CAPITAL INVESTMENT TRENDS AND NEEDS OF HEALTH CENTERS

Findings from the 2026 Capital Needs Assessment

JUNE 2026

CapitalLink

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EXECUTIVE SUMMARY

This Capital Needs Assessment evaluates historical capital investment trends, infrastructure lifecycle dynamics, funding composition, and projected capital requirements necessary to support national Health Center infrastructure expansion through 2030. The analysis includes both Section 330-funded Health Centers and Health Center Look-Alike organizations and provides a comprehensive estimate of national system infrastructure demand.

Between 2017 and 2030, the national Health Center patient population is projected to grow from approximately 28 million to nearly 40 million patients, representing an estimated 43 percent increase in demand for primary and preventive healthcare services. Supporting this level of growth will require Gross Fixed Assets (GFA) to expand from approximately $17.9 billion to more than $65 billion, reflecting both infrastructure expansion and modernization requirements.

The 2026 National Health Center Capital Needs Assessment was conducted to identify priority capital needs across Health Centers and Health Center Look-Alike organizations in the United States. The assessment was made available to all Health Centers nationally, and the findings reflect aggregated responses from participating organizations. Of responding Health Centers, 68% indicated they anticipate at least one capital project within the next three years, representing a significant pipeline of renovation, expansion, and new facility development activity.

The most pressing capital needs include expanding capacity to meet growing patient demand, replacing aging infrastructure, and diversifying services to address the full spectrum of community health needs. Financing patterns indicate that loans are the top-ranked funding source, followed by grants and capital campaigns, highlighting the critical role of programs such as the HRSA Loan Guarantee Program (LGP) in supporting access to capital.

Introduction

With rising uninsured rates and increasing poverty levels, the demand for safety net services continues to grow nationwide. Today, more than 17,000[1] Health Center service delivery sites provide accessible, community-based healthcare across urban, rural, and frontier regions. (For purposes of this publication, "Health Centers" refers to Health Resources and Services Administration (HRSA) Health Center Program participants, including Section 330-funded Health Centers and Health Center Look-Alike organizations.) In 2024, Health Centers collectively served more than 33.8 million patients[1], employed approximately 326,008 full-time equivalent employees (FTEs)[1], and managed fixed capital assets totaling nearly $35 billion[3]. These facilities represent essential infrastructure supporting healthcare access for medically underserved populations.

Sustaining and expanding Health Center infrastructure requires significant and ongoing capital investment. While federal operating support helps Health Centers to provide care to underserved populations, capital funding for facility development, equipment modernization, and infrastructure replacement remains limited and highly variable. At the same time, Health Centers face increasing operating expenses, expanding patient populations, and enhanced service delivery, all of which intensify demand for infrastructure expansion and modernization.

In early 2026, Capital Link conducted a national assessment of Health Centers[2] to better understand current capital needs and planned expansion activities. A total of 116 Health Center organizations responded. The findings are presented in this report and include historical capital investment trends, projected capital needs through 2030, and current priorities for planned growth. This report also incorporates data from Capital Link's proprietary database which includes financial audits and operational and utilization data reported by the Health Center Program Uniform Data System (UDS) for Section 330-funded Health Centers and Look-Alikes[3].

1 Bureau of Primary Health Care, HRSA, DHHS, 2024 Uniform Data System

2 Health Centers are outpatient clinics that qualify for specific reimbursement systems under Medicare and Medicaid. They include federally funded health centers known as "Section 330 grantees" and those that meet specific federal requirements but do not receive federal grant funding, known as "Look-Alikes." This document refers to both types as "Health Centers."

3 Data cited in this document is described in this publication's Methodology and Data Sources section.

SECTION

01

Overview of Health Center Capital Investment Trends and Projections

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1.1 INFRASTRUCTURE GROWTH
RELATIVE TO PATIENT DEMAND

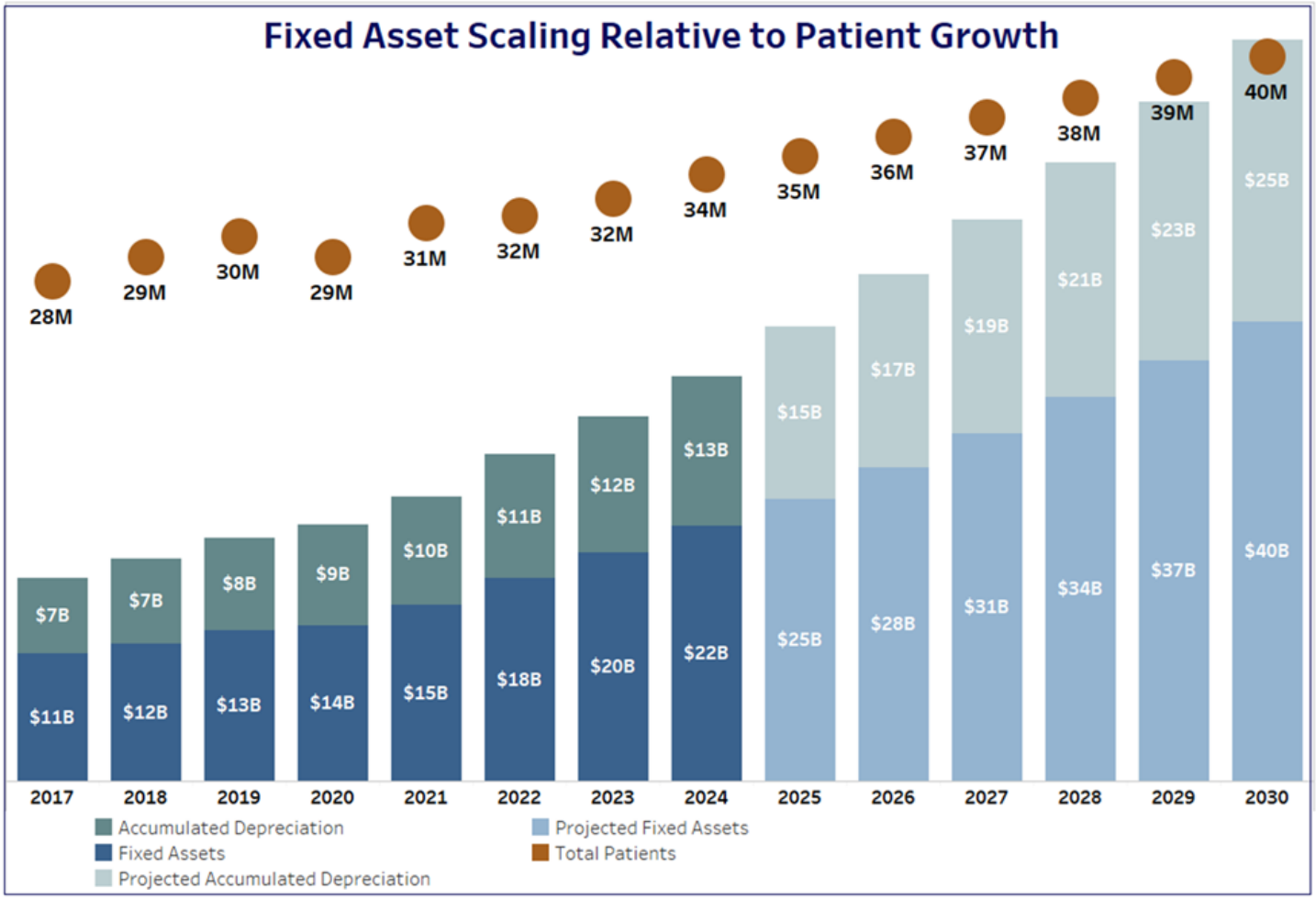
This Capital Needs Assessment (CNA) evaluates Health Center infrastructure needs using audited financial statements and Health Center Program Uniform Data System (UDS) historical data from 2017 through 2024, with projections extending to 2030.

Based on these data, Health Centers are projected to serve approximately **40 million**[4] **patients by 2030**. Supporting this growth requires both recruiting and retaining staff and securing capital for facility enhancements and expansion. Considering historical capital investment trends and anticipated construction costs — projected forward using an ARIMA (1,1,0) Machine Learning model — Health Centers will need to invest approximately **$29.6 billion in capital assets**[5] (property, plant, and equipment, or PP&E) through 2030 to meet both maintenance and expansion needs.

As patient demand increases, Health Centers must expand clinical service space, medical equipment capacity, and facility modernization efforts to maintain care quality and operational efficiency. Without sufficient capital investment, Health Centers may face service access limitations, overcrowding, and reduced care delivery effectiveness. These challenges are particularly significant in underserved and high-growth communities where Health Centers serve as primary points of access for essential healthcare services.

4 Projected patient volume assumes approximately 3% annual growth, based on the three-year trailing average growth rate observed from 2022 to 2024, which excludes the anomalous COVID-19 related patient volume decline in 2020. This methodology was selected over the full historical average to better reflect post-pandemic utilization patterns and underlying demand trajectory, resulting in an estimated 40 million patients by 2030.

5 Capital investment projections for 2025–2030 were generated using an ARIMA (1,1,0) Machine Learning model, implemented in Python using the stats models library and trained on eight years of audited financial data from 2017 to 2024. This machine learning methodology was selected over traditional linear modeling because health center capital investment has demonstrated significant historical volatility — ranging from $1.1 billion in 2020 to $3.8 billion in 2022 — driven by emergency public health funding cycles, federal grant timing, and post-pandemic infrastructure catch-up. The drift component prevents mean-reversion to historical averages, ensuring projections reflect the structural long-term growth trajectory of the health center system. Projections are expressed in nominal dollars and assume no major federal policy discontinuities. Actual investment levels will vary based on funding availability, construction cost escalation, and health center capacity to absorb capital.



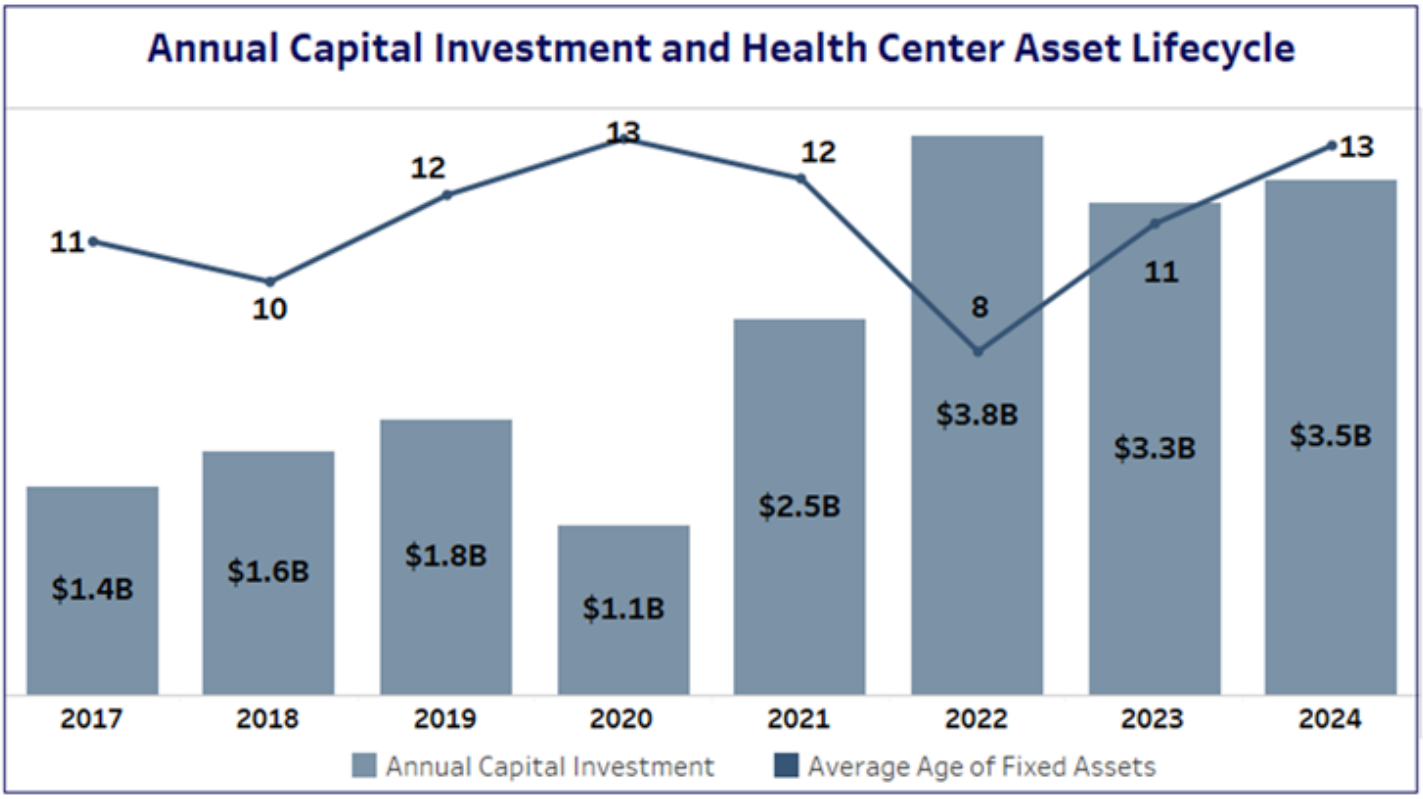
1.2 CAPITAL
FUNDING STRUCTURE

Financing patterns indicate that loans are the top-ranked funding source, followed by grants and capital campaigns. Federal capital grant funding[6], administered through the Health Resources and Services Administration (HRSA), has from time to time been a strategically important contributor to infrastructure financing. Grant funding often serves as a foundational capital funding source that enables Health Centers to leverage additional private and public funding sources. However, the historical volatility in the availability of grant funding underscores the importance of the ARIMA-based 2025–2030 projections, as relying on intermittent "windfall" equity is not a sustainable long-term strategy.

6 Federal capital grant funding included in this analysis reflects programs available exclusively to Section 330-funded health centers. However, this assessment evaluates infrastructure capital demand across both Section 330-funded Health Centers and Look-Alike organizations to provide a comprehensive national capital need estimate.

1.3 ANNUAL CAPITAL INVESTMENT AND ASSET LIFECYCLE TRENDS

Maintaining infrastructure within acceptable lifecycle thresholds requires sustained and predictable capital investment. This chart highlights the annual capital investment and health center asset lifecycle. A significant dip in fixed asset age occurred in 2022 (8 years), following a $3.8 billion investment surge. However, as investment leveled off in 2023–2024, the average age of fixed assets began increasing annually to 13 years. This gradual aging of capital assets suggests that, without consistent annual investment, facilities risk becoming obsolete or requiring more costly emergency repairs.



1.4 INVESTMENT STRATEGY
REPLACEMENT VS EXPANSION

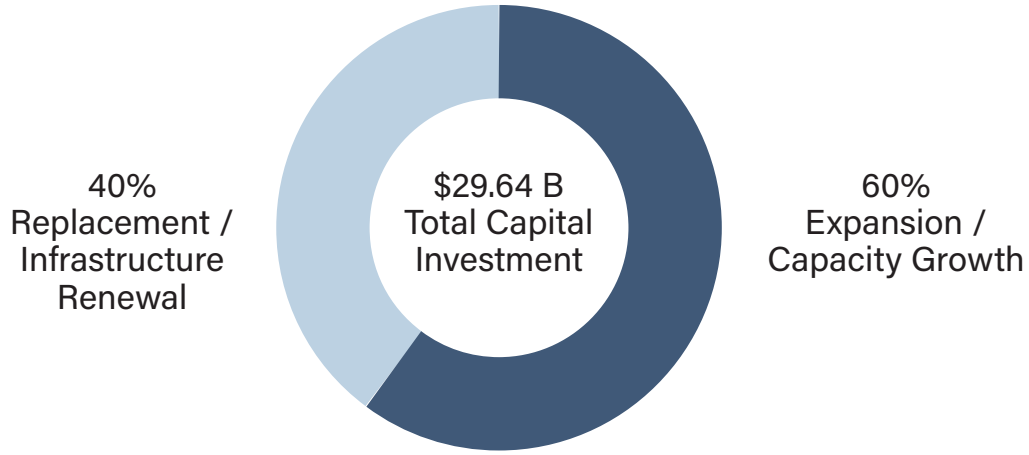
Projected capital investment between 2025 and 2030[7] is estimated at approximately $29.6 billion, reflecting two strategic priorities: infrastructure replacement and system expansion.

Approximately 40 percent of the projected investment ($11.8 billion) is allocated to "staying even", replacing[8] worn-out equipment, modernizing existing facilities, and renewing aging infrastructure. This portion ensures operational continuity, clinical safety, and regulatory compliance, maintaining the foundation of Health Center operations.

The remaining 60 percent ($17.8 billion) is directed toward expansion and capacity growth initiatives, including the development of new service sites, expansion of clinical services, and facility upgrades necessary to accommodate projected patient growth. This allocation underscores that the primary driver of capital need is system growth and not limited to maintenance requirements.

Health Centers are increasingly expanding their role as primary healthcare access providers, and this investment strategy ensures infrastructure keeps pace with the projected 40 million patients by 2030.

Capital Investment Priorities: Replacement vs Expansion (2025-2030)



* Data represents projected capital investment totals from 2025 through 2030 for replacement (infrastructure renewal) and expansion (capacity growth) investments.

7 Unlike traditional capital planning models that assume a fixed Property, Plant, and Equipment replacement lifecycle, projected PPE age in this analysis is estimated using time-series capital investment forecasting (ARIMA). This machine learning-based approach accounts for historical investment patterns and forecasted capital allocations. As a result, projected PPE age varies over time and reflects actual historical and projected investment behavior, rather than a fixed replacement assumption.

8 Replacement investment is calculated as the annual change in accumulated depreciation sourced directly from audited financial statements, representing the value of existing assets consumed each year requiring renewal to maintain operational continuity. Expansion investment is the residual difference between total gross fixed asset growth and the replacement component, reflecting net new infrastructure capacity added to support patient demand growth. This allocation is derived from audited data rather than assumed benchmarks, ensuring the split reflects actual system investment behavior.

SECTION

02

Current Capital Priorities Identified by Health Centers

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2.1 PARTICIPATION AND RESPONDENT PROFILE

The assessment was made available to the full national universe of 1,512 Health Centers. Responses were received from Health Centers across diverse geographic settings and funding streams, providing a nationally representative cross-section of the sector. Of the responses received, 101 (87.1%) were complete and included in the full analysis, while 15 (12.9%) were partial and included only where data were available. The high rate of completion among those who participated reflects strong engagement and the recognized importance of capital planning data for advocacy and resource development.

HEALTH CENTER LOCATION TYPE

Urban
52%

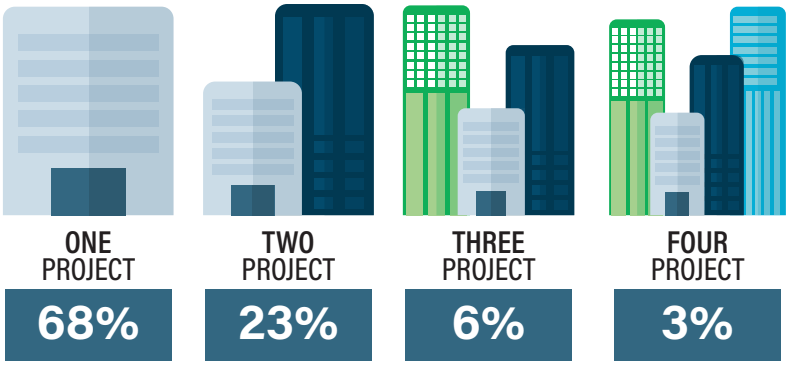
Rural
34%

Respondents represent Health Centers operating in both urban and rural settings. Urban Health Centers account for 51.7% of respondents, while rural Health Centers represent 34.5%. This distribution broadly reflects the sector's presence in diverse geographic contexts and underscores the need for capital funding solutions that serve both urban and rural organizations.

2.2 CAPITAL PROJECT OVERVIEW

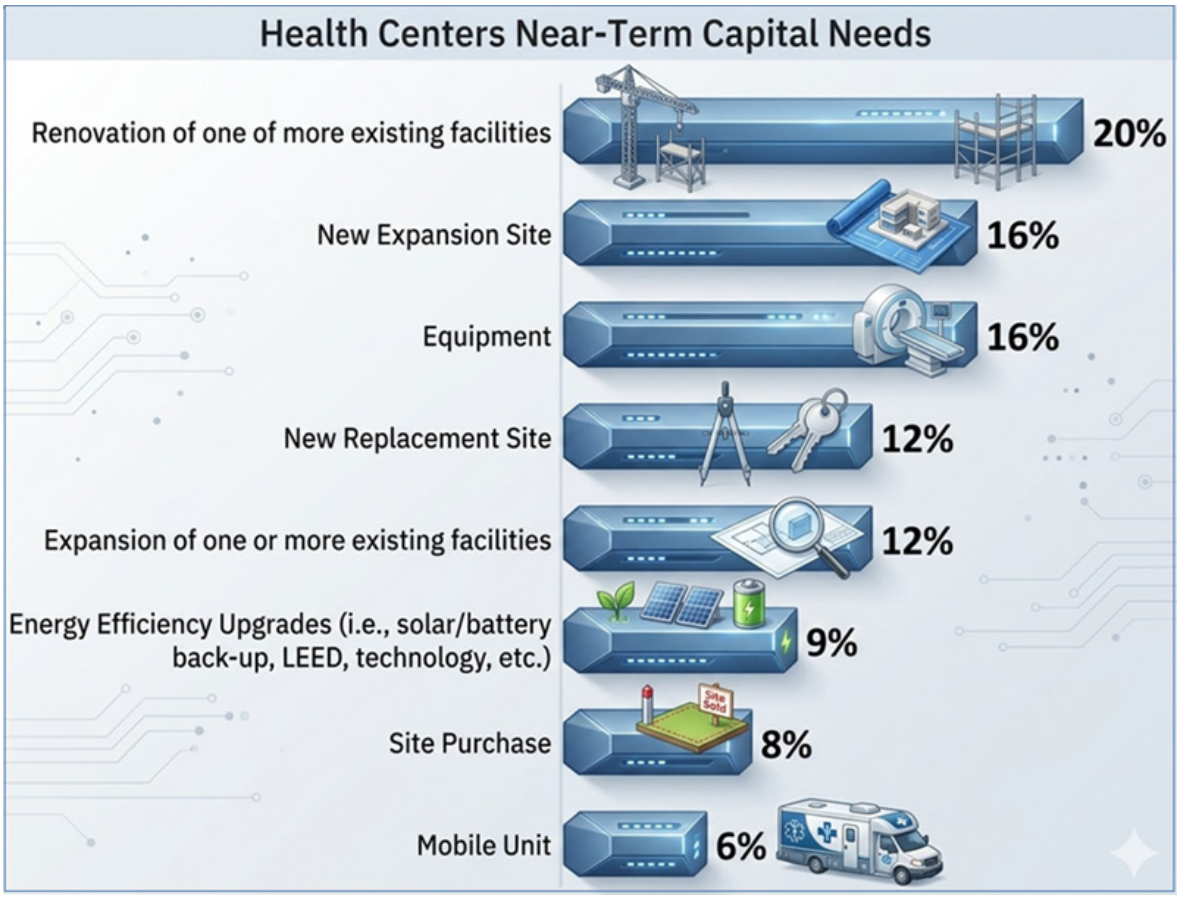
Among responding Health Centers, 68% plan at least one capital project within the next three years. Specifically, 23% are planning two projects, 6% three projects, and 3% four or more. This translates to a total pipeline of at least 115 distinct capital projects across the responding organizations.

Number of Anticipated Projects per Health Center



Nature of Capital Projects

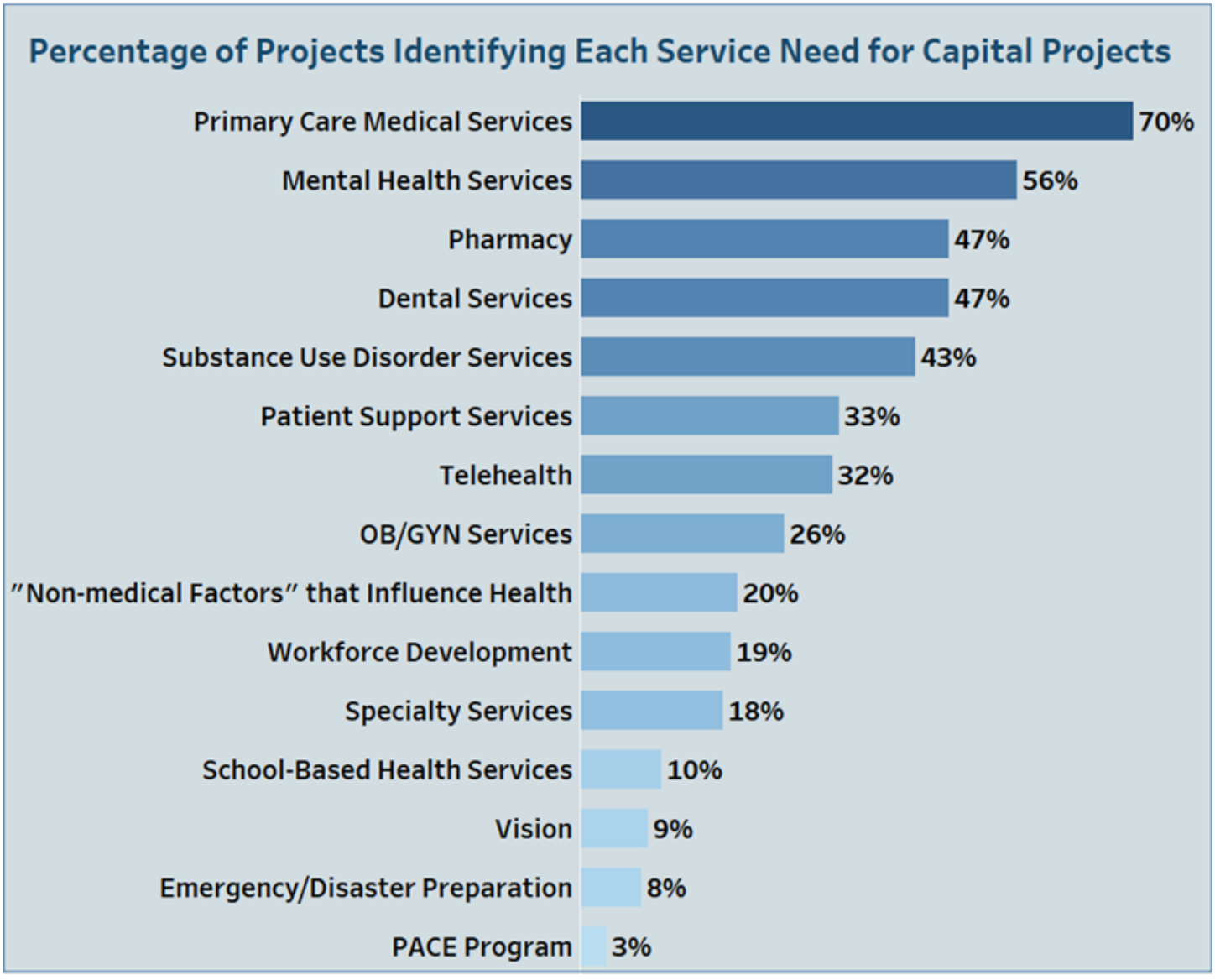
Health Center capital projects reflect various infrastructure needs: renovations lead at 20% due to aging facilities, while equipment and new expansion sites (16%) comprise nearly one-third of planned activity. Facility expansion and replacement sites (each 12%) address rising patient volumes and obsolescence. Rounding out the pipeline, energy upgrades (9%), site purchases (8%), and mobile units (6%) highlight an increasing focus on sustainability and reaching isolated communities



2.3 COMMUNITY AND SERVICE AREA NEEDS

Health Centers were asked to detail the community or service area needs for each project priority listed in their responses. Health centers with at least one project confirm that primary care capacity remains the sector's core priority, but reveal broad and growing demand for behavioral health, dental, pharmacy, and support services. Primary Care Medical Services was selected by 70% of respondents with at least one project, underscoring that expanding or sustaining primary care delivery is the fundamental driver of nearly all Health Center capital investment. Mental Health Services (56%), Dental Services (47%), and Pharmacy (47%) followed as the next most commonly cited needs, reflecting the sector's ongoing effort to build comprehensive, whole-person care delivery systems within a single care setting.

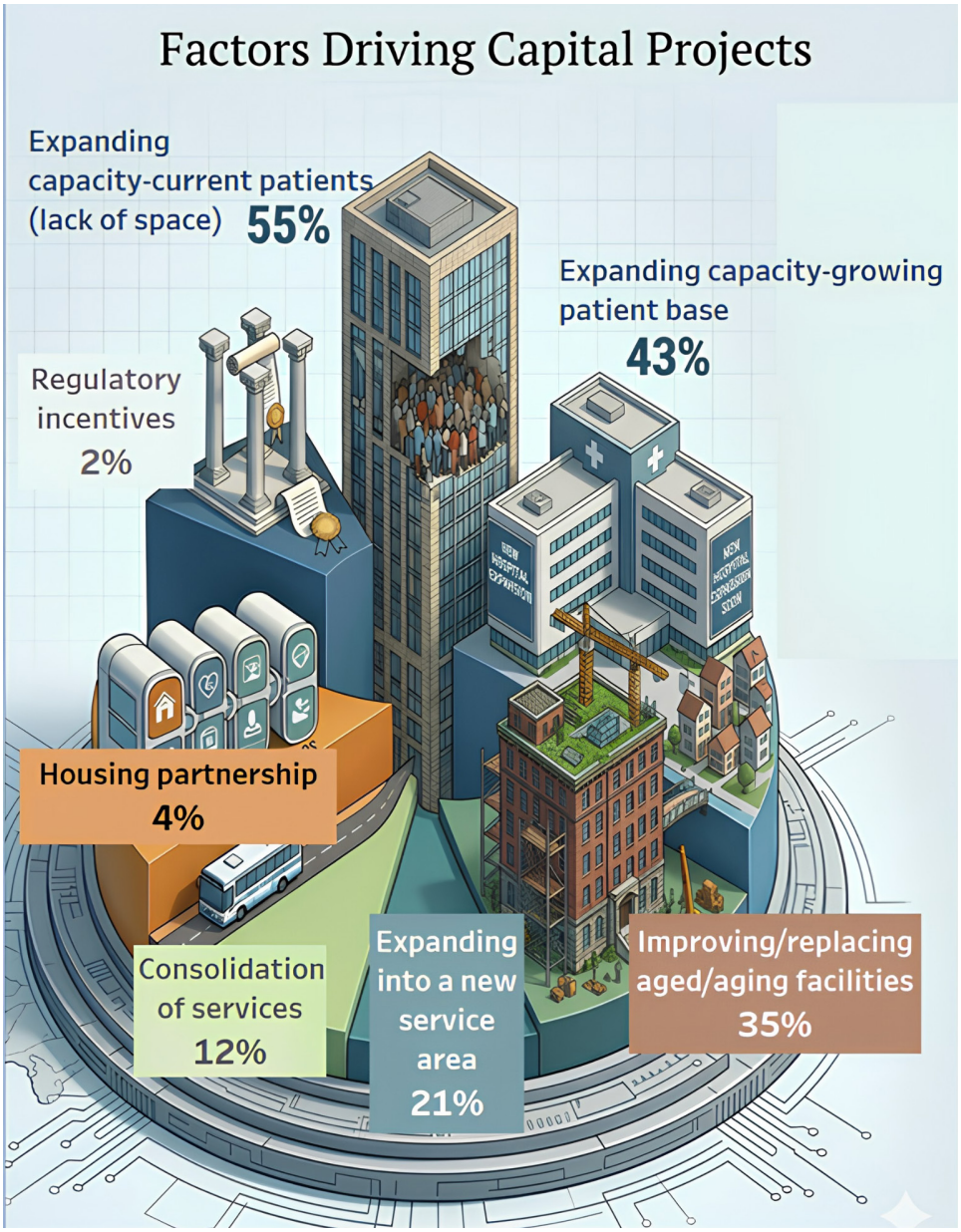
Substance Use Disorder Services (43%), Patient Support Services (33%), and Telehealth (32%) also rank highly, pointing to the integration of wraparound services as a central feature of Health Center capital planning. These findings are consistent with broader national trends toward integrated behavioral health and the expansion of enabling services.



2.4 FACTORS DRIVING
CAPITAL PROJECT DECISIONS

Understanding what motivates Health Centers to initiate capital projects is essential for aligning funding programs with real-world demand. Respondents were asked to select all factors that led them to consider each capital project.

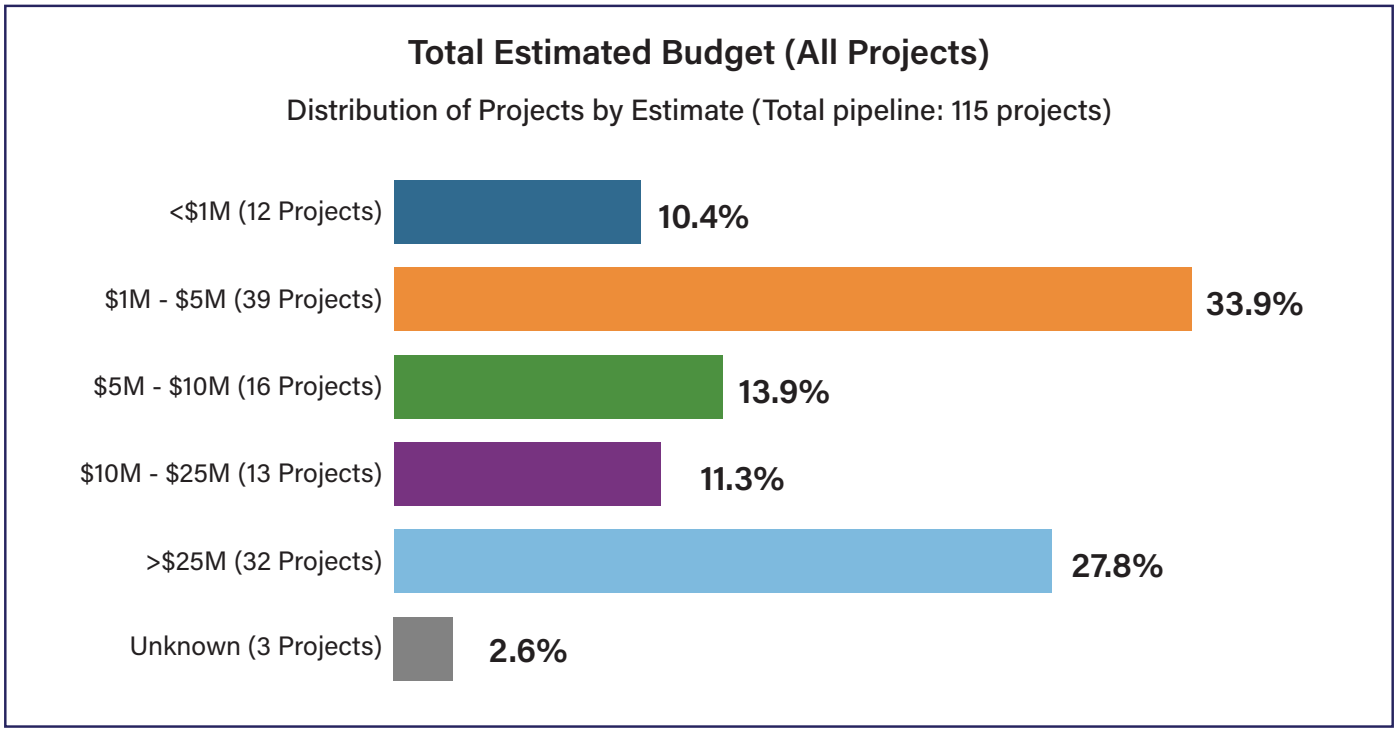
Across all factor selections, expanding capacity for the current patient base due to lack of physical space was cited most frequently (55%), followed by expanding capacity due to a growing patient base in the current service area (43%). Together, these two capacity-related factors are the top two drivers, signaling that Health Centers are feeling intense pressure to accommodate patient volume that has outgrown existing infrastructure. Improving or replacing aged or aging facilities was cited by 35% of respondents, highlighting infrastructure obsolescence as a significant and persistent challenge for the sector.



2.5 FUNDING SOURCES

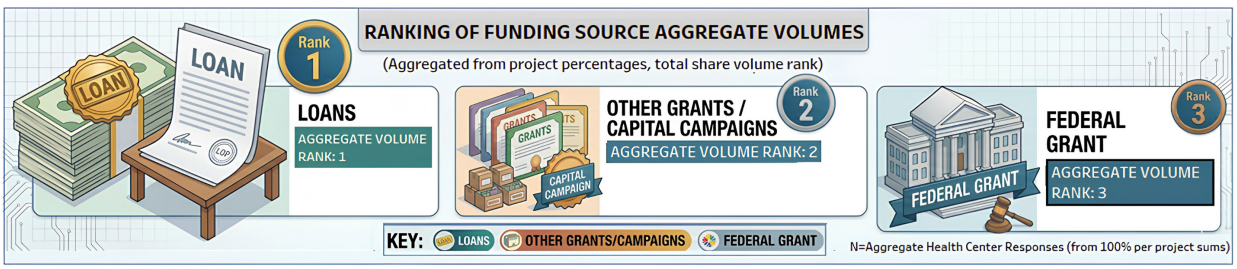
Estimated Project Budgets

The assessment reveals a diverse range of capital investment needs, from minor renovations to large-scale facility developments. Projects with budgets exceeding $25 million represent 28% of the pipeline, highlighting a significant focus on high-cost, transformational infrastructure. Conversely, 44% of projects are estimated at $5 million or less (including 10% under $1 million), underscoring a steady demand for mid-scale improvements and smaller equipment upgrades alongside major construction.



Funding Sources

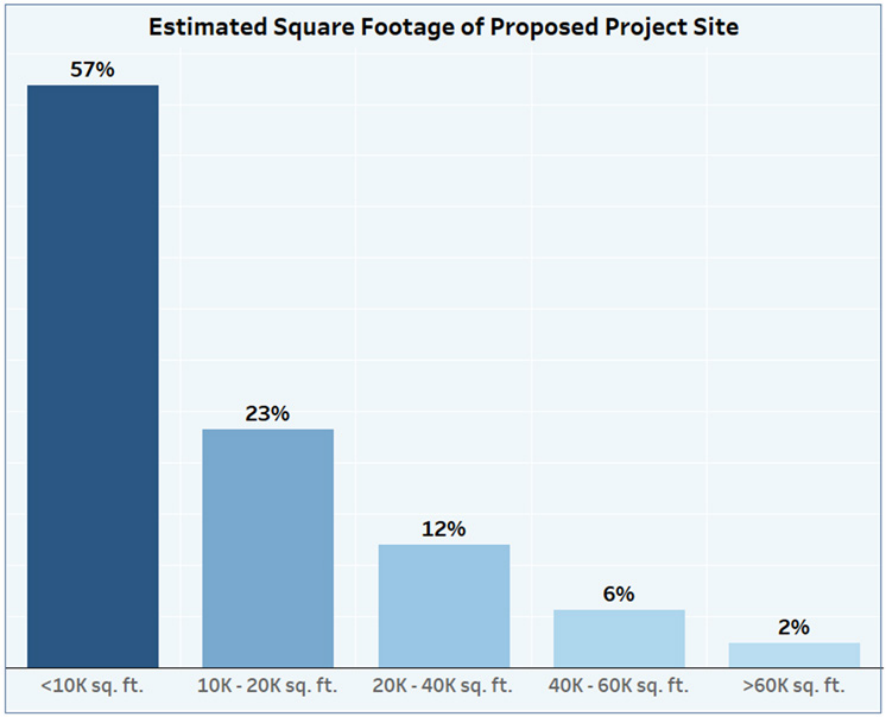
Health Centers reported their estimated funding mix, with individual project totals summing to 100%. When aggregated across the sector, Loans emerged as the primary funding source, followed closely by Other Grants and Capital Campaigns. This reliance on a diversified funding stack highlights a strategic shift toward mixed-financing models. The prominence of debt underscores the critical role of low-cost financing tools and guarantee programs in sustaining the capital pipeline.



2.6 PROJECT SIZE AND CONSTRUCTION TIMELINE

Estimated Square Footage

Across all projects with known square footage, the majority are relatively modest in scale. Projects under 10,000 square feet represent 57% of all planned projects, while projects in the 10,000 to 20,000 square foot range account for an additional 23%. Taken together, 80% of all planned projects involve spaces of 20,000 square feet or less, reflecting that most capital projects are targeted renovations, equipment deployments, or small-to-mid-sized expansions rather than large-scale new construction.



Construction Start Timeline

The near-term capital pipeline is concentrated in 2026 and 2027. Of the projects with a known construction start date, 39% are expected to break ground in 2026 and 35% in 2027, meaning 74% of the pipeline is set to begin within two years. An additional 20% are projected for 2028. This compressed timeline underscores the urgency of securing capital financing and completing pre-development work across the sector.

PROJECTED CONSTRUCTION START TIMELINE

2026	2027	2028
39%	35%	20%

Source: Aggregate health center data analysis (derived from N-96 responses)

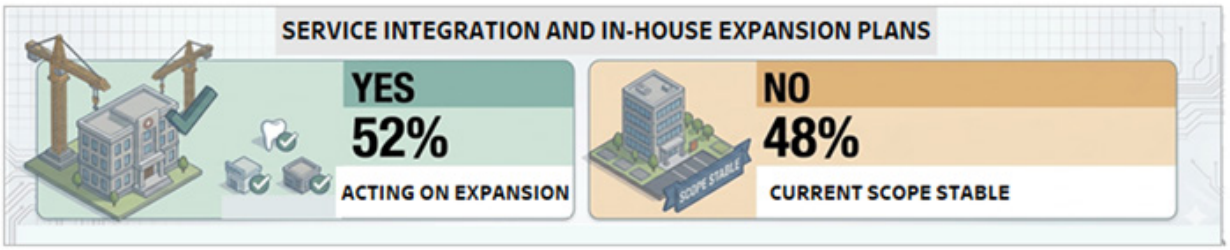
2.7 STRATEGIC PRIORITIES AND HRSA LOAN GUARANTEE PROGRAM

Expanding Service Delivery

Respondents were asked whether they are considering expanding their capacity to deliver services directly through operational planning, resource alignment, and integration into existing systems of care.

Of the 56 Health Centers that answered this question, 52% indicated yes, with respondents citing dental care, primary care, pharmacy, HIV services, school-based clinics, women's health, and vision services as target areas for direct expansion.

This finding reflects a broader trend toward Health Center diversification as organizations seek to deepen their impact and improve care coordination by bringing previously referred services in-house.



HRSA Loan Guarantee Program (LGP) Interest

Assessment data reveals a significant awareness and utilization gap regarding the HRSA Loan Guarantee Program. While 37% of respondents (20 centers) identified the LGP as a necessary resource for current or future projects, a majority—54% (29 centers)—were "not sure" if the program applies to their specific needs. Only 9% indicated they did not require the resource.

This finding underscores a critical need for targeted education and technical assistance to help Health Centers navigate LGP eligibility and leverage it within their capital financing stacks.

METHODOLOGY AND DATA SOURCES

This analysis uses data from Capital Link's proprietary database, including:

- Audited financial statements of Health Centers (both Section 330 grantees and Look-Alikes)
- Uniform Data System (UDS) reports submitted annually to HRSA

Category	2017	2018	2019	2020	2021	2022	2023	2024
Number of Audited Financial Statements of Health Centers by Fiscal Year	1,249	1,257	1,256	1,271	1,258	1,187	1,192	1,169
Number of UDS reports filed by Health Centers by calendar year	1,429	1,446	1,457	1,462	1,481	1,487	1,496	1,512

Capital Link maintains a database of over 21,000 Health Center audited financial statements from 2005 to 2024, incorporating nearly 85% of all Health Centers nationally in any given year. Given that some Health Centers are public entities or are part of larger health systems, not all public entity Health Centers produce individual audited financial statements. For this analysis, public entities, hospitals, and county community Health Centers were excluded to ensure comparability across organizations, resulting in an adjusted universe of audited Health Centers.

The ratios and metrics in this analysis were calculated to measure Health Center capital investment trends, infrastructure lifecycle performance, and projected capital requirements through 2030. Capital investment projections from FY2025 through FY2030 were generated using an ARIMA (1,1,0) Machine Learning model, implemented in Python and trained on eight years of audited financial data from 2017 to 2024. This machine learning methodology was selected over traditional linear modeling to account for historical investment volatility, post-surge mean-reversion risk, and long-term structural growth in Health Center infrastructure demand. The drift component ensures projections reflect the continued growth trajectory of the Health Center system rather than reversion to historical averages. Patient volume projections assume approximately 3% annual growth based on the three-year trailing average from 2022 to 2024, which excludes the anomalous COVID-19-related patient volume decline in 2020, resulting in an estimated 40 million patients served by 2030.

Infrastructure replacement investment is calculated as the annual change in accumulated depreciation sourced directly from audited financial statements, representing asset consumption requiring renewal. Expansion investment is the residual difference between total gross fixed asset growth and the replacement component, reflecting net new infrastructure capacity added to support patient demand growth. This methodology is derived from audited data rather than assumed benchmarks. Projections incorporate the following assumptions: accumulated depreciation held at approximately 38% of gross fixed assets, consistent with the stable ratio observed across 2017–2024; and Health Centers maintaining an average age of PP&E between 10 and 13 years to ensure operational continuity, clinical safety, and regulatory compliance. All projections are expressed in nominal dollars and subject to revision based on federal funding availability, construction cost conditions, and Health Center capacity to absorb capital.

Capital Link administered an assessment to all 1,512 Health Centers between February 2026 and April 2026 to understand current capital plans. The respondent sample (116 Health Centers) was nationally representative.

CONCLUSION

The national Health Center Program faces a critical infrastructure investment imperative. With patient volume projected to reach 40 million by 2030, representing approximately 43% growth from the 2017 baseline, Health Centers will need to invest approximately $29.6 billion in capital assets from 2025 through 2030, of which approximately 40% supports infrastructure renewal and 60% supports net new capacity growth.

The 2026 Capital Needs Assessment confirms this demand at the project level, with over 68% of responding Health Centers planning at least one capital project within the next three years, driven primarily by capacity constraints and aging infrastructure. Primary care expansion remains the dominant need, alongside growing demand for behavioral health, dental, and pharmacy services — reflecting the sector's broader shift toward integrated, whole-person care delivery.

A critical structural shift in Health Center capital financing is emerging. Historically, other equity sources dominated capital investment, peaking at 89% in 2022. As those one-time windfalls diminish, assessment findings confirm that Health Centers now anticipate loans as their primary financing mechanism going forward, followed by other grants and capital campaigns, and federal grants. This transition from equity-dominated to debt-dependent financing represents a fundamental change in the sector's capital structure, increasing the strategic importance of community development lenders as well as credit enhancement programs such as the HRSA Loan Guarantee Program — particularly given that 54% of respondents remain uncertain about their eligibility for the program.

Sustained investment in Health Center infrastructure is ultimately a public health imperative. As the primary point of access for essential healthcare services in underserved communities nationwide, ensuring that financing tools keep pace with both the scale and structure of capital demand is essential to maintaining the quality, safety, and accessibility of care for the populations Health Centers serve.

Acknowledgement

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About Capital Link

Capital Link is a national non-profit organization that has worked with hundreds of community Health Centers and Primary Care Associations for 30 years to plan for sustainability and growth, access capital, improve and optimize operations and financial management, and articulate value. Established through the Health Center movement, Capital Link is dedicated to strengthening Health Centers—financially and operationally—in a rapidly changing marketplace. For more information, visit us at www.caplink.org.