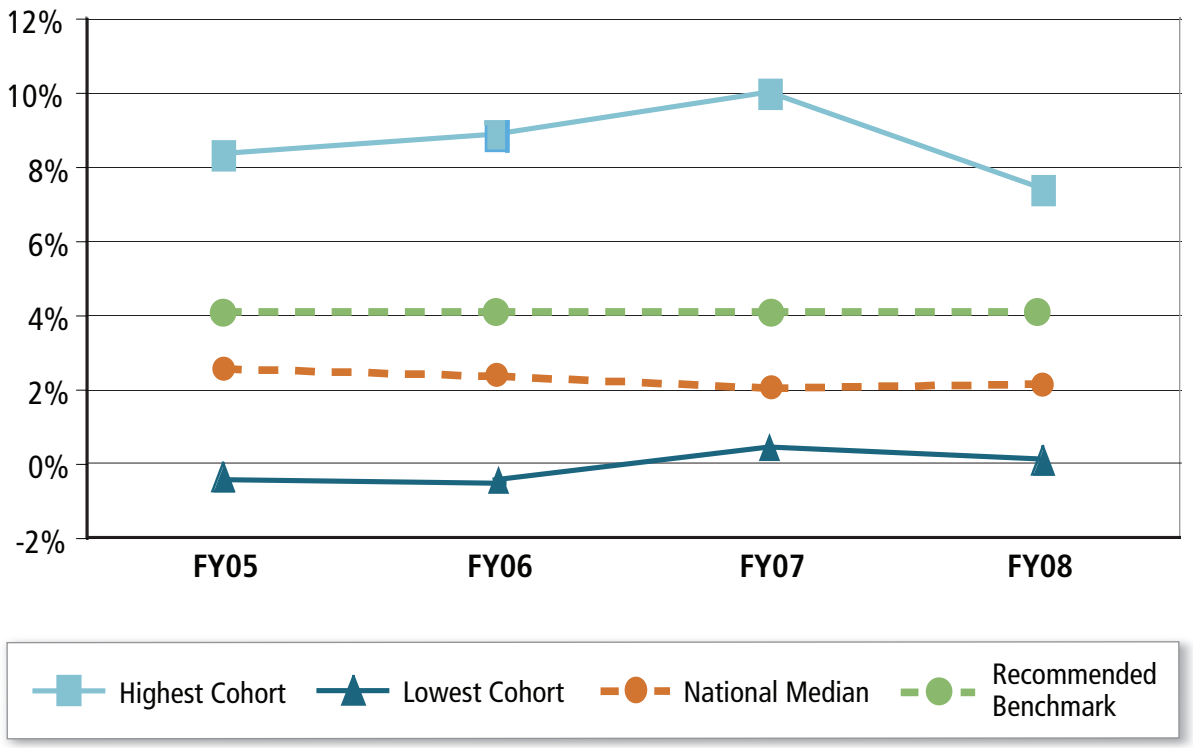
4

FINANCIAL CHARACTERISTICS OF CLINICS IN HIGHEST & LOWEST COHORTS

IN FOLLOWING WITH THE STATED METHODOLOGY, **Community Clinics within in the highest cohort consistently perform better on financial measures and are financially stronger than the clinics in the lowest cohort.** Clinics within the highest cohort have operating margins and bottom line margins that exceed 8 – 10% while clinics in the lowest cohort struggle to break even. Clinics in the highest cohort maintain healthy reserves of cash and net assets to support daily operating expenses at levels well above recommended levels of 90 days on hand. Clinics in the lowest cohort carry reserves below the minimum standards and are more vulnerable to any revenue delays or cash flow interruptions. For comparative purposes, this report also contains ratio information on:

- National median values, based on Capital Link's extensive database of audited financial statements of health centers across the country.
- Recommended benchmarks for California Community Clinics. These benchmarks are based on the median values of the fourth quintile (second highest cohort). Given some of the differences between states in factors such as insurance coverage and reimbursement rates and their impact on overall levels of financial performance within a specific setting, these California-specific benchmarks are reflective of the factors influencing financial performance of Community Clinics in the state.
- As available, comparative ratios of "A" rated hospitals for 2008, provided by Moody's Public Finance Corporation. Hospital ratio information is available for a limited number of ratios, including Operating Margin, Bottom Line Margin, and Days Cash on Hand.
- As available, comparative ratios of Critical Access Hospitals (CAHospitals) in California, based on data reported to OSHPD.

CA Community Clinics Operating Margin (Form 990), Median



	FY05	FY06	FY07	FY08
Highest Cohort	8.30%	8.83%	9.96%	7.37%
Lowest Cohort	-0.38%	-0.49%	0.40%	0.07%
CA Hospitals (OSHPD)	-7.00%	-4.70%	-5.10%	-3.70%
National Median	2.47%	2.27%	1.94%	2.05%
Recommended Benchmark	4.00%	4.00%	4.00%	4.00%

Operating Margin

Operating Margin measures the percentage by which Operating Revenues exceed Operating Expenses. This measure indicates the extent to which clinics are able to cover expenses related to patient care with revenues generated from, or allocated for, patient care. Funders prefer to see consistent operating margins of a least 3%, as well as an upward trend.

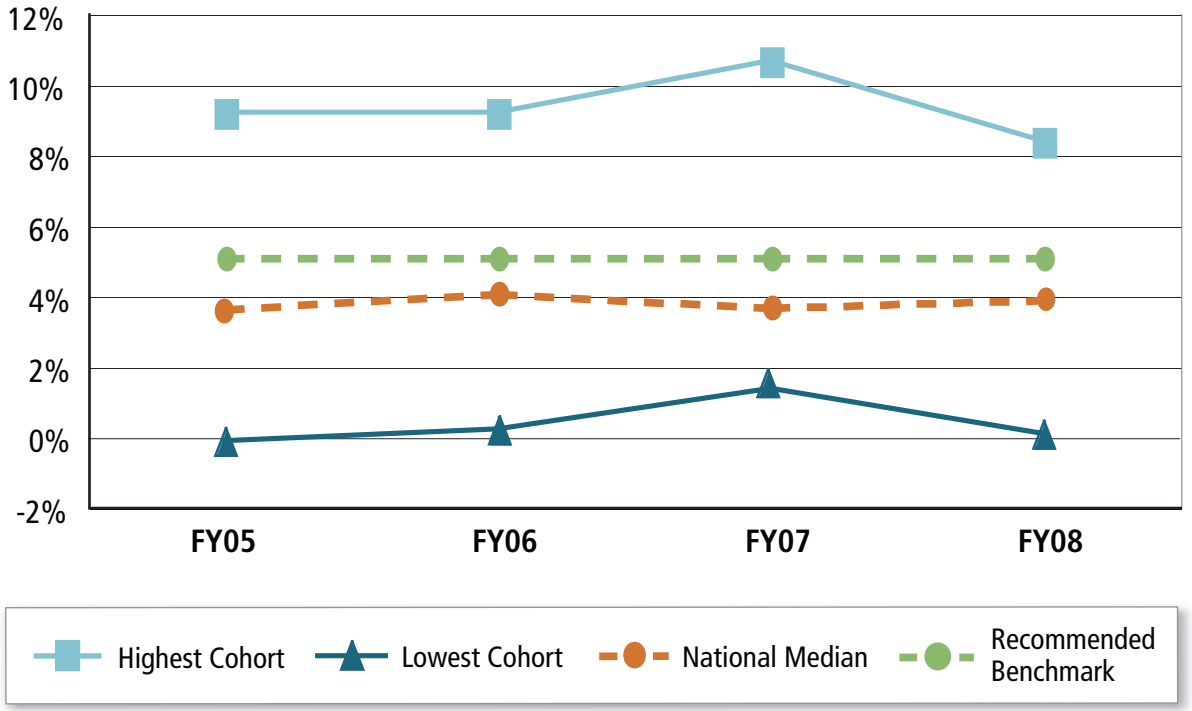
The group of highest performing clinics earn Operating Margins in the 8-10% range at the median, while the clinics in the lowest cohort struggle for breakeven performance, or 0% Operating Margin. At 4%, the Recommended Benchmark (RB) for California Community Clinics is about twice the national median of 2% in FY08. A-rated hospitals averaged 2.6% for 2008.

Bottom Line Margin

Bottom Line Margin measures the percentage by which Total Revenue exceeds Total Expense. This measure indicates the extent to which clinics were able to cover their Expenses with both Operating and Non-Operating sources of revenue. In general the major difference between Bottom Line Margin and Operating Margin is the presence of any investment income or contributions toward capital projects, which are reflected as Non-Operating Income. A Bottom Line Margin of 3% or higher as well as consistent growth over time indicates relatively healthy financial performance for clinics.

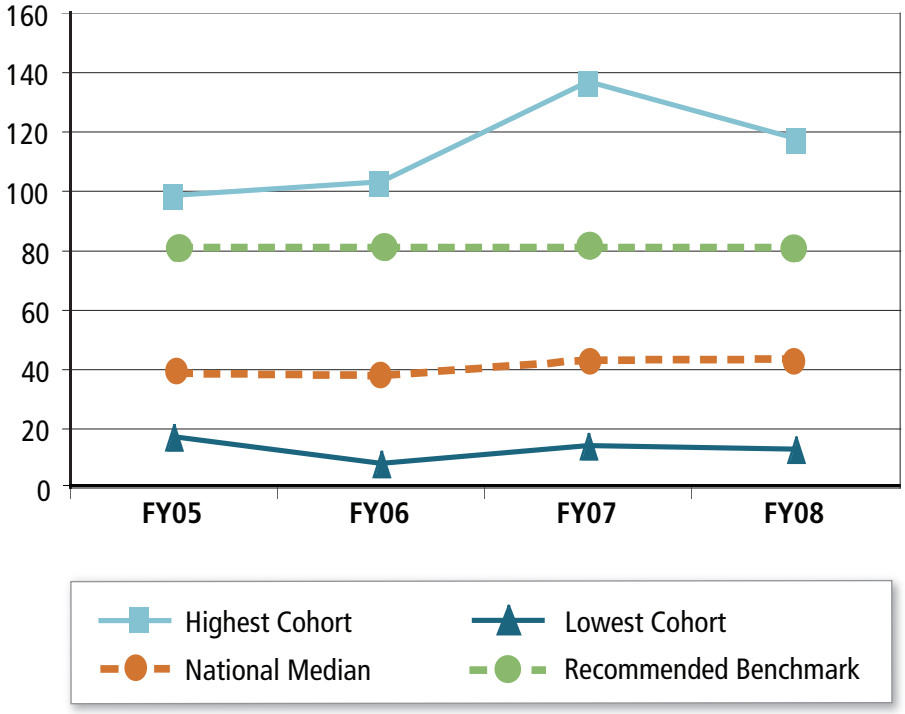
The group of clinics in the highest cohort performing clinics earns Bottom Line Margins that are in the 8-11% range at the median, just slightly higher than their Operating Margin range. Likewise, the clinics in the lowest cohort also generate Bottom Line Margins that are only slightly higher than their Operating Margins, and ultimately still at a breakeven performance level. The RB of 5% is about 1% higher than the national median, which was approximately 4% in each year. The bottom line margin for A-rated hospitals averaged 4.9% for 2008.

CA Community Clinics Bottom Line Margin (Form 990)



	FY05	FY06	FY07	FY08
Highest Cohort	9.19%	9.20%	10.67%	8.38%
Lowest Cohort	-0.13%	0.21%	1.35%	0.07%
CA Hospitals (OSHPD)	2.00%	3.10%	1.80%	3.80%
National Median	3.56%	3.98%	3.58%	3.82%
Recommended Benchmark	5.00%	5.00%	5.00%	5.00%

CA Community Clinics Days Cash on Hand (Form 990), Median



	FY05	FY06	FY07	FY08
Highest Cohort	98	102	136	117
Lowest Cohort	17	8	14	12
CA Hospital (OSHPD)	16	18	26	39
National Median	38	37	42	42
Recommended Benchmark	80	80	80	80

Days Unrestricted Cash on Hand

Days Cash on Hand measures the number of days of Operating Expense (less depreciation) that can be met with available unrestricted cash and marketable securities if no additional revenue were received. The higher the number of Days Cash on Hand, the better, with at least 45 days at a minimum recommended by Capital Link based on observed national values. HRSA (the major federal funding agency for FQHCs) recommends health centers maintain cash reserves of at least 90 days.

As illustrated, the highest performing clinics maintain, at the median, cash reserves in the 120 day range, or four months of operating expenses. This level is at or above the HRSA recommended level of 90 days, which is the desirable but often difficult to achieve level for smooth clinic operations, especially given the fiscal predicament of the state government and the inevitable reimbursement delays caused by delayed state budget reconciliations.

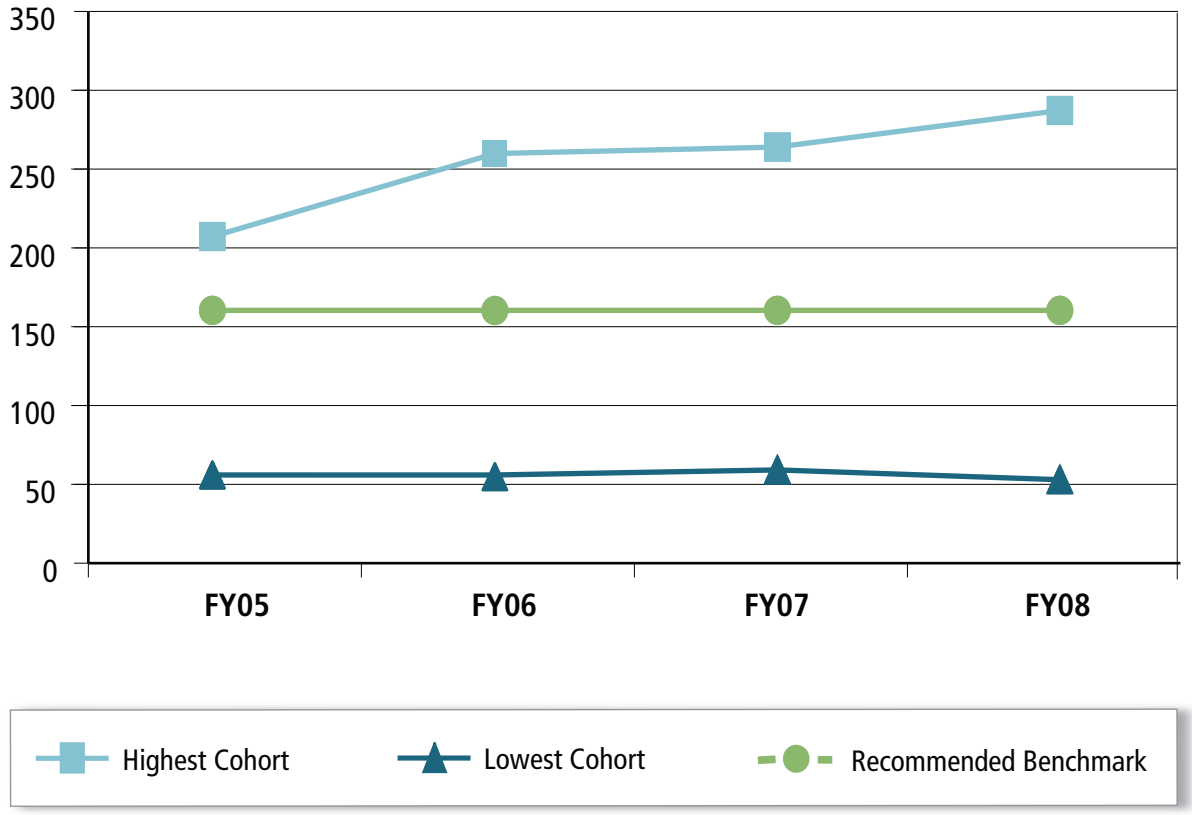
On the other side, the clinics in the lowest cohort are clearly vulnerable to any cash flow interruptions to their operations, as they maintain only about 2 weeks of reserves at the median level. Even without reimbursement delays from the state, these clinics are severely constrained by such limited cash and have almost no ability to weather any cash flow disruption unless they have access to outside operational financing. The California-specific RB of 80 days is almost twice the national median, but still slightly below the HRSA recommendation. A-rated hospitals exceeded the highest performing clinics' cash reserves with an average of 160 days in 2008.

Days in Reserves

Days in Reserves measures the number of days of Unrestricted Net Assets available to support daily operating expenses. In other words, this ratio measures the amount of operating days that the health center could operate before it became insolvent assuming no additional revenue were received. The higher the number of Days Reserves, the more fiscally sound the health clinic is. It is recommended that health centers maintain at least 90 days.

The clinics in the highest cohort have, at the median, 6-9 months of Days in Reserves, which suggests a healthy buffer to weather worst case revenue disruptions before becoming technically insolvent. On the other hand, the clinics in the lowest cohort have less than 2 months at the median level, implying very limited solvency in the event of major revenue disruption The California RB, at 160 days, also exceeds the broader, national-level general recommendation of 90 days. No comparative national median or A-rated hospital ratios were available for this ratio.

CA Community Clinics Days in Reserve (Form 990), Median



	FY05	FY06	FY07	FY08
Highest Cohort	207	260	264	287
Lowest Cohort	56	56	59	53
GAC Hospitals (OSHPD)				
National Median	NA	NA	NA	NA
Recommended Benchmark	160	160	160	160

5

HIGHEST AND LOWEST COHORT ANALYSIS: COMPARISON BY CLINIC SIZE AND TYPE

THIS SECTION PROVIDES A DEEPER ANALYSIS of the highest and lowest cohorts by comparing the characteristics of clinics within the two cohorts by size and type. The following represents the most notable similarities and distinctions when comparing the similar subgroups against each other.

While this more comprehensive analysis contains some notable findings, some of the findings are based on relatively small data sets that do not necessarily represent the larger cohorts. Therefore, the findings in this report should not be used to make broad policy-related decisions. However, they are useful in helping to further define the driving factors behind clinic performance.

The key findings of this analysis include:

- **Clinics in the highest cohort are substantially larger than clinics in the lowest cohort.** Across all clinic types and sizes, clinics in the highest cohorts have significantly higher average revenue than their peers in the lowest cohort.
- **The type of clinic doesn't matter by itself.** Similar distributions of clinic types can be seen in both highest and lowest cohorts across clinic size groups.
- **Certain payors do correlate both positively and negatively with clinic performance across types and sizes. Medi-Cal,** in terms of revenue per visit as well as a percentage of NPSR, correlates with clinic performance across types and sizes. **Family PACT** program activity also correlates with performance.
- **Clinics in the higher cohorts across all clinic groupings tend to have a larger percentage of revenue from Grants & Contracts.**
- **Small clinics in the lowest cohort have substantially lower reimbursement rates for all the major payors.**
- **Higher performing small clinics have a higher percentage of revenue from fundraising.**
- **Clinics in the highest cohorts tend to spend less of their operating budget on salaries as compared to their peers in the lowest cohorts.**

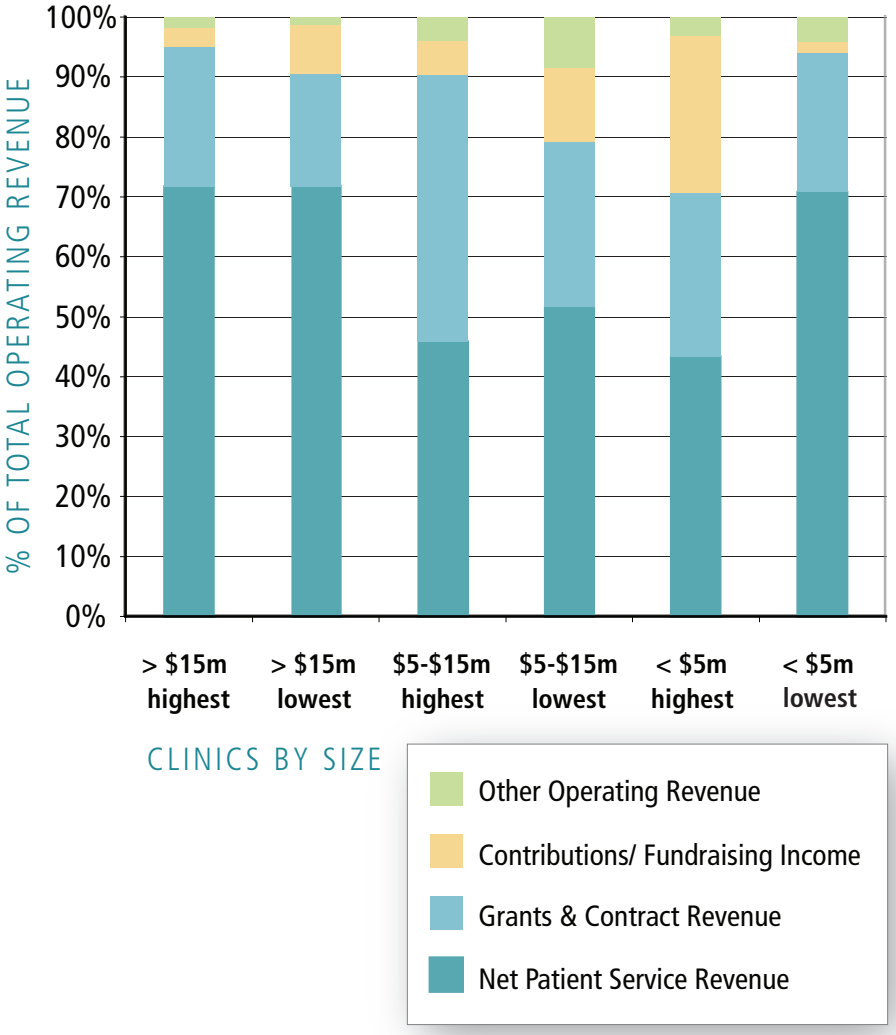
Distribution of Clinics within Cohorts

- **Clinic type is not by itself a defining indicator of clinic financial performance.** There is a very similar distribution between clinic types within the highest and lowest cohorts, with FQHCs making up roughly 2/3 of each cohort, FQHC-LAs 10%, and Neither clinics approximately 25%.
- **Larger clinics are more likely to be included within the highest cohort, while smaller clinics are more likely to be included within the lowest cohort.** More specifically, 40% of the highest cohort is clinics with revenues in excess of $15 million, while 45% of the clinics in the lowest cohort have less than $5 million in revenues. Similarly, just 27% of small clinics (<$5 million) are in the highest cohort, while just 24% of the lowest cohort are large clinics (<$15 million).

Distribution of Clinics by Type and Size within Highest and Lowest Cohort

	< $5MM		$5 – $15MM		> $15MM		TOTAL %	
HIGHEST COHORT								
FQHC	4	50%	5	50%	11	92%	20	67%
FQHC-LA	0	0%	3	30%	0	0%	3	10%
Neither	4	50%	2	20%	1	8%	7	23%
TOTAL	8	100%	10	100%	12	100%	30	100%
% of Total	27%		33%		40%		100%	
LOWEST COHORT								
FQHC	3	23%	9	100%	6	86%	18	62%
FQHC-LA	3	23%	0	0%	0	0%	3	10%
Neither	7	54%	0	0%	1	14%	8	28%
TOTAL	13	100%	9	100%	7	100%	29	100%
% of Total	45%		31%		24%		100%	

Revenue Mix for Highest and Lowest Cohorts by Size, 2008



Analysis of Clinics within Cohorts by Size and Type

The remaining report will provide deeper analysis of the characteristics of the highest and lowest cohort by grouping clinics by size and type within the cohort, beginning with an analysis of clinics by size.

Revenue Mix by Size Across All Cohorts

- **For both cohorts, Large clinics with revenue of over $15 million derive a higher proportion of overall revenue from NPSR relative to smaller size clinics.**
- **Medium Clinics in the $5 to $15 million size range have a greater percentage of overall revenue from grants and contributions.** Medium clinics in the highest cohort derive a significantly higher proportion of overall revenue from grants and contracts than Medium clinics in the lowest cohort.
- **For Small clinics (below $5 million in revenue), the highest cohort derives a significantly higher percentage of revenue from contributions and fundraising income,** whereas the clinics in the lowest cohort have a higher percentage of revenue from NPSR and very little from fundraising.

Distinguishing Characteristics of Clinics by Size within Cohorts

The following is an analysis of the clinics within the separate size subgroups for the highest and lowest cohorts. The analysis focuses on the characteristics that make each subgroup different from the others in terms of revenue size, revenue mix, payor mix, and average reimbursements.

LARGE CLINICS (>$15 MILLION): Large clinics within the highest cohort are characterized by greater total revenues, a higher proportion of revenues from Grants and Contracts and greater shares of revenues and visits from Family PACT.

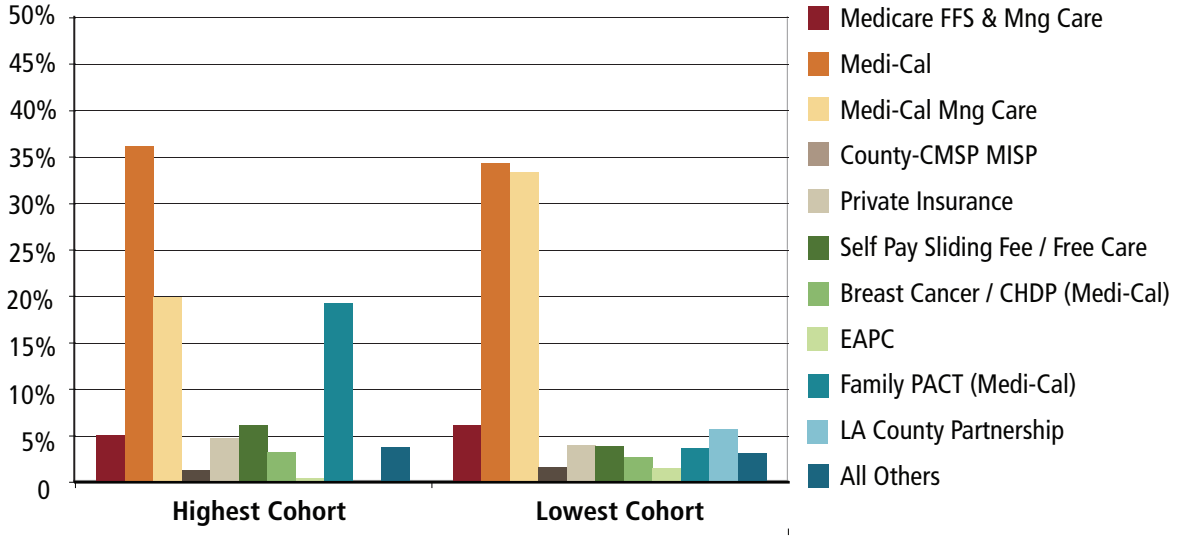
- Even within the Large Clinics, the clinics within the highest cohort are **substantially larger** than clinics in the lowest cohort. On average, the highest cohort of large clinics has a significantly higher revenue level than their lower performing peers ($35 million vs. $19 million).
- The highest cohort of large clinics **earns proportionally more of their revenue (5%) from Grants & Contracts** than the lowest cohort of large clinics.
- The two cohorts of large clinics **earn the same amount of their revenue from NPSR (72%).**
- **The payor mix for NPSR and average reimbursement rate per encounter is similar between the two cohorts.** Both cohorts have a similar Medi-Cal percentage of NPSR (~35%), but lowest cohort reports 13% more of NPSR from Medi-Cal managed care. The average reimbursement rates per encounter (at the median) were very similar for the major payors (Medicare, Medi-Cal, and related managed care programs).
- **The percentage of NPSR and visits generated by Family PACT for the Large clinics differs by cohort.** The highest cohort of large clinics reports 19% of NPSR from Family PACT while the lowest cohort reports just 4%. There is also a similar performance correlation in terms of encounters; the highest cohort of large clinics generates 17% of total visits from Family

Over $15 million in Annual Revenue
Median Reimbursement Per Encounter (Avg. 2005-2008)

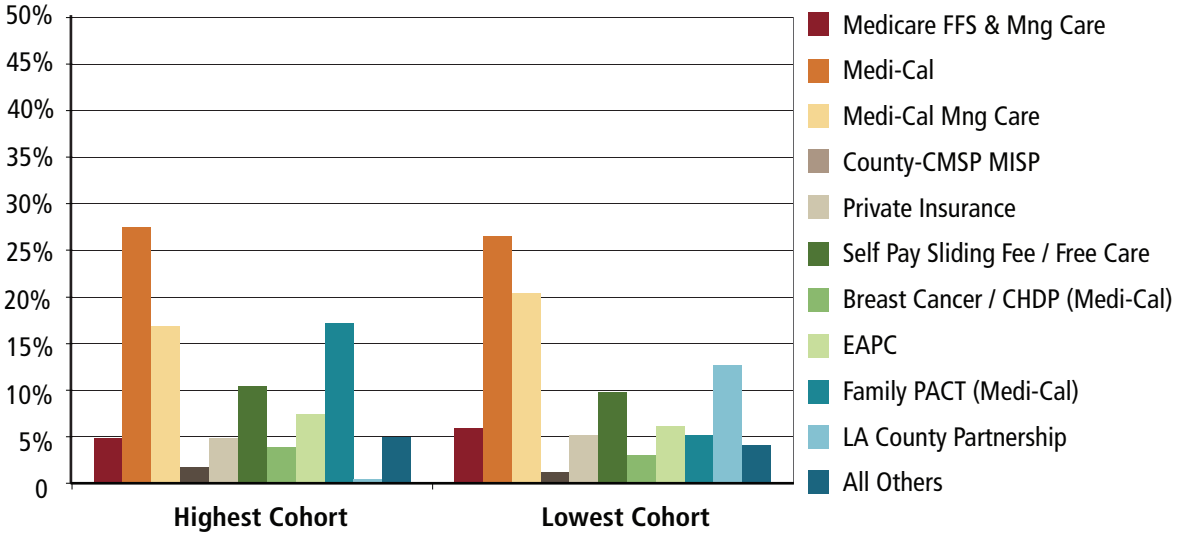
CLINIC SIZE IN ANNUAL REVENUES	HIGHEST		LOWEST	
	$ per visit	# of Clinics	$ per visit	# of Clinics
Medicare	$102	12	$102	6
Medicare Mgd	$84	4	$92	3
Medi-Cal	$140	12	$141	7
Medi-Cal Mgd	$118	10	$113	6
Family PACT	$62	12	$59	5
BCCCP	$49	11	$70	5
CHDP	$88	12	$74	7
Private Insurance	$86	12	$89	6
Self Pay / Free Care	$61	12	$44	7
LA County PPP + Grant	$176	1	$86	3
All Others	$57	12	$56	7
TOTAL NUMBER OF CLINICS IN COHORT	12		7	

The chart shows not only the reimbursement level, but the number of clinics that have revenue from a particular payor source. In some groupings, only a few clinics have activity from a particular payor, but that payor may account for a great deal of the overall activity for the subgroup within the cohort.

% of NPSR by Payor for Clinics Over $15 Million In Revenues, 2008



% of Visits by Payor for Clinics Over $15 Million In Revenues, 2008



PACT while the lowest cohort reports just 5%. Almost all Large clinics have Family PACT activity.

- **The analysis of the impact of the Los Angeles County Private and Public Partnership income on the cohorts is affected by the number of clinics reporting. As evident in the reimbursement per encounter chart displayed below, only one Large clinic in the highest cohort has Los Angeles County Private and Public Partnership income, as compared to three Large clinics in the lowest cohort.** LA County Private and Public Partnership accounts for a total of 13% of total visits in 2008 for Large clinics in the lowest cohort, even though only three clinics have this payor source. Note that the LA County Partnership provides funding that is captured both under NPSR and grants and contract revenue. The Payor Mix charts do not represent the grant portion of this revenue stream. The highest cohort has comparatively little operating revenue (0.5% total) from LA County Partnership, while Lowest Cohort earns roughly 8% of Operating Revenue (including 4% from NPSR and 4% of Grant & Contract Revenue) from this source.

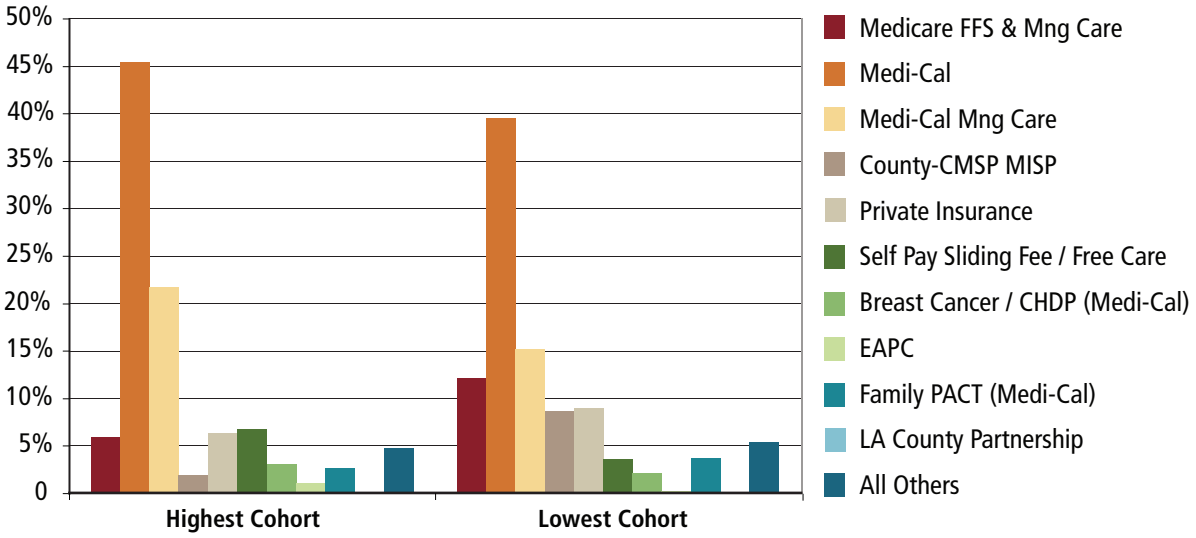
MEDIUM CLINICS ($5–$15 million):

Medium clinics have different drivers of financial performance than the other groups, characterized by differences in the revenues and expenses per encounter by cohort, in the NPSR mix by cohort, and in the number of visits seen by different payors.

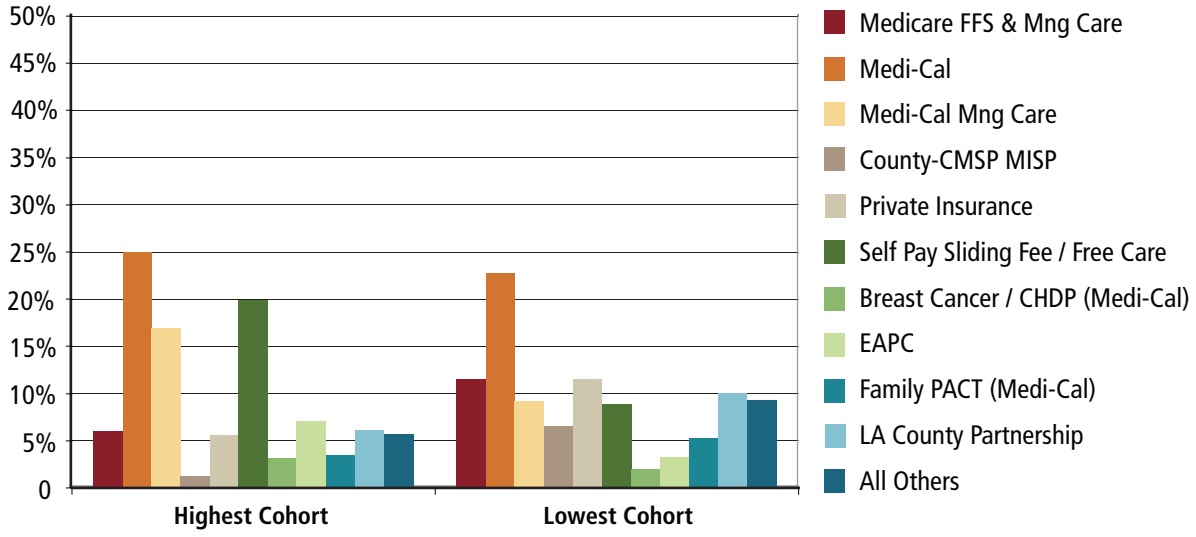
- Unlike the largest clinics, the average revenue size between the two cohorts for medium clinics is similar ($8-$9 million).
- **Like the large clinics, the highest cohort of medium size clinics has a higher percentage of revenue from Grants & Contracts.** The highest cohort earns 17% more from Grants & Contracts compared to lowest cohort. Revenue from Federal Grants/Contracts represents the largest difference between the two cohorts, with the highest cohort earning 20% more.

$5 to $15 Million in Annual Revenue Median Reimbursement Per Encounter (Average 2005-2008)				
CLINIC SIZE IN ANNUAL REVENUES	HIGHEST		LOWEST	
	$ per visit	# of Clinics	$ per visit	# of Clinics
Medicare	$74	10	$94	9
Medicare Mgd	$92	3	$46	4
Medi-Cal	$148	10	$152	9
Medi-Cal Mgd	$120	9	$158	5
Family PACT	$58	8	$63	9
BCCCP	$56	7	$53	7
CHDP	$96	10	$91	8
Private Insurance	$76	9	$77	8
Self Pay / Free Care	$41	10	$43	9
LA County PPP + Grant	$84	3	$79	2
All Others	$49	10	$77	9
TOTAL NUMBER OF CLINICS IN COHORT	10		9	

% of NPSR by Payor for Clinics Between $5 and $15 Million In Revenues, 2008



% of Visits by Payor for Clinics Between $5 and $15 Million In Revenues, 2008



- **Medium clinics in the highest cohort** earn a relatively larger percentage of their revenues from **Medi-Cal and Medi-Cal Managed Care.** The highest cohort of medium clinics earns over 45% of its NPSR from Medi-Cal FFS while their peers in the lowest cohort earn 39.6%. The highest cohort earns 6% more revenue and generates 8% visits from Medi-Cal Managed Care than the lowest cohort.
- Medicare makes up a smaller percentage of NPSR for the highest cohort compared to the lowest cohort (6% vs 12%)
- In addition, the highest cohort sees **significantly more self pay/free care visits** than the lowest cohort. The higher grant revenue may compensate for the higher level of free care provided by this group.

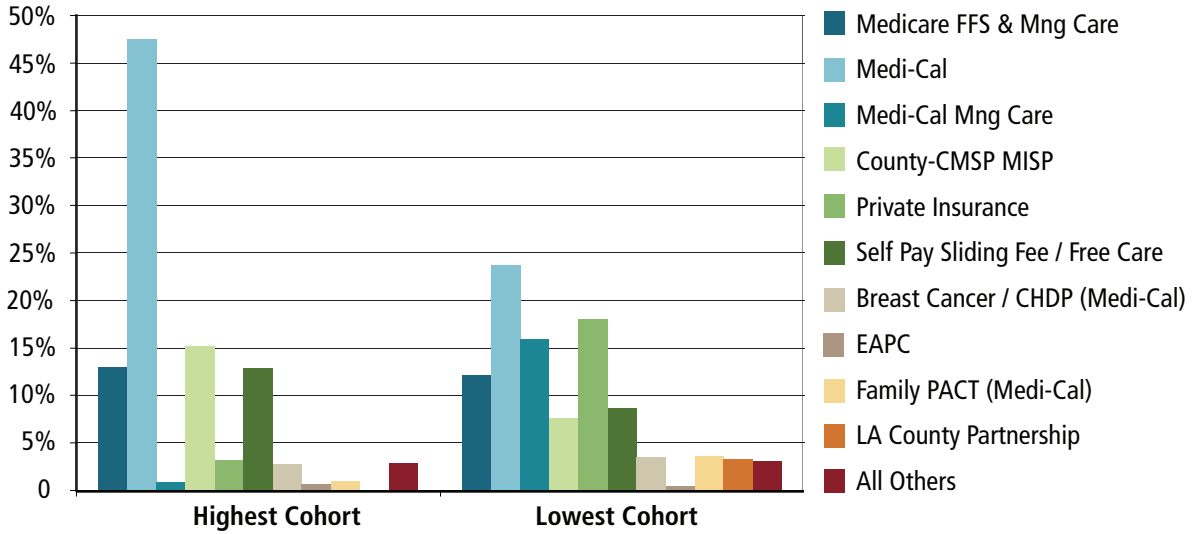
SMALL CLINICS (<$5 million): The differences in the highest and lowest cohort are very significant for clinics with revenues of under $5 million in terms of the number of clinics in the lowest cohort, revenue and expense per encounter, revenue mix, and reimbursement rates.

- The **lowest cohort** has a significantly **higher number of clinics with revenues under $5 million** compared to the highest cohort**.**
- However, **revenue and expenses per encounter** for the clinics within the **highest cohort are about 2/3 higher than that of the lowest cohort**, implying that the clinics in the highest cohort are more robust in terms of scale.
- **The NPSR mix** for Small clinics, similar to the Medium clinics, does differ with the **highest cohort reporting a greater percentage of revenues from Medi-Cal** compared to the lowest cohort**.** The Highest cohort earned 48% of NPSR from Medi-Cal compared to 24% for lowest cohort.
- Interestingly, Small clinics in the lowest cohort were more likely to have more Medi-Cal Managed care, while the highest cohort reported just 1% from this payor source.
- However, the Highest cohort generated 8% more of its NPSR from County CMSP MISP than its peers in the lowest cohort.
- **Reimbursement rates vary greatly between cohorts, with the highest cohort earning significantly more per visit from major payors.** The average reimbursement rates per

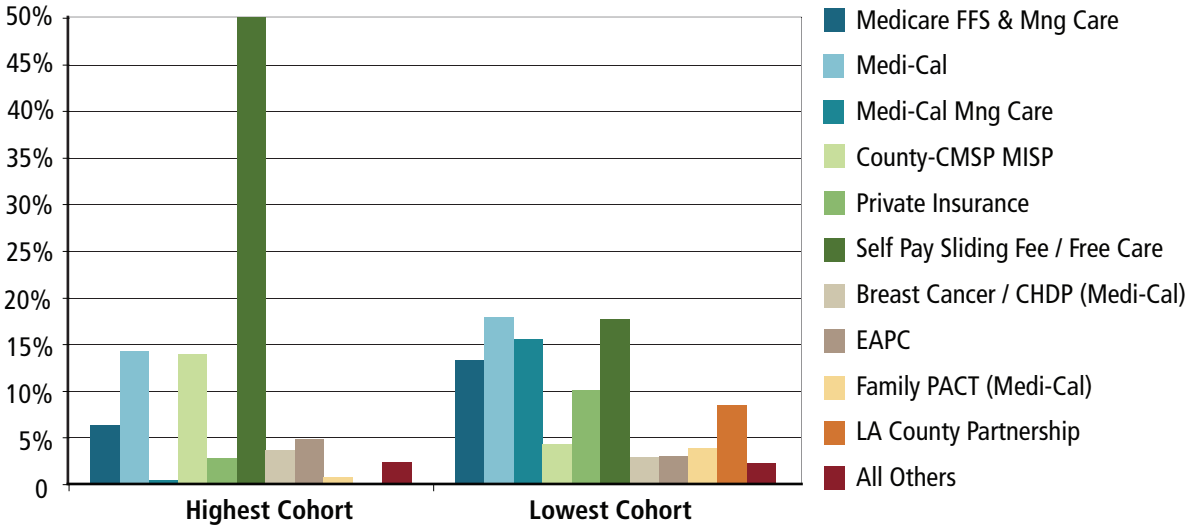
Under $5 Million in Annual Revenue
Median Reimbursement Per Encounter (Average 2005-2008)

CLINIC SIZE IN ANNUAL REVENUES	HIGHEST		LOWEST	
	$ per visit	# of Clinics	$ per visit	# of Clinics
Medicare	$99	4	$73	13
Medicare Mgd		0	$65	9
Medi-Cal	$159	6	$49	9
Medi-Cal Mgd	$111	2	$51	5
Family PACT	$60	3	$62	11
BCCCP	$61	4	$69	10
CHDP	$89	4	$29	13
Private Insurance		3	$90	4
Self Pay / Free Care	$20	8	$43	12
LA County PPP & Grant	0	0	$90	4
All Others	$45	6	$43	12
TOTAL NUMBER OF CLINICS IN COHORT	8		13	

% of NPSR by Payor for Clinics Under 5 Million In Revenues, 2008



% of Visits by Payor for Clinics Under 5 Million In Revenues, 2008



encounter (at the median) for the major payors (Medicare, Medi-Cal, and related managed care programs) was significantly more for the highest cohort vs. the lowest cohort (e.g. $159 vs. $73 Medi-Cal).

- **Unlike the other subgroups, the highest cohort for Small clinics earned a greater percentage of their revenue from Contributions and Fundraising,** but earned less of its revenue from NPSR. The highest cohort earned 24% more from Contributions and Fundraising, but earned 27% less of its operating revenue from NPSR.
- **The lowest cohort also reported a significantly higher portion of revenue from private insurance payors.** The Lowest cohort reported 18% of NPSR from private insurance payors while the highest cohort reported just 3% from this source.
- **The Highest cohort also sees a higher proportion of Free Care visits.** The Highest cohort reported 33% of its visits as Free Care while Lowest reported just 5%.

Revenue Mix by Type Across All Cohorts

For both cohorts, FQHC and Neither clinics derive a higher proportion of overall revenue from NPSR.

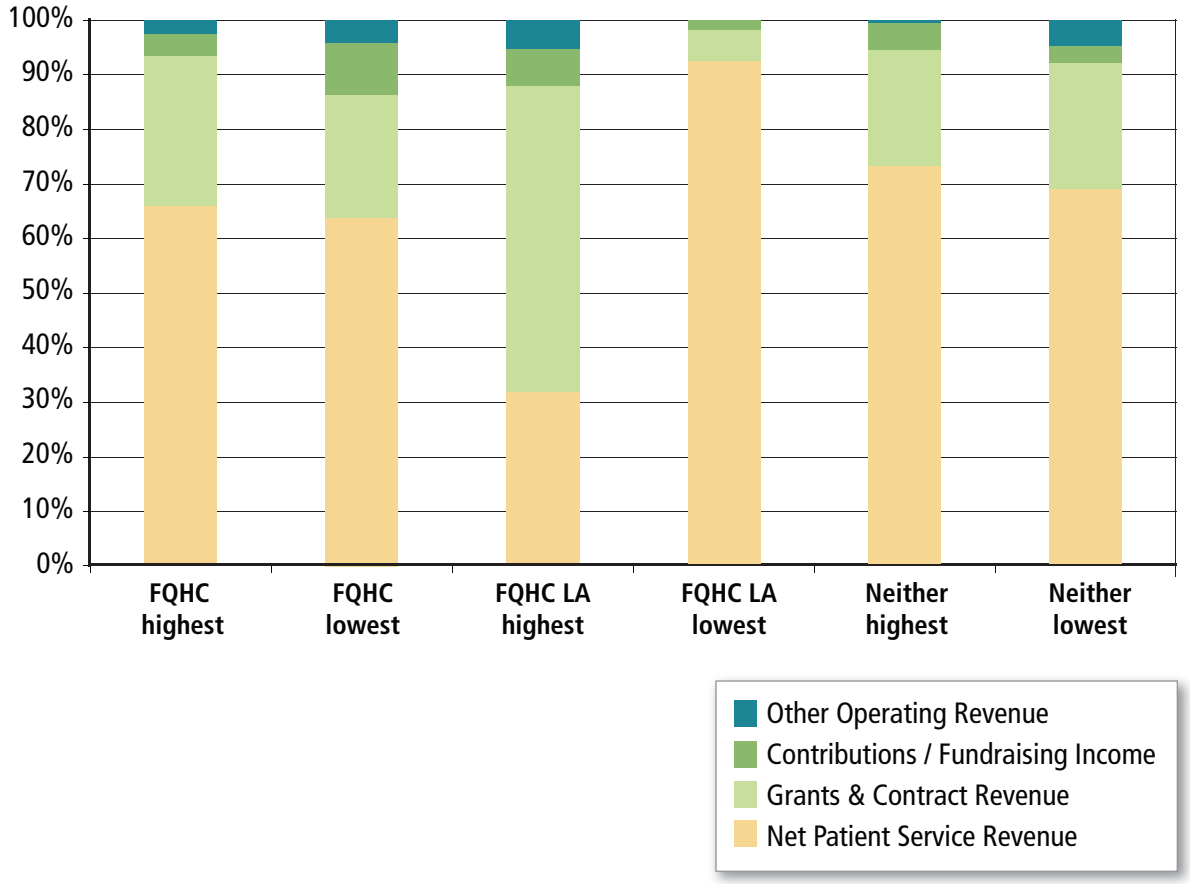
FQHC LOOK-ALIKES:

Although there are dramatic revenue variances between the highest and lowest cohorts of FQHC Look-alikes, the data set only includes three clinics and therefore is considered too small for meaningful analysis. Therefore, FQHC Look-alikes were not evaluated for other characteristics, as follows.

Distinguishing Characteristics of Clinics by Type within Cohorts

The following is an analysis of the clinics within the separate type subgroups within the highest and the lowest cohorts. The analysis focuses on the characteristics that make each individual subgroup different from the others in terms of revenue size, revenue mix, payor mix, and average reimbursements.

Revenue Mix by Type, 2008



Section 330 FQHCs Median Reimbursement Per Encounter (Average 2005-2008)				
CLINIC SIZE IN ANNUAL REVENUES	HIGHEST		LOWEST	
	$ per visit	# of Clinics	$ per visit	# of Clinics
Medicare	$98	19	$97	16
Medicare Mgd	$92	5	$56	8
Medi-Cal	$147	20	$149	18
Medi-Cal Mgd	$120	15	$149	12
Family PACT	$60	18	$63	16
BCCCP	$55	16	$53	13
CHDP	$94	19	$80	17
Private Insurance	$76	19	$80	16
Self Pay / Free Care	$59	20	$43	18
LA County PPP + Grant	$119	3	$86	5
All Others	$57	20	$60	18
TOTAL NUMBER OF CLINICS IN COHORT	20		18	

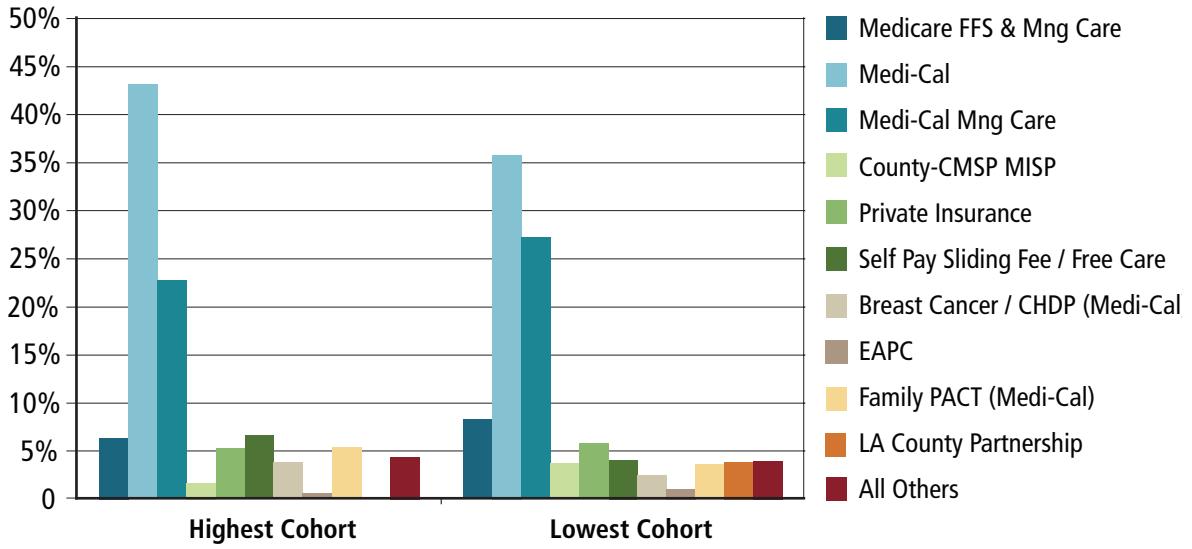
SECTION 330 FQHCS:

FQHCs within the highest cohort are characterized by greater total revenues and a higher proportion of revenues from Medi-Cal FFS, but also have a lesser share of revenues from the LA County Partnership.

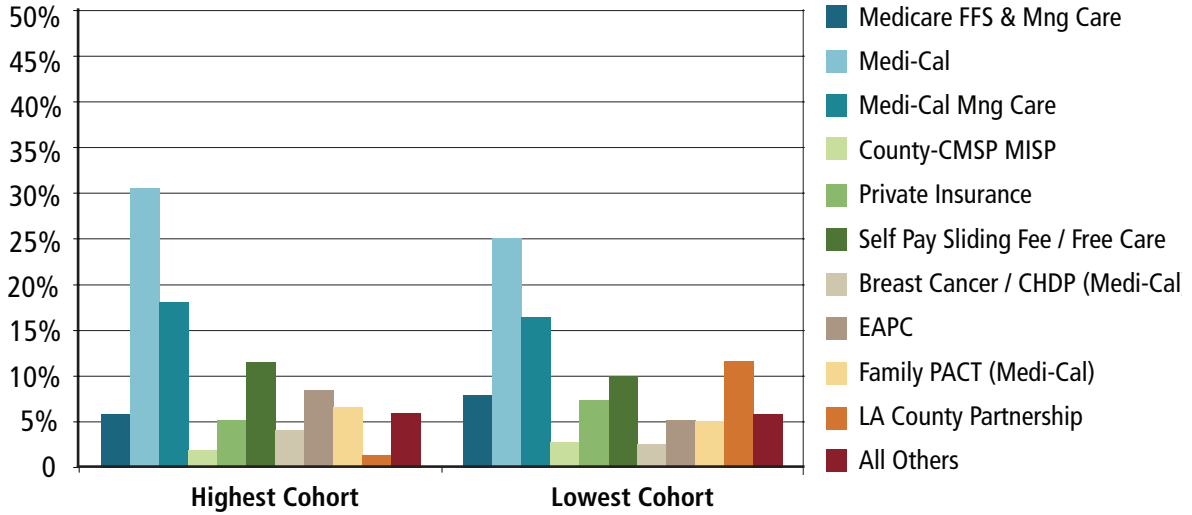
- **Section 330 FQHCs in the highest cohort were significantly larger than their peers** in the lowest cohort. The average Operating Revenue for the highest cohort of FQHCs is $20.7 million while for the lowest cohort of FQHCs is $12.2 million.
- **FQHCs in the highest cohort also earn more of their patient revenue from Medi-Cal FFS than their peers in the lowest cohort.** The highest cohort of FQHCs earned 7% more of their NPSR from Medi-Cal than their peers in the lowest cohort (43% vs. 36%).
- **The opposite is true for Medi-Cal managed care revenue.** The highest cohort earned slightly less of its NPSR from Medi-Cal managed care than the lowest cohort (23% vs 27%).

- The **highest cohort of FQHCs derives nearly 5% more of Operating Income from Grants & Contract sources** than the lowest cohort. The highest cohort earns a larger percentage of grants and contracts revenue from federal sources (3.7% more).

% of NPSR by Payor for Section 330 FQHCs, 2008



% of Visits by Payor for Section 330 FQHCs, 2008



Neither Clinics Median Reimbursement Per Encounter (Average 2005-2008)				
CLINIC SIZE IN ANNUAL REVENUES	HIGHEST		LOWEST	
	$ per visit	# of Clinics	$ per visit	# of Clinics
Medicare	$68	4	$38	8
Medicare Mgd	$92	1	$29	4
Medi-Cal	$136	5	$38	8
Medi-Cal Mgd	$120	4	$56	5
Family PACT	$82	2	$24	5
BCCCP	$40	4	$53	2
CHDP	$70	4	$55	6
Private Insurance	$97	3	$69	6
Self Pay / Free Care	$2	7	$29	8
LA County PPP + Grant	$-	0	$90	4
All Others	$46	5	$35	7
TOTAL NUMBER OF CLINICS IN COHORT	7		8	

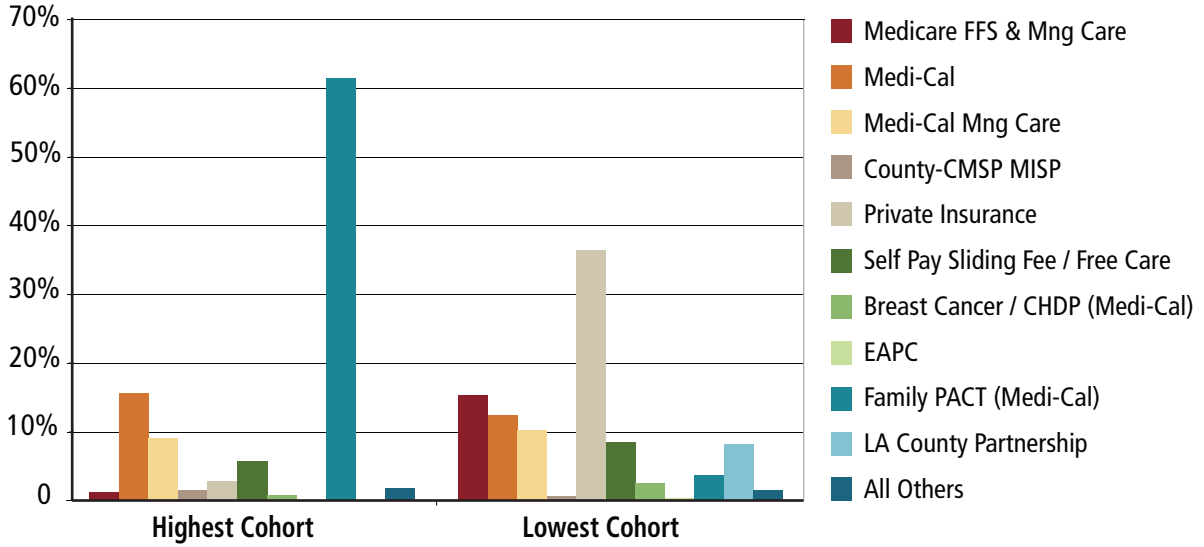
NEITHER CLINICS:

As with the other sub-groups, larger Neither clinics are more likely to be in the highest cohort compared to their smaller peers. Positive correlations of payor sources with the highest cohort of Neither clinics include Medi-Cal and Family PACT, while inverse relationships appear to exist with Medicare, Private Insurance, and LA County Partnership.

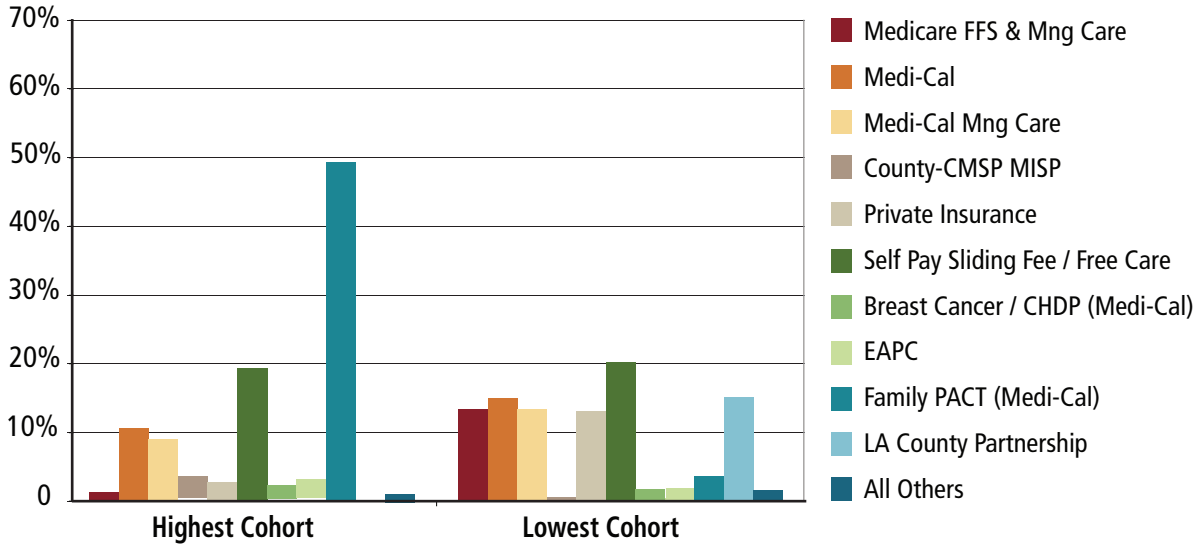
- **Neither clinics in the highest cohort were significantly larger than their peers** in the lowest cohort. The average revenue for the highest cohort of Neither clinics is $14 million while the average Operating Revenue for the lowest cohort of Neither clinics is $1.7 million.
- **The highest cohort of Neither clinics earns a larger percentage of Operating Revenue from Grant & Contract sources (11.7% more)** than the lowest cohort.
- **Reimbursement rates for Neither clinics in the highest cohort are substantially higher** for all the major payors compared to the lowest cohort.

- Neither clinics in the lowest cohort had roughly 10% more visits from Private Pay insurers than the higher cohort. In addition, over 35% of its NPSR is from Private pay, versus less than 5% for higher clinics. Private pay reimbursement rates were a third less for Neither clinics in the lowest cohort versus their peers in the highest cohort.
- While Family PACT dominates the Payor Mix for Neither Clinics in the Highest Cohort, only two clinics in that group receive Family PACT revenue. One of those organizations is a large Planned Parenthood Organization, whose primary revenue source is Family PACT revenue. Due to the size of that one organization, the payor mix charts are skewed and show a particularly large percentage of Family PACT volume. Many Neither clinics have very small Family PACT volume, if any at all.

Percentage of NPSR by Payor for Neither Clinics, 2008



Percentage of Visits by Payor for Neither Clinics, 2008



Salaries as a Percentage of Operating Revenue:													
	CLINIC SIZE							CLINIC TYPE					
	<5 M	#	5-15 M	#	>15 M	#		Neither	#	FQHC-LA	#	FQHC	#
HIGHEST	65%	8	71%	10	70%	12		64%	7	78%	3	70%	20
LOWEST	74%	13	70%	9	76%	7		70%	8	74%	3	75%	18

Salaries by Clinic Size & Type

From an operating expense standpoint, salaries are by far the most significant budget item for community clinics, typically accounting for 65-80% of Operating Revenue.

- The highest cohorts tend to spend less of their operating revenue on salaries as compared to their peers in the lowest cohorts.
- The lowest cohorts (at the median) of all clinic sizes and types spend 70% or more of their operating budget on salary expense.

6

METHODOLOGY

Data Sources

The analysis and results contained in this report are based on two major data sources:

- The Office of Statewide Health Planning and Development (OSHPD), and
- Internal Revenue Service (IRS) Form 990 data

The Office of Statewide Health Planning and Development (OSHPD) collects data and distributes information on health and healthcare in California. All licensed clinics in California are required to submit an annual report to OSHPD that includes financial, utilization, and patient demographic information. The reporting period covers one calendar year (January to December). While the Office of Statewide Health Planning and Development conducts both a preliminary as well as a desk-audit of the data submitted by the clinics, one of the limitations of the data is that it is self-reported by each organization, with no independent verification. This method of reporting results in inherent limitations and variability of the data based on how individual organizations interpret and report specific input requests.

Internal Revenue Service (IRS) Form 990 data is available for most non-profit organizations through GuideStar, an organization that combines information on the mission, programs, leaders, goals, accomplishments, and needs of non-profit organizations, including health centers and community clinics nationally. Form 990 data, which is reported based on an organization's fiscal year end to the IRS, includes many of the same financial data elements that are reported on audited financial statements. While Form 990 data does not provide the same level of detail, it is still a useful and readily accessible source for financial data for the generation of a number of key financial ratios and trends. A recent comparative analysis by Capital Link, as part of the research involved in identifying appropriate data sources for specific ratios and trends included in this report, showed no material differences for specific financial ratios and trends generated based on Form 990 data vis-à-vis audited financial statement data.

Clinics included in the Cohort Analysis

The clinics included in this analysis are a sub-group of the final list of screened clinics used in the *2010 California Community Clinics – Financial Profile, 2005 – 2008* report. The final list of screened clinic organizations included those that met a number specific criteria, as defined by Capital Link in collaboration with a CHCF Advisory Committee. Please refer to the methodology section of the report for a detailed description of the screening criteria and process used to develop the final list.

The sub-group used for the Cohort analysis consists of the 136 clinics on the final list for which both OSHPD data sets and Form 990 data sets were available for all four years of the period under review (2005 through 2008).

Using Form 990 data, the financial performance of each of the 136 clinics over the 4-year period was assessed as detailed below:

A. Financial ratios assessed were:

- Operating Margin
- Bottom Line Margin
- Days Cash on Hand
- Days in Reserve

B. The above ratios were calculated for each clinic for each of the 4 years.

C. Each ratio was assigned a score between 0 (weakest) and 4 (strongest) as follows.

- **Operating Margin**
  - **4:** 6.0 % or higher
  - **3:** 3.0 % - 5.9 %
  - **2:** 1.5 % - 2.9 %
  - **1:** 0.1 % - 1.4 %
  - **0:** 0.0 % or less
- **Bottom Line Margin**
  - **4:** 8.0 % or higher
  - **3:** 4.0 % - 7.9 %
  - **2:** 2.0 % - 3.9 %
  - **1:** 0.1 % - 1.9 %
  - **0:** 0.0 % or less
- **Days Cash on Hand**
  - **4:** 90 days or higher
  - **3:** 60 - 89 days
  - **2:** 30 - 59 days
  - **1:** 15 - 29 days
  - **0:** 14 days or less
- **Days in Reserve**
  - **4:** 200 days or higher
  - **3:** 120 - 199 days
  - **2:** 60 - 119 days
  - **1:** 30 - 59 days
  - **0:** 29 days or less

D. The total score was compiled for each clinic. Maximum total score possible for each clinic was 64, which included all four ratios across all four years. Based on this approach, clinics whose ratios were consistently strong across all four years had the highest total score.

E. Clinics were ranked by quintile based on their total score from highest to lowest.

F. Clinics were divided into five cohorts based on their total score.

- Clinics in the highest cohort quintile: 47 and higher
- Fourth quintile 40 - 46
- Middle quintile: 31 to 39
- Second quintile 22 - 30
- Clinics in the lowest cohort quintile: 21 and lower

In the next step of the analysis, the OSHPD data of the clinics in the highest and lowest quintiles were analyzed and compared for the following characteristics:

- Clinic Type: FQHC, FQHC-Look Alike, Neither
- Patient Demographics: Race, Ethnicity, Federal Poverty Level, Age
- Total Revenue (Form 990)
- Total Operating Revenue
- Operating Revenue Mix
- Expense per Encounter
- Revenue per Encounter
- Encounters per Primary Care Provider
- Net Patient Service Revenue by Payor

Data Presentation

Results of the cohort characteristics analysis were presented in a number of ways, depending on the type of data, and included:

- Bar charts showing distribution by percentages
- Median of the 2005-2008 Averages. For a particular measure, the average value across all four years is determined for each clinic in the cohort. The Median value for each cohort is the median value of the individual clinic averages. The 40th and 60th percentile of the 2005-2008 Averages give an indication of the variability around the Median.
- Median Percentage (%), 2008: For a particular measure, the percentage of total (e.g. NPSR as a percentage of Total Operating Revenue) is determined for 2008. The Median Percentage for the year is the median value of the individual clinic percentages.

Median and Percentiles

Statistical measures used to describe the financial ratios and trends include the median, 60th percentile, and 40th percentile.

The median is the number in the middle of a set of numerically ordered data; by definition, half the values in the set are greater than the median, and half are less. For example, the median value of the set {3, 8, 9, 10, 11, 11, 15} is 10. If there is an even number of values in the set, the median is calculated as the average of the two values in the middle of the set. The median is not skewed by extremely large or small values outside the typical range of the rest of the data. This attribute is particularly important when dealing with relatively small data sets. At the same time, it is important to note that this presentation treats each clinic's data as having equal weight in the group. An organization with $40 million in annual revenue and an organization with $2 million in annual revenue will affect the results equally.

The percentile is the percentage of observations in a distribution that is at or below a given value. The 60th percentile is a value that is equal to or greater than 60 percent of the values. The 40th percentile is a value that is equal to or greater than 40 percent of the values. The 50th percentile is the same as the median value.