

# Community Health Center Financial Perspectives

## Issue 4

### *Impact of Capital Projects on Health Centers: Growth, Financial Trends, and Operational Transformation*

#### *A Guide for Lenders*



# Acknowledgements



Capital Link is a national, non-profit organization that has worked with hundreds of health centers and Primary Care Associations over the past 15 years to plan capital projects, finance growth, and identify ways to improve performance. We provide innovative advisory services and extensive technical assistance with the goal of supporting and expanding community-based health care. Established in the late 1990s as a joint effort of the National Association of Community Health Centers (NACHC), several state-based Primary Care Associations (PCAs), and the Bureau of Primary Health Care, Capital Link grew out of the community health center family and continues to support it through creative capital development and analytic activities. For more information, visit [www.caplink.org](http://www.caplink.org).



Community Health Center Capital Fund (Capital Fund) supports the growth and development of community-based health centers serving low-income and uninsured populations by providing capital structured to meet health centers' needs. Capital Fund manages several health center loan programs and provides targeted direct loans to health centers to assist them in leveraging multiple sources of financing for their capital projects. Capital Fund was one of Capital Link's founding partners and now serves as its lending affiliate. For more information, visit [www.chc-capitalfund.org](http://www.chc-capitalfund.org).

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# Contents

<b>Executive Summary</b>	1
Key Findings	1
<b>Section I: Introduction and Background</b>	5
Background on Community Health Centers	5
Current Operating Environment of Community Health Centers	7
Data Analysis Approach for this Report	7
<b>Section II: Financial Impact of Capital Projects on Community Health Centers</b>	9
Impact on Profitability	9
Impact on Liquidity	10
Capital Project Impact on Operations: Revenue and Expense Growth Compared	16
Staffing Trends	17
Impact to Balance Sheet	19
Other Debt-Related Ratios	21
<b>Section III: Impact of Capital Projects on Community Health Center Operations</b>	25
Impact of Capital Projects on Patient Utilization	28
Impact of Capital Project Implementation on Service Mix	29
Impact of Capital Project Implementation on Payer Mix	31
<b>Section IV: How Health Center Capital Projects Differ by Project Scale and Organizational Budget</b>	33
Operating Budget by Project Size	33
Constant Expansion Health Centers	34
<b>Section V: The Impact of Project Debt</b>	35
Does Debt as a Financing Source Differ by Project Size?	35
Impact of Debt Financing on Profitability	36
Impact of Debt Financing on Liquidity	37
Impact of Debt Financing on Balance Sheet Composition	38
<b>Section VI: Conclusion</b>	40
Takeaways for Lenders	40
<b>Section VII: Methodology and Limitations</b>	42
<b>Appendix A</b>	45
Summary of Obligations and Benefits of FQHC Status	45

# Executive Summary

Based on a study of 176 organizations, the following report summarizes the impacts of a capital project on a health center's operations and financial performance. This report is *Issue 4* in a series titled **Community Health Center Financial Perspectives**, supported by the Citi Foundation and prepared by Capital Link, in collaboration with Community Health Center Capital Fund. Written for a lender audience, this document offers data-informed analysis to guide lenders as they underwrite health center capital projects.

## Key Findings

### *Financial and Operational Impacts of a Capital Project*

The period of highest risk for health center capital projects is between the project implementation year (i.e. the project year) and the first full fiscal year following project completion (i.e. Year 1). Based on an analysis of health center projects completed between 2004 and 2008, the data supports the following findings:

**Impact on Profitability:** For health centers completing capital projects, profitability dropped to its lowest level in Year 1. Total operating expense growth rates outpaced total operating revenue growth through Year 1 before the trend reversed in Year 2. By Year 3, expenses and revenues grew at nearly identical rates for the median health center with a capital project.

**Impact on Cash Flow:** Lenders should expect to see a drop in cash in the project year for health centers with capital projects. The typical health center experienced a drop in cash of 10 days cash on hand, and it took two years to fully recover. By Year 3, most health centers ended up with the same or slightly higher days cash on hand levels than before a project was completed.

**Operational Ramp-Up:** The data revealed a defined ramp-up period during the project year that is a primary driver of the profitability trends. During the ramp-up, staffing expense growth and growth of full-time equivalents (FTEs) were significantly greater than patient growth, which in turn peaked in Year 1. Lenders should expect to see elevated staffing expense growth for several years, with one to two “lag years” (typically the project year and Year 1) before growth in operating revenue once again outpaces operating expense.

### *Minimal Impact of Capital Projects on Capitalization*

Capital projects have a minimal impact to health center capitalization, which is by and large quite healthy and within recommended ranges. The typical health center with a capital project experienced an increase in leverage from 0.7 to 0.95 in the project year. Leverage dropped to pre-project levels by Year 2 for the median health center. At the median, health centers maintained a debt service coverage ratio of at least 3.0,

even during the challenging period between the project year and Year 1.

### *Potential Positive Effects of a Capital Project*

**Boost for Strong Organizations:** Although a less-strong operating model appeared to be weakened by the completion of a capital project, capital projects appeared to enhance the performance of already strong organizations. From the historical data we can infer that if a health center begins a project with sound profitability, greater-than-average cash reserves, and positive working capital growth, they are more likely to end up stronger along these measures three years after project completion.

**Improved Payer Mix:** Capital projects also appear to be associated with an improved payer mix. Compared to health centers that did not take on a capital project, health centers in the project group saw greater growth in Medicaid patients, as well as a slight reduction in the proportion of self-pay patients (although this group still grew substantially on a nominal basis).

**Transformative Growth:** Health centers that complete capital projects experience transformative organizational growth. At the median, operating budgets for health centers with capital projects grew by 47% over the 5-year review period, compared to health centers without projects, which grew by 24%. Growth at this level was nearly twice that of the control group, suggesting an evolution of small organizations to medium-sized organizations, and medium to large.

**Improved Cash Levels:** The typical health center had modestly improved cash levels upon completing a capital project as compared to pre-project levels. At the median, health centers completing a capital project began with 39 days cash on hand in Year -1 and ended with 43 days cash on hand in Year 3.

**Preserved Productivity:** Although provider productivity has declined on a sector-wide basis, capital projects appeared to help health centers preserve greater medical productivity as compared to health centers that did not build during the review period.

**Improved Care:** Capital projects also appeared to allow health centers not only to add patients but also broaden and deepen the level of care they were able to provide to all patients, as indicated by the increased visits per user for health centers with capital projects.

### *Debt as a Funding Source has Predictable Effects*

Debt mostly affected leverage and profitability and did not appear to affect working capital growth. Health centers that used debt to finance some portion of their projects experienced smaller fluctuations in cash in the project completion year as they were less likely to self-fund their projects. Health centers that used debt also experienced enhanced net patient service revenue growth in the final year of the project period.

Health centers in the cohort that used debt to finance their capital projects were more likely to be in a constant-growth cycle (as signified by stronger net patient service revenue growth and personnel expense growth in final analysis year).

This report is organized in the following sections:

**Section I:** Introduction and Background

**Section II:** Financial Impact of Capital Projects on Community Health Centers

**Section III:** Impact of Capital Projects on Health Center Operations

**Section IV:** How Health Center Capital Projects Differ by Project Scale and Organizational Budget

**Section V:** The Impact of Project Debt

**Section VI:** Conclusion and Takeaways for Lenders

**Section VII:** Methodology and Limitations

## Key Ratio Summary:

Key Financial Metric	Report Page	Trend for Health Centers with Capital Projects (based on median results)	
Operating Margin	9	Year -1 (pre-project year)	4.1%
		Project Year	2.6%
		Year 1	1.4%
		Year 2	2.8%
		Year 3	2.1%
Days Cash on Hand	11	Year -1	39
		Project Year	30
		Year 1	30
		Year 2	39
		Year 3	43
Leverage	20	Year -1	0.7
		Project Year	0.9
		Year 1	0.8
		Year 2	0.7
		Year 3	0.7
Revenue Growth Rate	13	Project Year	13%
		Year 1	12%
		Year 2	11%
		Year 3	9%
NPSR Growth Rate	14	Project Year	13%
		Year 1	15%
		Year 2	10%
		Year 3	8%
Expense Growth Rate	16	Project Year	15%
		Year 1	13%
		Year 2	10%
		Year 3	9%
Personnel-Related Expense Growth	17	Project Year	13%
		Year 1	13%
		Year 2	10%
		Year 3	11%

Key Operational Metric	Report Page	Trend for Health Centers with Capital Projects (based on aggregate, average results)	
Patient Growth	25	Project Year	9%
		Year 1	9%
		Year 2	5%
		Year 3	4%
Visit Growth	26	Project Year	9%
		Year 1	9%
		Year 2	6%
		Year 3	6%
Staffing (FTE) Growth	25	Project Year	11%
		Year 1	8%
		Year 2	7%
		Year 3	7%

# Section I: Introduction and Background

Currently the largest network of primary care providers nationally, Federally Qualified Health Centers (FQHCs) are expected to grow from serving 22.3 million patients currently to 40 million patients over the next several years, as a result of the Affordable Care Act.<sup>1</sup> This level of projected growth is even greater than the growth health centers experienced between 2005 and 2011, during which time they grew from 15.9 million to 21.1 million patients. According to a 2012 analysis by Capital Link, within that same time frame health centers added an estimated \$11.1 billion in leased and owned buildings, property, and equipment, and will need to add at least \$13.1 billion in capital assets in the future to meet the growth goals of serving 40 million patients. This document, and a companion piece written for health centers, is the second installment of a publication series intended to provide insight on issues related to health center financial and operational performance, particularly as they affect access to capital. The first issue, *Community Health Center Financial Perspectives, Issue 1: Financial and Operational Ratios and Trends of Community Health Centers*, focused on financial and operational performance of community health centers between 2008 and 2011, with health center leaders as the intended audience. As a companion, *Issue 2* was written with lenders in mind, serving as an introduction to health center operations and financial health.

*Issue 4* (and a companion *Issue 3*, written for health centers) in the publication series describes the impact of a capital project on a health center's financial and operational performance and health. This report seeks to answer questions Capital Link frequently receives about capital projects, such as: How quickly do health centers usually grow after a capital project? How do their financial trends change as a result? Are there usually losses in the early years? How long is the "high risk" period before operations stabilize? How many health centers utilize debt as a funding source, and how much do they use? This report also provides some data points related to "typical" project budget size, and how capital project size relates to the size of the organization. Some key background information on community health centers, how they differ from other healthcare providers, and their current operating environment has been included below for reference.

## Background on Community Health Centers

This document refers to a category of primary health care providers known variously and colloquially as "community health centers," "neighborhood health centers," "community clinics"—and sometimes by the technical terms "Federally Qualified Health Centers" or "FQHC," "Section 330" health centers, or "Look-Alikes (LALs)."<sup>2</sup> These references generally denote a type of "safety net" provider that serves primarily

<sup>1</sup>2012 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS. The Uniform Data System (UDS) provides a Roll-up Report that tabulates FQHC and FQHC Look-Alike data.

<sup>2</sup>A federally qualified health center (FQHC) is a type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHC designation carries certain obligations and benefits for providers so designated. See Appendix A for a listing of FQHC requirements and benefits.

low-income and uninsured patients regardless of their financial status. This document assumes a working knowledge of the definition of FQHC (including Section 330s and LALs) and will refer to the group generally as “health centers” unless we are specifically referencing subgroups of this “universe” of providers. The following paragraphs provide a brief overview of health centers, and more information on the benefits and obligations of health centers is included in Appendix A.

Established as a result of the War on Poverty in the mid-1960s, the first community health centers were organized in Boston, Massachusetts and in Mound Bayou, in Northwest Mississippi, as part of a demonstration project funded through President Johnson’s Office of Economic Opportunity. Since that time, they have expanded to comprise a network of over 1,200 corporate entities offering a range of primary and preventive health care services at almost 9,200 sites nationwide.

While it is beyond the scope of this document to fully describe the history of health centers in the United States, several features of their founding continue to strongly impact their growth trajectory today:

### *Patient-Centered Care*

Most health centers provide a combination of primary and preventive health care, dental, and behavioral health care, with wrap-around “enabling services” geared toward eliminating barriers to care.

### *Community Control*

A hallmark of health centers is that they are almost exclusively organized on a tax-exempt basis and governed by a board of community stakeholders. At least 51% of the members of a Federally Qualified Health Center’s board are required to be patients of the health centers.

### *Engines of Economic and Social Empowerment*

With roots in the Civil Rights Movement, health centers have always emphasized community empowerment as much as access to health care. Today, health centers employ almost 154,000 people<sup>3</sup> and are often the largest employers in their predominantly low-income communities, providing a range of relatively high paying jobs and job ladders for the communities they serve.

### *Low-Cost, High-Quality Providers*

The average cost of care for patients served at health centers is approximately 24% lower than care provided in other primary care settings—with quality measures that equal or exceed many other providers.<sup>4</sup>

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<sup>3</sup>2012 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

<sup>4</sup>Leighton Ku et al. *Using Primary Care to Bend the Curve: Estimating the Impact of Health Center Expansion on Health Care Costs* GWU Department of Health Policy. *Policy Research Brief no. 14*. (September 2009).

## Current Operating Environment of Community Health Centers

Like all health providers, health centers are functioning in a changing and uncertain operating environment on the eve of the implementation of the Affordable Care Act (ACA), the most important features of which are scheduled to roll out in 2014. Health centers are highly dependent on Medicaid as the major payer for services provided to a large proportion of health center patients. While health centers share a similar business model, individual state-run Medicaid programs create operational environments with economic impacts for health centers that differ from state to state. Although it is a federal program, each state has the latitude to develop and administer its own Medicaid program, resulting in state-specific eligibility, claims submission, reimbursement, and payment rules, all of which impact an individual health center's financial profile and operating performance to a certain degree.

Most health centers are reliant on "Section 330" federal operating grants to subsidize the cost of care provided to uninsured and under-insured families and individuals—at a time when federal funding of any sort is becoming more difficult to secure. Health centers' long history of operating in uncertain funding environments will likely serve them well over the next decade as they navigate the inevitable changes to the health care marketplace. In particular, their positioning as relatively low-cost, high-quality providers for a population that is in many respects difficult to serve should argue well for health centers' continued growth, particularly in states that choose to expand Medicaid eligibility, a major strategy employed by the ACA for expanding access to health insurance coverage.

By virtue of their historical funding sources, health centers have always operated in a highly-regulated environment as dictated by federal and state grant sources and a plethora of public payers, principally Medicaid. FQHCs are subject to multiple ongoing reporting and certification standards to maintain their FQHC status and to qualify for the benefits that derive from it. Some of these benefits include a cost-based prospective payment system (PPS) for services to patients covered by Medicaid and Medicare and eligibility for free medical malpractice insurance through the Federal Tort Claims Act. This experience operating within a highly regulated system should provide health centers with a competitive advantage—or at least a head start on their competitors—as they navigate the new and uncharted waters of the ACA.

## Data Analysis Approach

To begin to answer questions related to the impact of capital projects on health center operations and financial trends, Capital Link developed the following analysis using our industry-specific database of health center audits, which represents an average of 70% of all health centers in any given year between 2003 and 2011. The year-over-year change in land, buildings, and leasehold improvements was calculated from 2004 through 2008, and any change in land, buildings, and leasehold improvements that exceeded \$1 million was classified as a "capital project." This group was further honed to identify health centers with capital projects for which five consecutive years of audits were available (in which the project year was the second year), and 118 organizations were identified as meeting this criteria.

In order to have a basis for comparison, we also assembled a control group that had no more than a \$150,000 change in land, buildings, and leasehold improvements from 2004 through 2008. We identified 58 organizations with five consecutive years of audits that met the criteria of no major capital growth over the review period. For the financial impact section of this report, all data was reported at the median for the “Project” and “No Project” groups. In addition, health center financial data from the project group was also reported at the 25<sup>th</sup> and 75<sup>th</sup> percentile.

The data and charts in the operational impact section are based upon organization-level Uniform Data System (UDS) data from 108 health centers that had completed capital projects between 2004 and 2008; these 108 organizations are a subset of the 118 health centers studied in the financial data analysis section of this report. Similarly, the control group consists of UDS data from 43 organizations, a subset of the 58 studied in the financial analysis. Some organizations were excluded from this portion of the analysis simply because there was no detailed UDS data available for the analysis timeframe, most often because they were FQHC Look-Alikes, which were not required to report detailed data to HRSA prior to 2012. Unlike the median and percentile data reported in the financial analysis, data in the operational impact charts is based on aggregate or average growth; therefore direct comparison of the financial and operational data sets will be less conclusive. More information on methodology and limitations is included at the end of this report.

The financial and operational analysis in this report tracks health centers over an extended period of 2003 to 2011. We included health centers that had capital projects that occurred anywhere between 2004 and 2008, and we followed health centers for one year before the project and three years following the project. We consolidated this data into a five-year period described by the following terminology:

- **Year -1** is the fiscal year before the project was completed.
- **Project Year** is the fiscal year during which the project was completed.
- **Year 1** is the first full fiscal year following the project completion year.
- **Year 2** and **Year 3** were also studied using Capital Link’s financial database of audited statements, while the UDS analysis went through **Year 4** on relevant measures such as payer mix, productivity, and utilization.

## Section II: Financial Impact of Capital Projects on Community Health Centers

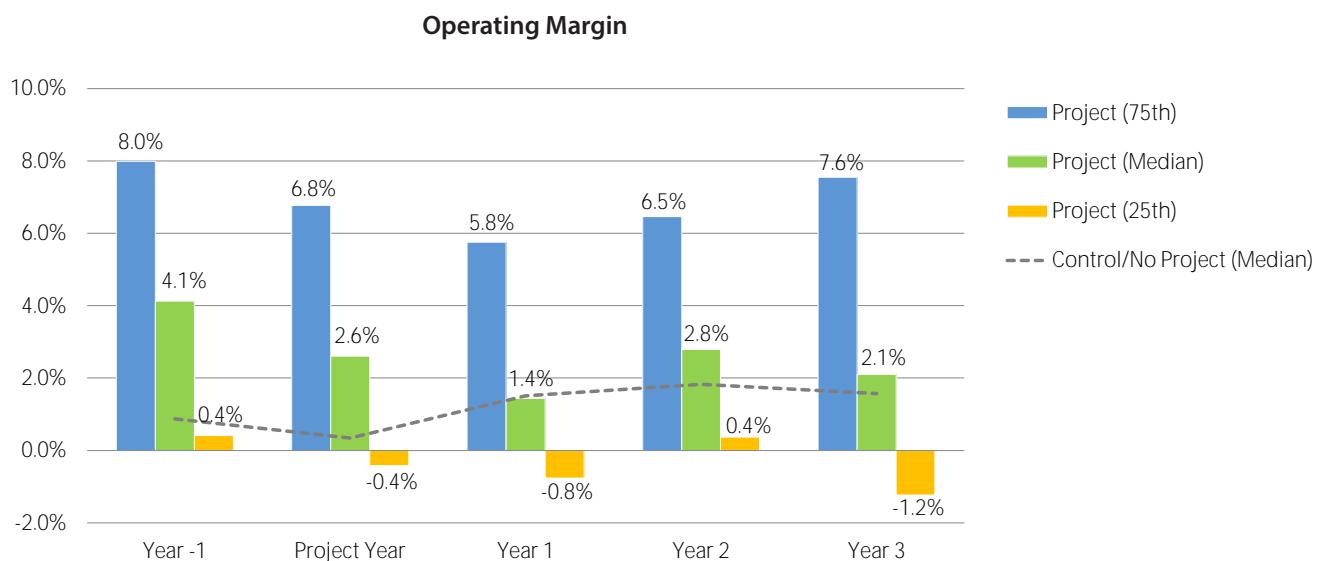
The analysis in this section of the report provides a set of findings around profitability, cash fluctuations, and capitalization for lenders to keep in mind as they consider financing a health center capital project. The data in the charts below is based upon audited financial statements from 118 health centers that had capital projects for which Capital Link possessed five consecutive years of audits. A control group of 58 organizations was included for comparison in the charts below. While the project year could have occurred anytime between 2004 and 2008, all data was consolidated into Year -1, the project year, and Years 1 to 3. More information on methodology is available at the end of this report.

The financial charts that follow include the following elements: data for health centers with capital projects is displayed for the median, as well as for the 25th and 75th percentiles throughout the five-year review period. The median results for the control group have been included for comparison purposes and appear as a dotted line.

### *Impact on Profitability: Operating Margin*

(Change in Net Assets from Operations / Total Operating Revenue)

The operating margin is perhaps the most telling indicator of financial health, as it succinctly explains the proportion of operating revenue that is left over after all expenses are covered. Any operating surplus can then be reinvested into the organization in the form of expanded programming, building reserves, or capital expansion.



Compared to the control group, which hovered between an operating margin of 1% to 2% throughout the review period, health centers with projects showed a clear shift in profitability throughout the review period. Operating margin was lowest in Year 1, the first full fiscal year following completion of the capital project. At the median, health centers with capital projects started with a margin that is healthy by community health center standards, at 4% (the recommended minimum range is between 1% and 3% for this industry). The median operating margin declined in the project year to 2.6%, reaching a low of 1.4% the first full fiscal year after the project was completed (Year 1). The median operating margin recovered to 2.8% by Year 2 and declined somewhat to 2.1% by Year 3, still within the recommended range.

Year 1 was the least profitable year for the project group, representing a period in which a number of events were happening simultaneously (each of which will be discussed in detail throughout this report): revenue growth was outpaced by expense growth, the full effect of depreciation expense hit the income statement, and maintenance and operating expenses increased. As is discussed later in the report, more than two thirds (70%) of the 118 health centers in this study group funded at least a quarter of their projects using debt; for this group, interest expense is also fully felt in Year 1.

Interestingly, health centers in the upper quartile (the 75<sup>th</sup> percentile group) appear to demonstrate strong profitability both before and after project completion, although it takes three full fiscal years after the project year to approach pre-project levels of profitability. In contrast, health centers in the 25<sup>th</sup> percentile grew less profitable as they took on capital projects, ending with a negative 1.2% operating margin in Year 3. This result suggests that completing a capital project with a weak financial profile might worsen any underlying financial or operational issues that existed before the project, while strong operations are less likely to be affected. Health centers at and below the 25<sup>th</sup> percentile for operating margin are strong candidates for some preliminary technical assistance and advice to improve their operations. Once organizations in this quartile have stronger operations, they will be ready to finance their capital projects sustainably.

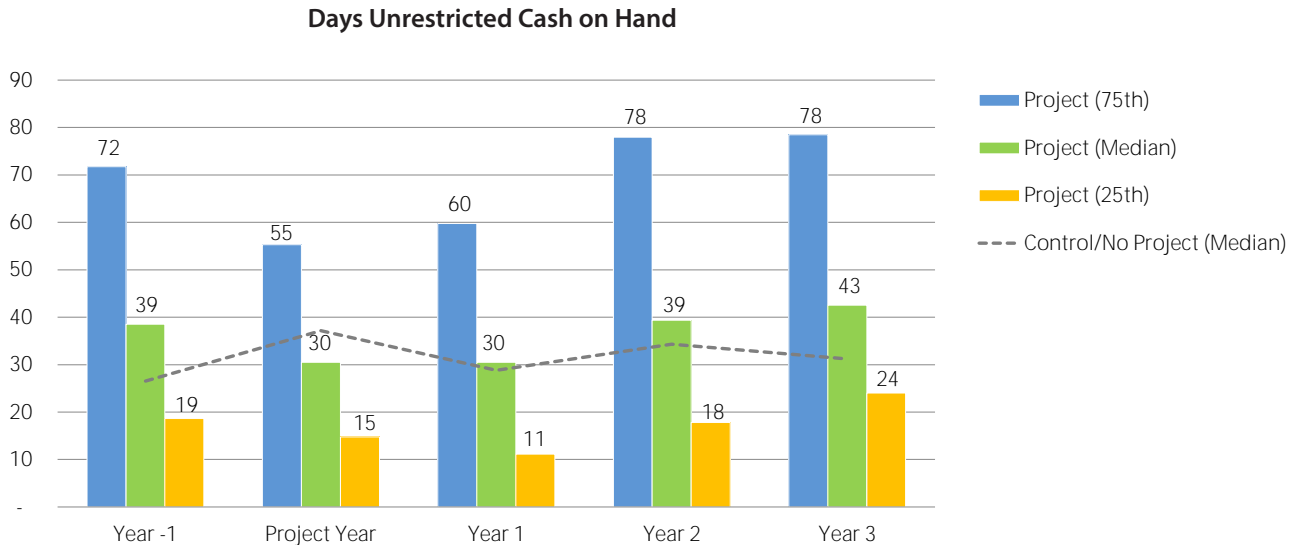
### *Impact on Liquidity: Days Cash on Hand*

(Total Unrestricted Cash and Investments / Daily Operating Expenses)

Days cash on hand is a liquidity measure that represents the number of days an organization could cover its daily cash operating expenses with its current level of cash and investments in the event all cash inflows ceased. For this measure higher is better, although a reasonable range for health centers is between 30 and 60 days cash on hand.

The median health center that completed a capital project lost about 10 days cash on hand during the project year. The project completion year was the most cash-consuming time for any capital project as health centers bridged pre-development costs and/or used their reserves as a funding source, at the same time that the operating margin began its temporary drop. Cash levels appeared to take about two years to recover fully (by Year 2) as operations stabilized and ended up slightly higher than before the project by Year 3. In any quartile, health centers followed the same trajectory of a reduction in days cash on hand in the project year, followed by a rebounding that left them with a slightly higher level of days cash on hand than before they began the project. This rebound to better-than pre-project levels of cash occurred the most

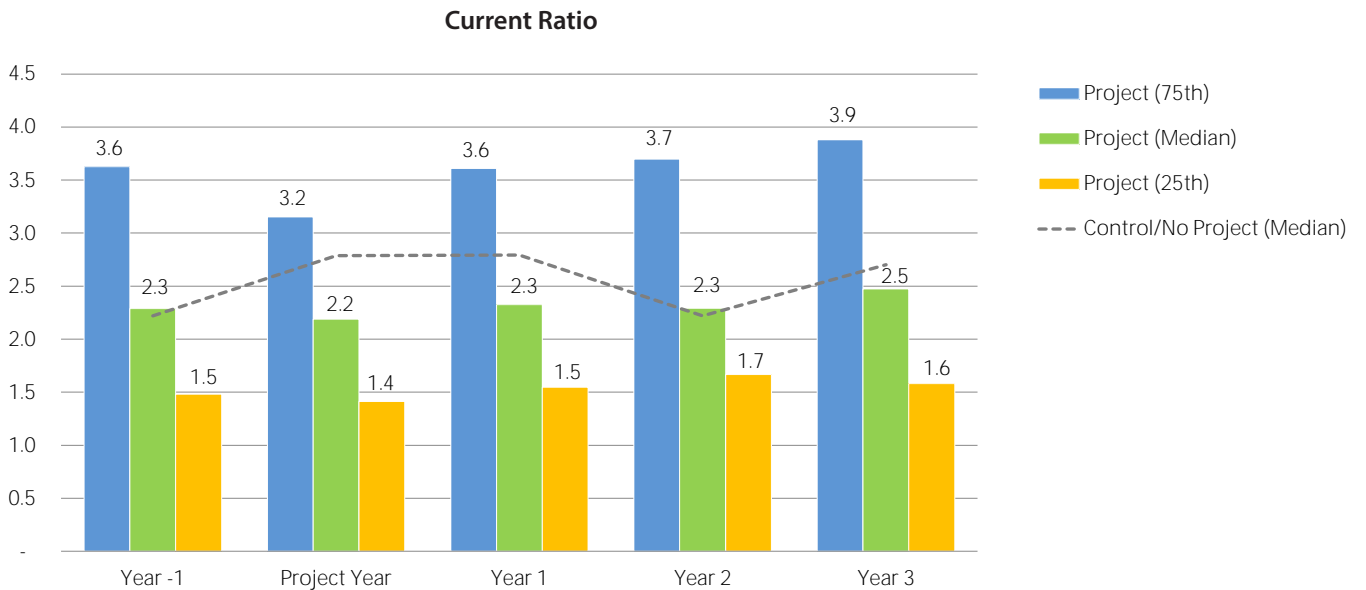
quickly and at the greatest volume of days cash on hand for projects in the 75<sup>th</sup> percentile. Health centers in the 25<sup>th</sup> percentile took on a capital project with cash levels that were below recommended cash level of at least 30-to-60 days cash on hand, but recovered closer to the suggested minimum by Year 3.



**Impact on Liquidity: Current Ratio**

(Current Assets ÷ Current Liabilities)

The current ratio measures an organization’s ability to meet its current obligations (due within one year) with its current assets (i.e. cash, receivables, and other assets that could be converted to cash within one year). The chart below indicates that a health center’s current position was largely unaffected by capital projects, as this ratio stayed quite level for the median health center in the project group. The 75<sup>th</sup> percentile had the most pronounced decline in the project year; this quartile was most likely self-funding their projects with more cash given their healthy current position prior to the start of the project.

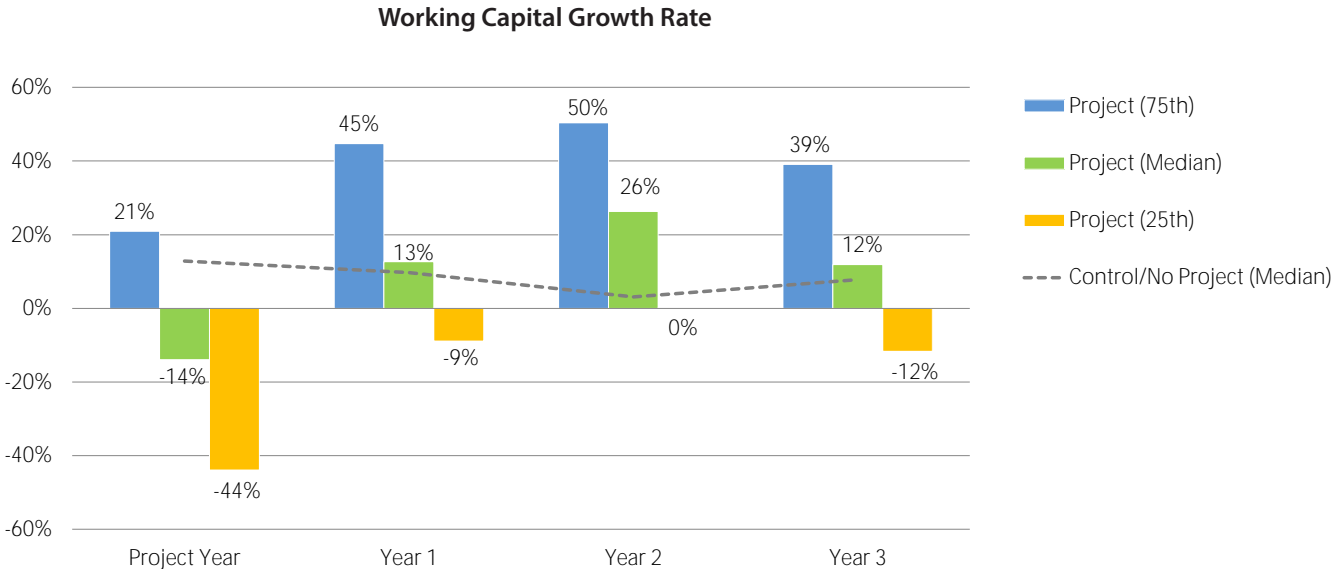


In all quartiles as well as in health centers not taking on capital projects, the current ratio remained well-above the recommended minimum of 1.25.

**Impact on Liquidity: Working Capital Growth**

(Year-over-year change in Working Capital, which is defined as: Current Assets - Current Liabilities)

The chart below delineates the trend in the growth rate of health center working capital throughout the project period. Because working capital growth rate is a year-over-year calculation, the first year of data available is for the project year (unlike the financial ratio charts that also capture Year -1, the year prior to project completion). Working capital is a measure of a health center’s short-term financial health and ability to cover short-term obligations, so growth in this measure is good for the organization.



At the median, health centers experienced one year in which working capital shrank: the project year, while working capital growth for the control group was fairly consistent throughout the period, ranging between 5% and 10%. The drop in working capital for the project group was most likely driven by the drop in cash as health centers self-financed portions of their project. This result was demonstrated in the days cash on hand trend, as well as additional analysis of the data set that concluded that there was little fluctuation in payables or receivables. In all other years, working capital grew at a healthy pace for the median and 75<sup>th</sup> percentiles, but peaked for all quartiles in Year 2.

In the project year, health centers in the 25<sup>th</sup> percentile experienced a dramatic drop in working capital, which continued to shrink in Year 1. Analysis of data available for the 25<sup>th</sup> percentile for Year -1 indicated that this group had slightly shrinking working capital even before taking on a capital project.<sup>5</sup> One conclusion that can be drawn from the 25<sup>th</sup> percentile is that capital projects exacerbate any existing

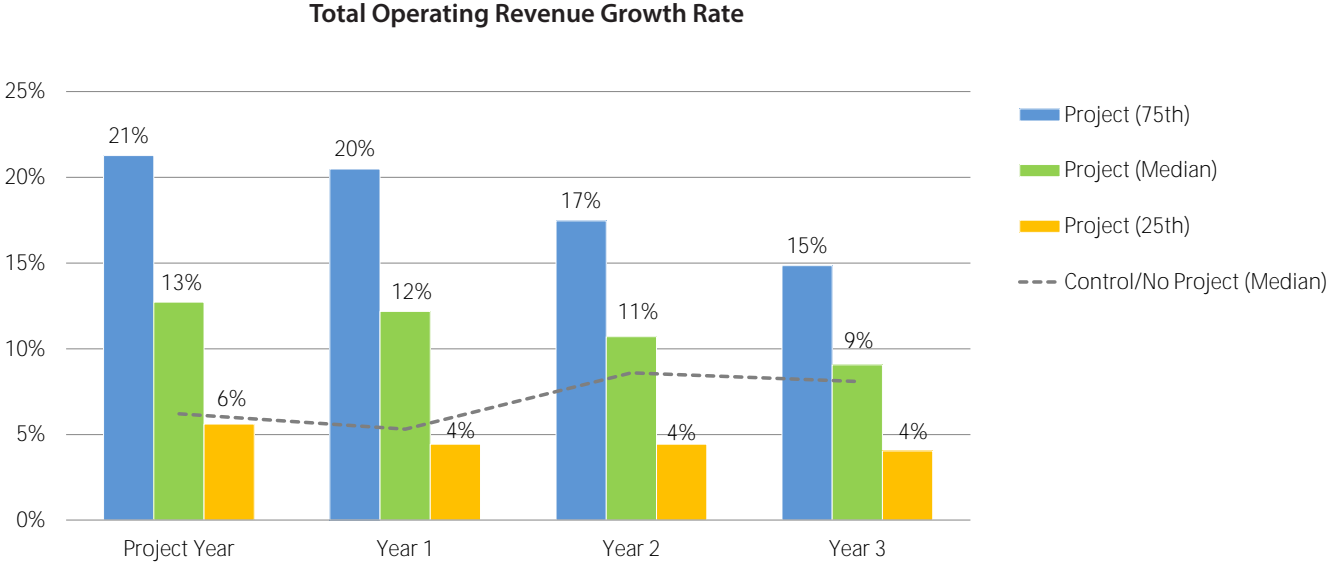
<sup>5</sup>Data available for Year -2, or two years before the project year, represented audits for 79% of the 118 projects. Year -2 data allowed us to view the year-over-year growth rate for Year -1 for the majority of the health centers in the project group.

weaknesses. Health centers in this percentile saw the largest drops in working capital growth, and the least recovery in growth rate, reaching zero change in Year 2 before turning negative again in Year 3.

**Impact on Revenue Growth: Total Operating Revenue**

As discussed in the first installment of this series, *Financial and Operational Ratios and Trends of Community Health Centers, 2008 – 2011*, health centers experienced rapid operating revenue growth between 2009 and 2011, driven in part by multiple operating grant application cycles from the Health Resources and Services Administration (HRSA) during this period.

Between 2009 and 2010, HRSA administered several rounds of New Access Point and Increased Demand for Services funding opportunities through the American Recovery and Reinvestment Act (ARRA). In addition, the Affordable Care Act (ACA) that was passed in 2010 included \$9.5 billion in operating grants for Section 330 health centers over a period of five years. Many of the health centers (39%) in the control group and the project group (59%) had a five-year review period that overlapped with the timing of these grant funds, which largely explains the jump in total operating revenue growth the control group experienced in Years 2 and 3 as the large HRSA operating grants were awarded.<sup>6</sup> This effect is also demonstrated in the grant and contract revenue growth chart presented later in this report.



Despite the increased grant revenue most health centers in this study received in at least some years, revenue growth for the median health center was much higher in the project group than in the control group. For the median health center there was a clear peak in the project year (12.7% growth) as well as another year of strong growth in Year 1 (12.2%) for total operating revenue, followed by a period of steady

<sup>6</sup>It should be noted that HRSA also awarded a total of \$3 billion in capital grants to health centers between 2009 and 2011. However, given that this report analyzes projects completed between 2004 and 2008, before the grants were released, the impact of these capital grants will not be seen in the project group analyzed.

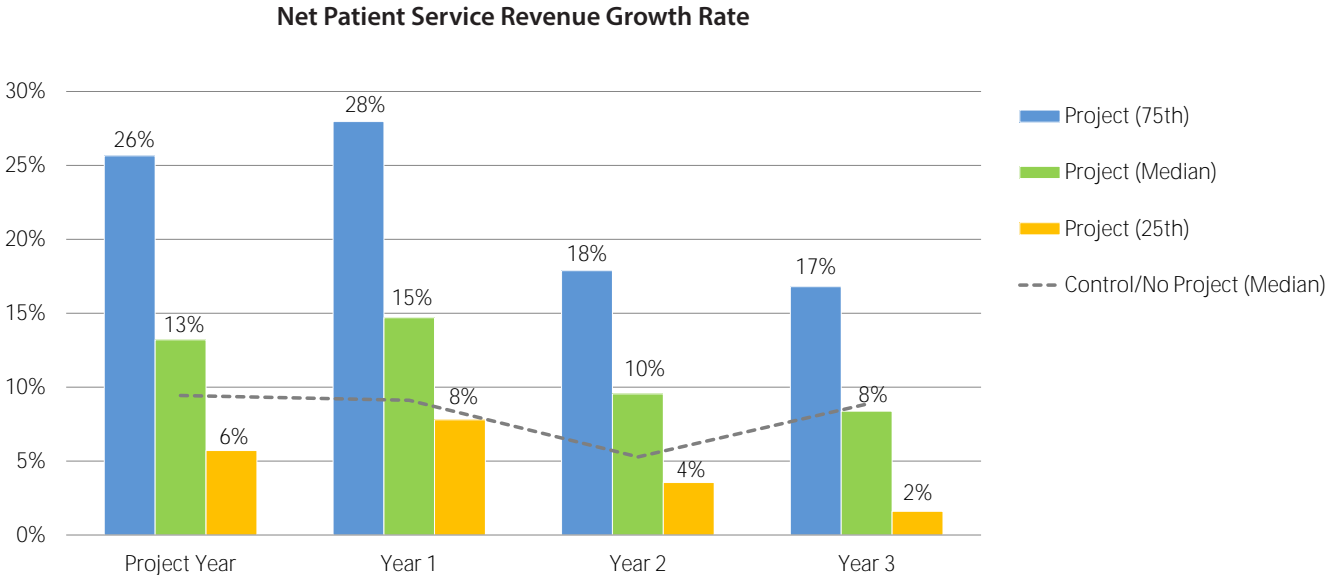
if slightly smaller growth. Health centers in the 75<sup>th</sup> percentile exceeded 20% revenue growth in the first two years of the project period.

Health centers at the 25<sup>th</sup> percentile for this measure experienced growth that was less than that of the control group. It is possible that the 25<sup>th</sup> percentile projects were not focused on adding visit capacity, but rather on projects that either replaced existing square footage or added administrative or other non-revenue-generating space.

*Impact on Revenue Growth: Net Patient Service Revenue*

The following chart depicts the growth rate of health center net patient service revenue (NPSR) for health centers with and without capital projects. For the typical health center, NPSR comprises approximately 60% of total operating revenue. As such, it is not surprising that it showed a similar if more dramatic growth pattern as total revenue for the median health center, with 13.2% growth in the project year and 14.7% growth in Year 1. NPSR can be considered a proxy for visits as it represents Medicare, Medicaid, insurer, and patient payments for services provided. As will be further discussed in the next section that discusses the impact of capital projects on operations, patient and visit growth also peaked in Year 1.

NPSR growth showed a leveling off in Year 3 for the median project health center and an increase in growth rate for the control group. These results were likely influenced by the boost in the aforementioned operating grants that happened in Years 2 and 3 for many of the control and project health centers in the study group. Operating grants often help health centers add provider staff, thereby boosting earned revenue in the form of NPSR.

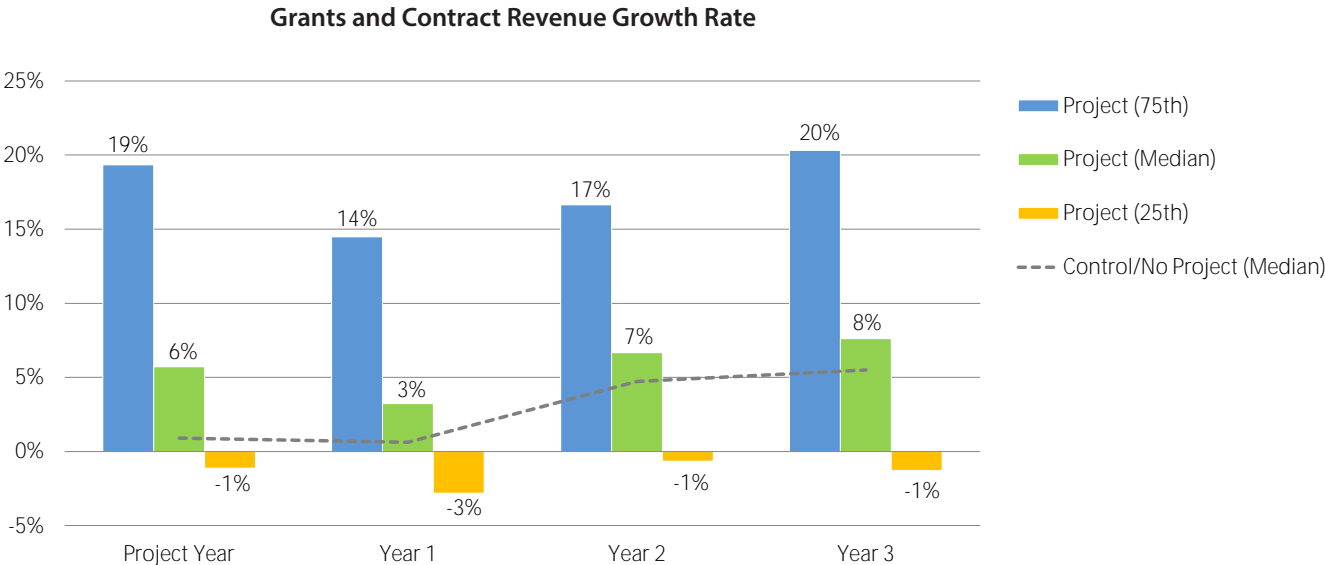


As mentioned in the total operating revenue discussion above, the 25<sup>th</sup> percentile might have represented projects that were primarily replacement projects and/or administrative facility projects that did not add

capacity to serve more patients. In contrast, the 75<sup>th</sup> percentile experienced tremendous growth in NPSR, above 25% in the first two project years.

**Impact on Revenue Growth: Grants and Contracts Revenue**

The chart below provides additional detail on another major component of health center operating revenue, grants and contracts, which typically comprise 30% of health center revenues (although grants and contracts peaked at 37% of total operating revenue in 2010 due to the roll out of the HRSA grant programs). The typical health center that completed a capital project peaked at 5.7% grant and contract revenue growth in the project year. Much of this growth was likely fueled by New Access Point or Change in Scope grants provided by HRSA for health centers planning to increase medical capacity. These are ongoing grants for new sites and expansion projects that are above and beyond 2009 and 2010 ARRA-related grants. These grant awards typically range between \$400,000 and \$700,000 per year, and occur on an ongoing, annual basis once they are awarded.

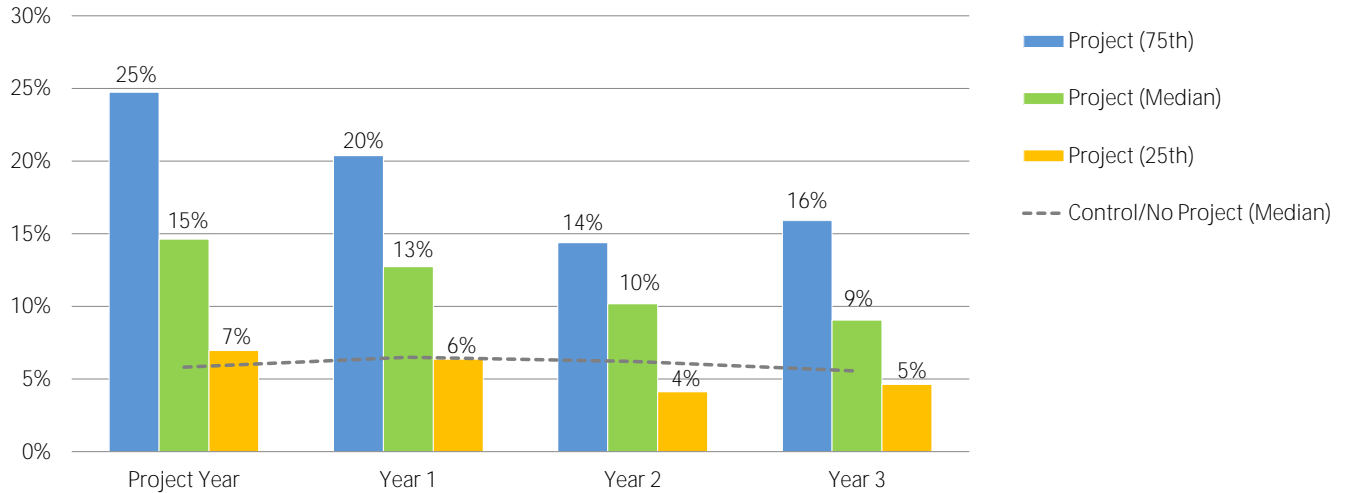


Following the project year, the median health center’s pattern of grant and contract growth began to look more like that of the control group, although it always grew at a slightly higher rate.

**Impact on Expense Growth: Total Operating Expenses**

Similar to total operating revenue, there was a clear peak in operating expense growth during the project year, with a growth rate of nearly 15% for the median health center. Available data for the growth rate as of Year -1 (not included in the below chart) also suggests that health centers taking on projects were already growing more quickly than health centers not completing projects. However, it is clear that the control group grew only modestly, with 5%-to-6% growth in any given year. At the median, total operating expenses for health centers with capital projects grew by a total of 47% over the review period, compared to health centers without projects, which experienced total growth of 24% from Year -1 to Year 3.

### Operating Expense Growth Rate

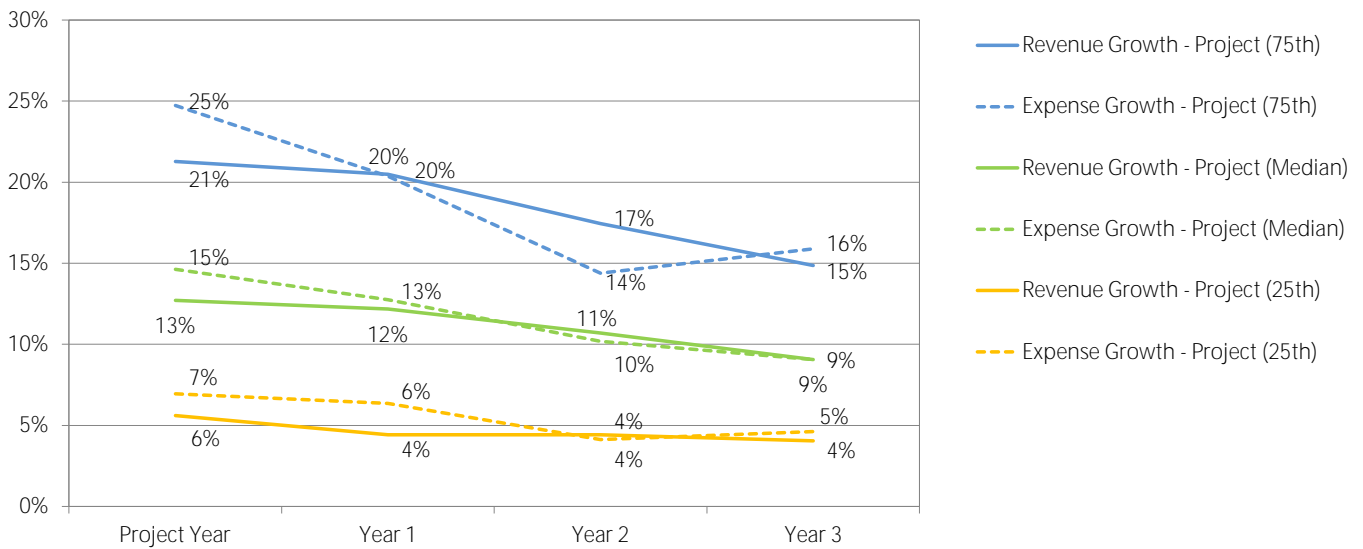


The primary drivers of expense growth for health centers that completed capital projects were personnel-related expenses and building-related expenses, both discussed in a later section.

### Capital Project Impact on Operations: Revenue and Expense Growth Compared

The chart below compares operating revenue and operating expense growth for the 75<sup>th</sup> percentile, median, and 25<sup>th</sup> percentile within the group of health centers that completed a capital project during the review period.

#### Revenue and Expense Growth Rates: Health Centers with Capital Projects



Projects in each quartile demonstrated the same pattern of expense growth outpacing revenue growth through Year 1 before the trend reversed. The sustained period in which expenses grew more rapidly than revenues caused the operating margin to hit its lowest point in Year 1. The more quickly a health center completing a capital project can reverse this trend and accelerate revenue growth, the sooner it will return to greater profitability.

By Year 3, revenue and expense growth are quite similar for the median health center (with 9.1% growth for both), while expense growth appears to slightly outpace revenue growth for both the 25<sup>th</sup> and 75<sup>th</sup> percentile health centers.

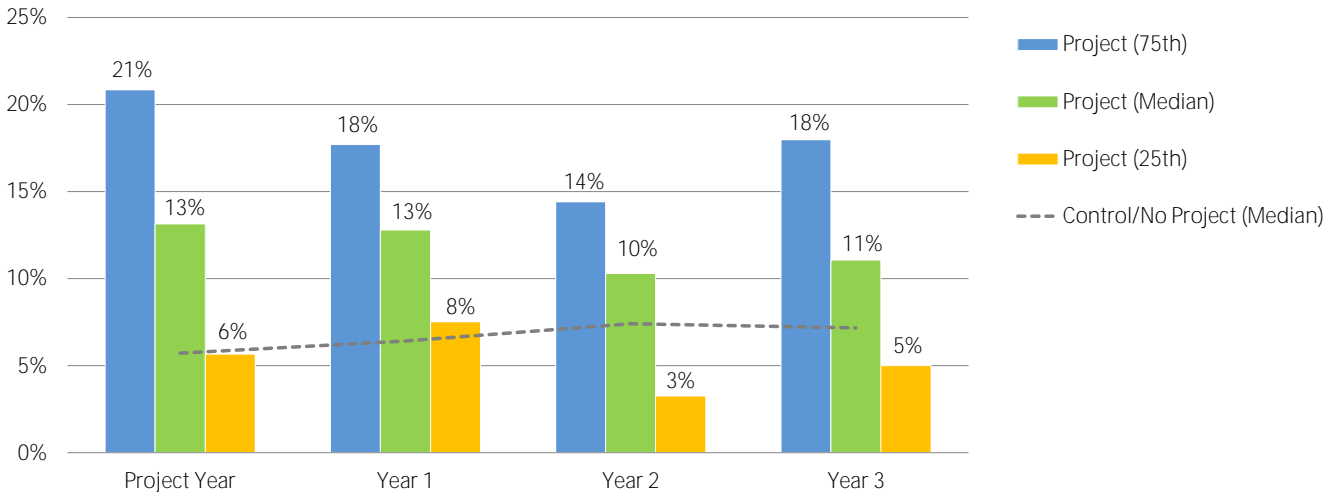
The charts below explore the primary drivers of total operating expenses, staffing, and building expenses.

*Staffing Trends: Personnel Expense Growth*

Comprising approximately 70% of all health center expenses, personnel expenses are a major expense driver and accounted for much of the growth in expenses for health centers completing capital projects. As health centers expand their medical capacity with capital projects, a necessary and substantial expense is adding providers and supporting staff.

At the median, personnel expense (which includes staff salaries, benefits, and contracted personnel), grew by 13.1% in the project year and 12.8% in Year 1. Personnel expense continued to grow more than the control group in Years 2 and 3, suggesting that there is a sustained hiring effort that does not stop once the doors open. Primary care provider recruitment can be a major challenge for health centers as they staff up for a capital project, particularly in rural areas. This challenge helps explain why some health centers at the median and 75<sup>th</sup> percentiles experienced continued growth in staffing, since many health centers hired providers and their associated support staff as they were able to recruit them.

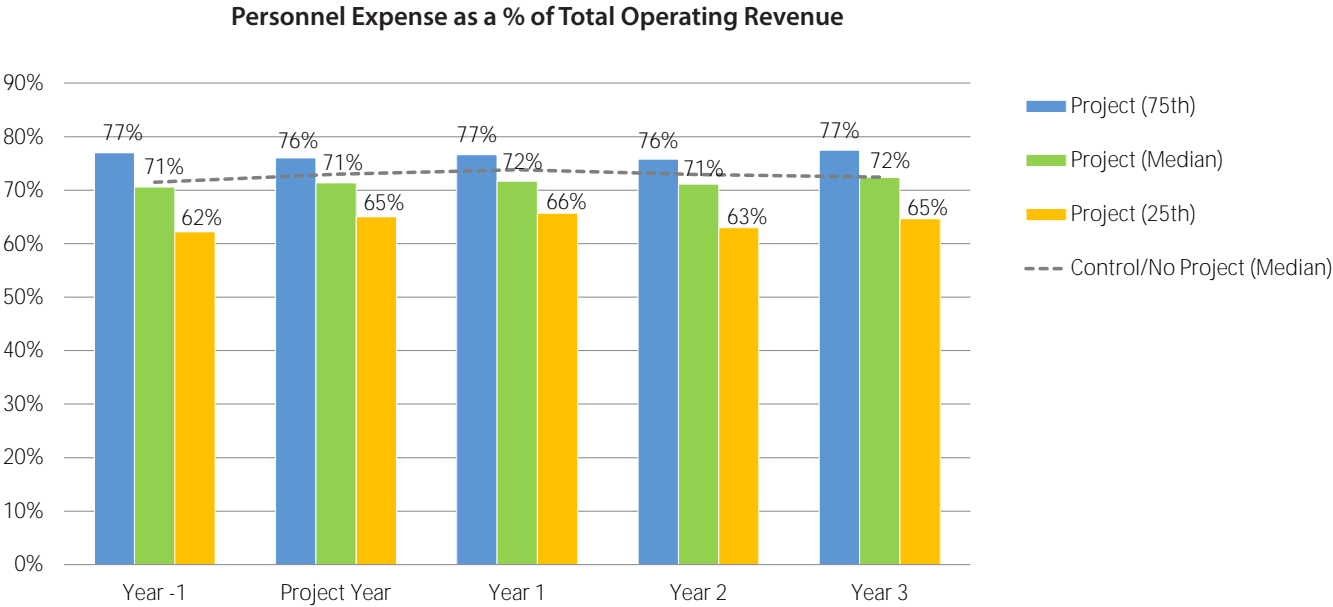
**Personnel Expense Growth Rate**



As mentioned earlier, more than half of the projects studied were completed in 2007 and 2008, so it is possible that the second small wave of staffing expense growth in Year 3 was fueled by the large wave of HRSA operating grants that occurred during 2009 and 2010. However, during Year 2 many health centers go through a period of retooling and reevaluation of operations in their new buildings. This post move-in retooling is typically followed by some additional hires in Year 3 following the reevaluation process.

*Staffing Trends: Personnel Expense as a Percentage of Total Operating Revenue*

The chart below demonstrates that the median health center that completed a capital project stayed within the recommended range of 70% to 75% for personnel expense as a proportion of total operating revenue.



Unlike most of the measures in this report, the 75<sup>th</sup> percentile category in this case most likely represents the weaker organizations, as having high personnel expenses as a proportion of total revenue typically correlates with lower profitability. However, it should be noted that many health centers are compelled to pay their medical providers competitively, as provider recruitment/retention is a looming issue that is out of a health center’s control if they want to reduce staff turnover (which in turn has a negative effect on productivity). Enhanced provider salaries result in a higher personnel expense as a proportion of total operating revenue.

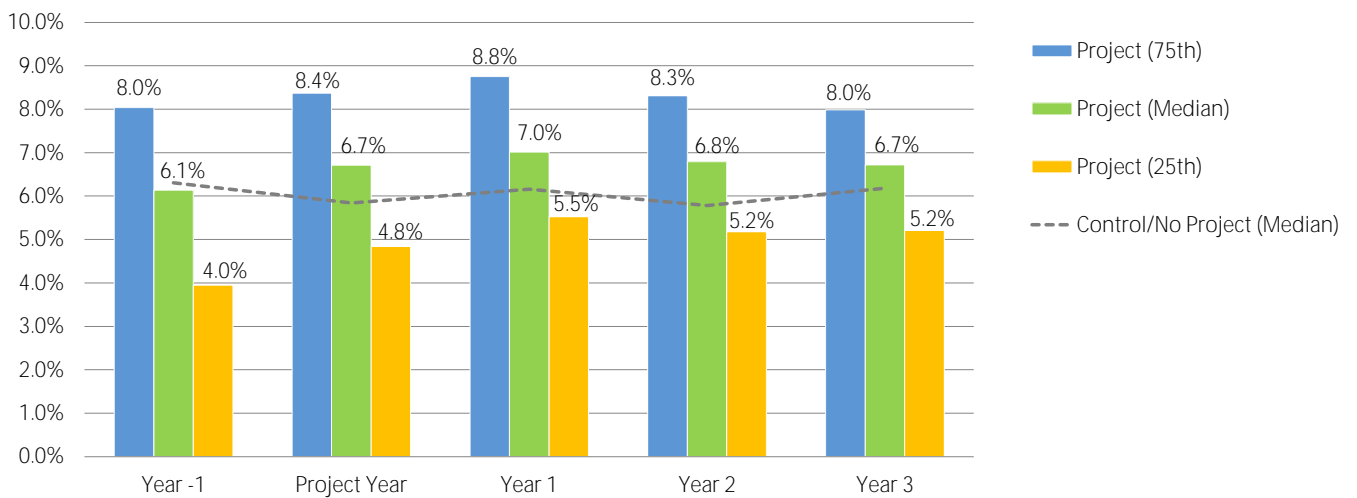
At the median, health centers with and without capital projects remained relatively stable throughout the project period with their staffing cost structures. Both the project and control groups had a small increase in Year 3; this increase was likely due to an overall decrease in productivity that has been occurring across the health center sector, discussed in *Issue 1* of this series as well as later in this report. At the 25<sup>th</sup> percentile, health centers saw greater fluctuations in personnel expense as a proportion of total operating revenue; this result may have been more influenced by fluctuations in revenue than in staffing, but further investigation is warranted.

## Impact on Profitability and Capital Structure: Building-Related Expenses as a Proportion of Total Operating Revenue

$(\text{Rent} + \text{Utilities and Maintenance} + \text{Depreciation}) / \text{Total Operating Revenue}$

Although a much smaller percentage of total revenue, building-related expenses grew even more rapidly than personnel expense, increasing by 19% in the project year, compared to 13% for personnel-related expenses. The chart below provides detail on building-related expenses as a proportion of total operating revenue. As a percent of revenue, building-related expenses comprised approximately 6% of total operating revenue in the year prior to project completion for the median health center. As depreciation and increased utilities and maintenance expenses were introduced to the income statement for at least part of the fiscal year in the project year, and then in full in Year 1, building-related expenses grew to become 7% of total operating revenue. As depreciation and increased utilities and maintenance expenses were introduced to the income statement for at least part of the fiscal year in the project year, and then in full in Year 1, building-related expenses grew to become 7% of total operating revenue.

**Building-Related Expenses as a % of Total Operating Revenue**



As mentioned in the operating margin discussion, between the pre-project year (Year -1) and Year 2 the median health center experienced a decrease to the operating margin of about 1 percentage point as new costs (such as personnel, interest, and building expenses) affected the income statement. While it is tempting to first look to operational efficiency as an explanation for the change in profitability, it should be noted that increased building-related expenses, particularly depreciation, also play a major role in the operating margin trend described earlier in this report.

## Impact to Balance Sheet: Leverage

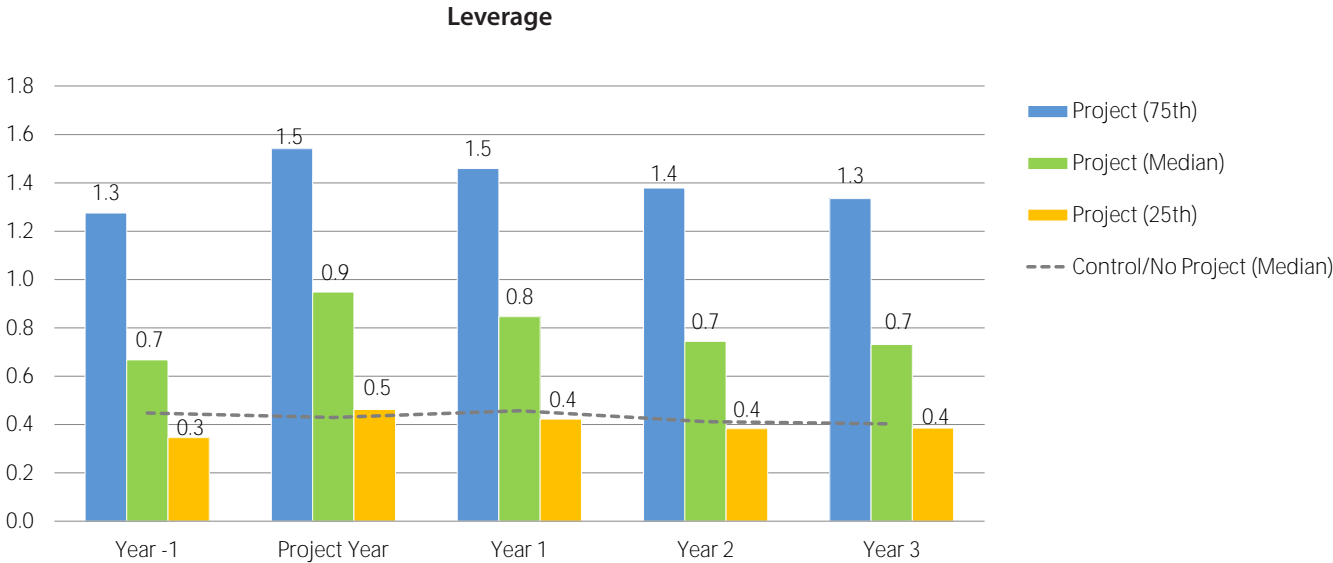
$(\text{Total Liabilities} / \text{Total Net Assets})$

A later section in this report includes the finding that 70% of capital projects in the study group utilized at least some amount of debt to finance their capital projects. This helps explain the trend in leverage demonstrated in the chart below. The leverage ratio measures an organization's total liabilities as compared

to its total net worth, and reflects how an organization is financing its assets – either with debt, its net assets, or a combination of both. The lower this ratio, the less leverage it is using and the less risk it is assuming. This leverage is mainly in the form of debt, but occasionally health centers also finance their operations by lengthening payables and other current liabilities.

All organizations in the project group remained within the recommended range of 1.0 to 3.0 for leverage. For the typical health center at the median, leverage did increase but only modestly, from 0.7 in Year -1 to 0.95 in the project year, before slowly declining again to close to pre-project levels by Year 2 (0.74). Projects at the 75<sup>th</sup> percentile showed the same 0.3-point increase in leverage as health centers at the median. In contrast, health centers with projects in the 25<sup>th</sup> percentile for leverage showed a 0.2-point change, suggesting that less debt was utilized as a funding source for the projects.

The results in the below chart suggest that by and large, health centers are utilizing debt at an appropriate level that creates only a temporary, modest increase in leverage, never exceeding or even approaching the suggested maximum of 3.0, even at the 75<sup>th</sup> percentile.



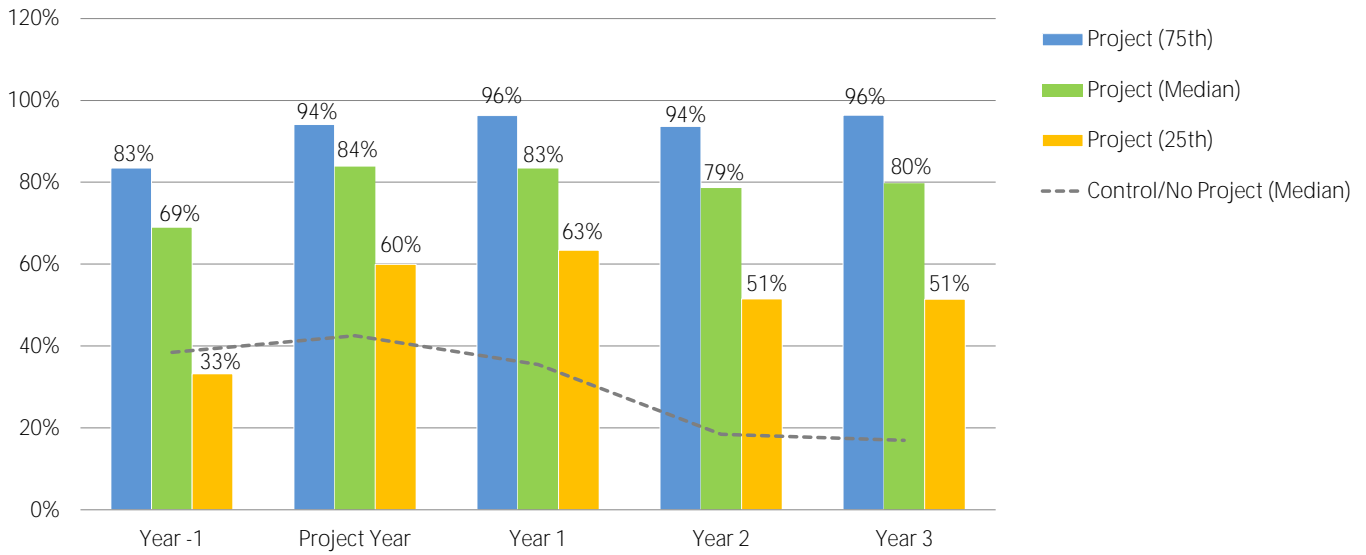
**Impact to Balance Sheet: Debt to Capitalization**

$$\text{Total LT Debt} / (\text{Total LT Debt} + \text{Total Net Assets})$$

Reported debt in the charts below includes short- and long-term loans, lines of credit, and/or long-term capital leases, although some charts only include long-term debt.

Debt to capitalization is another measure of an organization’s financial leverage, or how it is financing its operations (including capital investment). It measures the long-term debt component of an organization’s capital structure or financial capitalization (long-term debt plus net assets). A lower ratio indicates an organization with a lower debt burden relative to its capital structure; like the leverage ratio above, the lower the debt to financial capitalization, the lower the risk.

### Debt to Capitalization



Based on the chart above, it is clear that health centers with capital projects experienced a change in their capital structure in the project year. At the median, health centers went from a debt capitalization of 69% to a debt capitalization of 84%. Health centers with the highest debt to capitalization to begin with had the least increase in this ratio during the project period.

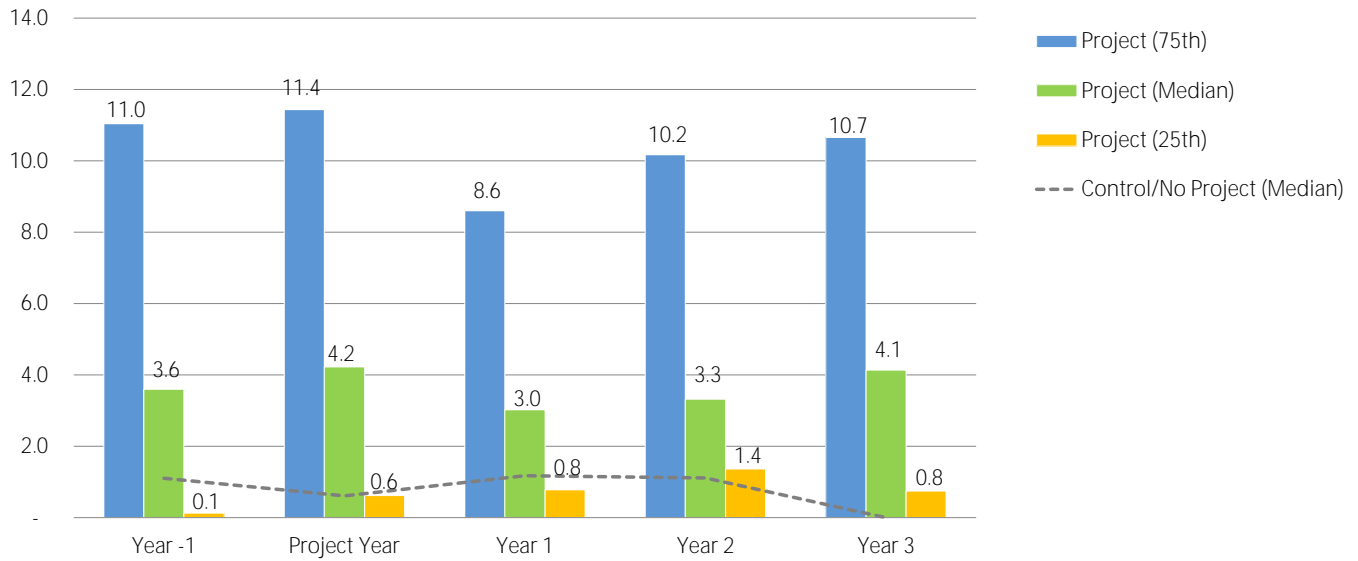
### *Other Debt-Related Ratios: Debt Service Coverage Ratio, Operations*

$$\frac{(\text{Operating Change in Net Assets} + \text{Depreciation Expense} + \text{Interest Expense})}{(\text{Current Maturities of Long-Term Debt} + \text{Current Capital Lease Payments} + \text{Interest Expense})}$$

Debt service coverage ratio (DSCR) measures an organization's ability to pay its existing debts, including principal and interest payments due within the next year. The above calculation for DSCR utilized the operating change in net assets rather than the total change in net assets; this approach is used in order to focus on ongoing sources of cash earnings available for debt service, rather than including possible one-time, non-operating sources.

The typical, median health center taking on a capital project began the project period with DSCR of 3.6, indicating that its debt service due in the current period could be met 3.6 times and reflects ample cash earnings to service existing debt (and/or minimal debt service). This measure hit its lowest point in Year 1, which is not surprising given how closely tied DSCR is to the operating change in net assets, which was also lowest in Year 1. It took two years for DSCR to fully recover to greater than pre-project levels. Health centers at and above the 50<sup>th</sup> percentile had more than adequate earnings to service debt in all years, while the 25<sup>th</sup> percentile, as well as the control group in some years, reported very low DSCR, indicating that cash earnings were insufficient to service debt levels.

### Debt Service Coverage Ratio, Operating Only



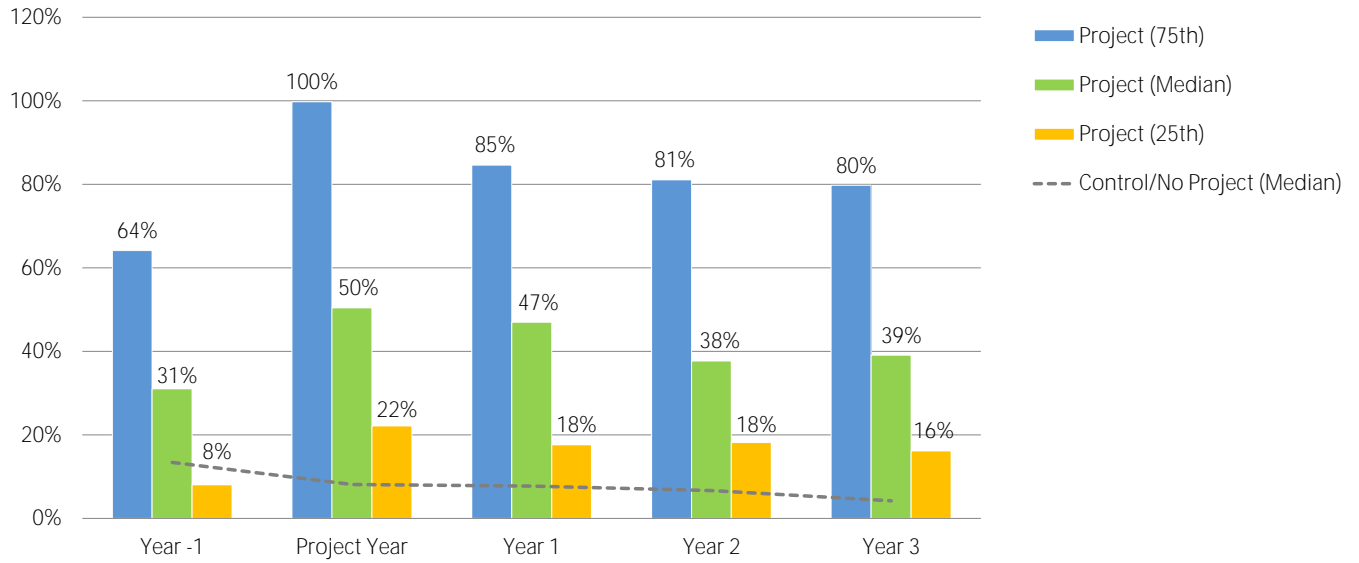
### Other Debt-Related Ratios: Debt to Earnings Before Interest, Depreciation, and Amortization (EBIDA)

$(\text{Total Debt}) / \text{Total Change in Net Assets} + \text{Depreciation Expense} + \text{Interest Expense}$

The debt to EBIDA ratio helps compare an organization’s total debt amount to its actual annual cash earnings and indicates the length of time it would take to pay off all debt, assuming no additional inflows or outflows of cash. The chart indicates that this measure peaked in the project year, as the typical health center with a capital project takes on at least some measure of additional debt.

At the median, health centers that completed capital projects saw only a modest increase in debt/EBIDA. In the project year debt/EBIDA was 50% for the median project, indicating that the health center could pay off its entire debt with approximately half a year’s earnings. The fact that all quartiles reported at or below 100% in all years despite undertaking a capital project indicates that health centers had sufficient cash flow to repay debt (or limited debt), and suggests that health centers were using debt in a responsible manner to finance their capital projects.

### Debt/EBIDA

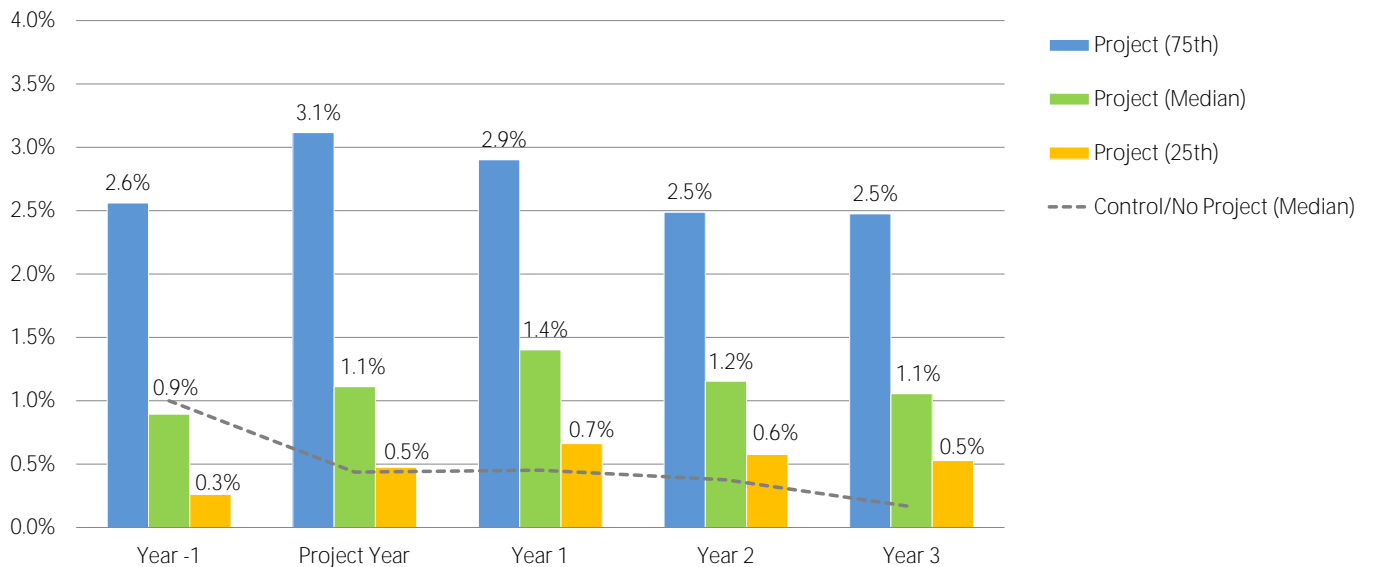


### Other Debt-Related Ratios: Debt Service to Total Operating Revenue

(Annual Debt Service / Annual Operating Revenue)

The debt service to total operating revenue ratio indicates the relative burden of debt service (interest, principal, and capital lease payments) to operating revenues on an annual basis. Lower percentages indicate more room for variances in operating results. As such, it is another ratio used to gauge financial stability and solvency. In all years studied and in all quartiles, health centers reported extremely low percentiles on this measure. For the median health center, debt service (interest, principal, and capital lease payments) as a proportion of total operating revenue increased modestly from the pre-project year to Year 1, or from 0.9% to 1.4%.

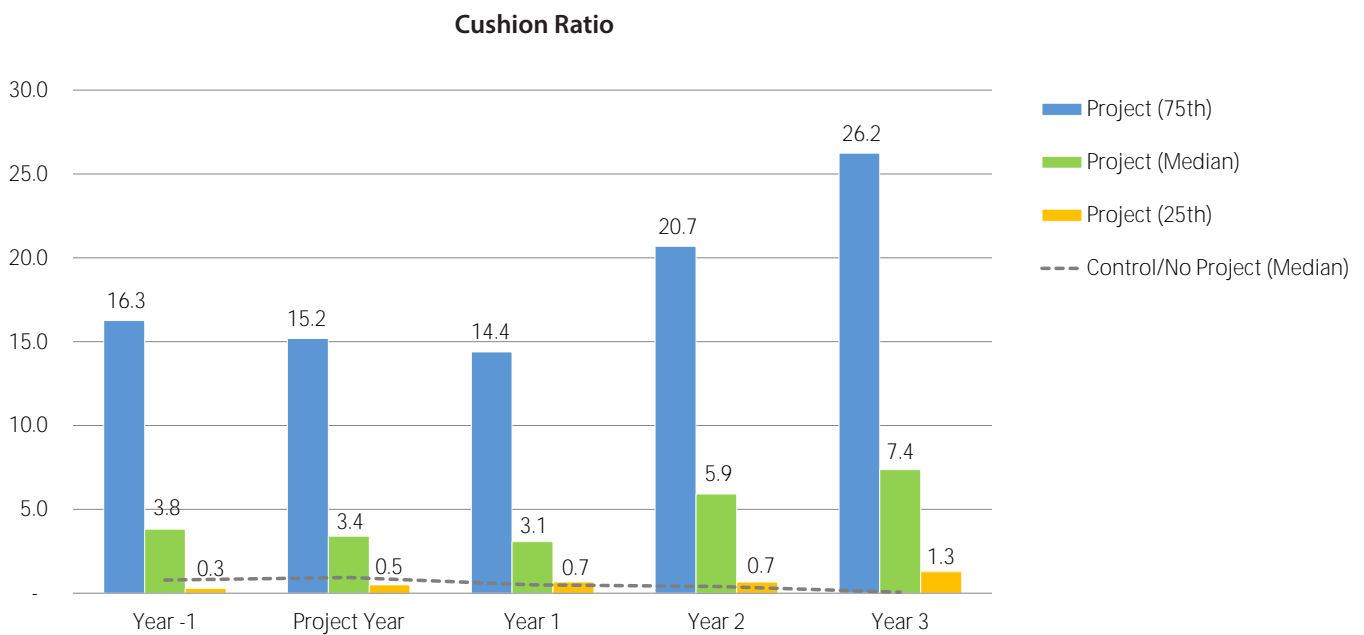
### Debt Service/Total Operating Revenues



### Other Debt-Related Ratios: Cushion Ratio

(Unrestricted Cash and Investments / Debt Service)

A financial “cushion” is the amount of unrestricted cash or other highly liquid assets available to service debt in the event of a short-term liquidity crunch. For the typical health center at the median, this measure remained healthy throughout the project implementation period, reaching its lowest point of 3.1 in Year 1, at which point debt service could be paid three times over with current cash reserves. The cushion ratio nearly doubled by Year 3 as compared to Year -1 for the median health centers. At the 75<sup>th</sup> percentile, health centers with capital projects had even healthier cash reserves as compared to their debt service that only grew stronger in the final two years. However, at and below the 25<sup>th</sup> percentile, health centers reported a much smaller financial cushion that emphasized the tight liquidity position for health centers within this quartile.



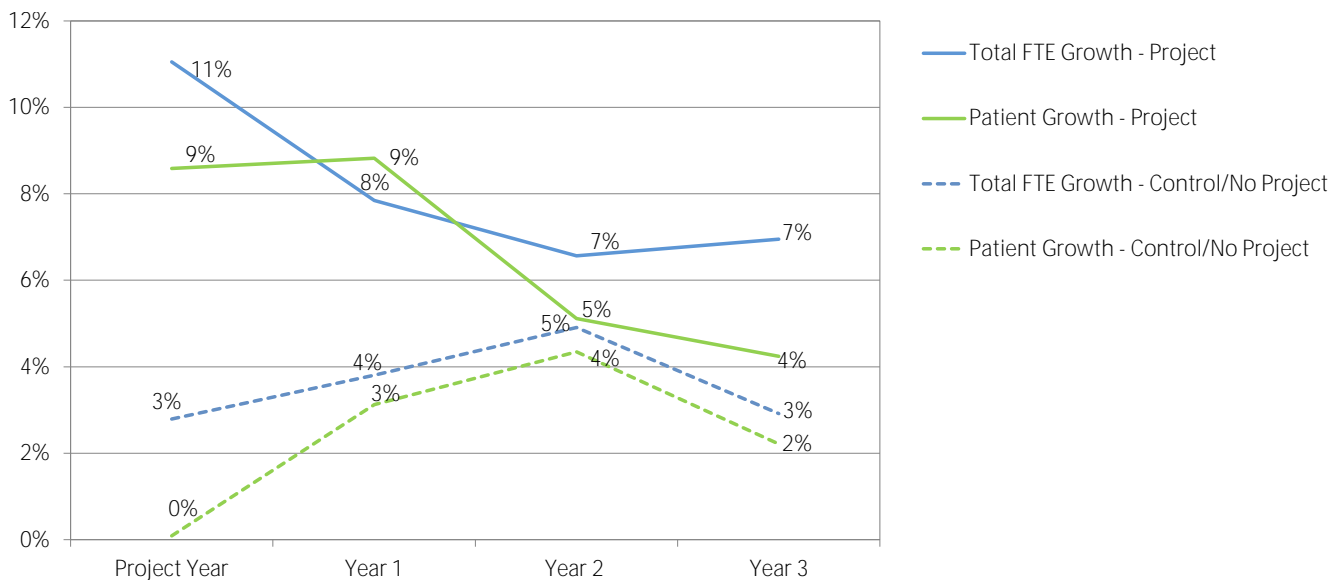
## Section III: Impact of Capital Projects on Community Health Center Operations

This section of the report explores how health center patients, staffing levels, and other operational indicators evolve as health centers complete capital projects. The charts in this section are based upon organization-level UDS data from 108 health centers that had capital projects between 2004 and 2008. This group is a subset of the 118 health centers studied in the financial data analysis section of this report. Similarly, the control group consists of UDS data from 43 organizations, a subset of the 58 studied in the financial analysis. Unlike the median and percentile data reported in the financial analysis, the charts are based on aggregate or average growth; therefore direct comparison of the financial and operational data sets is less conclusive. More information on methodology and limitations is included at the end of this report.

### *Capital Project Implementation: Impact on Patient and Staffing Growth*

The chart below provides an overview of the growth trajectory of patients and staff, the two main drivers of revenue and expenses, respectively. For health centers with capital projects, there was a clear peak in staff growth as defined by total full-time equivalents (FTEs) growth in the project year, as these organizations ramped up their provider and supporting staff to boost capacity. The only year in which patient growth exceeded FTE growth was Year 1.

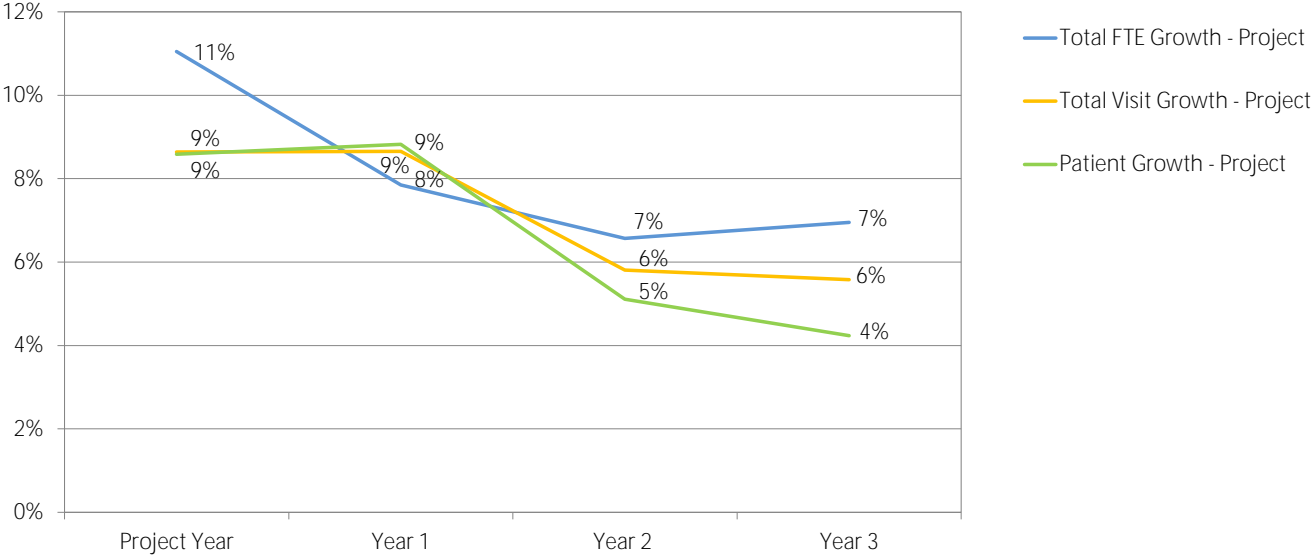
**Total FTE and Total Patients Growth Rate - with and without Capital Projects**



Total staff (FTEs) grew by 11% in the project year. This finding is similar to the project year personnel expense growth of 13% noted in the financial data portion of this report. It is also important to note that health centers taking on projects continued to hire at a more rapid rate than the control group throughout the period of review. In contrast to the clear growth pattern of the project group, health centers without capital projects demonstrated modest, somewhat random growth, averaging at about 2.4% for annual patient growth and 3.6% for FTE growth. It is possible that the control group was able to generate some growth in place, i.e. operational growth without capital expansion, through operating grants, new leases, and facilities reconfigurations. However, growth in the control group was more modest than that of the project group, which averaged 6.7% for annual patient growth and 8.1% for annual FTE growth over the period.

The next chart evaluates the relationship between hiring, patients and the visits that they generate for health centers with capital projects.

**Total FTE, Patient and Visit Growth Rate for Health Centers with Capital Projects**



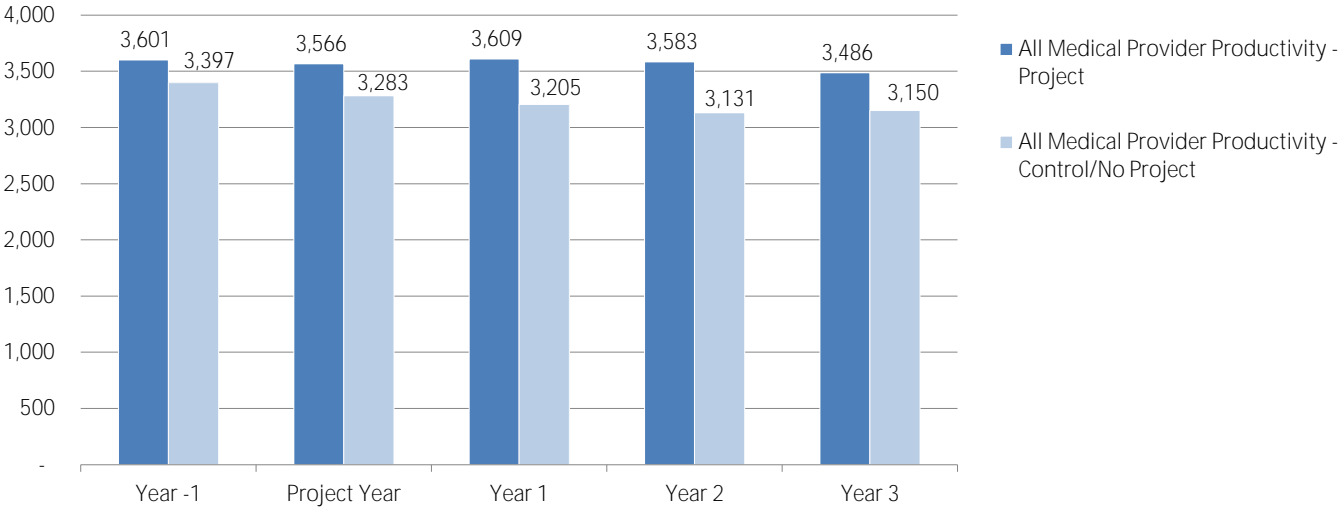
Total patients, visits, and FTEs all grew by similar amounts in the first two years (18% for patients and visits each, and 19% for FTEs), but the growth pattern looks quite different. The total FTE growth rate peaked in the project year, while patients and visits peaked in the first full year after the project. Visits continued to grow more rapidly than patients in later years, indicating that health centers with capital projects were able to deepen their services with existing patients, while also adding new patients. This result is also demonstrated in the utilization discussion later in this section.

FTEs grew more quickly than visits or patients in the final two years; this trend is similar to the control group in all years, although the growth rates of the project group are further apart. It is possible that health centers that completed capital projects were preparing for the next cycle of growth, but the trend of staffing growth outpacing visit growth is worth following into future years to understand how profitability is affected.

*Capital Project Implementation: Impact on Medical Provider Productivity*

Provider productivity can have a major impact on a health center’s income statement, as additional billable visits are produced across the same fixed cost staffing structure. However, as the first issue of the *Community Health Center Financial Perspectives* series noted, provider productivity (billable, medical visits seen by physicians, nurse-practitioners, and physician assistants) has been in decline. Much of this decline is likely tied to the implementation of Electronic Health Records (EHR) systems, which adds time to the visit process, thereby slowing down productivity.<sup>7</sup>

**Provider Productivity (Visits per Provider) with and without Capital Projects**



The above chart demonstrates that all health centers had an overall drop in productivity between Year -1 and Year 3, which was likely influenced by the introduction of EHRs. However, it is of note that capital projects appeared to help stave off some of this productivity drop, with a modest increase to productivity

<sup>7</sup>While the productivity data in this report was calculated on a dataset that is from a longer period of time than the 2008-2011 review period in the first issue of this series, EHR implementation for FQHCs was under way as early as 2003, the first year of the analysis period in this report. Based on analysis by the National Association of Community Health Centers, by 2006 only an estimated 8% of all FQHCs had implemented EHR systems at all sites. By 2012 nearly 80% of all FQHCs had implemented these systems at all sites (and 90% had EHR systems installed in at least one site), indicating a ten-fold growth in EHR adoption in six years (per the 2012 UDS National Roll-up Report).

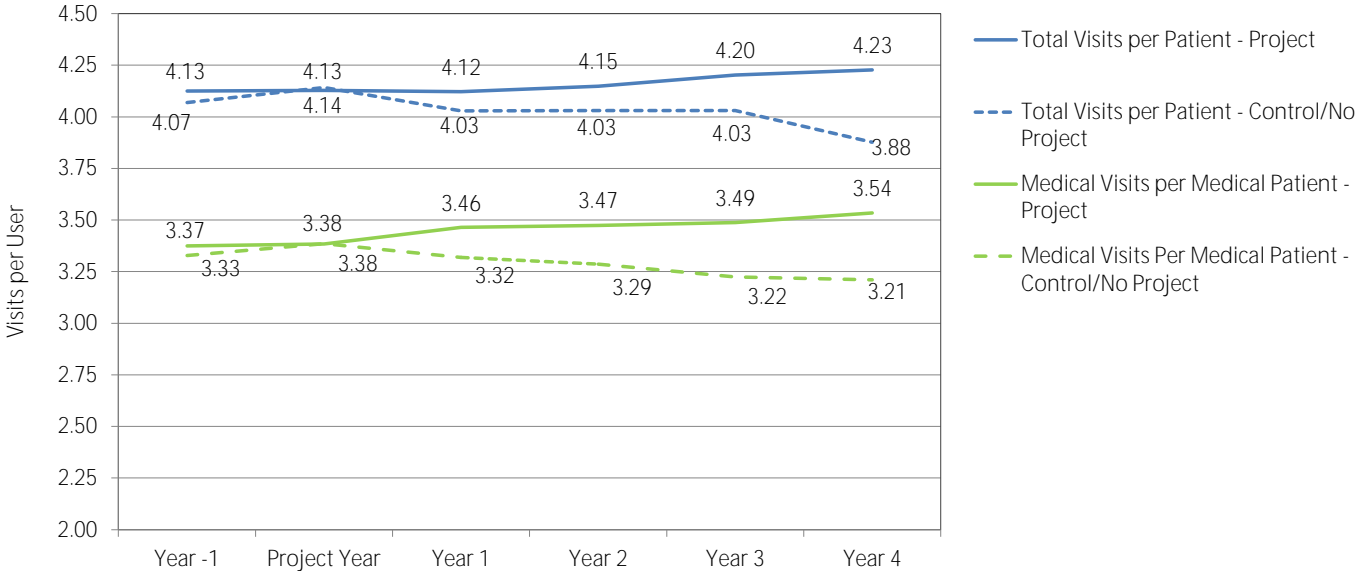
in Year 1 of the project. The Year 1 increase in productivity may be explained by the likelihood that most health centers were moving from inefficient facilities that lacked the ideal ratio of three exam rooms per medical provider, into purpose-built buildings that had ample space for optimal productivity. By Year 2, health centers with capital projects were following the same trend of declining productivity that the control group demonstrated across the period of review, with the exception of a modest increase in Year 3. However, the decline for those with projects was much more modest than for the control health centers, and productivity remained higher than the control group in all years.

**Impact of Capital Projects on Patient Utilization**

(Visits per Patient per Year)

The chart below analyzes how capital projects influence the way patients utilize health center services. Patient utilization is calculated as visits per user in a calendar year, and can be calculated for total visits for all patients, or just for medical patients. As the number of visits per patient increases, the more likely it is that a health center patient’s medical, dental, and mental health needs are being fully met.

**Total and Medical Visits per Patient**



Depending upon service mix and staffing levels, visits per patient will vary widely for any given health center. However, by tracking the same group of organizations over time, a clear trend emerged during the review period showing a divergence between health centers that completed a capital project versus the control group that did not complete a project. While both groups started out with very similar levels of total and medical visits per patient, the project group experienced modest growth in utilization, ending up at 4.23 visits per user in Year 4 up from 4.13 in Year -1, while medical utilization grew from 3.37 to 3.54

over the same timeframe. As a reference, the national average for total visits per patient is 3.96, and 3.31 for medical visits per medical patient, according to the UDS 2012 national roll-up report.

The more notable trend is the visits per user for the control group, which declined from 4.07 in Year -1 to 3.88 by Year 4, and medical visits per user, which declined from 3.33 to 3.21. While health centers with projects began with utilization slightly above the national average, the control organizations shifted from above average to below average over the review period. This result suggests that health centers with projects are not only showing growth in their patient base, but are also able to increase the depth of services they provide to each patient. Further, it is likely that with each successive year, the control group was becoming more limited in their ability to provide all of the visits needed by each patient as they ran out of physical capacity in their existing facilities.

Visits have historically been the primary driver of health center revenue, not patients; however this relationship will likely change with the advent of new payment systems. While health centers are by and large reimbursed on a fee-for-service basis, a shift to global payments may be inevitable in the future,<sup>8</sup> meaning that eventually health centers will be reimbursed based on the number of patients they serve, not their encounters. It is essential to note that when and if this shift happens, visits will go from driving revenue to driving costs, meaning that utilization (and how it is impacted by capital expansion) will be managed from a cost-containment rather than a revenue enhancement perspective. In any case, the findings indicate that health centers with capital projects are not only able to accommodate new patients, but also to deepen their services to existing patients thereby improving the quality of care they are able to provide.

### *Impact of Capital Project Implementation on Service Mix*

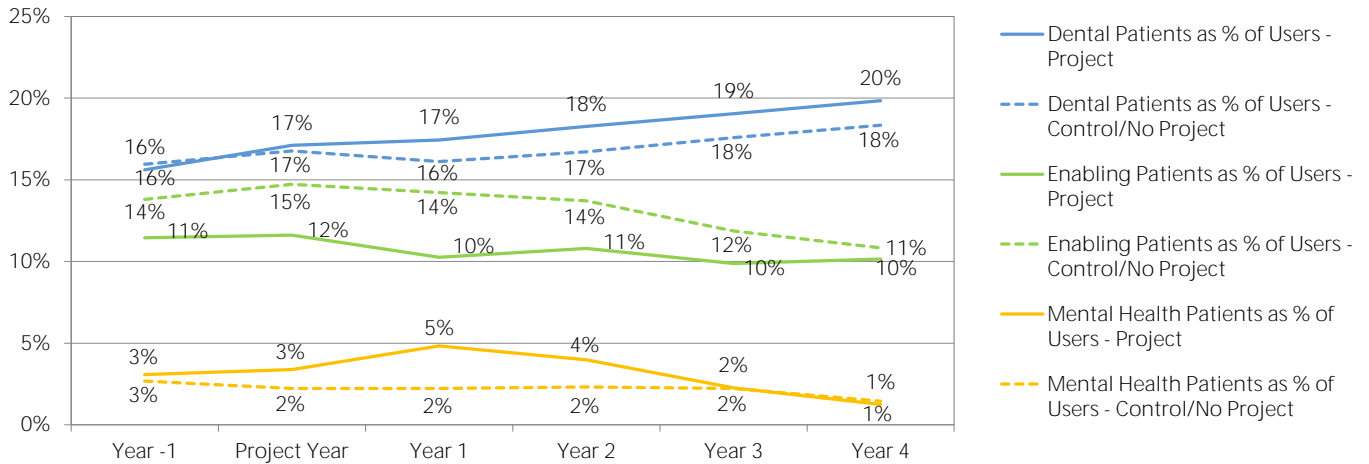
The chart below provides detail on dental, mental health, and enabling patients (defined as patients that utilize enabling services such as case management, financial counseling, and health education classes) as a percent of all patients, or users. For scale and clarity, the proportion of medical patients as a percent of all users has been excluded from this chart. This measure remained between 88% and 86% for both the project and control groups throughout the project period, showing a slight drop as other user groups grew as a proportion of total users, as demonstrated below.<sup>9</sup> The chart indicates that the model of care appeared to stay relatively consistent for health centers with capital projects, although there were more dental patients at the end of the project (20%) period than when they began (16%).

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<sup>8</sup>*A Chat with Dr. Farzad Motashari – Head of ONC* (Office of the National Coordinator for Health Information Technology), Forbes Magazine, September 24, 2013.

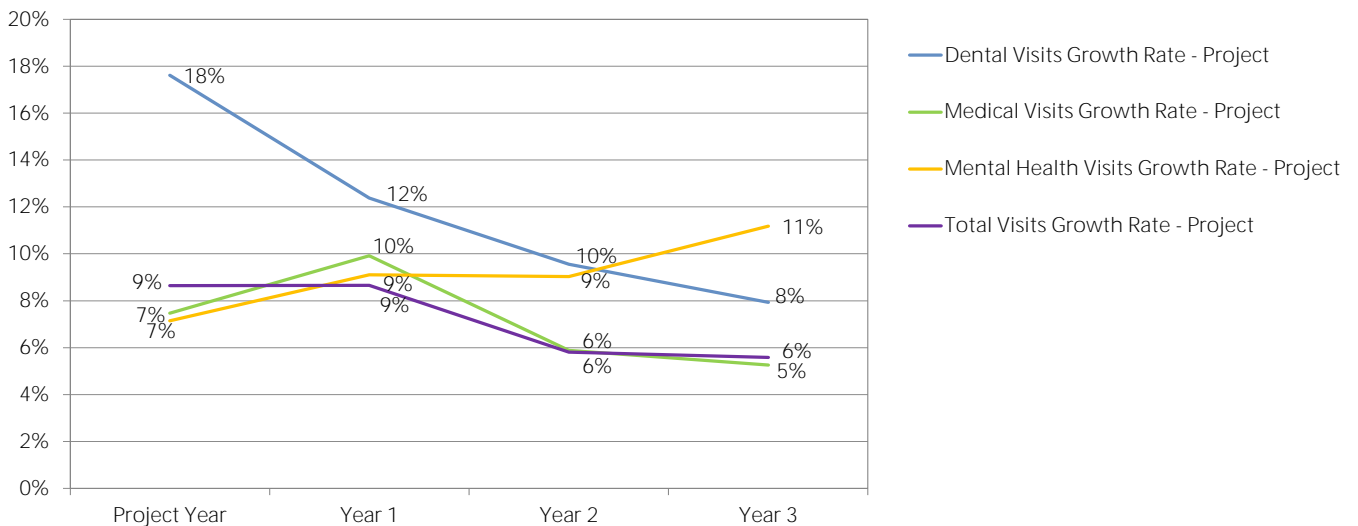
<sup>9</sup>Please note that there is overlap among medical, dental, mental health and enabling patients, such that the proportions add up to more than 100%.

### Service Mix, with and without Projects



While mental health users declined slightly as a proportion of total patients after peaking in Year 1, their visits tell a different story, as indicated in the next chart. This chart depicts the growth pattern for visits, including total visits, as well as medical, dental, and mental health visits. As was noted in *Issue 1* of this series, health centers are continuing to diversify their services, with the highest growth in dental and behavioral health. Dental visit growth was by far the highest over the project period, with nearly 18% growth in the project year that suggests a pent up demand for services. It appears that dental visit growth is a driver behind growth in total visits, exceeding the growth in medical visits (which represent 71% to 72% of total visits in any given year). In contrast, the growth pattern for mental health visits appeared to have less to do with the capital project, particularly in Years 2 and 3 when the growth rate continued to increase. It is likely that mental health visit growth was related more to the general trend of health centers adding behavioral health services as they moved towards a more integrated model of care (formalized by the Patient-Centered Medical Home (PCMH) model that was further promoted in the Affordable Care Act).

### Visit Growth: Total and by Service Type for CHCs with Capital Projects

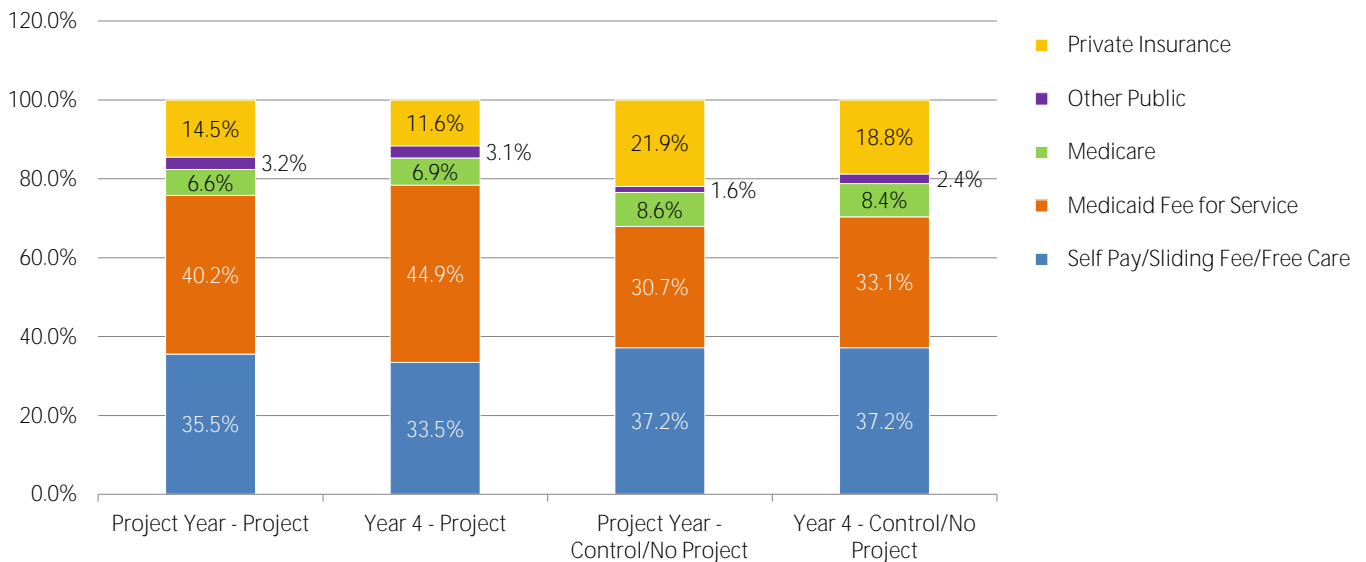


## Impact of Capital Project Implementation on Payer Mix

Perhaps the most interesting finding within the operational analysis is that the completion of capital projects appeared to be associated with an improved payer mix, although not in an expected manner. The chart below includes pre- and post-project payer mixes for the project and the control groups. Health centers with capital projects began with a healthy payer mix, and by Year 4 ended up with an even stronger payer mix, growing the best-paying category of patients (Medicaid) while the uninsured, or self-pay, patients declined as a percentage of total patients. The very fact that health centers without capital projects had less favorable payer mixes initially might have influenced their risk sensitivity and debt capacity, making them less likely candidates to take on a capital project at the outset.

In the aggregate, health centers that completed capital projects ended up with a nearly five percentage point growth in the proportion of Medicaid patients, which represent the best paying category for health centers thanks to the cost-based reimbursement health centers receive. Self-pay patients (the lowest paying category) declined by two points as a percentage of total patients to 33.5%. In contrast, for the control group, self-pay patients remained level, and Medicaid patients only increased by two percentage points as a share of total patients. However, it should be emphasized that self-pay patients were still growing in number, just not as rapidly as Medicaid patients. Between the project year and Year 4, self-pay patients grew by 17.1% for the project group and 12.6% for the control group, while Medicaid patients grew by 38.8% and 23.1% for the project and control groups respectively. Medicare patients grew by 31.6% for the project group and 12.7% for the control group, although remained relatively consistent as a proportion of total patients for both cohorts.

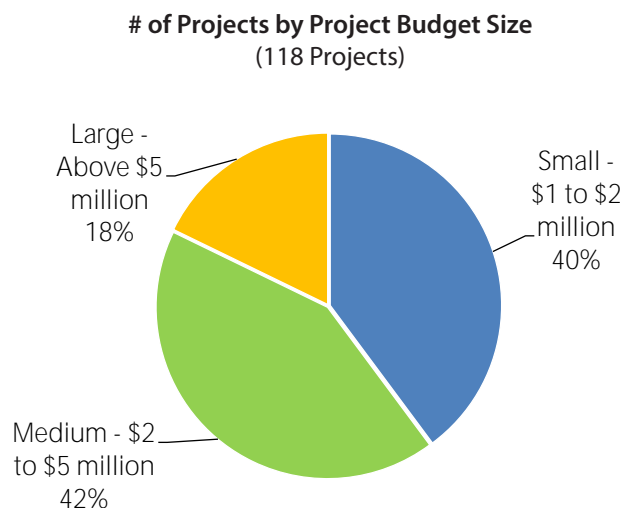
Payer Mix - with and without Projects



At first glance, the surprise in this analysis is that patients with private insurance did not grow as a percentage of total patients, but instead declined by two percentage points. However, it should be noted that this decline in the proportion of privately insured patients does not reflect a significant absolute drop; on a nominal basis, total privately insured patients remained relatively flat for the project group, shrinking by just half a percentage point, indicating that health centers neither gained nor lost a significant number of privately insured patients. For health centers in the control group, privately insured patients dropped by 1.8%; this result suggests that a capital project actually helped preserve privately insured patients to a modest extent. It should be noted that the drop in the proportion of privately insured patients in the above chart is likely in part driven by the health centers with project periods that occurred during the 2008-2010 Great Recession, in which unemployment increased, and many people lost their private insurance as a result.

## Section IV: How Health Center Capital Projects Differ by Project Scale and Organizational Budget

This section of the report explores the range in size found among health center projects and organizations. For this report, a “project” has been defined as the year-over-year or multi-year change in land, buildings, and leasehold improvements. It should be noted that the change in equipment was not considered, so the project budget cut-offs represent slightly larger projects. For example, furniture, fixtures, and equipment typically represent between 10% and 15% of total project costs,<sup>10</sup> so a \$5 million change in land, buildings, and leasehold improvements could represent total project costs of anywhere between \$5.6 and \$5.9 million.



Health center capital projects were placed in the following three categories:

- **Small projects:** \$1 to \$2 million projects (47 organizations)
- **Medium projects:** \$2 to \$5 million projects (50 organizations)
- **Large projects:** Above \$5 million projects (21 organizations)

### *Operating Budget by Project Size*

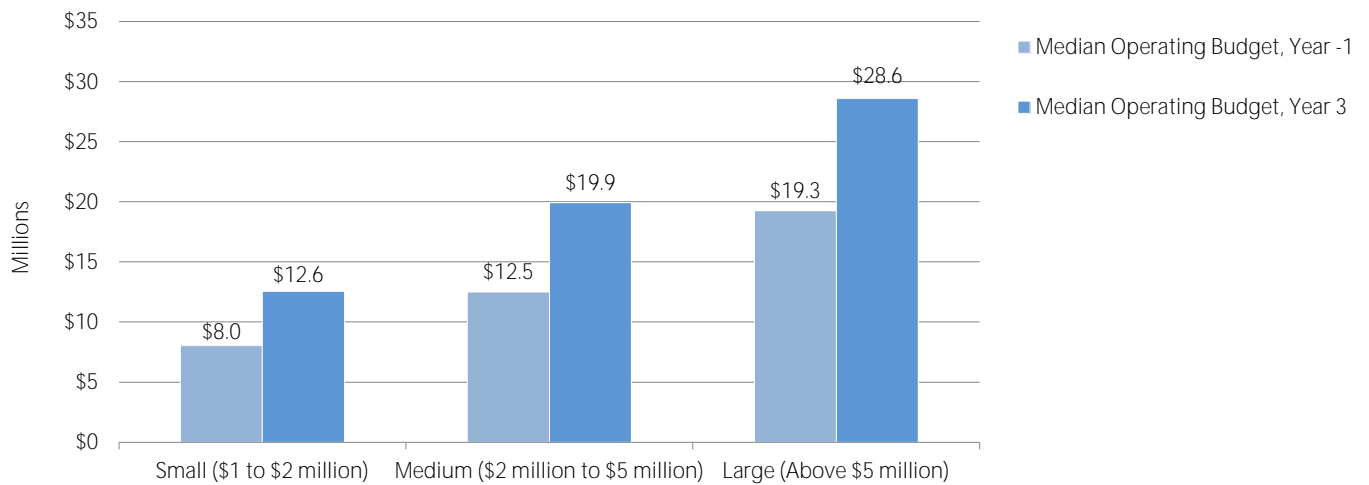
The below chart is based on an analysis of the median organization’s budget size (as defined by total operating expenses) by project size for the year prior to project completion (Year -1) and in Year 3. In each project size cohort, the median operating budget grew similarly over the project period, with budget growth ranging from 48% to 60% as compared to 37% growth for the median operating budget for health centers in the control group. As expected, health centers taking on larger projects tend to be larger themselves.

One pronounced finding from the below analysis is that the capital project appeared to accelerate organizational growth, catapulting organizations to the next size category. Based on this analysis of the median operating budget by cohort, by the end of their project period organizations in the small cohort had operating budgets (\$12.6 million in Year 3) that were similar in size to organizations in the medium project cohort at the beginning of their respective projects (\$12.5 million in Year -1). Likewise, health centers in the medium project cohort look at the end of their project period (with a median operating budget of \$19.9

<sup>10</sup> As determined in Capital Link’s 2013 national report: *Estimating Capital Project Costs for Health Centers*, an analysis of over 500 recent health center capital project budgets.

million in Year 3) very much like health centers about to take on a large project (\$19.3 million in Year -1).

**Trend in Median Operating Budget for CHCs with Capital Projects,  
Year-1 vs. Year 3**



### *“Constant Expansion” Health Centers*

As health centers with projects were selected for analysis in this study, it was noted that a number of health centers demonstrated regular, substantial growth in their land, building, and leasehold improvements. A “constant expansion” label was given to any health center who added at least \$1 million in land, building, and leasehold improvements for each of at least three years within a five-year period (not necessarily consecutive years). While larger projects were more likely to be labeled as a constant expansion organization, the table below indicates that many health centers expand in this manner. While outside the scope of this report, it would be interesting to compare the financial performance of these organizations to their more periodic-expansion peers. It is likely that different staffing patterns and visit growth would be observed for these organizations.

**Constant Expansion Health Centers by Project Size**

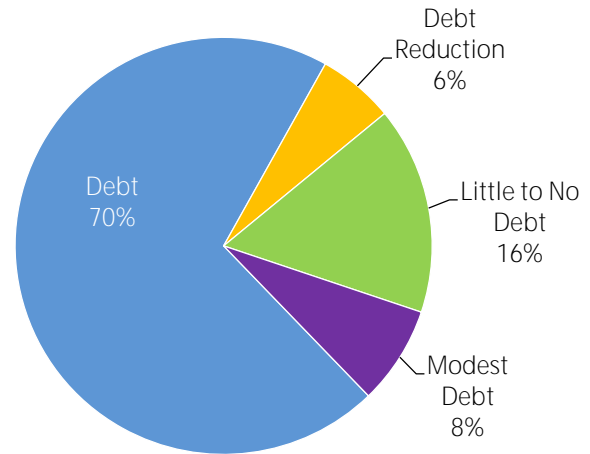
	Total	Constant Expansion	% Constant Expansion
Small	47	9	19%
Medium	50	12	24%
Large	21	8	38%

# Section V: The Impact of Project Debt

The final section of this report explores the way in which health centers finance their capital projects, and how the inclusion of debt affects financial performance. To calculate this measure, each health center's change in long-term debt was calculated as a proportion of their estimated total project budget.<sup>11</sup>

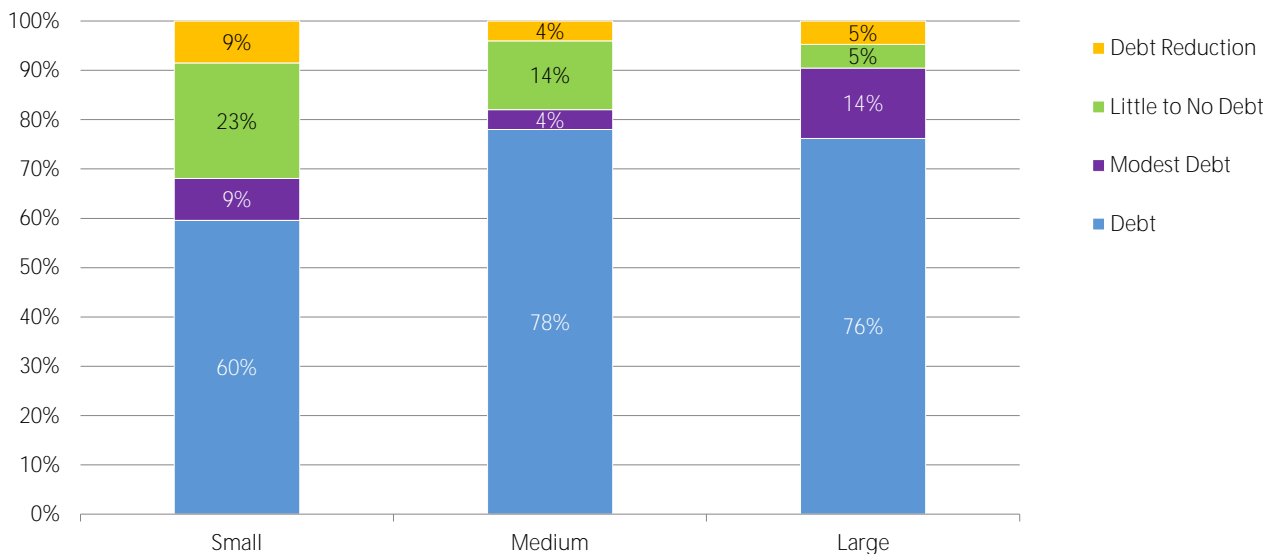
The chart to the right shows the breakdown of the extent to which health centers utilized debt. "Modest Debt" was defined as anywhere between 10% and 25% of the project budget, while "Debt" was defined as financing from debt comprising 25% or more of the total project budget; 70% of the 118 projects were classified in the debt cohort. About 16% of health centers were classified as "little-to-no-debt," which was a change in debt less than 10% of total project costs, while "Debt Reduction" showed actual reductions in debt that were most likely not related to capital project financing.

**Debt as a Part of Capital Projects**  
(118 projects)



## *Does Debt as a Financing Source Differ by Project Size?*

**Debt Category, by Project Size**



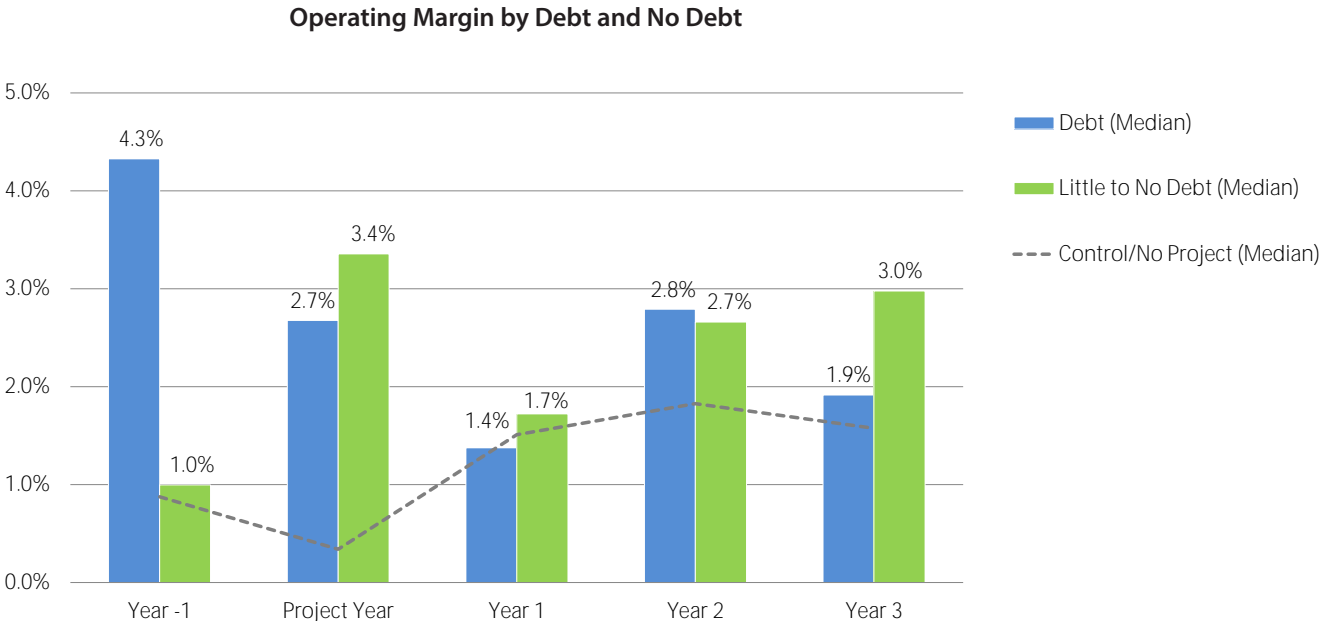
<sup>11</sup>To estimate the project budget, we first tabulated the year-over-year change in land, buildings and leasehold improvement. An estimated 15% in furniture, fixtures and equipment expense was then added to this figure to approximate the total project budget.

As indicated above, medium projects were the most likely to assume at least 25% of their project budget in the form of long-term debt, which impacted the operating margin. As the chart demonstrates, more than three quarters (78%) took on debt at this level, and another 4% assumed modest debt (i.e. 10% to 25% of their project costs). Large projects were the most likely to take on debt in any form, with 76% assuming debt amounts that were equal to at least 25% of their project costs, and another 14% of health centers with large projects assumed at least modest debt. More than half (60%) of small projects also used debt.

The next series of charts explores how debt affected profitability, liquidity, and leverage, as well as the extent to which debt impacts how health centers are able to staff up or grow their earned revenue.

*Impact of Debt Financing on Profitability*

The chart below shows the five-year trend for profitability for the debt cohort, the little-to-no-debt cohort, and the control group for comparison. The median operating performance for health centers in the debt cohort looked much like the median health center assuming a capital project, beginning with 4.3% profitability and recovering at a slightly lower operating margin of 2.8% by Year 2 as depreciation, interest, and building-related expenses hit the income statement. The operating margin for both cohorts remained within or above the recommended range of 1% to 3% throughout the review period.



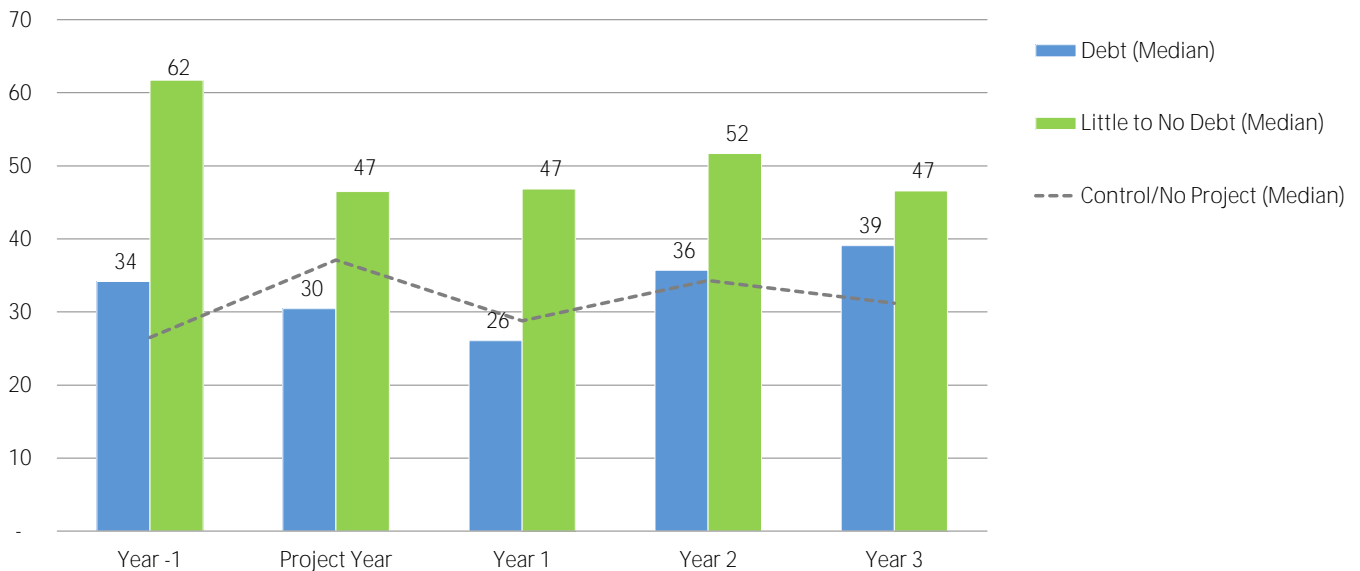
In contrast, health centers financing their project only with their own reserves and/or grants showed an overall improvement to profitability by one percentage point at the median. In either case, both the debt and no debt cohorts had profitability that was quite similar in Year 1, at 1.4% and 1.7% respectively. The higher profitability for the little-to-no-debt cohort in the project year was likely due to a delay in staffing expense growth discussed in a later chart.

## Impact of Debt Financing on Liquidity

As could be expected, the median health center in the little-to-no-debt cohort experienced a large drop in days cash on hand from the pre-project Year -1 to the project year, going from 62 to 47 days cash on hand as health centers in this group used their own cash reserves to finance portions of their projects. Health centers in the little-to-no-debt cohort ended with 47 days cash on hand, far lower than their pre-project levels.

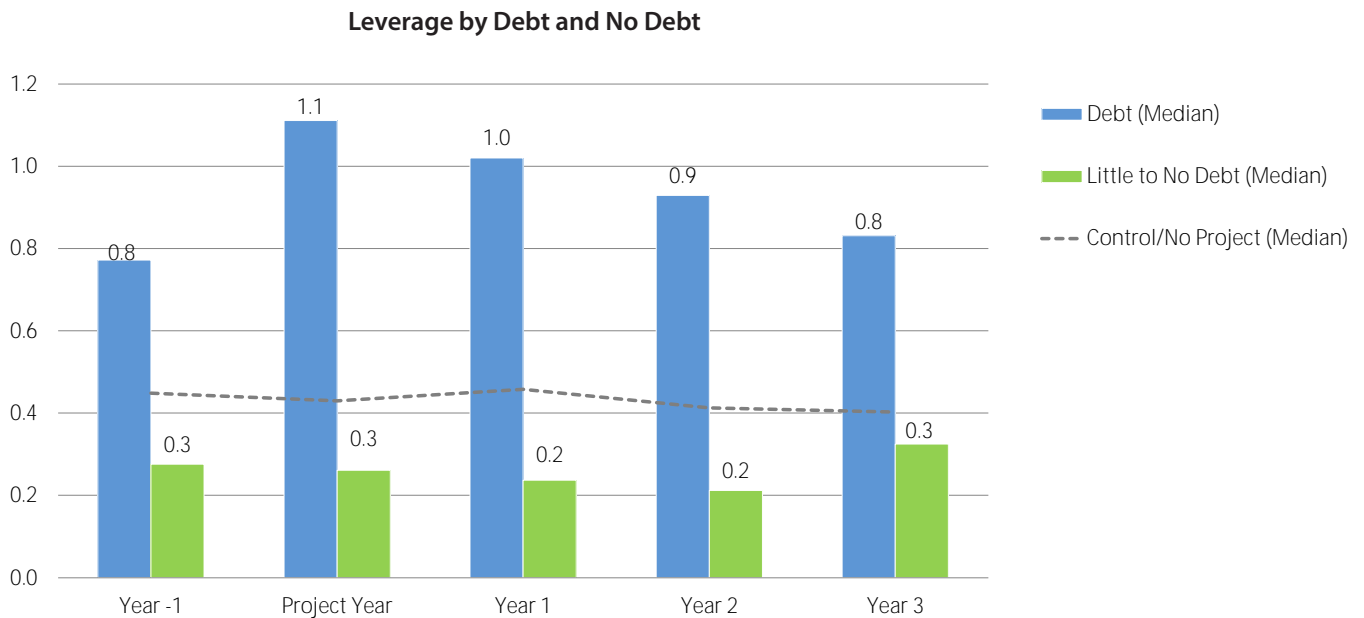
In contrast, cash levels in the debt cohort dropped by much less, just 4 days cash on hand, although it should be noted that the typical health center that used debt began at a lower level of cash than the little-to-no-debt cohort, with 34 days cash on hand. The debt cohort had its largest cash drop in Year 1, most likely as profitability dropped temporarily at the same time as cash principal payments were initially due (which are not a part of the income statement). Similar to the full group of health centers that complete capital projects, health centers in the debt cohort had a two-year period in which days cash on hand was lower, recovered by Year 2, and continued to increase beyond pre-project levels in Year 3. Most notably, cash levels for the debt cohort returned to better-than pre-project levels by Year 2 and continued to improve through Year 3, ending with 39 days cash on hand.

Days Unrestricted Cash on Hand by Debt and No Debt



## Impact of Debt Financing on Balance Sheet Composition

Another distinction between health centers that utilized debt and those that did not is the change in leverage. Debt financing will change the way a balance sheet is composed, increasing the proportion of debt such that leverage (or total liabilities divided by total net assets) increases. While this measure obviously changed for health centers taking on debt, leverage always remained within the recommended range of 1.0 to 3.0.

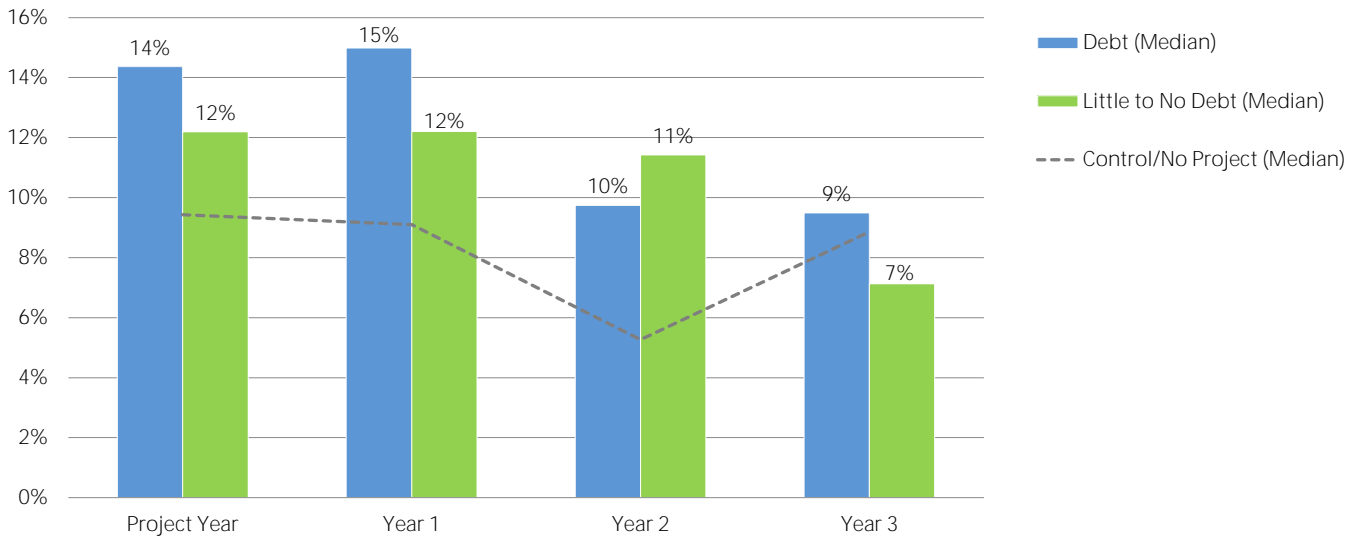


The next two charts explore how health center operations were impacted by a debt-financed capital project as compared to projects in which little to no debt was assumed. Net patient service revenue (NPSR) serves as a proxy for visits, while measuring personnel expense growth conveys a sense of how health centers increased their staffing levels.

## Net Patient Service Revenue Growth for Debt-Financed Health Center Projects

Based on the chart, it is clear that at the median, health centers with debt-financed projects saw a boost to NPSR in the project year as well as in Year 1 that the little-to-no-debt cohort did not experience, as well as sustained NPSR growth in Year 3. Although a review of the UDS data was not a part of this analysis, larger and more sustained growth in patient visits for the debt cohort would most likely also have been observed, suggesting a more regular and constant growth cycle. Over the review period, health centers that used debt financing had total NPSR growth (at the median) of 48.6%, while the little-to-no-debt cohort had 42.9% total NPSR growth.

**NPSR Growth Rate for Debt and No Debt**

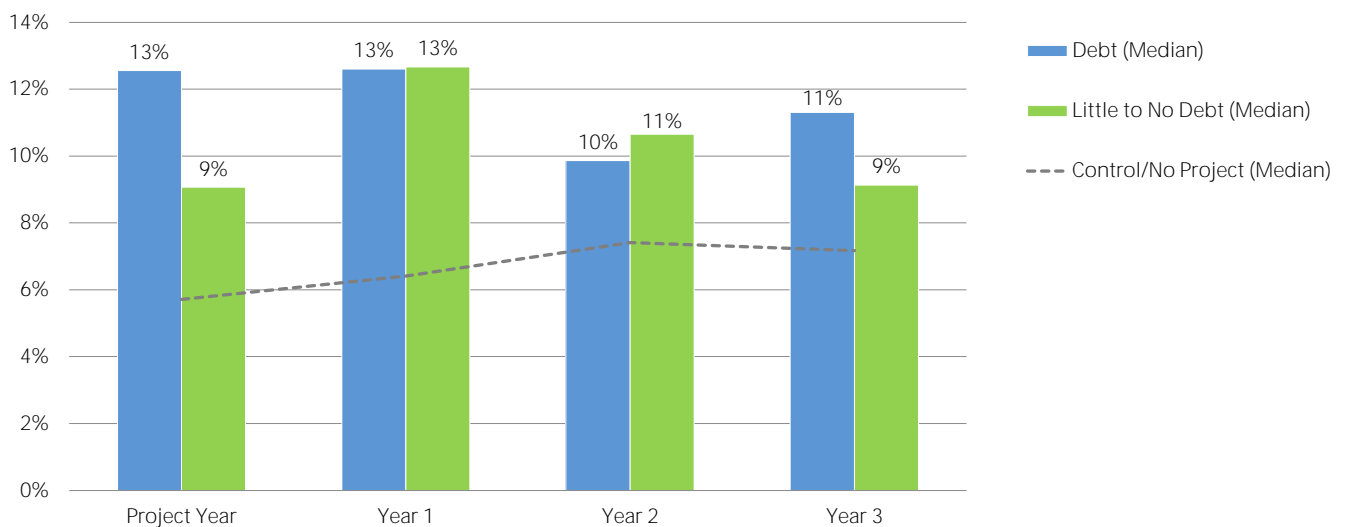


*Personnel Expense Growth for Debt-Financed Health Center Projects*

Health centers with debt-financed projects showed a different staffing ramp-up than health centers that used little to no debt to fund their capital projects, which appear to add the greatest staffing expenses in Year 1 instead of in the project year. This staffing pattern suggests a more conservative approach to ramping up at a new facility.

At the median, health centers in the debt cohort grew their staffing expense by a total of 46.3%, while the little-to-no-debt cohort grew by 41.5%. The debt cohort also showed a second peak of staffing up in Year 3 unlike the little-to-no-debt cohort, in which staffing expenses began to taper off. These findings suggest that health centers that use debt financing are more likely to be in the “Constant Expansion” cohort briefly mentioned in the last section – those that are constantly expanding their facilities and most likely also their operations.

**Personnel Expense Growth Rate for Debt and No Debt**



## Section VI: Conclusion

As this report has demonstrated, capital projects result in clear (albeit temporary) financial and operational effects for the typical health center. The following table encapsulates the most tangible key lessons to which lenders can refer as they consider financing a health center capital project.

### Takeaways for Lenders

**Consider debt covenants that acknowledge that health centers require a recovery period following project completion.** Although the median health center remained within recommended ranges throughout the review period, there were clear trends for four key financial ratios:

- Profitability is lowest in Year 1 but recovers by Year 2.
- Days cash on hand declines in the project year and recovers by Year 2.
- Leverage peaks in the project year and returns to pre-project levels after two years (Year 2).
- Debt-service coverage hits its lowest point in Year 1 and takes two years to fully recover (Year 3).

As you structure loans, consider debt covenants that are stepped in to reflect these operating realities.

**Health centers with capital projects require financing that helps maintain cash flow.** At the median, health center cash levels dropped by 10 days' worth of expenses, or by a 25% drop in days cash on hand in the project year, which took two years to recover.

1. Consider allowing health centers to include a reserve of 10 days cash on hand in the project budget as an additional operating cash reserve.
2. A pre-development line of credit that gets rolled into the permanent financing can be another way to help health centers prepare for this temporary cash setback.
3. While the health center you are underwriting might already have an operating line of credit, it is likely not large enough given the nature and scale of the operating budget growth the health center will experience as a result of the capital project. Be prepared to allow this line to increase as the health center grows to avoid liquidity issues.

**Know the basic “anatomy” of the operating ramp-up for a health center capital project.**

The most successful capital projects have the strongest staffing growth in the project year rather than later years; expect that patient and visit growth will not peak until the year after the doors open.

**Ask for detailed financial projections, both balance sheet as well as statement of activities, to assess health center planning.** A quick glance at the operating projections will indicate the extent to which a health center has thought realistically about staffing needs, and the typical lag before patient and visit growth peak in Year 1. In addition, a projected balance sheet will be essential to assessing the extent to which your potential borrower has thought through the changes in cash levels.

**Require a business plan as part of your application, especially a detailed market analysis.**

A capital project should be appropriately sized, both to the organization taking on the project, as well as to the demand and provider capacity in the service area. A business plan, in particular a detailed market assessment, will help you assess the extent to which the health center has thought this through.

**Debt is an excellent tool for capital project financing,** and most health centers have been using it wisely. Debt reduces the need to self-fund a large portion of a capital project, preserving precious cash reserves to fund ongoing operations. Further, because debt appears to free up resources, it leverages enhanced growth in net patient service revenue later in the project period. While there is an impact on the operating margin for health centers utilizing debt as a funding source, the setback observed was temporary, and the operating margin remained within the recommended range of 1% to 3% in all periods.

## Section VII: Methodology and Limitations

Determining the impact of capital projects on health center growth and financial performance required the selection of groups of health centers to be studied. For the sake of feasibility, health centers who had submitted financial audit data to Capital Link were identified. Between 2003 and 2011, Capital Link's database represents an average of 70% of all health centers in any given year; from this set, two specific groups were parsed out for study.

To create a distinct group of health centers that had completed capital projects that was sufficiently large enough to study, we chose to evaluate projects over a period of time, selecting health centers with projects completed between 2004 and 2008. We classified a "capital project" as any change in land, buildings, and leasehold improvements that exceeded \$1 million. We further honed this group to identify health centers with capital projects for which five consecutive years of audits were available (in which the project year was the second year). The 2004 to 2008 project completion timeframe utilized our most recent financial audit data, while also creating a group of 118 health centers for study.

In order to have a basis for comparison, we also assembled a control group that had no more than a \$150,000 change in land, buildings, and leasehold improvements for 2004 through 2008. We identified 58 organizations for which we had five consecutive years of audits that met this criteria of no major capital growth over the review period. For the financial impact section of this report, all data was reported at the median for the "Project" and "Control," or "No Project" groups. In addition, health center financial data from the project group was also reported at the 25<sup>th</sup> and 75<sup>th</sup> percentiles.

The data and charts in the operational impact sections of the report are based upon organization-level Uniform Data System (UDS) data from 108 health centers that had capital projects between 2004 and 2008; this group is a subset of the 118 health centers studied in the financial data analysis section of this report. Similarly, the control group consists of UDS data from 43 organizations, a subset of the 58 studied in the financial analysis. Some organizations were excluded from this portion of the analysis simply because there was no detailed UDS data available for the analysis timeframe, most often because they were FQHC Look-Alikes, which were not required to report detailed data to HRSA prior to 2012. In some cases, only partial data was available because a health center obtained FQHC status during the review period; these organizations were excluded.

The financial and operational analysis in this report tracks health centers over an extended period of 2003 to 2011, as we followed health centers for a five-year period (one year before the project and three years following the project), and we included health centers that had capital projects that occurred anywhere between 2004 and 2008. We consolidated this data into a five-year period described by the following terminology:

- **Year -1** is the fiscal year before the project was completed.
- **Project Year** is the fiscal year during which the project was completed.
- **Year 1** is the first full fiscal year following the project completion year.
- **Year 2** and **Year 3** were also studied using Capital Link’s financial database of audited statements, while the UDS analysis went through **Year 4** on relevant measures such as payer mix, productivity, and utilization.

### *Limitations*

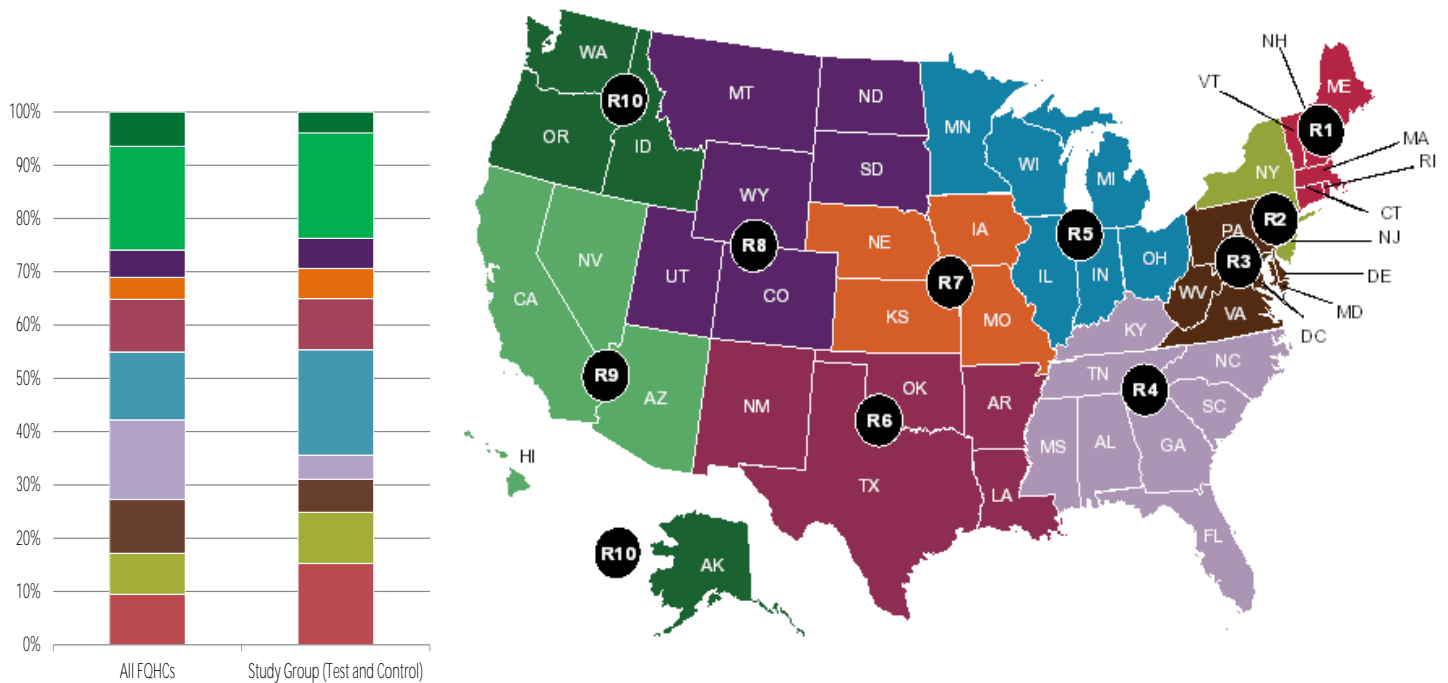
Since we obtained the financial and operational data from two separate sources, the reporting periods are not always identical. UDS data is reported on a calendar year basis, while financial audit data is based on fiscal years, which can end in any month (although typically June, the middle of the calendar year). Each health center decides its own fiscal year end, so even within the financial audit dataset these are only approximately in sync. This limitation is something intrinsic in the nature of the data, but our approach of choosing a base reference year (i.e. the project year) minimizes the impact of this limitation.

Another limitation of the analysis is that while we have full control over our audited financial dataset, our use of the UDS dataset is more limited as a result of HRSA restrictions on its use. Because of these restrictions, metrics pulled from UDS could only be used in aggregated analysis. These data limitations should not present flaws in the analysis, but are worth discussing to better understand the methods chosen.

When looking initially at the data, the sample set for all Test and Control groups were skewed to smaller capital projects. For example, within the small project cohort that was defined as projects between \$1 and \$2 million, 32% of the projects were \$1.1 million or less, while just 7% of projects were \$1.9 million and greater. Because of the asymmetrical nature of these groups, the mean (or average) is not a very helpful measure for central tendency nor is variance helpful in understanding the variability of the data. An alternative and more useful measure of “center” for skewed data is the median. The median is essentially the sample value at the middle of the list of sorted sample values. If there is no exact middle value, an average of the two closest values is taken as the median. In the same way, the sample x percentile (such as 25<sup>th</sup> percentile for example) is the value at or below which x% (25%) of the sample values lie. Similar to the median, if there is no exact value, the average between the closest lower and upper values is used. Sample percentiles can provide a good understanding of the spread of the population. Instead of looking at variance, looking at the quartiles (the 25<sup>th</sup> and 75<sup>th</sup> percentiles) gives a sense of the spread of the data and its variability. This gives the best output for looking at our dataset and understanding what is occurring.

It should be emphasized that unlike the median and percentile data reported in the financial analysis, data in the operational impact charts is based on aggregate or average growth due to the aforementioned limitations of the dataset; therefore direct comparison of the financial and operational data sets will be less conclusive.

Comparison of All FQHCs to 176 CHCs in Study Group (Projects and Control) by HRSA Region



The above chart compares all Federally Qualified Health Centers by HRSA Region to the 176 organizations that were studied in this report (118 health centers with projects and 58 control organizations). While some regions are overrepresented (particularly regions 1 and 5) and others underrepresented (regions 3 and 4) to varying degrees, the chart illustrates a fair representation of health centers nationally given the sample size utilized. It should also be noted that for the project year, there is some better representation of the later project years (particularly 2007 and 2008), simply because more projects were undertaken by health centers in those years. Health centers in the control group were distributed across the five “project years” relatively equally, with a slight over-representation in 2007 and a slight under-representation in 2008.

# Appendix A

## Summary of Obligations and Benefits of FQHC Status<sup>13</sup>

Federally Qualified Health Center		
Criteria	Section 330 Health Center	FQHC Look-Alike
	Urban or Rural	Urban or Rural
Designation By	HRSA <sup>14</sup> initially and through renewal of designation application every five years in addition to an annual recertification application.	HRSA initially and through renewal of designation application every five years in addition to an annual recertification application.
Designation Requirement	Must serve a defined geographical area or population which is federally designated as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP).	Must serve a defined geographical area or population which is federally designated as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP).
Corporate Structure	Non-profit entity (some public entities also qualify).	Non-profit entity (some public entities also qualify).
Board of Directors	Governing board with full authority over operations. Majority of board members must be users of center services.	Governing board with full authority over operations. Majority of board members must be users of center services.
Management Staff	Must have at least an Executive Director, Clinical Director and a Finance Director.	Must have at least an Executive Director, Clinical Director and a Finance Director.
Services	Must provide defined scope of comprehensive primary and preventive health services to include all lifecycle stages. Must also provide supplemental services necessary to assure the effectiveness of the required primary health services.	Must provide defined scope of comprehensive primary and preventive health services to include all lifecycle stages.

<sup>13</sup>This summary is provided as an overview only and is necessarily incomplete. For complete requirements for FQHC certification, see [www.bphc.hrsa.gov](http://www.bphc.hrsa.gov).

<sup>14</sup>HRSA: Health Resources and Services Administration is the agency within the U.S. Department of Health and Human Services that administers the Federally Qualified Health Center (FQHC) program through its Bureau of Primary Health Care (BPHC).

## Federally Qualified Health Center

Criteria	Section 330 Health Center	FQHC Look-Alike
	Urban or Rural	Urban or Rural
Financial Access	Services must be available to all regardless of ability to pay. Sliding fee scale based on income must be in place.	Services must be available to all regardless of ability to pay. Sliding fee scale based on income must be in place.
After Hours Coverage	Must be open at least 32 hours per week and provide professional coverage when practice is closed.	Must be open at least 32 hours per week and provide professional coverage when practice is closed.
Quality Improvement/ Assurance Plan	Must maintain ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records.	Must maintain ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records.
Audit and Reporting Requirements	Must conduct an annual audit that meets federal compliance requirements. Must submit an annual Uniform Data System (UDS) report to the BPHC.	Must conduct an annual audit that meets federal compliance requirements. Beginning in 2012, must submit an annual Uniform Data System (UDS) report to the BPHC.

## Federally Qualified Health Center

Criteria	Section 330 Health Center	FQHC Look-Alike
	Urban or Rural	Urban or Rural
Benefits	Section 330 operating grant to provide care to medically underserved.	
	Reimbursement under the Prospective Payment System (PPS) or other State-approved Alternative Payment Methodology (APM) for services provided under Medicaid.	Reimbursement under the Prospective Payment System (PPS) or other State-approved Alternative Payment Methodology (APM) for services provided under Medicaid.
	Cost-based Medicare reimbursement.	Cost-based Medicare reimbursement.
	<p>Eligibility for other federal programs/initiatives:</p> <ul style="list-style-type: none"> <li>• Federal Tort Claims Act malpractice coverage of clinicians.</li> <li>• Access to discounted pharmaceuticals through the US Public Health Service's 340B Drug Pricing Program.</li> <li>• Access to on-site eligibility workers to provide Medicaid and Child Health Insurance Program (CHIP) enrollment services.</li> <li>• Access to Vaccines for Children Program for uninsured children.</li> <li>• Access to National Health Service Corps (NHSC) medical, dental, and mental health providers.</li> <li>• Eligible for HRSA Loan Guarantee Program.</li> <li>• Access to discounted pharmaceuticals through the US Public Health Service's 340B Drug Pricing Program.</li> <li>• Access to National Health Service Corps (NHSC) medical, dental, and mental health providers.</li> </ul>	<p>Eligibility for other federal programs/initiatives:</p> <ul style="list-style-type: none"> <li>• Access to discounted pharmaceuticals through the US Public Health Service's 340B Drug Pricing Program.</li> <li>• Access to National Health Service Corps (NHSC) medical, dental, and mental health providers.</li> </ul>