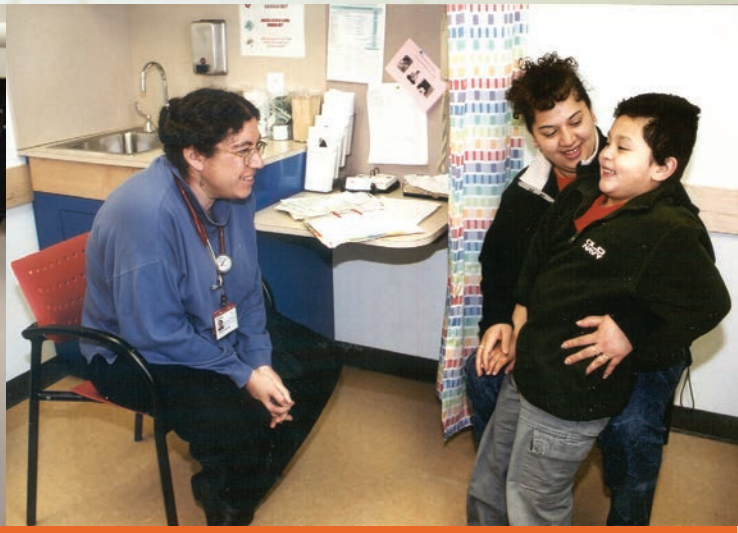
Community Health Center Financial Perspectives

Issue 1

Financial and Operational Ratios and Trends of Community Health Centers, 2008-2011

A Guide for Community Health Centers



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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.

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.

The Citi Foundation supports the economic empowerment and financial inclusion of low- to moderate-income people in communities where Citi operates. We work collaboratively with a range of partners to design and test financial inclusion innovations with potential to achieve scale and support leadership and knowledge building activities. Through a "More than Philanthropy" approach, we put the strength of Citi's business resources and people to work to enhance our philanthropic investments and help improve communities.

Contents

Executive Summary

This report provides a national operational and financial analysis of the community health center industry for the years 2008 – 2011. It is intended to provide health center personnel and board members with relevant trends and guidelines to assist them in better understanding and improving individual health center performance. This document is the first in a series of studies supported by Citi Foundation to increase visibility and knowledge of and within this important industry.

Key Findings

The Health Center Industry is Maturing and Stabilizing

The underlying business model for all Federally Qualified Health Centers (FQHCs) is complex—and given that it relies on implementation by a large number of independent, community-controlled, not-for-profit organizations, the health center program's success was not guaranteed from the start. The fundamental trade-off between serving every patient without concern for their ability to pay in return for receiving federal grant subsidies and full-cost Medicaid reimbursement has proven workable for the majority of health centers as can be seen in consistent positive operating margins at the median. Moreover, the key financial and operational ratios for the median health center indicate balance sheet stability: consistent (though somewhat marginal) cash balances and operating reserves, reasonably efficient cash cycles (collection of patient receivables and grant proceeds) and low debt. While the industry continues to grow through the expansion of existing health centers and the addition of new sites, it has achieved an operating scale that reflects its evolution from a small "movement" to a sizable industry group that has the maturity and capacity for a greater volume of private investment.

Health Centers Continue to Diversify Services with the Highest Growth in Dental and Behavioral Health

While all health center services are growing, dental and behavioral health services within health centers have been growing rapidly over the last four years, as measured by corresponding visits and FTEs. It seems reasonable to anticipate that these two service areas will continue to grow – especially behavioral health, as health centers adopt a more integrated model of care. The demand for dental services is likely to remain steady, though the Affordable Care Act (ACA) does not necessarily include dental services in the patient centered medical home model (PCMH) promulgated by the Act. Enabling service visits[1] are also growing, despite the fact that they are generally not reimbursed by insurance. This situation does not necessarily

[1]Per Section 330(b)(1)(A)(iv) of the Public Health Service Act (42 USCS § 254b), authorizing legislation of the health center program, enabling services are non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, and outreach.

change under the ACA, thus health centers may need to advocate strongly to be sure that some or all of the cost of these important services is incorporated into the rates they are paid by insurers and Accountable Care Organizations (ACOs).

Provider Productivity is Leveling off or Declining

An analysis of provider productivity statistics from the UDS suggests that productivity has leveled off and actually declined recently (especially for physicians). This trend is likely related to the implementation of electronic health record (EHR) systems at a growing number of health centers. What the data does not tell us is whether this is a temporary situation that will improve as providers adapt to using EHR systems (and systems get easier to use) or if productivity will remain stagnant at the current levels. The immediate financial implications of lower provider productivity in a fee-for-service system have been felt by many health centers. As the patient-centered medical home model of care and related payment systems continue to evolve, however, methods for measuring and comparing productivity may become less relevant at the individual provider level and more relevant at the team level.

The Performance of Health Centers in the Top and Bottom Quartiles is Diverging

The best performing health centers appear to be financially outpacing their counterparts to a disproportionate degree, and according to the data, they may be separating themselves from the majority of the industry. Perhaps more importantly, the data also suggests that there are a sizable number of health centers that are struggling to break-even. While the success of the high performers is to be celebrated, it may be more important to the industry as a whole to determine what common challenges, if any, the low performers face.

The analysis and findings are presented in six sections:

Section I provides an introduction to community health centers, which as a group constitute the largest network of primary care providers in the United States. In 2011, these organizations served more than 22 million patients. This section briefly discusses their current operating environment.

Section II presents a high-level overview of health center operations from 2008 – 2011, focusing on the current size of the industry as well as recent growth patterns. Patient demographics and employment patterns are also introduced.

Section III provides a more detailed analysis of community health center revenue sources and expense components/structure as well as services offered, provider productivity and payer sources.

Section IV examines profitability, liquidity and capital structure ratios based on audited financial statements for fiscal years 2008 – 2011.

Section V offers a few concluding comments.

Section VI describes the data sources used for this report and explains the development of these data sets for the analysis presented.

Summary of Key Ratios

Key Ratio	Report Page	Quartile Metrics: 2011	
		Percentile/Quartile	Metric
Operating Margin	33	75th	7.9%
		Median	2.1%
		25th	(1.6%)
Bottom Line Margin	35	75th	11.2%
		Median	4.8%
		25th	0.6%
Days Unrestricted Cash on Hand (DCOH)	36	75th	90
		Median	44
		25th	19
Current Ratio (CR)	37	75th	4.1
		Median	2.4
		25th	1.5
Accounts Receivable Days: All (AR)	38	75th	66
		Median	44
		25th	31
Accounts Receivable Days: NPSR	39	75th	69
		Median	45
		25th	30
Accounts Receivable Days: GCR	40	75th	54
		Median	21
		25th	0
Accounts Payable Days	41	75th	64
		Median	35
		25th	20
Total Liabilities to Total Net Assets	45-46	75th	107%
		Median	52%
		25th	21%
Debt Service Coverage Ratio (DSCR)	46-47	75th	14.6
		Median	4.1
		25th	0.8

Section I:
Introduction and Background

Community health centers constitute the largest network of primary care providers in the United States, serving more than 22 million patients at close to 9,000 sites across the country. With annual operating revenues of approximately $14 billion in 2011, health centers have doubled the number of patients served over the last decade,[2] and are poised to grow to serve 30-to-40 million patients on an annual basis over the next several years as a result of the Affordable Care Act (ACA). As documented by Capital Link, the capital requirements for new and expanded health center sites to accommodate this level of growth is estimated at $13.1 billion—an amount far higher than health centers have raised historically. However, very little information about this industry's financial and operational profile is available to health centers on a consistent basis as they take on the challenges of managing this growth.

Judging from discussions on the FQHC social media forums, health centers are hungry for data against which to benchmark their financial and operational performance. As one health center executive recently observed: "Health centers are like the Galapagos turtles; each of us has evolved differently in our own little world—or at least we think we have." Without easily available comparative data, it has been difficult for management to understand how their health centers compare to their peer organizations. This lack of information has likely slowed the identification and adoption of best practices—a critically-important activity as health centers seek to thrive in the highly-competitive health care ecosystem. Going forward, these executives will also be interested in a more refined definition of peer organizations – to reflect health centers within the same state (operating under largely the same reimbursement rules), of the same revenue size, utilizing similar practice models and in similar urban/rural communities.

Current Operating Environment of Health Centers

Like all health providers, health centers are functioning in a changing and uncertain operating environment resulting from the ongoing implementation of the ACA, the most important features of which are scheduled to roll out in 2014. As discussed in this document, 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. Despite being 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

[2] 2001 – 2011 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

operating performance to a certain degree. Given the prominence of Medicaid funding in state budget disputes, each state's financial situation and budgeting cycle can also impact a health center's liquidity and financial prospects. As a result, it is important to consider state-specific variability when reviewing and analyzing any single community health center and the state policy environment in which the health center operates.

Most health centers are also 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, they should be able to leverage their experience as relatively low-cost, high-quality primary care providers to a population that is difficult to serve (due to historically inconsistent access to primary care services and health care issues that have been linked to poverty). This should augur 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 they derive from it. 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. Health center experience operating within a highly regulated system should provide a competitive advantage as they navigate the new and uncharted waters of the ACA.

What may be more challenging is the adjustment necessary to move from a predominantly fee-for-service reimbursement environment to a managed care and/or risk-based payment model. While health centers are well positioned to provide quality 'patient-centered' care, they will need to adjust from a reimbursement system that rewards more services to one that rewards better health outcomes.

This document, and a companion piece written for lenders,[3] is a starting point for health centers to benchmark their performance and catalyze performance improvement, further increasing their abilities to access capital. Subsequent publications will seek to build upon this knowledge base with an increasingly nuanced analysis of the financial and operational performance of health centers as they continue to evolve over the coming decade.

[3] See also *Community Health Center Financial Perspectives, Issue 2: Financial and Operational Ratios and Trends of Community Health Centers, 2008 – 2011: A Guide for Lenders*, (Capital Link and Community Health Center Capital Fund, 2013).

A Note on Terminology

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)." These references generally denote a type of "safety net" provider that serves primarily 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.

Section II:
Operational and Financial Overview

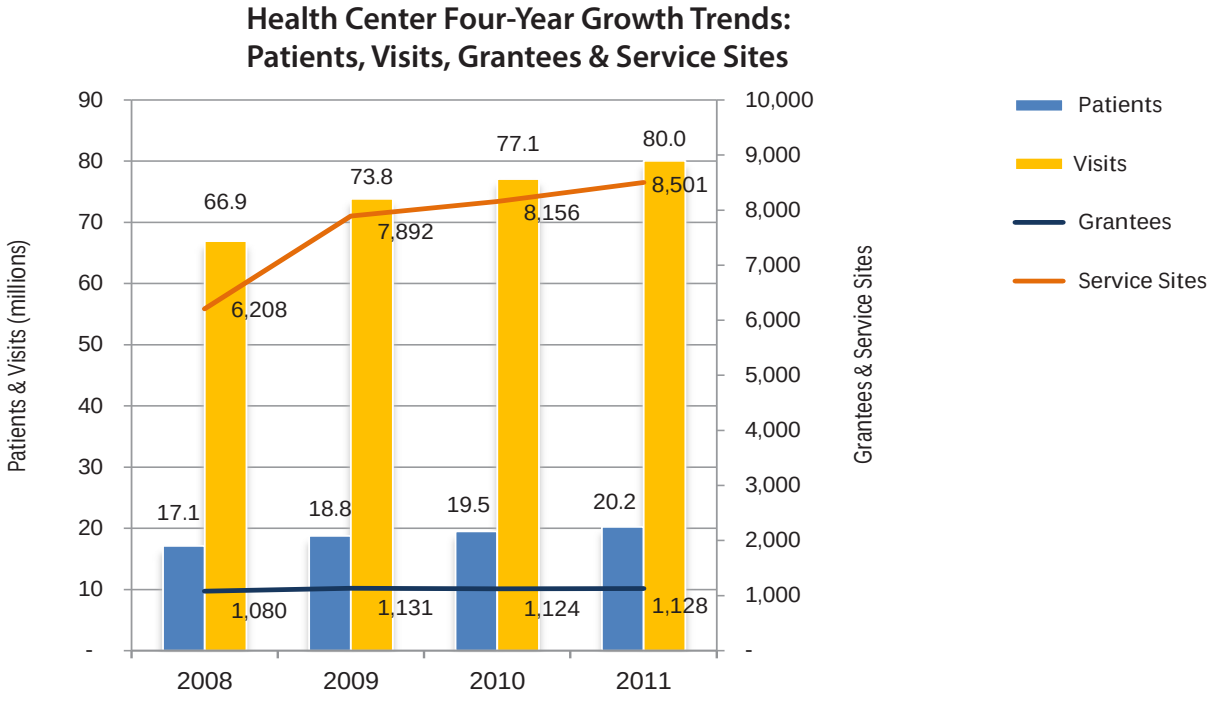
While most health center managers and boards are very knowledgeable about the financial and operational histories of their own health centers, they may be less familiar with the overall trends in the industry. This section serves to contextualize an individual health center's circumstances by providing an overview of the industry's operational and financial profile from 2008 – 2011.

The dataset included annual UDS information from HRSA grantees (approximately 1,100 health centers) as well as audited financial information for over 500 health centers each year.

The following tables and charts provide a high-level view of the health center sector. They specifically focus on the current size of the industry, and recent growth and employment patterns as well as demographics on who health centers serve and their basic revenue and expense structure.

Health Center Industry Profile and Growth Trends

Including estimates for LALs, the National Association of Community Health Centers (NACHC) estimated that by 2011 almost 1,200 FQHCs (at close to 9,000 sites) served approximately 22.3 million patients through 88.3 million visits.[4] The following chart provides growth trends for Section 330 FQHCs only, the largest sub-set of FQHCs.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

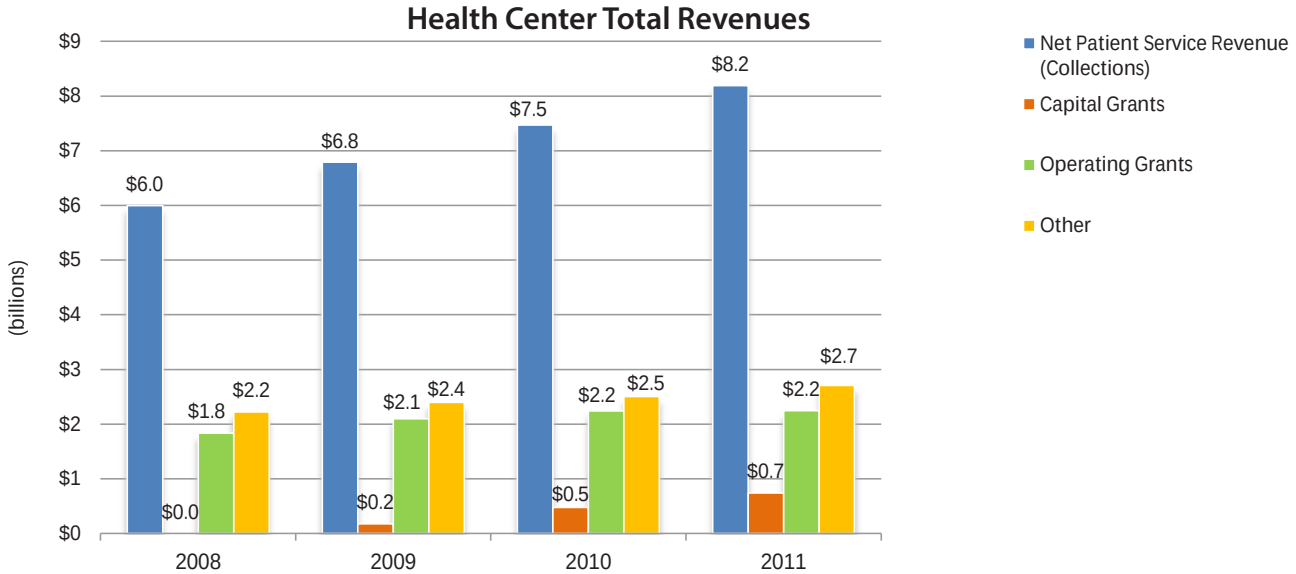
[4] NACHC Infographic, "Who Do Community Health Centers Serve?", February 2013.

Strong Growth over the Study Period

Despite the prolonged national economic downturn that began in 2008, health centers experienced strong growth over the study period. As the previous chart delineates, while patients and visits grew rapidly at 18% and 20%, respectively, over the four-year period, the number of grantees grew only modestly at 4%. The number of sites increased dramatically during this time period, however, as existing health centers took advantage of multiple funding opportunities from the Health Resources and Services Administration (HRSA) to expand or establish new sites in underserved areas.

Between 2009 and 2010, HRSA offered several rounds of "New Access Point," "Increased Demand for Services" or capital grant funding opportunities through the American Recovery and Reinvestment Act (ARRA). In addition, the ACA was passed by Congress in 2010, which provided an $11 billion "Trust Fund" of new funding for health centers over a five-year period. It included $9.5 billion for Section 330 operating grants and $1.5 billion for capital grants.

During this time period, HRSA invested a cumulative amount of approximately $827 million in increased operating grants and $1.37 billion in capital grants to health centers, fueling their growth. By 2011, Section 330 grantees had total revenues of $13.9 billion, a 38% increase from revenues of $10 billion in 2008. While HRSA's $2.2 billion in total increased investment constituted approximately 57% of this growth, 43% came from other sources, as discussed later in this section. Consistent with this rapid pace of growth—and assuming continued funding of new and expanded operating grants through the ACA Trust Fund—health centers are expected to increase their patient base to 30-to-40 million over the next several years with the implementation of the ACA.

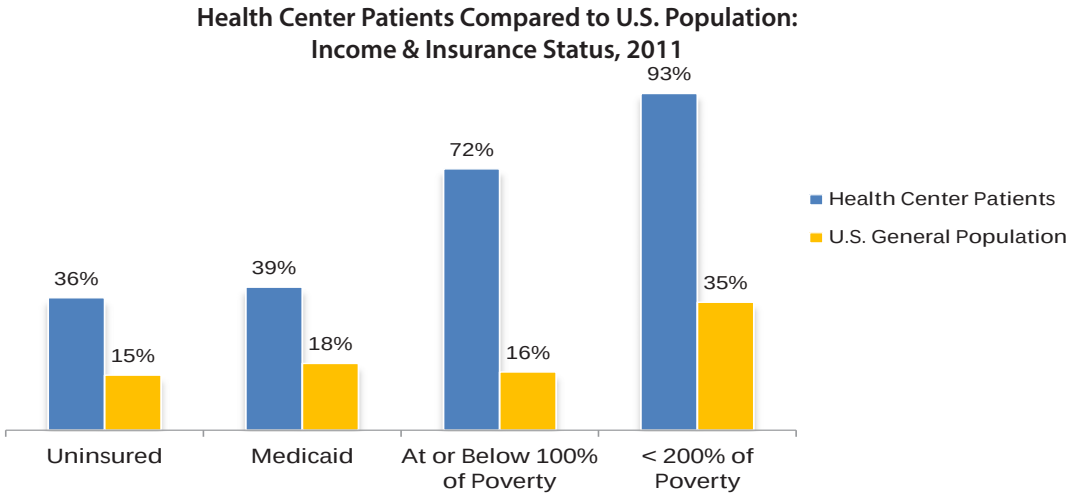


Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Capital Grants include ARRA, ACA and other capital grants.
Operating Grants include Section 330 Operating Grants , ACA and ARRA operating grants.
Other includes other federal, state, local, private and foundation grants as well as other revenue.

Health Center Patient Diversity

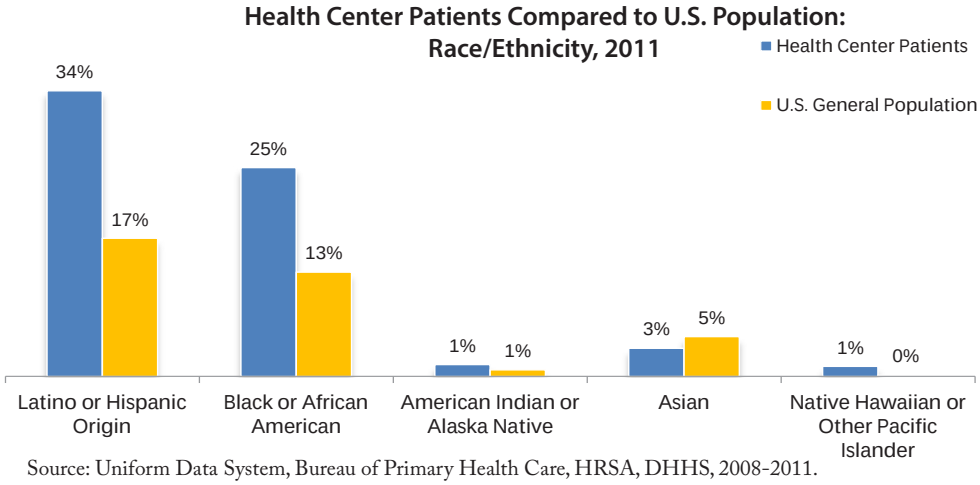
Health centers serve a highly diverse patient base, most of whom have income levels below 200% of the federal poverty level (FPL) guidelines. As shown in the following chart, health center patients are disproportionately poor, uninsured and publicly-insured as compared to the population of the United States as a whole.[5] The extent to which a health center's patient population reflects or diverges from the national health center data may provide insights into the challenges and opportunities it may face in the coming years with the implementation of the ACA and as payment reform efforts roll out in individual states.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Race/Ethnicity

As shown in the following chart, health centers serve a higher proportion of racial and ethnic minorities as compared to the population of the country as a whole.[6] It should be noted that the health center data is self-reported by patients, some of whom do not indicate any specific race or ethnicity, so this data reflects only those patients that chose to report.

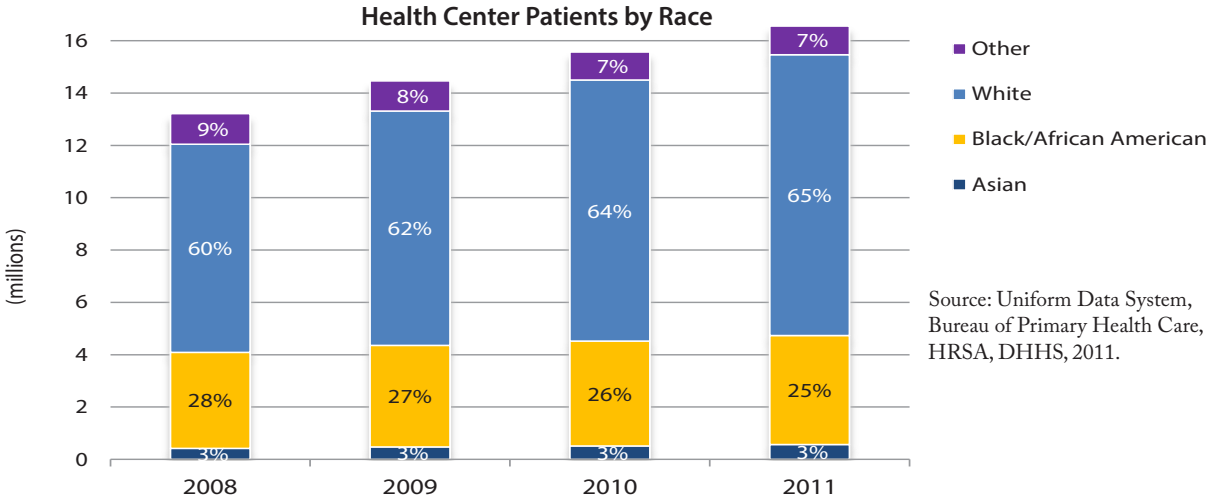


Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

[5]Data Sources: 2011 UDS National Roll-Up; US Census, American Community Survey, 2011 Estimates; CMS 2011 Medicaid Enrollment Report.

[6]Data Sources: 2011 UDS National Roll-Up; US Census, American Community Survey, 2011 Estimates.

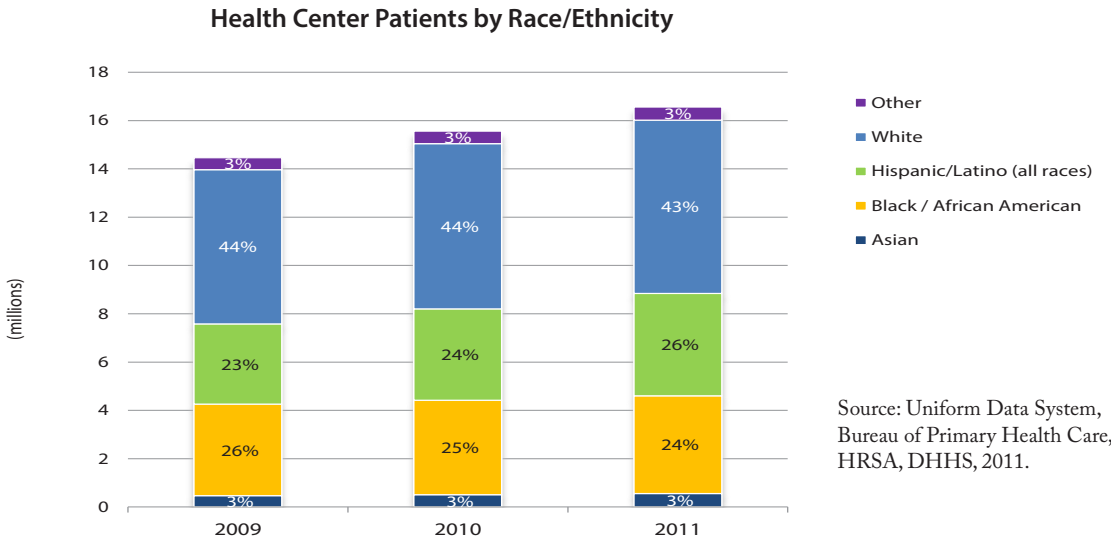
The racial make-up of the health center patient base has shifted somewhat over the study period—with Black/African American patients declining from 28% in 2008 to 25% in 2011 and White patients increasing from 60% to 65% over the same time period.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2011.

Other includes Hawaiian/Pacific Islander - 1% average, American Indian - 1% average and those patients reporting more than one race - 5% average.

Consistent with the growth in the Hispanic/Latino population (which may include individuals of any race), patients who identify as Hispanic constitute a large and growing portion of the health center patient base. Beginning in 2009, the UDS required reporting of Hispanic/Latino origin by race, which showed that a significant portion of both the White and Black populations identified as Hispanic/Latino, with this population increasing from 23% of patients in 2009 to 26% in 2011. The chart below details the growth of the Hispanic/Latino population regardless of race, as compared to non-Hispanic/Latino populations. Evaluating a health center's changing patient demographics as compared to the national trends may provide insights into the types of services and supports its patients may need in the future.



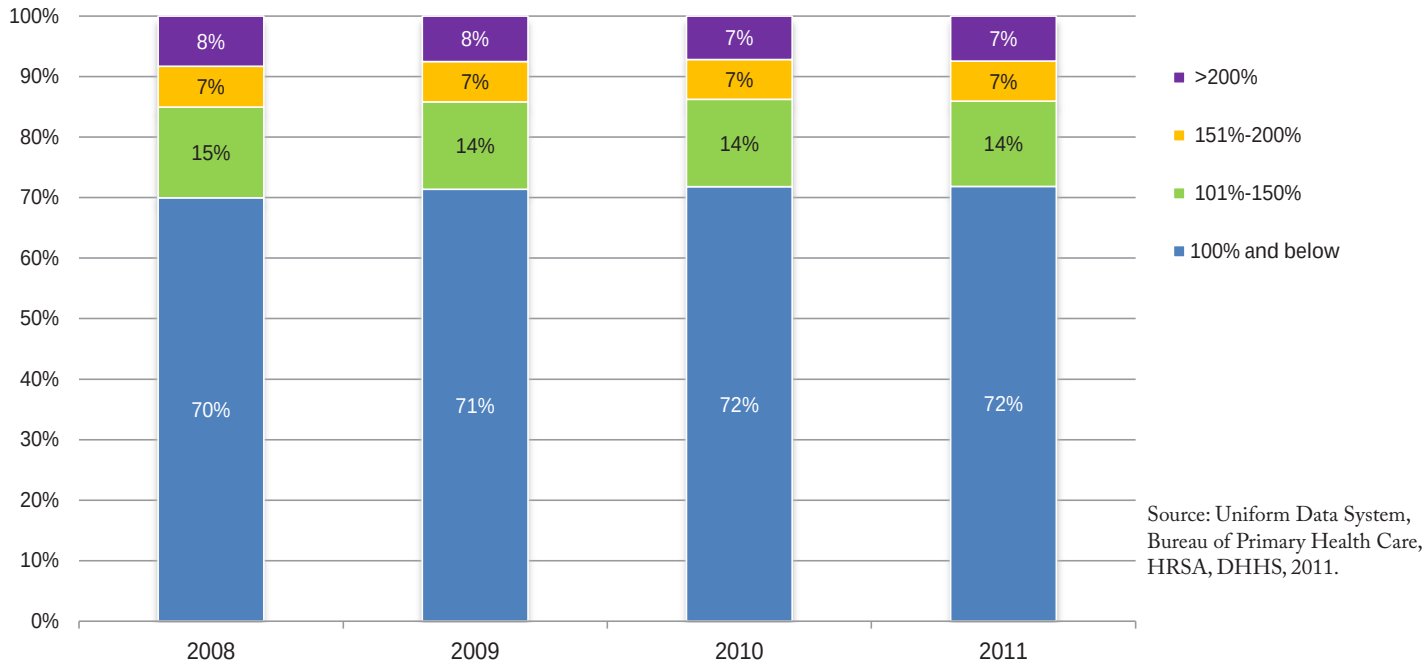
Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2011.

Excludes patients for which race/ethnicity is not known.
Other includes Hawaiian/Pacific Islander - 1%, American Indian - 1% and those patients reporting more than one race - 1%.

Income Status of Health Center Patients

Virtually all health centers primarily serve a low-income patient base. In 2011, 93% of their patients with known income status had incomes at or below 200% of the federal poverty level (FPL) guidelines.

Health Center Patients by Income Compared to Federal Poverty Level



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2011.

Over the review period, the number and proportion of extremely low income patients (<100% FPL) grew every year—a likely reflection of the difficult economy which increased the proportion of people living in poverty across the country. To put this data in perspective, the following table illustrates the FPL guidelines across all four years, for a four person family – at 100%, 133%, 150% and 200% of the FPL.

Four Person Family

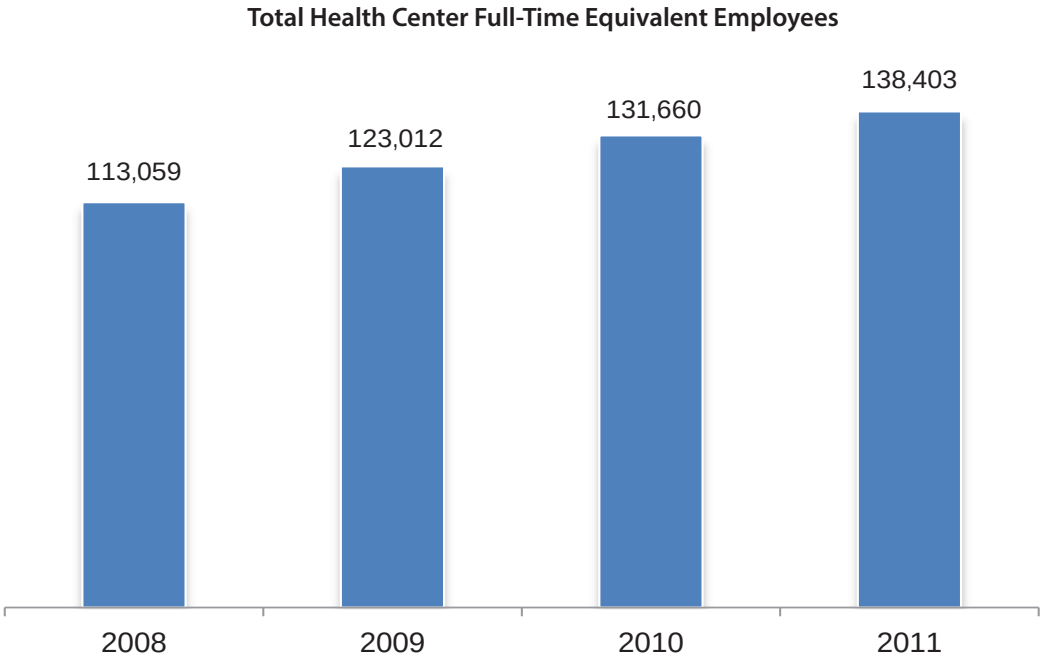
Year	100% FPL	133% FPL	150% FPL	200% FPL
2008	$21,200	$28,196	$31,800	$42,400
2009	$22,050	$29,327	$33,075	$44,100
2010	$22,050	$29,327	$33,075	$44,100
2011	$22,350	$29,726	$33,525	$44,700

Source: http://aspe.hhs.gov/poverty/figures-fed-reg.cfm.

For health centers, careful tracking of patient incomes—and matching those incomes to appropriate sources of insurance/financial support—is a critical activity to maintain financial viability. Later in this section and in Section III, the typical revenue profile of health centers and the sources of payment that support health center services are described in more detail.

Health Center Employment

Community health centers have grown to become significant employers across the United States, adding over 25,000 jobs between 2008 and 2011 on a full-time equivalent (FTE) basis. This 22% growth rate is especially notable given that this period overlaps with the economic recession. Many health centers have documented their own employment growth and highlighted their roles as "economic engines" in their communities. In doing so they have attracted the attention of funders and decision-makers at the local and state levels, often garnering increased financial support as a result.

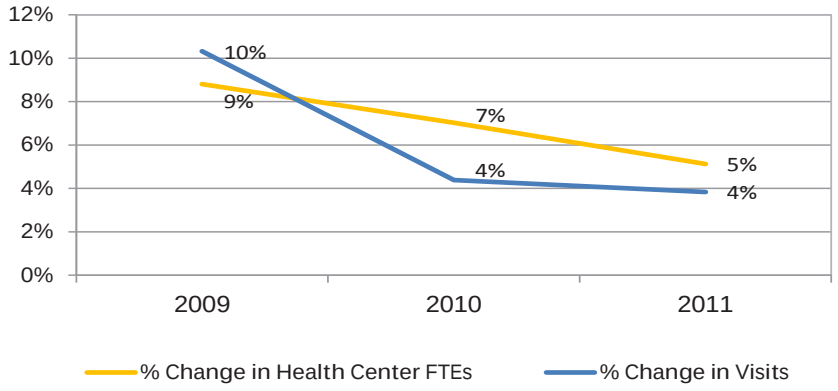


Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Of particular note, the vast majority of new jobs at health centers were created in the low-income communities in which health centers typically operate. By emphasizing that most health center jobs come with fringe benefits such as medical insurance, paid sick leave and vacation, health centers have become "employers of choice" in their communities. In addition, health center employment often comes with opportunities for ongoing education and training, a benefit not often found in jobs typically available to low-income persons.

The following chart shows that FTE growth at health centers is closely tied to the growth in total visits—as one might expect given the currently predominant fee-for-service payment system. It will be interesting to see how these growth rates change as new non-visit-based payment structures evolve in the coming years—and as heath centers fully implement team-based practice models.

Health Center Full-Time Equivalent Growth Rate Compared with Total Visit Growth Rate



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Overview of Operating Revenues: Growth by Quartile

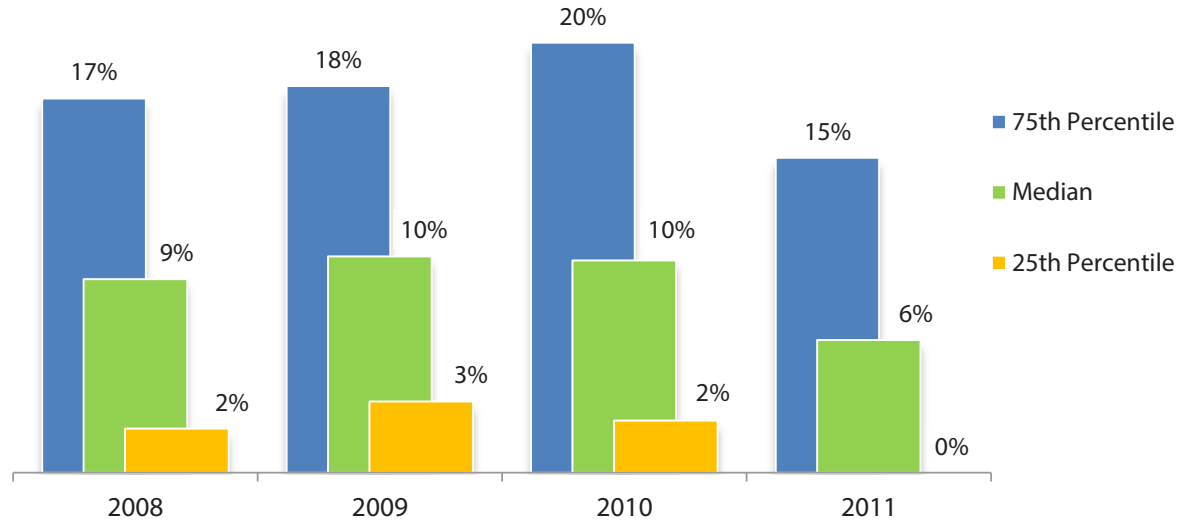
In 2011, health centers ranged in revenue size from small organizations with under $100,000 in annual revenues, to large organizations with close to $134 million in revenue. As shown in the chart below, the median health center had just over $10 million in operating revenues in 2011. The bottom 25% had revenues under $5.2 million and the upper 25% had revenues above $20.4 million.

Total Operating Revenues by Health Center Quartile (Millions)

Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

It is important to note, however, that revenue growth varied significantly among the quartiles. Though revenue growth of health centers at the median averaged 9% annually, at the 75th percentile growth was significantly stronger at 18%. At the 25th percentile, growth averaged 2% annually. Another trend worthy of monitoring going forward is the decline in revenue growth across all quartiles between 2010 and 2011.

Operating Revenue Growth by Health Center Quartile



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

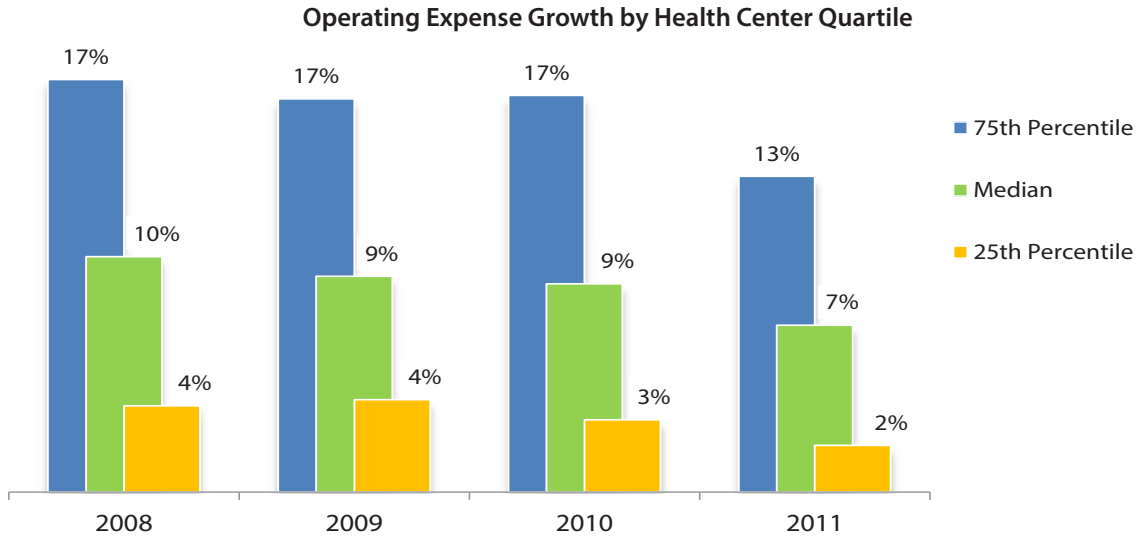
Overview of Operating Expenses: Growth by Quartile

The median health center had operating expenses of $9.7 million in 2011, with health centers reflecting the full range of operational sizes from very small to large.

Operating Expenses by Health Center Quartile (Millions)

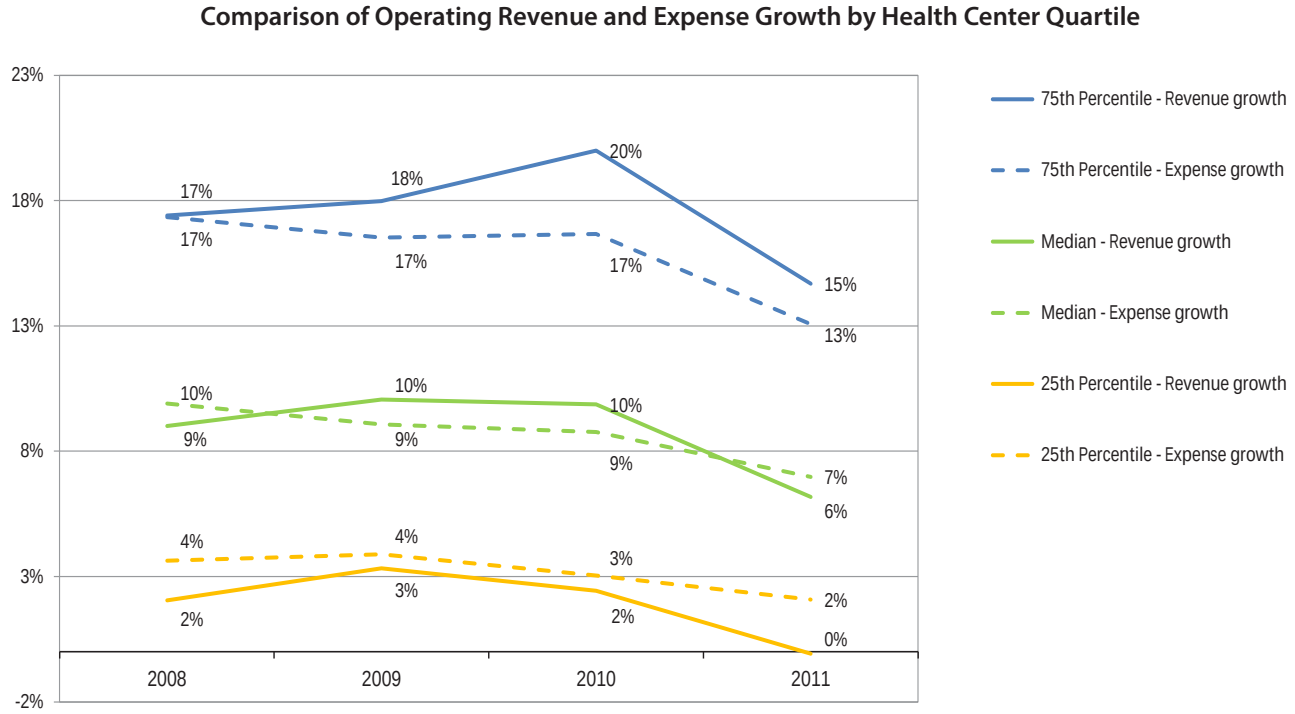
Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

The median health center saw average annual operating expenses grow 9% over the study period, comparable to revenue growth. Health centers at or above the 75th percentile averaged 16% annual expense growth over the study period, lower than the average growth in operating revenues of 18%. These comparative rates indicate that the upper quartile of health centers were successful in keeping expense increases below operating revenue growth, resulting in operating surpluses in all years studied. Health centers at or below the 25th percentile, however, experienced more challenging operations as expenses grew faster than revenues, pointing to tighter margins and for some, operating losses.



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

The chart below compares operating revenue and expense growth for each quartile over the study period.



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

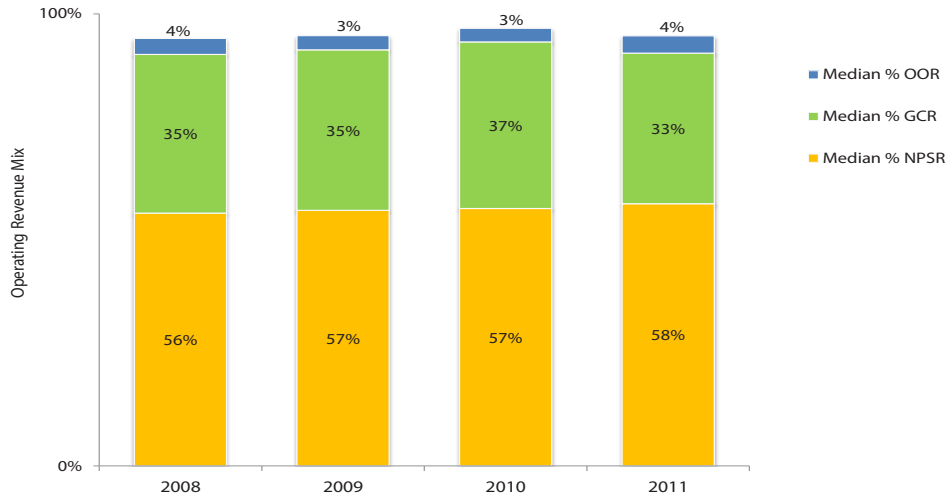
Section III:
Health Center Revenues and Expenses Detailed Analysis

This section delves more deeply into the revenue and expense structure of health centers, examining net patient service revenue (NPSR) and grants and contract revenue (GCR). Except where otherwise indicated, this section analyzes data from the 2008 – 2011 UDS National Roll-Up report.

Composition of Operating Revenues

Health center operational funding falls into two major categories: Net Patient Service Revenue and Grants and Contracts. Trends for the median health center across the study period are shown below. The extent to which a health center's revenue composition differs significantly from the national median may provide insights into the operating environment and/or the age of the health center, given that younger health centers often have a higher proportion of grant revenue.

Revenue Composition for the Median Health Center

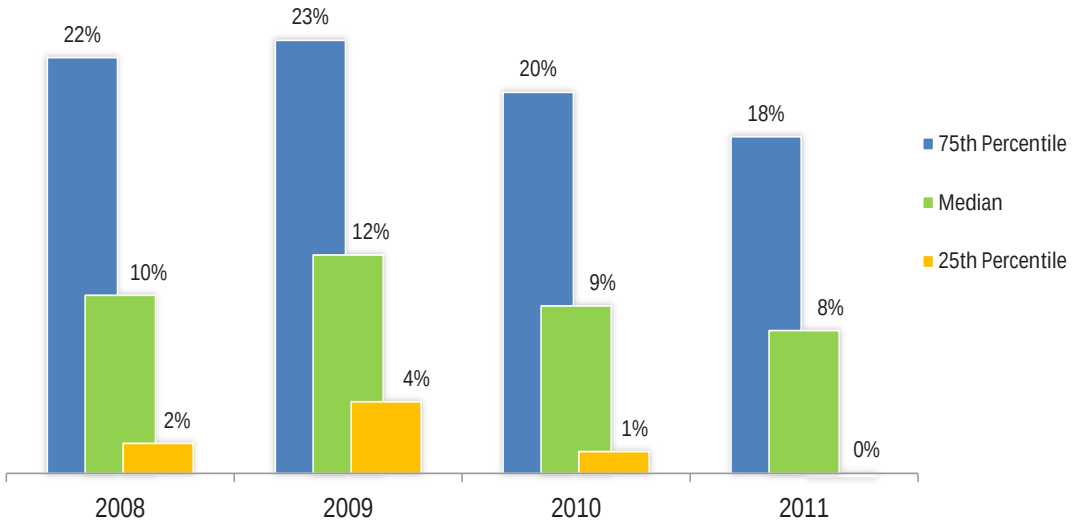


Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

NPSR, derived from patient or insurance payments, represented nearly 60% of the median health center's operating revenue in all years. GCR, composed of public and private grants and contracts from federal, state and local sources, provided approximately 35% of operating support. The remaining 3-4% of revenues consisted of "other operating revenue" (OOR) including in-kind and cash donations as well as rental income and miscellaneous fees received. Over the four-year study period, these percentages have remained very consistent and reflect both the stability of the revenue mix for the industry as a whole and the leveraging effect of grant dollars on the health center financing system: for every grant dollar available to health centers, two dollars are typically leveraged from other sources.

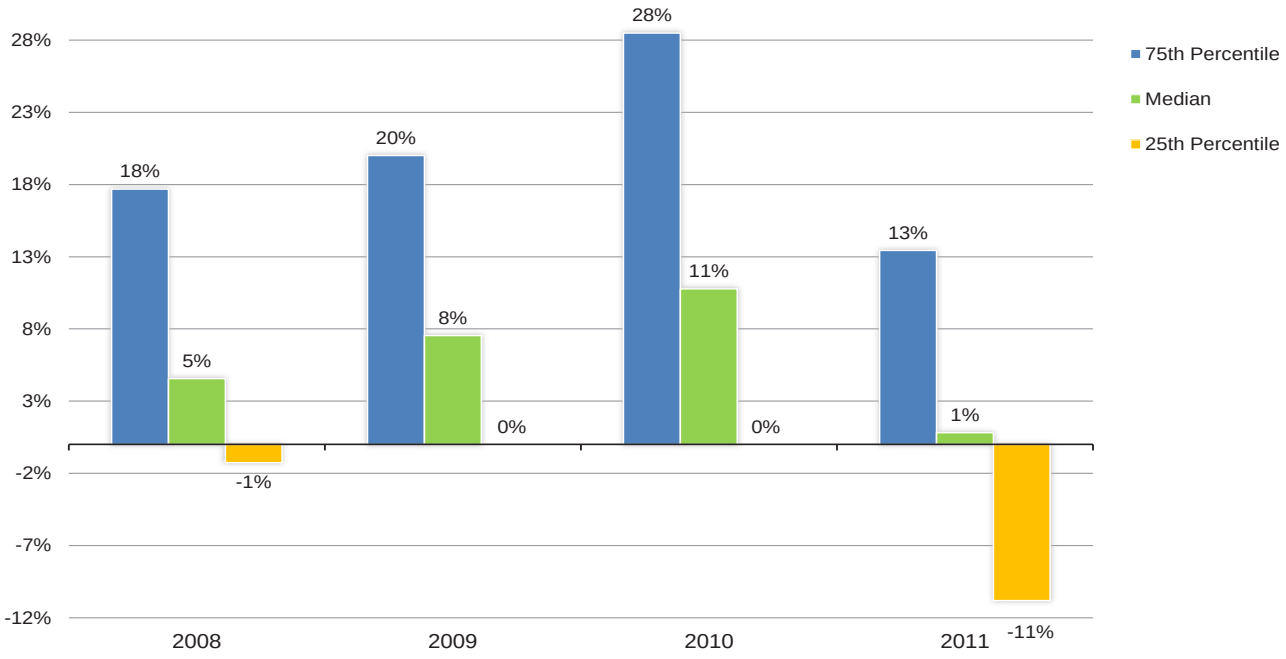
NPSR and GCR have both grown significantly over the study period for most health centers. However, the rate of growth for NPSR declined in 2010 and 2011, while the GCR growth rate peaked in 2010.

Health Center Net Patient Service Revenue Growth



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

Health Center Grants and Contracts Revenue Growth



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

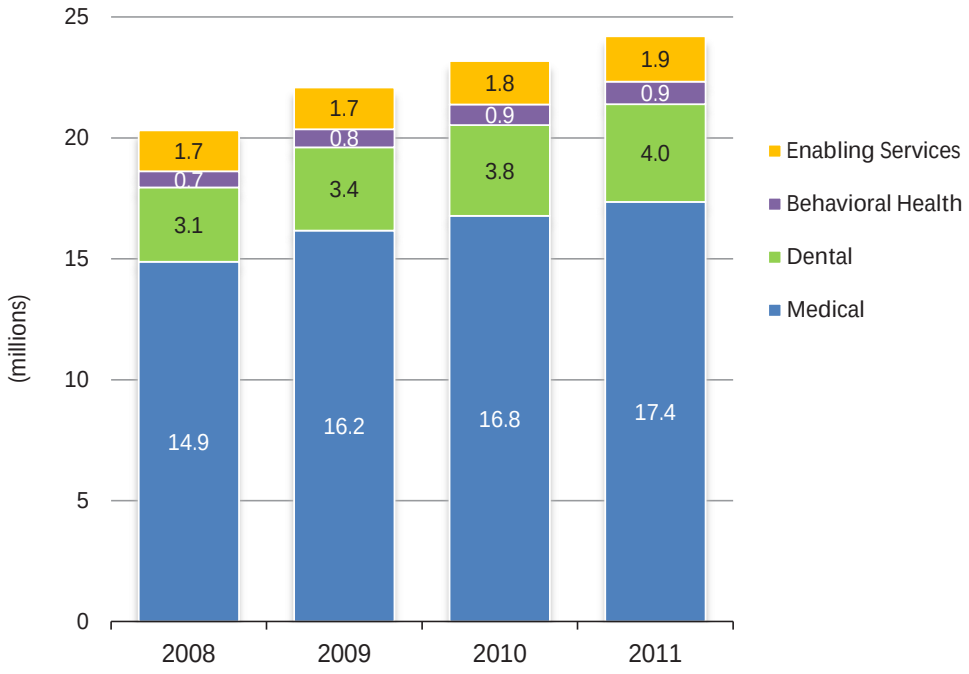
Net Patient Service Revenue

For most community health centers under the predominant fee-for-service payment model, NPSR is impacted by three variables: number of (and type) of providers by service type, the productivity of those providers, and the payer mix. The following three sections discuss the trends in these areas from 2008 - 2011.

Service Growth, Provider FTEs and Type

In exchange for the federal support they receive, health centers are expected to provide a widening spectrum of primary care services including medical, dental, behavioral health and, increasingly, vision services. As noted in the analysis below, most of these services are billable. However, health centers are also expected to provide additional "enabling services," which typically include: case management, patient/community education, outreach, transportation, program eligibility assistance and interpretation services. Although these services facilitate the provision of quality health care, none of them are billable to health center payers. Some may be grant-funded through government or foundation grants, but there is no consistency across the industry. The variances in enabling services funding between health centers can have a significant P&L impact and may make comparisons between centers difficult.

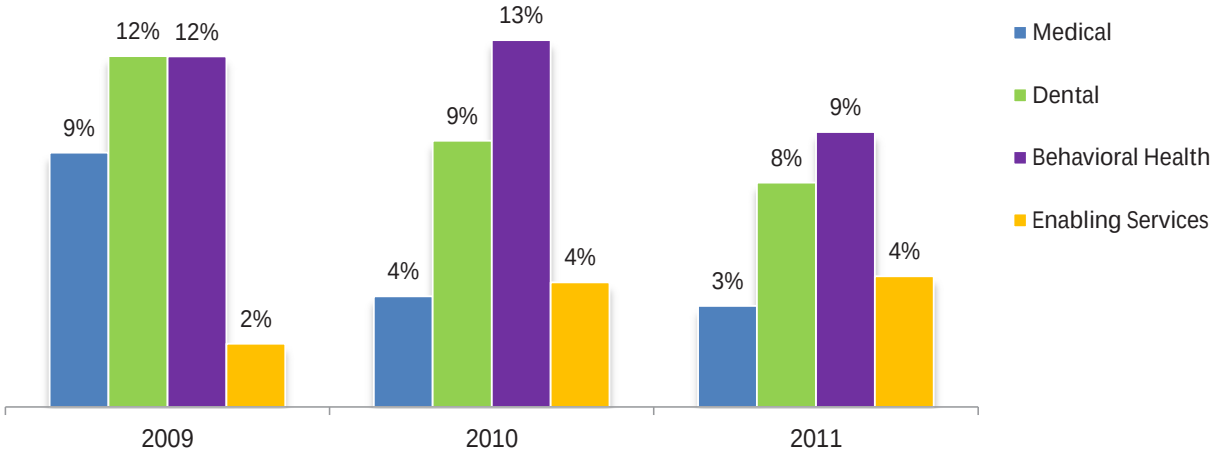
Total Health Center Patients by Service



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

The total number of patients served at community health centers has grown every year since 2008, with many patients accessing several services. While all services (medical, dental, behavioral health and enabling services) have experienced growth, some service categories are growing faster than others. The number of patients utilizing behavioral health services has increased more rapidly than the number utilizing other services, due in part to the relatively recent emphasis on integrating medical and behavioral health services in health centers. While this trend is similar to the growth pattern in dental patients a decade ago when existing health centers were encouraged by HRSA to add dental services, the absolute number of behavioral health patients remains relatively small compared to the number of patients for other services. Over the past four years, dental services have continued to grow at a rapid pace. Likewise, enabling services have experienced consistent growth, which is especially notable given that enabling services are generally not billable.

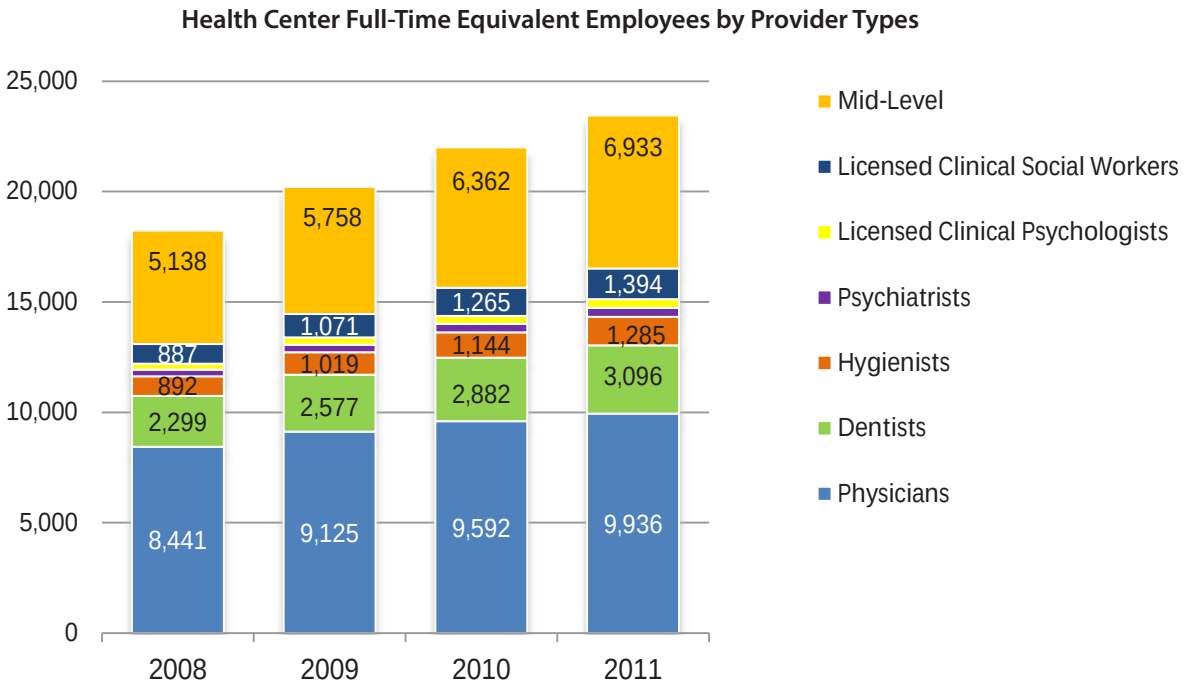
Patient Growth Rate by Service



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

As services expanded, health centers added medical, dental and behavioral health professionals to meet the health care needs of their growing patient populations. In so doing, they faced challenges recruiting and retaining primary care practitioners, which are in short supply nationally. As shown in the following chart, while health centers succeeded in attracting and retaining a significant number of physicians to their practices, they also recruited a higher proportion of mid-level providers (nurse practitioners, physician assistants and certified nurse midwives) as "physician extenders" to round out their increasingly team-based practice models.

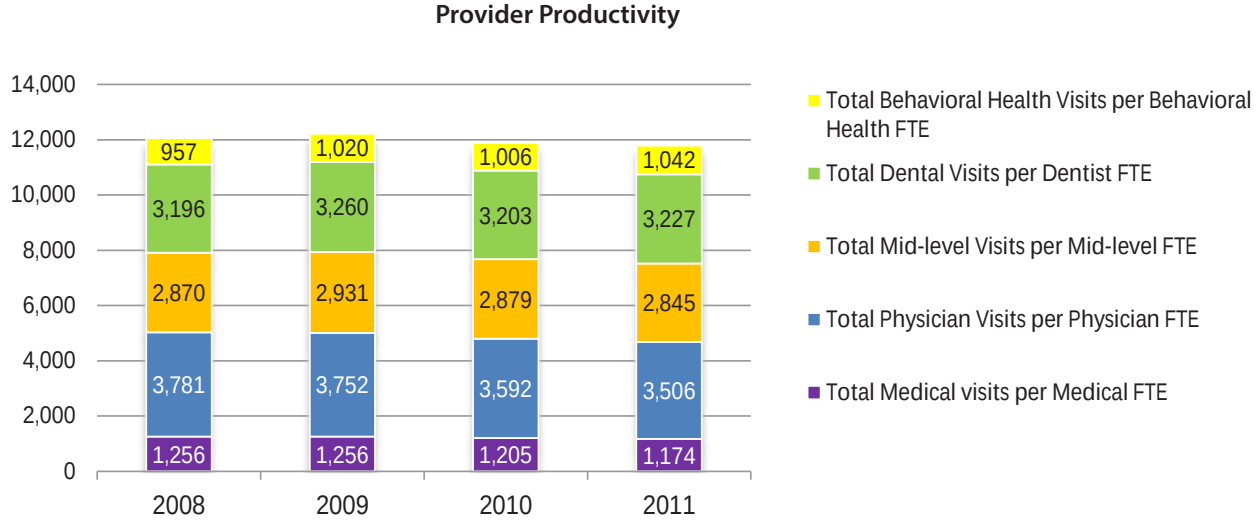
Two areas of significant growth over the study period included the addition or expansion of dental and behavioral health services staff, as HRSA has placed a stronger emphasis on integration of these services into health centers' practices. The chart below details the growth in provider staff at health centers over the study period. Administrative and facilities-related staff, not included in this chart, grew by over 8,000 FTEs-or 18%, over the study period.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Productivity

An increase in provider productivity has a direct and dramatic effect on a health center's revenue model as additional billable visits produce new revenue with little or no extra staff cost and minor additional supplies expense.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

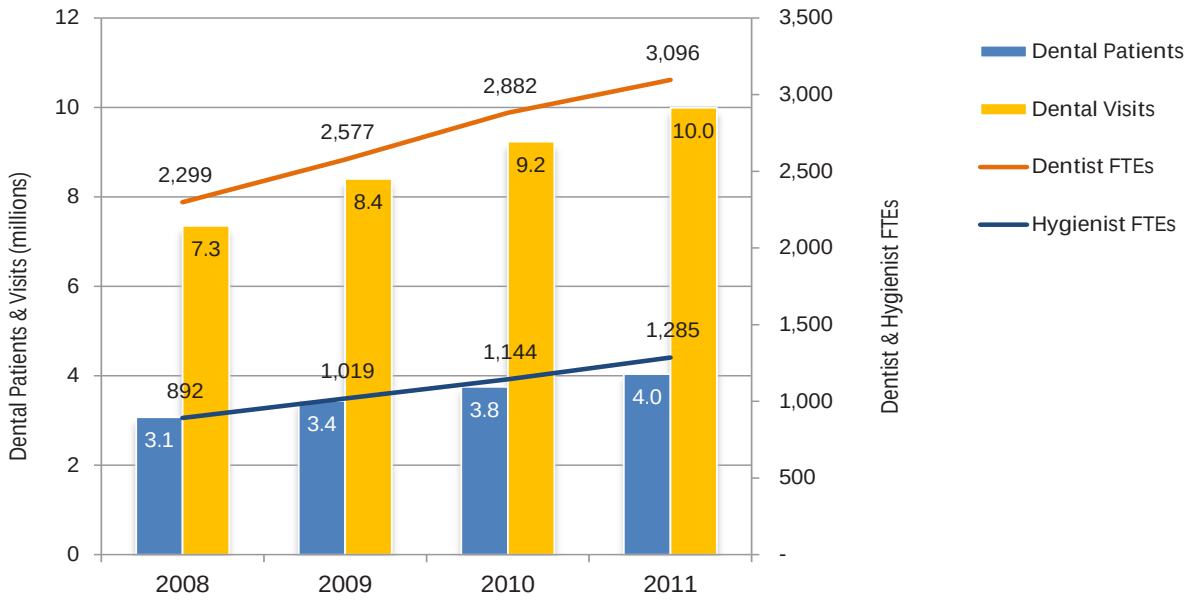
However, as can be seen in the chart above, medical provider productivity has been slowly declining over the study period. There are likely many reasons for this downward trend, including the recent push by HRSA for health centers to purchase and adopt electronic health records systems to better monitor and coordinate patient care. While there is general agreement that this change is both inevitable and in the best interests of patient health, implementation is difficult, time-consuming and usually lowers provider

productivity considerably. The implementation of the ACA, the advent of new payment models structured around outcomes rather than visits, and the growing emphasis on team-based care could significantly alter the relationship between "provider productivity" and patient visits in the future.

Health centers faced with physician recruitment problems and declining physician productivity may have no choice but to focus on recruiting more mid-level providers. These are nurse practitioners, physician assistants and certified nurse midwives, who are less highly trained than physicians but who can handle many of the primary care health issues with which patients typically present at health centers. Mid-levels are also significantly less expensive to hire, which also influences an individual health center's mix of providers.

Dental programs have expanded significantly at health centers over the last decade. The number of dental patients and visits has continued to grow at a fairly consistent pace over the last four years as seen in the following chart. Despite strong demand for dental services in the overall health center population, dental program growth can vary significantly from state to state because there is much less consistency in the reimbursement system for dental services than for medical services. Furthermore, the eligibility rules and reimbursement systems are unpredictable and continuously evolving. States also differ in their treatment of dental hygienists – limiting the work that a hygienist can do or not allowing hygienist work to be billable under Medicaid. Despite this unpredictable funding environment, the high demand for safety net dental services has resulted in strong growth in both dentist and hygienist FTEs at health centers over the last four years.

Dental Full-Time Equivalent Employees Compared with Patient Visits

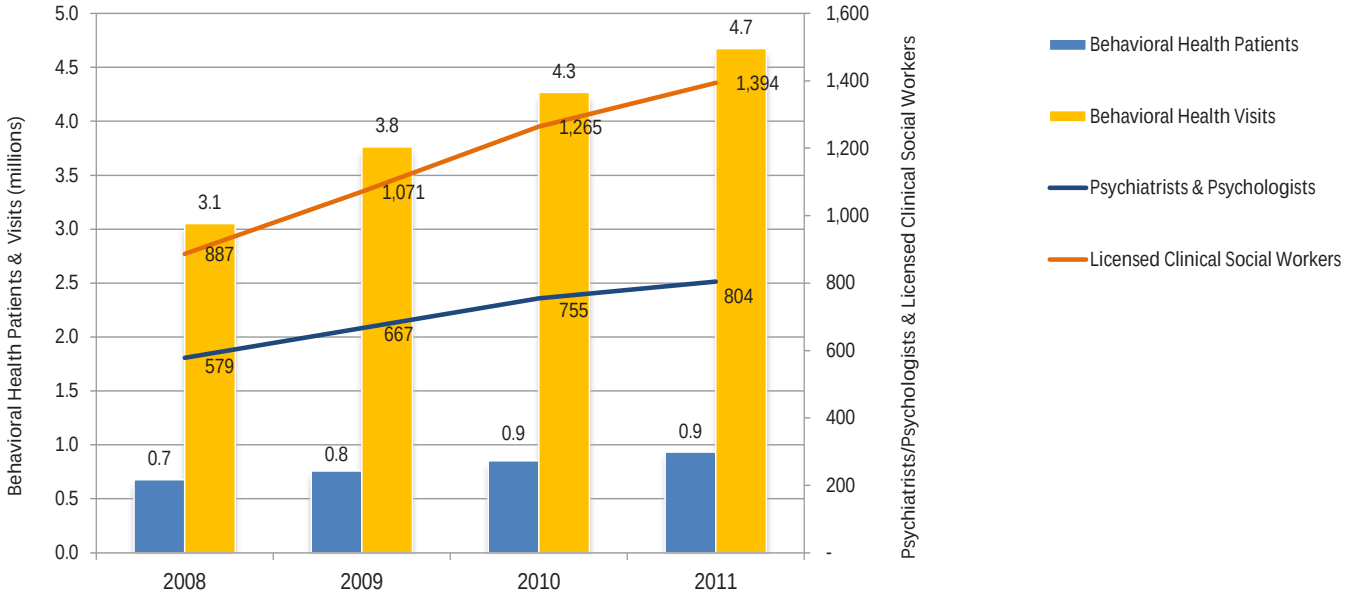


Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Provision of behavioral health services at health centers is growing as a result of a movement across the medical and mental health fields to provide integrated care. Typically, health centers are not the primary mental health providers for the seriously mentally ill – those patients are served at local or regional community mental health providers. Health center behavioral health providers often treat patients for depression

and addiction/substance abuse issues. The prevalence of co-occurring disorders (medical and behavioral health) in the safety net population suggests that the demand for behavioral health services will continue to grow. As can be seen in the following chart, the number of visits per behavioral health patient at health centers has been growing over time (as measured by the gap between the column heights) and behavioral health staffing at health centers is growing proportionately. Behavioral health patients typically have the highest number of visits per patient since care often consists of ongoing therapy, requiring multiple visits.

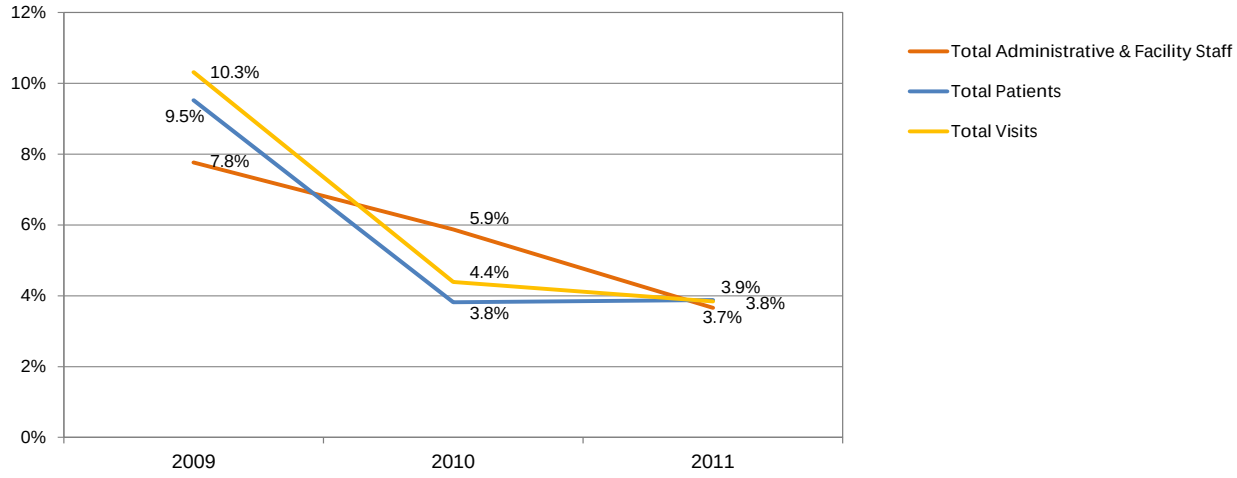
Growth in Behavioral Health Full-Time Equivalent Employees Compared with Patient Visits



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Though not directly tied to provider productivity, it is useful to consider how overhead staffing at health centers has changed over time. As can be seen in the chart below, the rate of growth in administrative and facility FTEs has closely matched the growth rate in patients and visits from 2008 - 2011. This trend is not surprising given the administrative burden associated with simultaneously managing significant growth and multiple federal and state grants and payers.

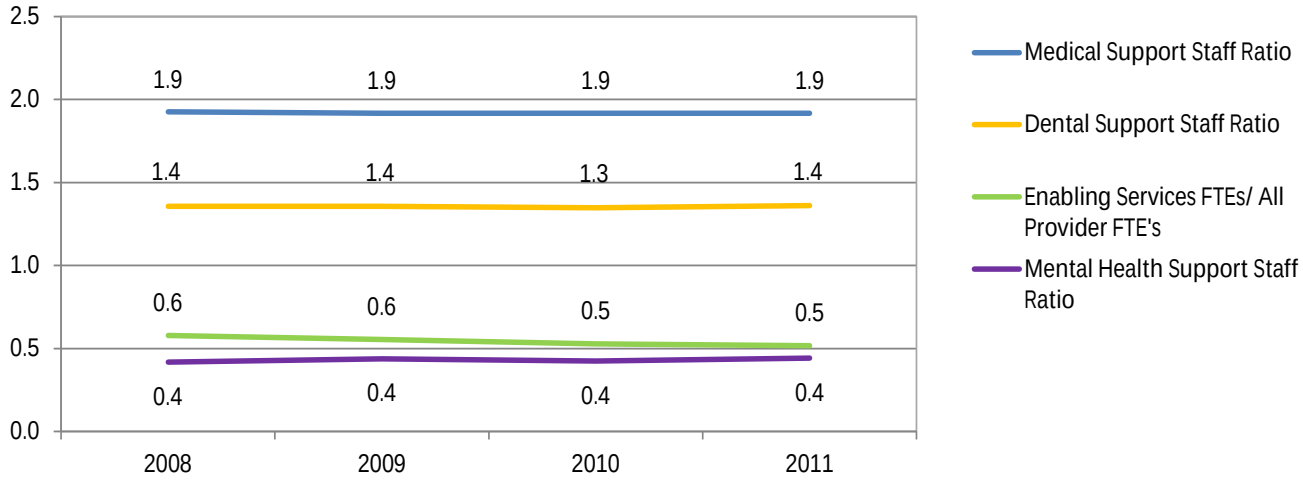
Growth Rate of Administrative Staff Compared with Patient Visits



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

The final staffing ratios to consider involve the support staff required for the various providers by type. Though their work is not directly billable, the number and competency of support staff can have a significant impact on provider productivity when they are effectively utilized to manage patient flow and recordkeeping. This way providers can spend the majority of their time providing direct patient care. As can be seen in the following chart, the support ratios for medical, dental and behavioral health have all been remarkably consistent over the four-year review period. It will be interesting to track these ratios as the PCMH model is implemented across the industry, as many observers expect this team-driven approach to require different staffing patterns than health centers have used historically.

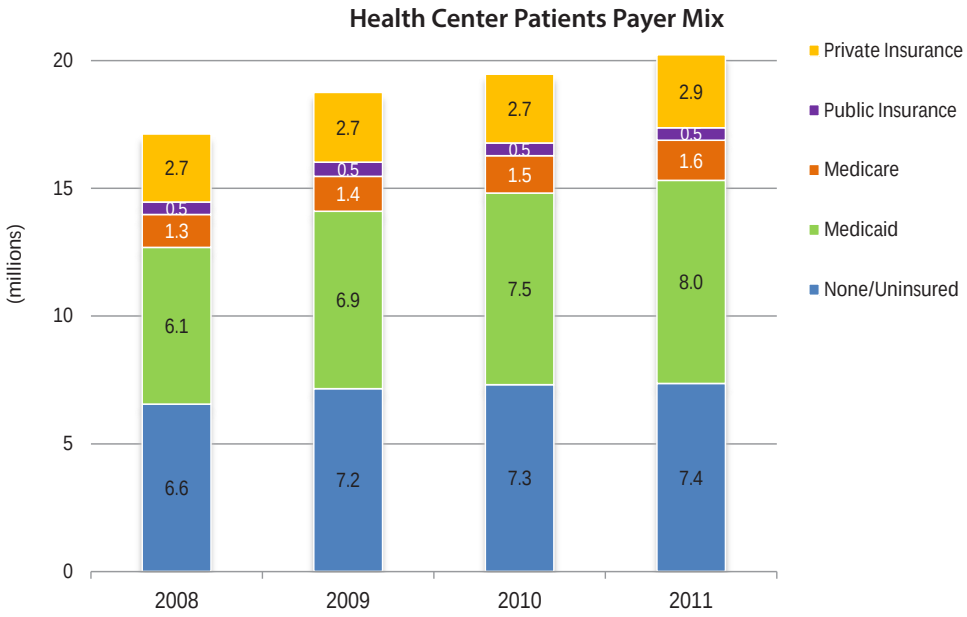
Staff Support Ratios



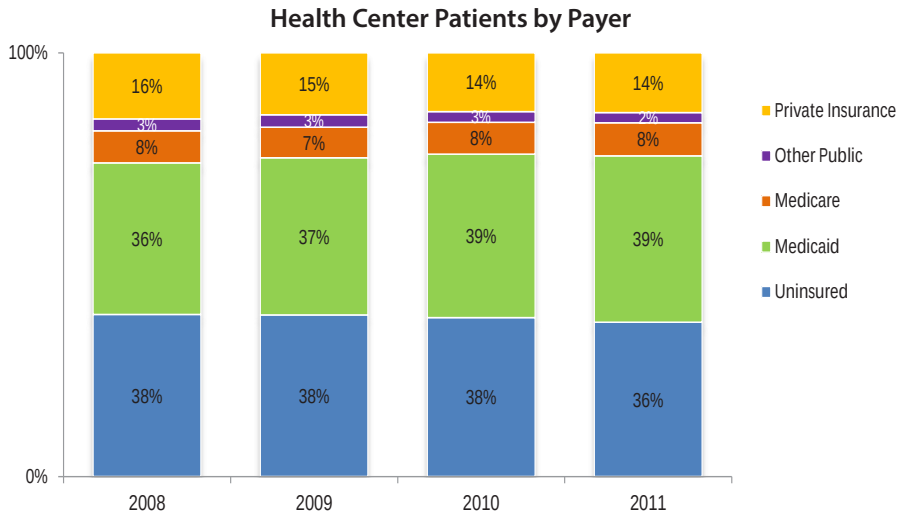
Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Payer Mix

A health center's payer mix is the combination of revenue sources received from all payer types for patient services provided. In 2011, 20.2 million patients received services at Section 330 health centers and of those almost 8 million received Medicaid services and almost 7.4 million were uninsured.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

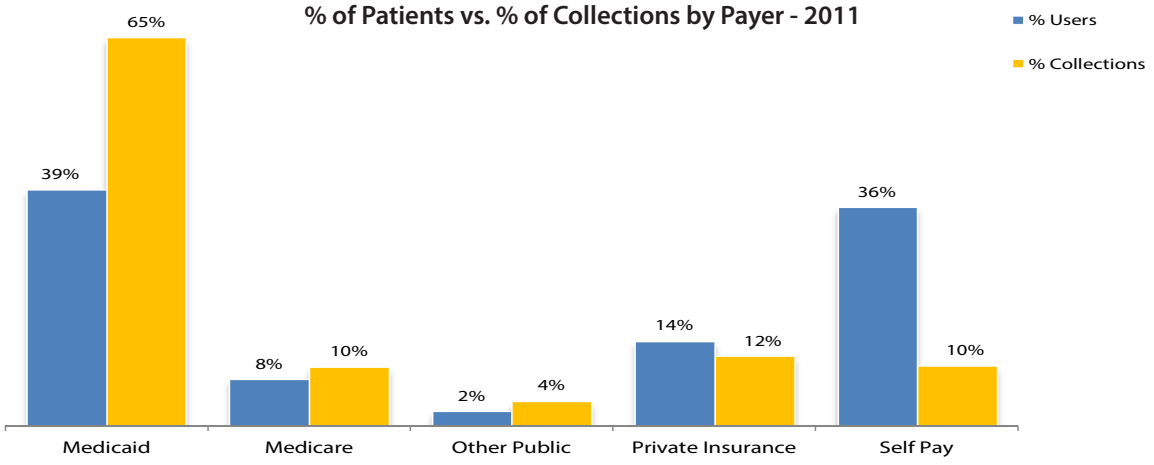
As these charts indicate, health center patients consist primarily of the uninsured and those on Medicaid (collectively over 70% in every year). The two most significant payer mix trends for health centers over the four-year study period are the notable increase in the percentage of patients covered by Medicaid and the decrease in the percentage of uninsured.

One potential cause of these shifts could be that more of the uninsured have become eligible for Medicaid as their incomes declined during the economic downturn. It's also possible that during this time period, health centers redoubled their efforts to assist patients in signing up for Medicaid, generating much-needed revenue to support health centers' services during a time of fiscal austerity. As the country proceeds with implementation of the ACA, which will expand Medicaid eligibility in many states, this trend towards a decreasing proportion of uninsured patients and an increase in patients covered by Medicaid is likely to continue–to the financial benefit of health centers.

The Importance of Medicaid to Health Centers' Payer Mix

While 39% of health center patients were covered by Medicaid in 2011, Medicaid revenues comprised almost 65% of health center collections for patient services. Because of FQHCs' prospective payment system (PPS) reimbursement, payments from Medicaid come close to covering the full cost of providing a broad range of health center services to the Medicaid population. Private payers often do not cover the full cost of services provided—and certainly the uninsured, who pay for services based on a sliding fee scale relative to their income—are not able to pay for the full cost of their care. As a result, Medicaid is a critically important payer for virtually all health centers.

To illustrate this point, the following chart compares the percentage of health center patients who have a particular type of insurance with the percentage of dollars collected by health centers from the respective payment source. It is important to note that this chart examines only the proportion of patients as compared to NPSR collections and does not include GCR, which is often specifically designated to cover the cost of care for the uninsured.



Source: Capital Link Database of Health Center Audited Financial Statements, 2011.

This kind of analysis is useful for understanding how health centers view various payers. They prefer payers whose collection percentage exceeds their user percentage (the orange column is higher than the blue). By this measure, Medicaid is clearly the best payer for health centers–generating positive cash flow to make up for shortfalls in payments from other sources. This chart dramatically illustrates why the expansion of Medicaid through the implementation of the ACA is so important to health centers.

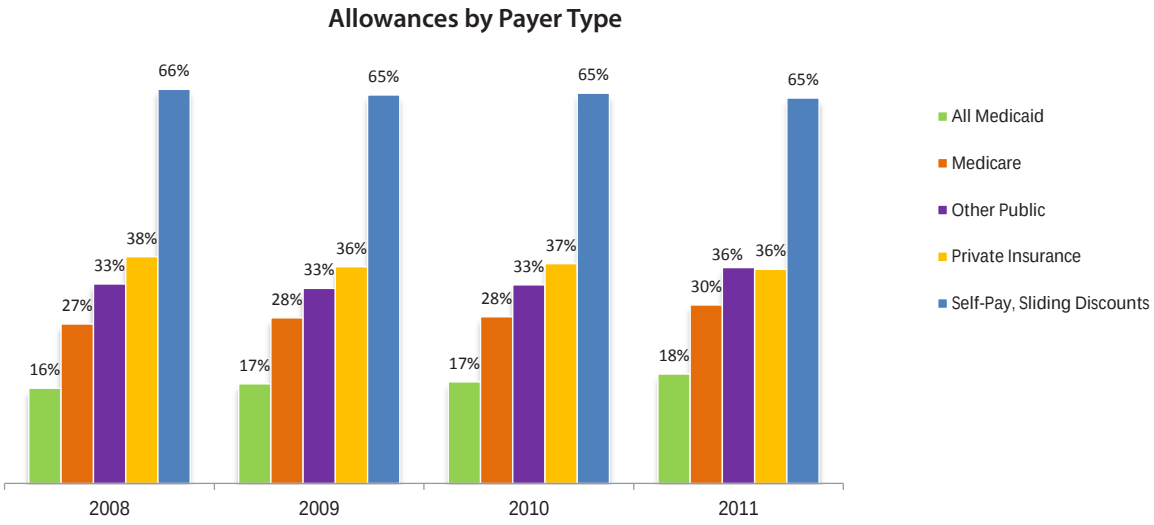
Currently, most private insurers pay health centers somewhat less than the full cost of care. This situation may change after implementation of the ACA when insurers offering plans through the federal and state-run Insurance Exchanges will have to reimburse health centers at rates closer to their full-cost Medicaid rate (prospective payment system or PPS rate). This requirement could result in a further financial benefit to health centers as a result of the full implementation of the ACA.

Allowances

Another way to evaluate the payment and reimbursement system for health centers is to analyze the contractual allowances (or differences between what health centers bill and what they receive in payment from third party payers) and self pay discounts that health centers report. Both of these measures are an indication of potential revenue not earned because either a lower rate has been agreed to contractually (as is often the case with private insurers) or due to claim denials. Any insurer may deny a claim if:

- it is not properly filed, (including data entry errors, which can be exacerbated during the implementation period of an electronic health records system);
- the patient is no longer enrolled with that insurer (which can happen with the Medicaid program because it requires periodic confirmation of eligibility); or
- the treatment as coded is not covered by the individual's policy.

As noted, some portion of the allowances may be within the control of the health center and potentially could be reduced by improved billing and collection policies and procedures. Other allowances are due to programmatic changes. For example, the rise in allowances associated with other public insurance over the review period could well be due to changes in eligibility standards mandated by individual states as part of budget balancing measures. Medicaid allowances are the lowest (best) of all payers largely due to the effects of the PPS, which reimburses health centers for the full cost (or something close to it) of its Medicaid-insured patient visits. The fact that there remains some positive allowance is due to the difficulty of keeping patients enrolled in the program over time and billing visits correctly.



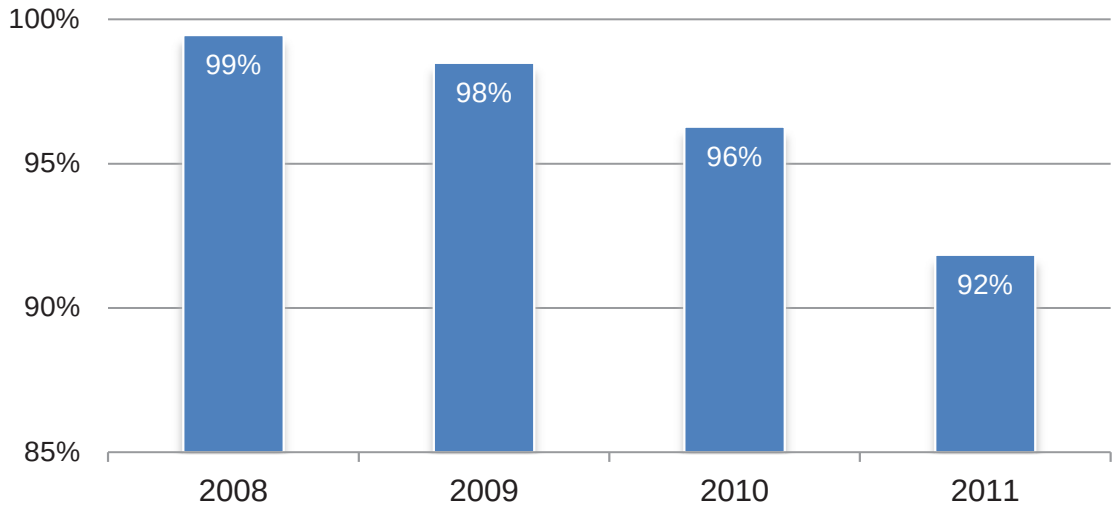
Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Relationship between Section 330 Grants and Sliding Fee Discounts

Under the community health center program administered by HRSA, Section 330 grantees receive an annual grant that is intended to offset (in whole or in part) the reduced revenue from uninsured patients who pay a discounted amount for services received. This sliding fee discount (for uninsured and under-insured patients) is the amount of charges the health center agrees not to collect, and is determined by a standardized system based on each patient's income level. Health centers located in areas of high poverty may realize a significantly lower amount of net revenue from their uninsured patients than centers located in higher income areas.

Initially determined at the time the center is approved as a Section 330 grantee, the amount of the grant is only increased if the center adds approved new services (called a Scope of Service change) or Congress passes an overall increase in the grant (known as a Base Grant Adjustment). Both of these events are episodic and difficult to forecast, so over time the amount of the federal Section 330 grants[7] has fluctuated (usually declining) as a percentage of the sliding fee discounts, which health centers must offer their uninsured patients. The following graph illustrates this trend.

Section 330 and ARRA Grants as a Percentage of Sliding Fee Discounts



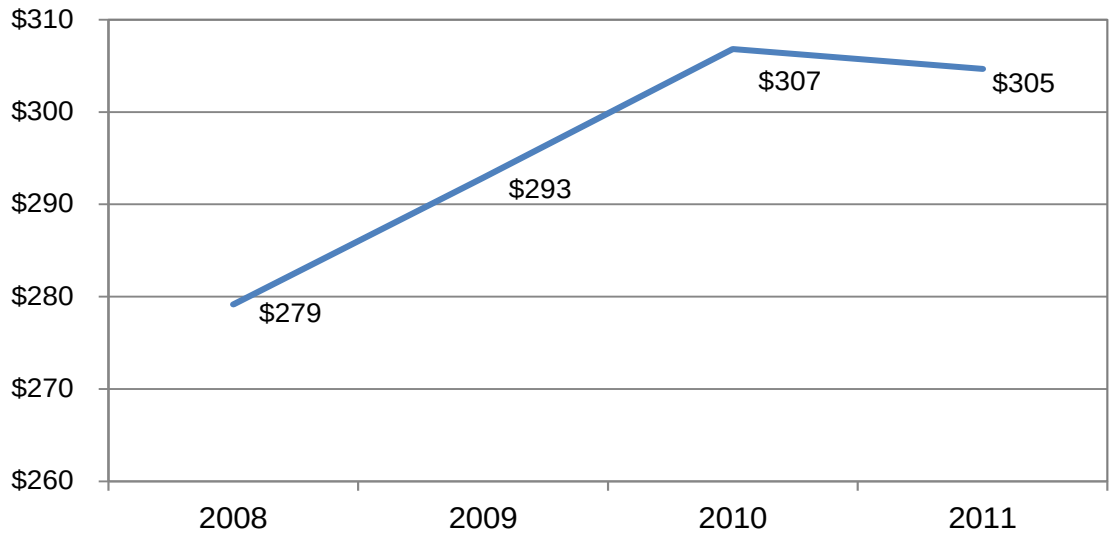
Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

[7]In 2009 – 2011, HRSA awarded additional operating grants to health centers through ARRA. Because these grants function like Section 330 grants, they have been included in this chart and the following one.

One of the challenges health centers face—especially during an economic downturn—is providing care to a growing uninsured population, without necessarily receiving commensurate increases in Section 330 or other funding meant to offset the cost of providing care to the uninsured. Generally, sliding fee discounts increase faster than federal grant funding to offset these costs. Between 2008 and 2011, health centers experienced this trend, with Section 330 grant funding declining in each year as a percentage of sliding fee discounts, despite increasing annually in absolute dollar amounts (following chart) per uninsured patient. By 2011, Section 330 grants represented just 92% of the sliding fee discounts health centers provided to patients—seven percentage points lower than in 2008 just prior to the economic downturn. To the extent that Section 330 grant revenue fails to fully cover sliding fee discounts, health centers must seek subsidies from other sources to make up the difference.

Another way to analyze the relationship between Section 330 grant revenue received (including ARRA grant funding) and sliding fee discounts is to divide the dollar amount of this grant funding by the number of uninsured patients. The results (shown in the following table) demonstrate that HRSA operating grants per uninsured patient increased by approximately 5% per year from 2008 through 2010 and remained essentially flat in 2011. Due to timing differences, it is necessary to use caution in analyzing any single year-to-year change in the amount of Section 330 grants. The award of New Access Point grants in any given year may boost the total, but those awards precede by some amount of time the actual provision of services to the uninsured (since a portion of the grant funding can be used for certain start-up costs, such as purchasing minor furnishings and equipment).

Section 330 and ARRA Operating Grant $ Per Uninsured Patient

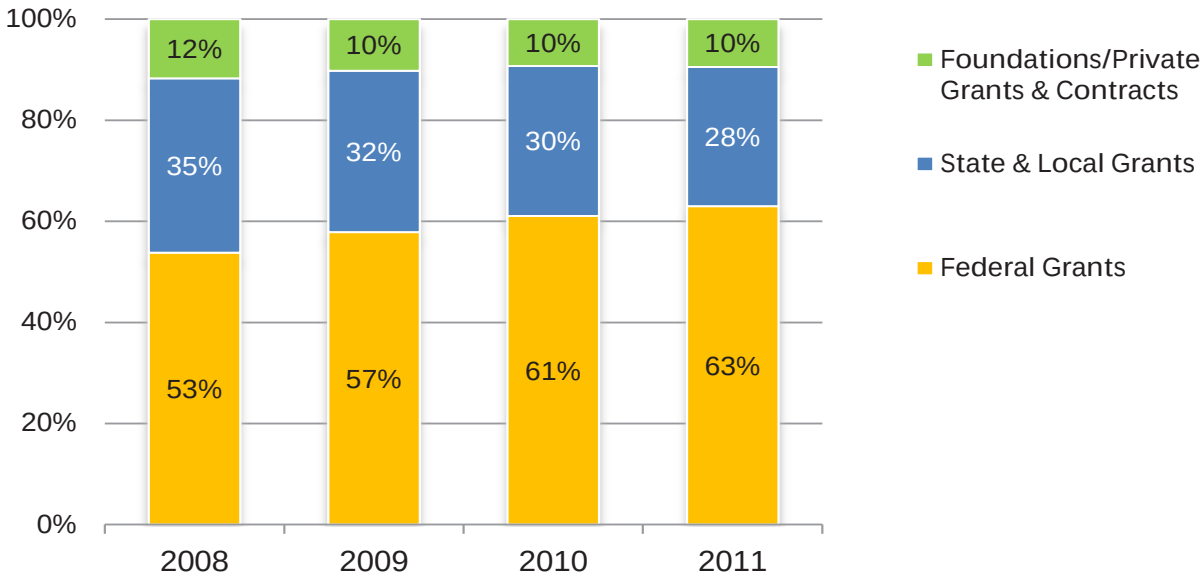


Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Grants and Contracts

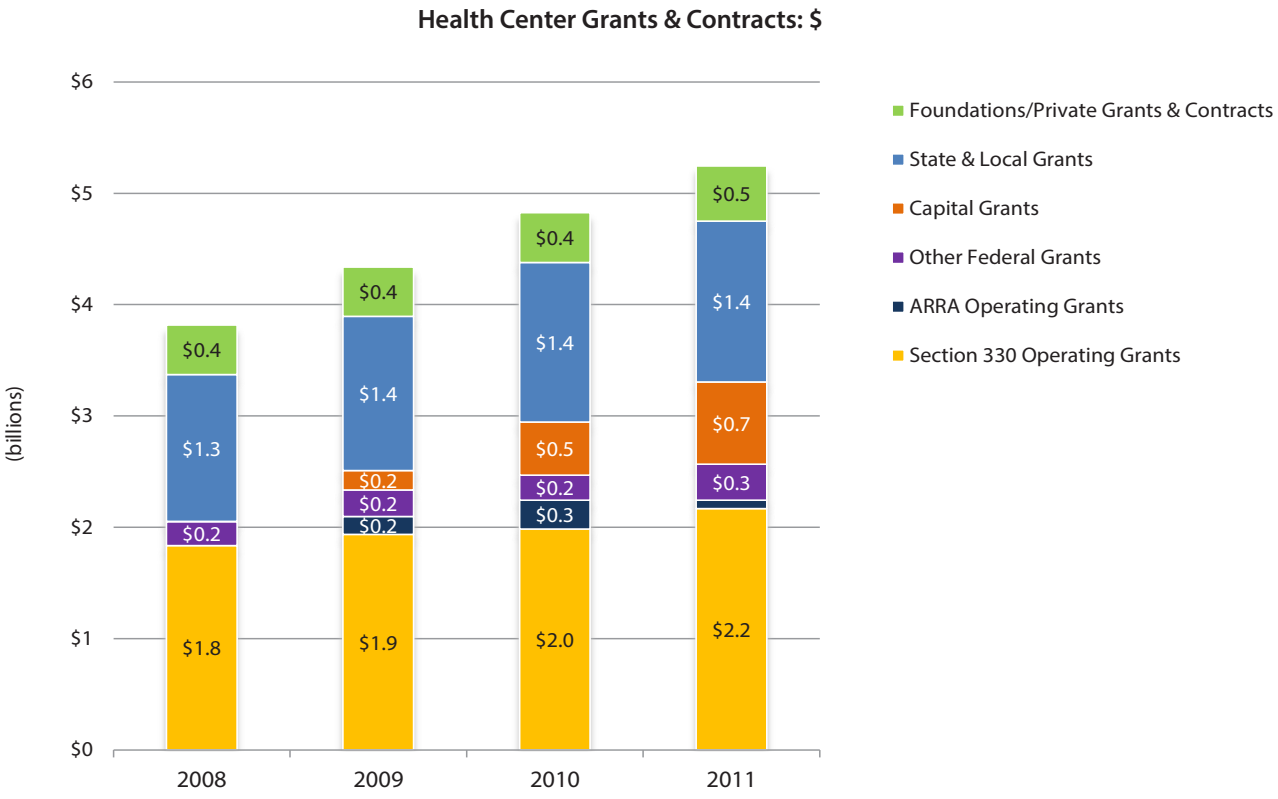
As discussed previously, approximately 35% of health center revenues come from grants and contracts, generally from a combination of federal, state and local as well as private sources. The chart below shows the relative contribution of each grant funding source. The trend shows an increasing proportion of federal grant funding, at about 63% of total grant and contract funding in 2011, up 10 percentage points from 53% in 2008.

Health Center Grants and Contracts: Major Sources



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

While state, local and foundation grants have been holding steady on an absolute dollar basis over the study period, federal grants have grown significantly on an absolute and on a percentage basis, as shown in the following chart. Clearly, investments by the federal government through ARRA and ACA have been driving health center growth since 2009. While the ARRA operating and capital grants available through HRSA were substantially awarded by 2012, the $11 billion in ACA operating and capital dollars began to take effect as increases to Section 330 operating grants and capital grants in 2010 and 2011. This growth in ACA funding should continue until at least 2015 and bodes well for health center finances.



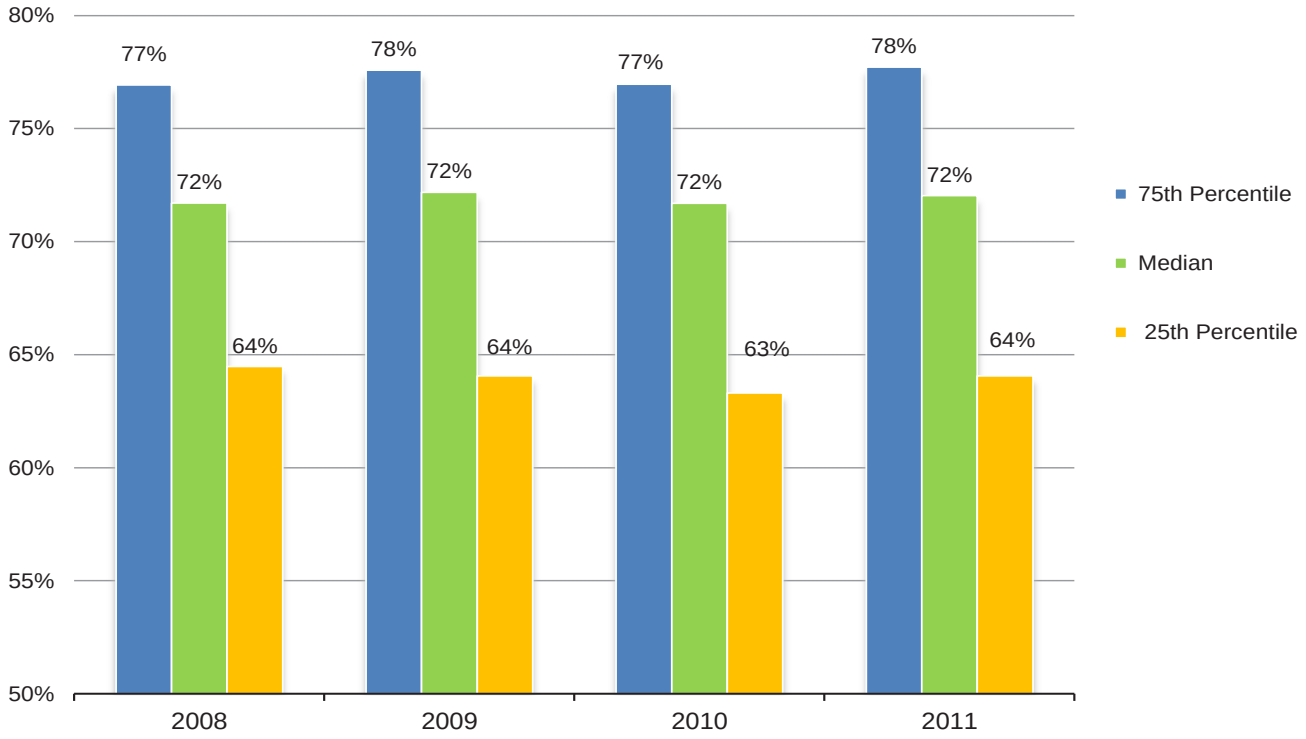
Capital Grants includes ACA, ARRA, and Other.

Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Operating Expenses

Personnel-related expenses are generally the most significant component of health center operating budgets, and the ability to control these costs is critical for financial success. Personnel-related expenses include salaries, fringe benefits and professional/contracted services. Half of all health centers spent 72% or less of their operating revenues on personnel-related expenses and 50% of this group spent 62% or less, affording them the most flexibility related to incurring other expenses. The remaining half of health centers spent in excess of 72% on personnel-related expenses, with 50% of this group spending more than 77% of operating revenues on this expense, leaving limited budget flexibility to cover other operating expenses. Over the study period, this ratio has been extremely stable indicating that, for the majority of health centers, this significant expense category is consistently managed.

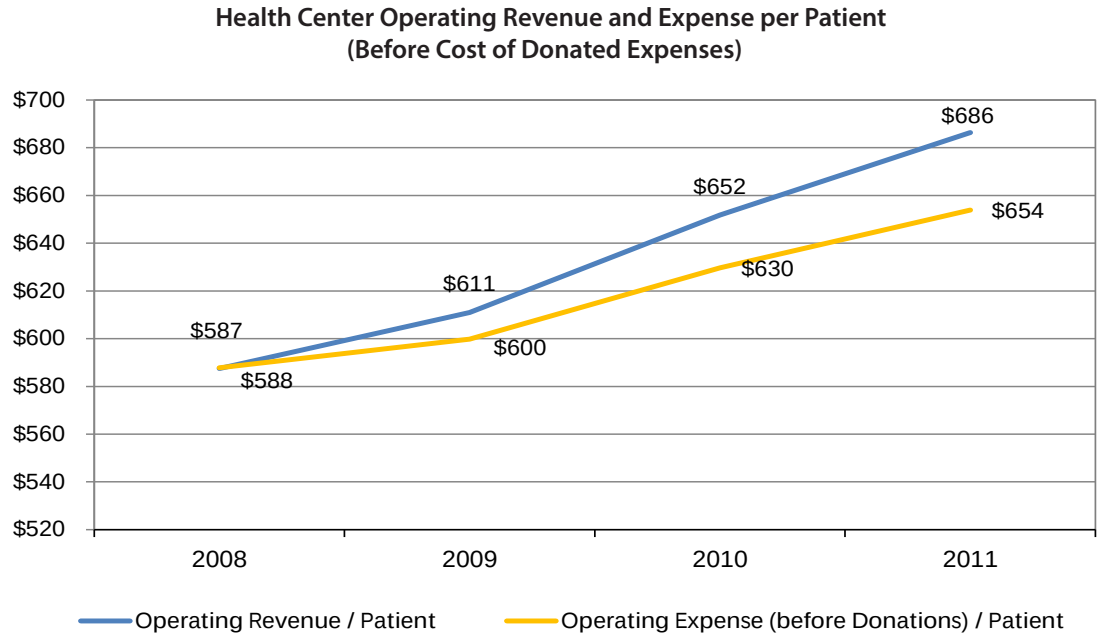
Health Center Employment-Related Expense as a Percent of Operating Revenue



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

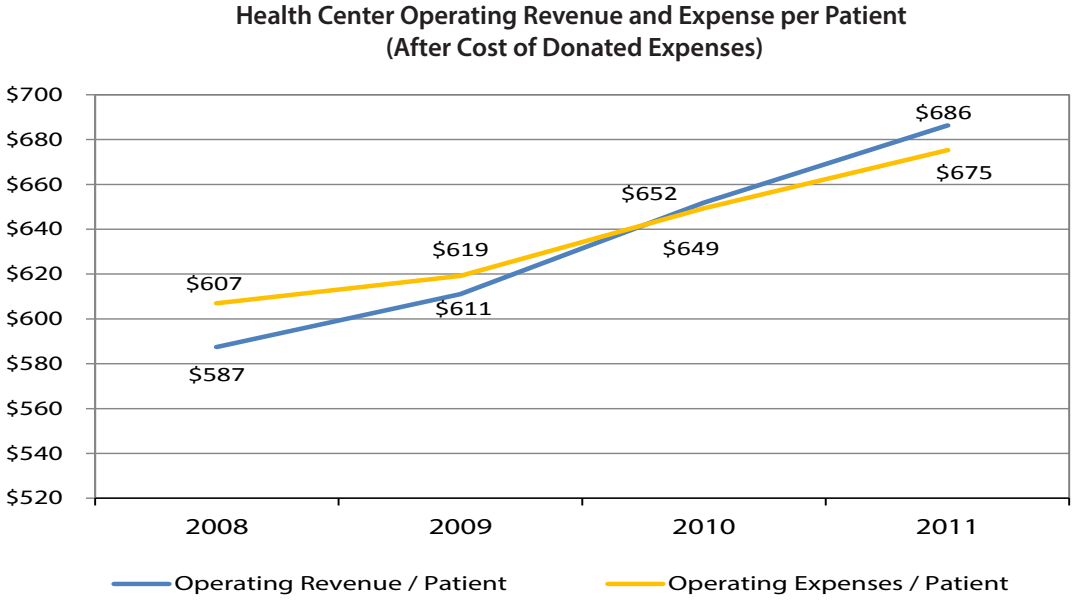
Average Annual Revenues vs. Expenses per Patient

The health center industry as a whole operates with a relatively narrow margin between average revenues and expenses per patient. The following chart offers a window on the average revenues collected per patient versus the average amount spent in providing services per patient. The UDS data indicates some improvement over time in the average revenue collected per patient as compared to the average expense per patient – with the differential turning more positive in 2010 and 2011.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

However, it is sobering to view the same data with the value of donated goods and services included as expenses (see chart below). A different conclusion on the financial health of the industry might be drawn when it is understood how much of the margin between average revenue per patient and average cost per patient is dependent on the good will of providers (some of whom volunteer their time) and suppliers (some of whom provide free materials such as pharmaceuticals). The trends are the same under both scenarios, but it is clear that industry margins are thin and dependent to some degree on the largesse of participants.



Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

It must be recognized, however, that this data reflects the industry as a whole and not the experience of individual health centers, which varies across a range of measures.

Section IV:
National Financial Ratios and Trends

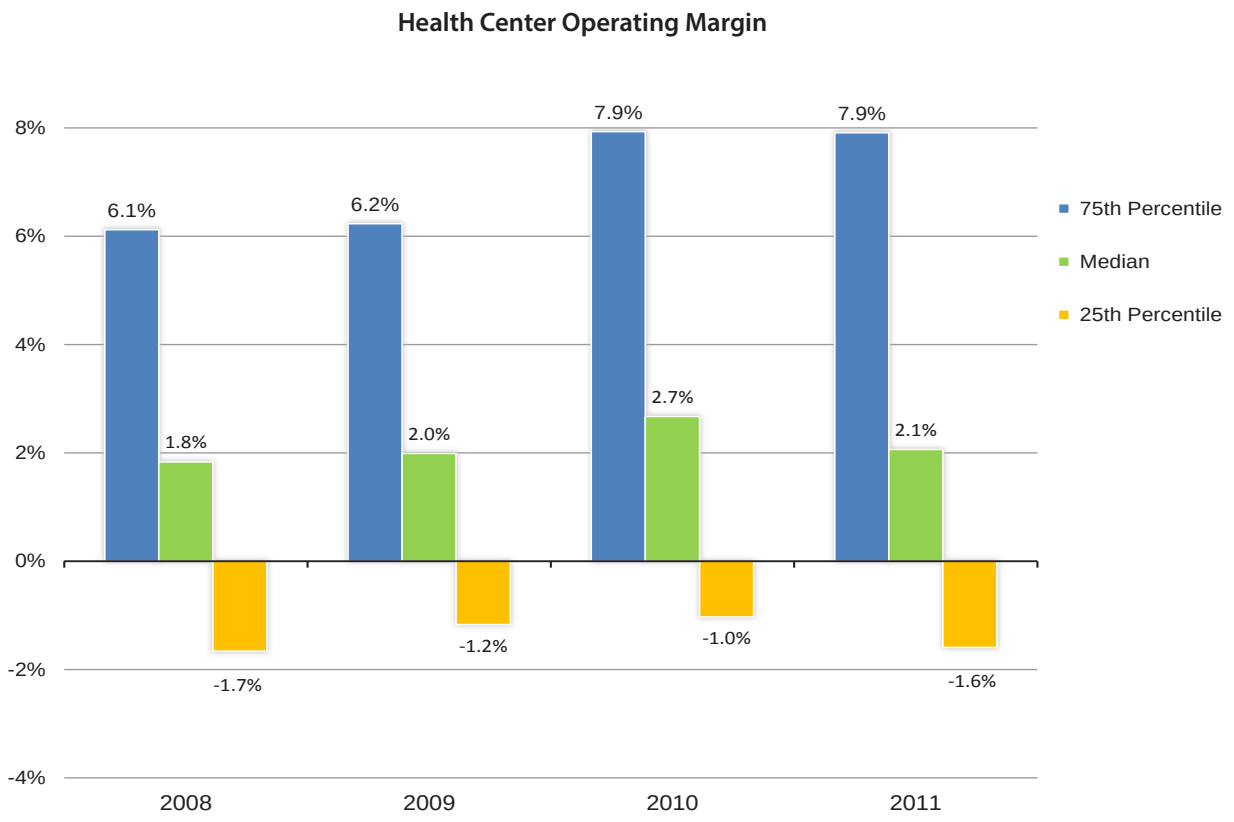
This section examines profitability, liquidity and capital structure ratios and reports health center trends from 2008 – 2011, based on audited financial data included in Capital Link's national database.

Profitability Measures

Operating Margin

(Change in Net Assets from Operations / Operating Revenue)

Operating Margin is a critical measure of a health center's financial health. Health centers in this analysis had a wide range of operating margins as reflected in the chart below.



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

At the median, health centers operated with relatively tight margins as reflected by the 2% average operating margin. This margin is not high enough to allow for the accumulation of recommended operating reserves as well as sufficient capital reserves to self-finance capacity growth. At the 75th percentile, health centers generated an average 7% operating margin over the four-year period while at the 25th percentile, health centers generated operating margins that averaged a negative 1.4%, reflecting less-than-break-even operations.

These results indicate that at least one quarter of health centers in the data set in any given year posted operating losses. An inability to maintain at least break-even operating margins over time is not sustainable. Such an outcome on a repeated basis would suggest that some of these centers may need to ramp up their development efforts, appeal to their state legislatures for additional assistance or look for merger partners. For centers in the 25th percentile, the implementation of the ACA may have come at the right time as most observers agree that the law will significantly improve the payer mix for most health centers. It should be noted that this improved payer mix will likely not materialize for centers in states that do not choose to expand Medicaid as the law allows.

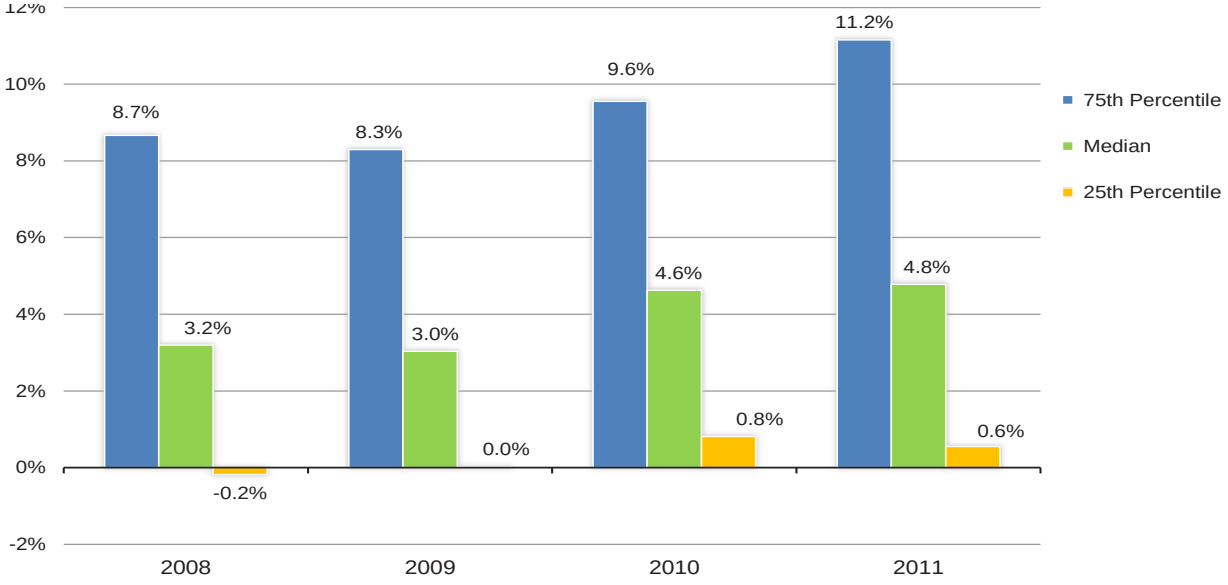
The fact that the 75th percentile line is farther from the median than the 25th percentile line suggests that the best performing health centers are financially outpacing their counterparts to a disproportionate degree. Efforts to understand how they achieved this success could be extremely useful to the field as it seeks to improve its performance over time.

Bottom Line Margin

(Change in Net Assets / Operating Revenue)

The bottom line margin measures the proportion of change in net assets (or net income) to operating revenue after taking into account all revenues and expenses. Most health centers do not have significant non-operating income as few have significant cash balances from which to generate investment/interest income and their capital campaign fundraising tends to be relatively modest. As a result, bottom line margins tend not to differ greatly from operating margins. It is noteworthy that from 2009 – 2011 HRSA awarded approximately $1.37 billion in capital grants to certain health centers as a result of ARRA and ACA, contributing an average of 3% of health center revenues during this time period. When including such non-operating sources of revenue, health center bottom line margins improved, on average, approximately 2% for all quartiles. It is notable that the bottom line results for the health centers in the 25th percentile have improved above the break-even level in recent years. With the end of the recent HRSA capital grant cycles resulting from ARRA and the ACA, it will be interesting to see if this quartile can sustain its recent success

Health Center Bottom Line Margin



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

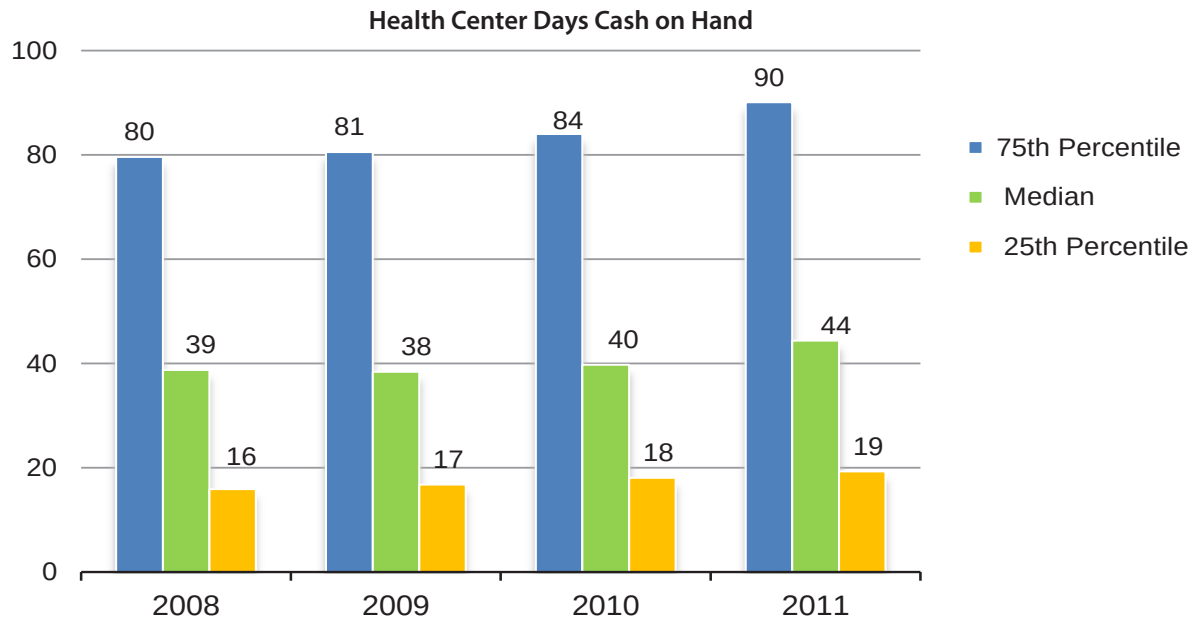
Liquidity Measures

Days Unrestricted Cash on Hand (DCOH)

(Total Unrestricted Cash and Investments / Daily Cash Operating Expenses)

DCOH is a liquidity measure that calculates and represents the number of days an organization can cover its daily cash operating expenses with its current level of cash and investments; for this measure, higher is better. Unrestricted cash and investments refers to those funds not restricted by time or purpose that are available for general operating uses.

Relative to hospitals, health centers tend to have more limited cash reserves. Due to the income ranges and insurance status of the patients they serve, health centers operate with relatively narrow operating margins. This, in turn, limits their ability to generate significant cash reserves. In addition, many centers have several months of revenue tied up in accounts receivable, not all of which may be collectible. With a high percentage of government insurance payers, health centers can be subjected to interruptions in their payments due to state and federal budget issues. Given these challenges, it is essential that every health center accumulate an operating cash reserve to allow sustained operations during cash flow crises. While a strong argument can be made that health centers should have at least 60 days of operating cash reserves on hand to safely weather cash flow interruptions, an analysis of the data in the chart shows that this is clearly the exception in the industry. The median level is closer to 40 days, but it is increasing across all cohorts.



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

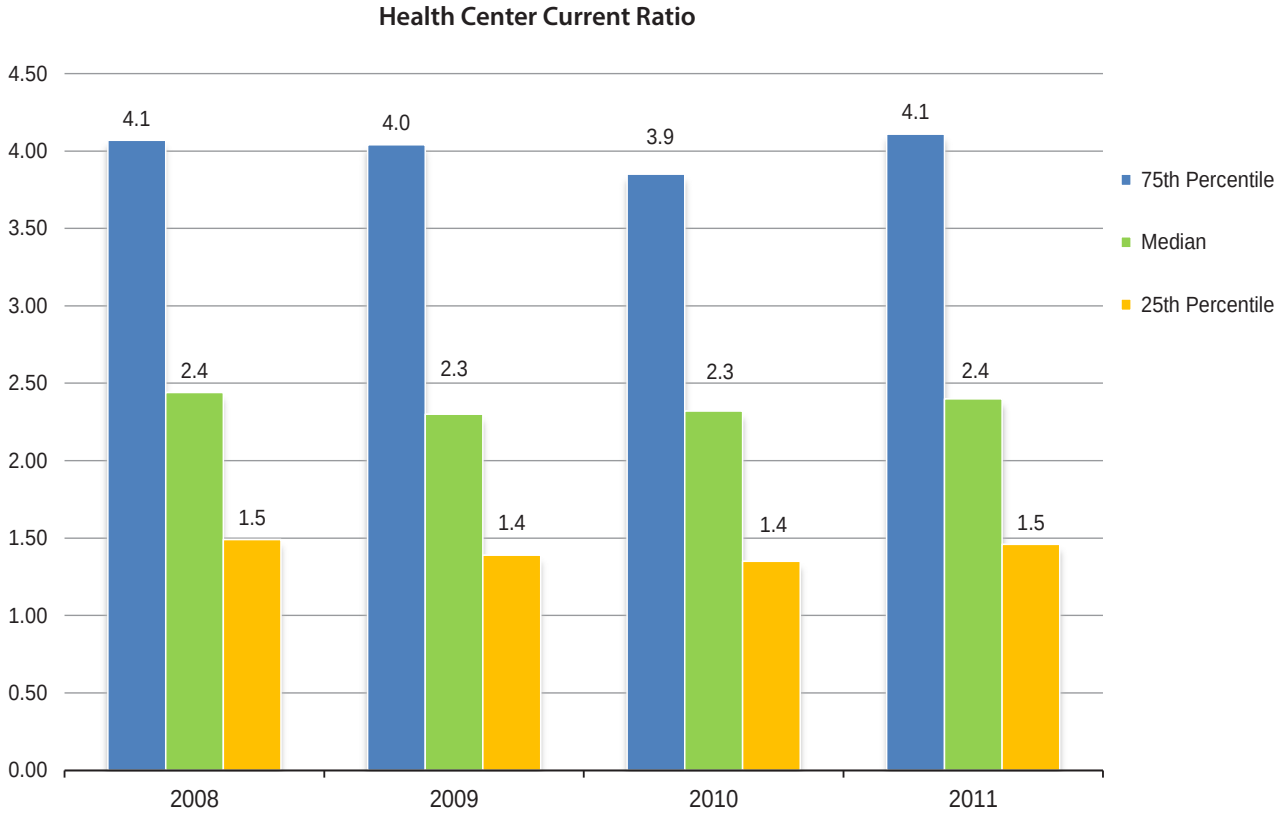
For centers in the 25th percentile, cash reserves were extremely low. At only 20 days, they barely exceed one payroll cycle. At these cash levels, survival becomes the paramount concern and a center's ability to provide optimal health care services to their community is severely constrained.

Current Ratio (CR)

(Current Assets / Current Liabilities)

Another liquidity ratio, the current ratio is a measure of an organization's ability to meet its current obligations (due within one year) with its current assets (cash, receivables and other assets that can be converted into cash within one year). A higher ratio indicates a greater amount of current assets available to meet current liabilities. The current ratio gives a sense of the efficiency of a company's operating cycle or, for health centers, the ability to turn receivables into cash. Similar to DCOH, health center current ratios were stable over the study period and consistently indicated good short-term financial strength for the majority of organizations. At the median, CR averaged 2.4, indicating that current assets covered current liabilities up to 2.4 times for half of the health centers studied. Notably, health centers at or above the 75th percentile reported strong CRs of four or better. Acceptable current ratios vary from industry to industry and are generally between 1.5 and 3 for healthy businesses.

However, with an average current ratio of 1.4 over the period, the 25th percentile, as a group, is more challenged with its operating cycle. With low cash reserves in most of this cohort, maintaining a positive current ratio is dependent on the collectability of these centers' accounts receivable, which can be challenging given the myriad of payers that health centers usually bill.

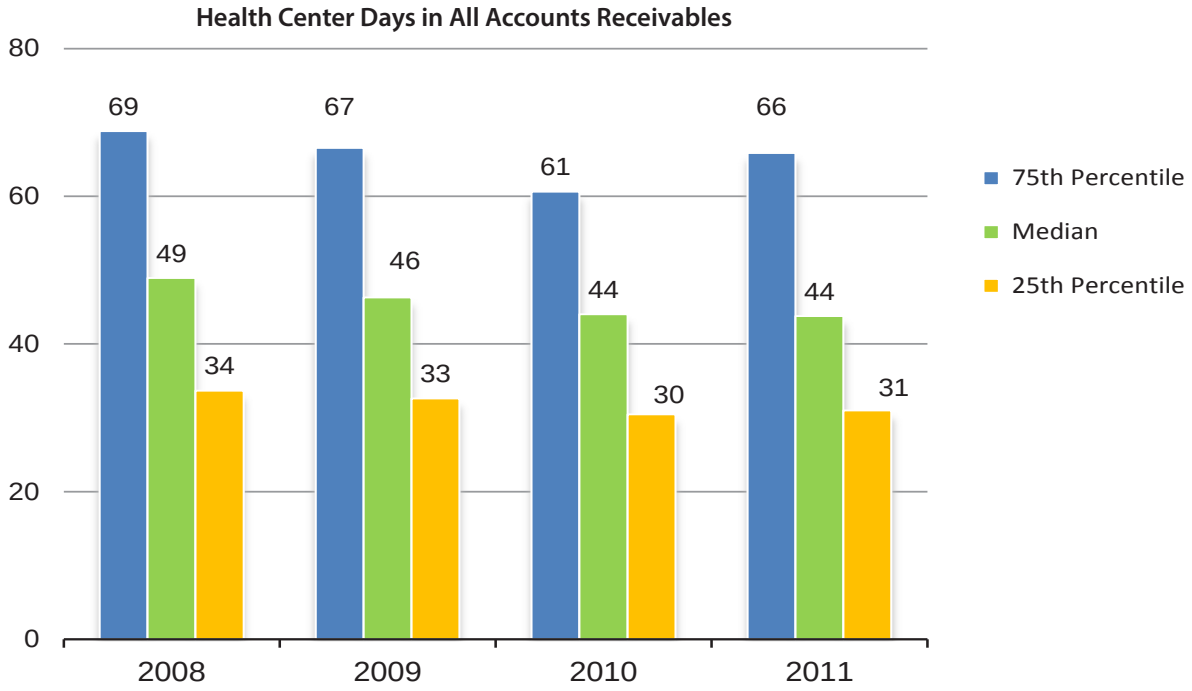


Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

Accounts Receivable Days (AR Days): All Receivables, Net Patient Receivables and Grant and Contract Receivables

All Receivables Days: (Total Receivables / Total Operating Revenue divided by Number of Days in Period measured)
Net Patient Receivables Days: (Total Net Patient Service Receivables / Total Net Patient Service Revenue divided by Number of Days in Period measured)
Grant and Contract Receivable Days: (Total Grant and Contract Receivables / Total Grant and Contract Revenue divided by Number of Days in Period measured)

For health centers, receivables primarily consist of net patient service accounts from all payers plus operating grant and contract payments. AR Days is a measure of an organization's ability to bill and collect its accounts and receive payments in a timely fashion. Since the goal is to turn receivables into cash as quickly as possible, lower receivable days are positive and reflect organizations that are able to more quickly convert these assets to cash. Since NPSR represents, on average, 57% of all health center revenue, it drives all receivable days, which averaged 46 days at the median.



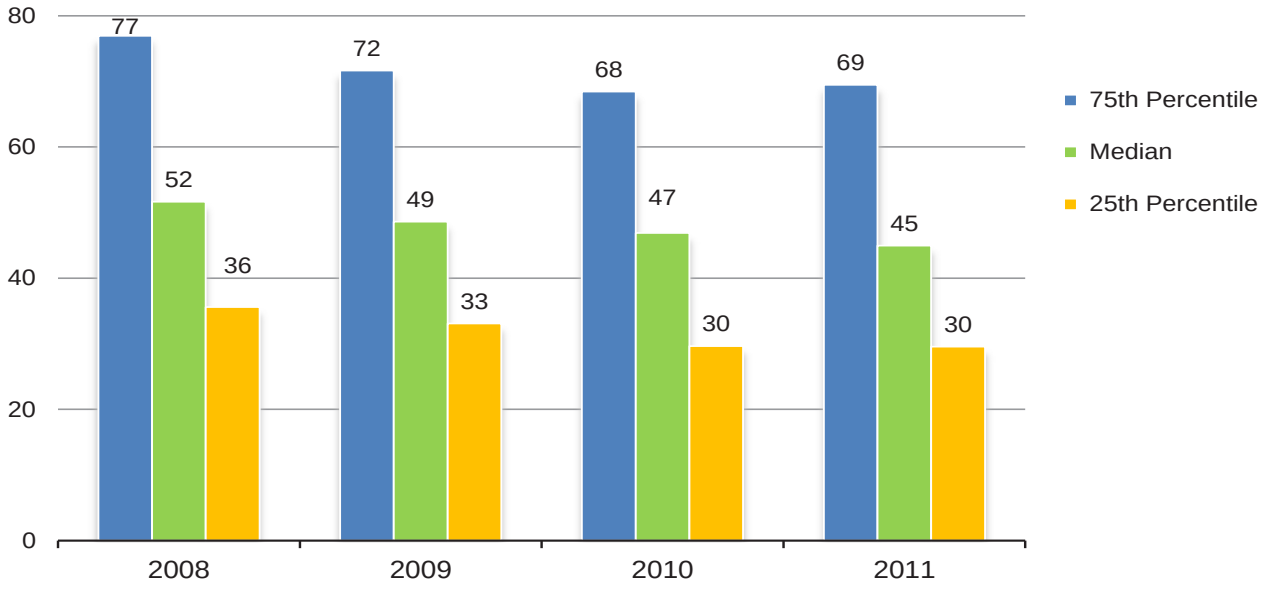
Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

As indicated in the following chart, half of all health centers turned their patient receivables into cash within 48 days, on average, over the four-year study period. Within this group, the strongest cohort collected at 32 days or less, all under the recommended maximum range of 65 – 75 days. The remaining half of health centers reported greater than 48 NPSR receivable days, with half of these taking the longest time, or at least 72 days, to turn patient receivables into cash.

It is important to consider why there is a 40 day discrepancy between the collection rate of the centers at the 25th and 75th percentiles. Though Medicaid is often thought of as a federal program, it is run by the individual states and it is probably safe to say it is run in 50 different ways. Claims submission and payment rules differ from state to state, which likely accounts for some of the difference in collection experience. Further, billing and collection departments of health centers are not staffed and trained identically.

Lastly, this collection discrepancy may be due to the quality of the receivables themselves. Policies differ from center to center for writing off receivables, adjusting for allowances and/or assigning them to collection agencies. In under-staffed finance departments, uncollectible receivables may age on the books longer than centers with the luxury of more and/or better-trained staff and more sophisticated practice management systems.

Health Center Days in Net Patient Services Receivables

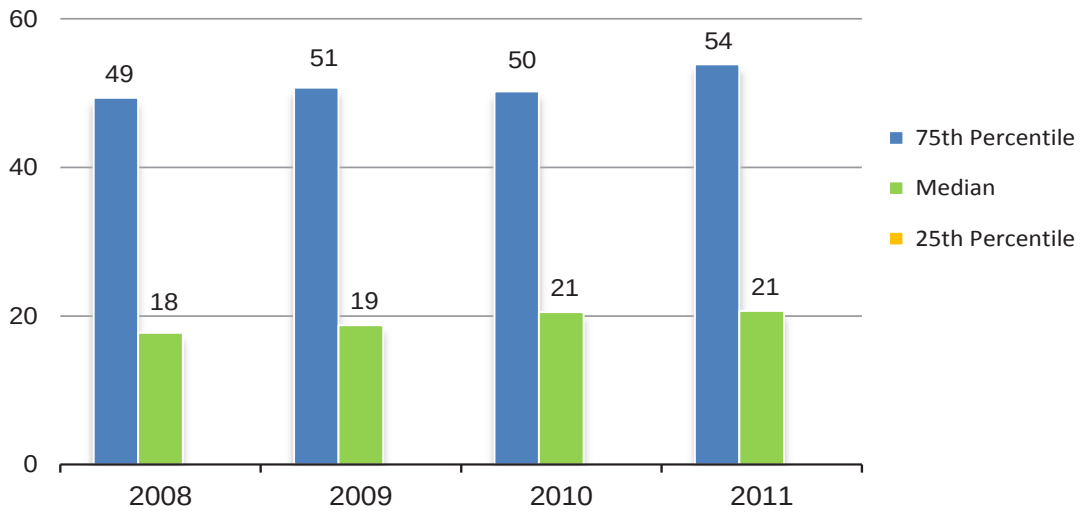


Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

The days in grants and contracts receivable chart indicates that: (1) health centers at or below the 25th percentile reported no Grant or Contract receivables, hence the 0% ratio for this group and (2) the lower median and 75th percentile grant and contract receivable days, when combined with net patient receivable days, lowers all receivable days. In many cases grant funding is available for drawdown as costs are incurred or through a "ready payment" system, putting these funds into health center operating accounts relatively quickly, decreasing the proportion of grant funding carried as overall receivables. Therefore, net patient receivables days tends to be a more helpful and accurate measure of a health center's collection process.

While days in grant and contract receivables has been fairly consistent over the study period, there appears to be significant variability in grant receivables turnover rates across health center cohorts. This variability is difficult to interpret as high or low rates are often not correlated with health center performance. Drawing grant revenue down ahead of the provision of related services (creating a deferred revenue liability) is generally the result of a grant funder's policy of upfront payment of the grant when it is awarded. Moreover, differences in the timing of a health center's fiscal year and the grantmakers' fiscal year can automatically create grant balances on the audited financials of the health center that tell us nothing qualitative about how the health center is performing.

Health Center Days in Grants and Contracts Receivables

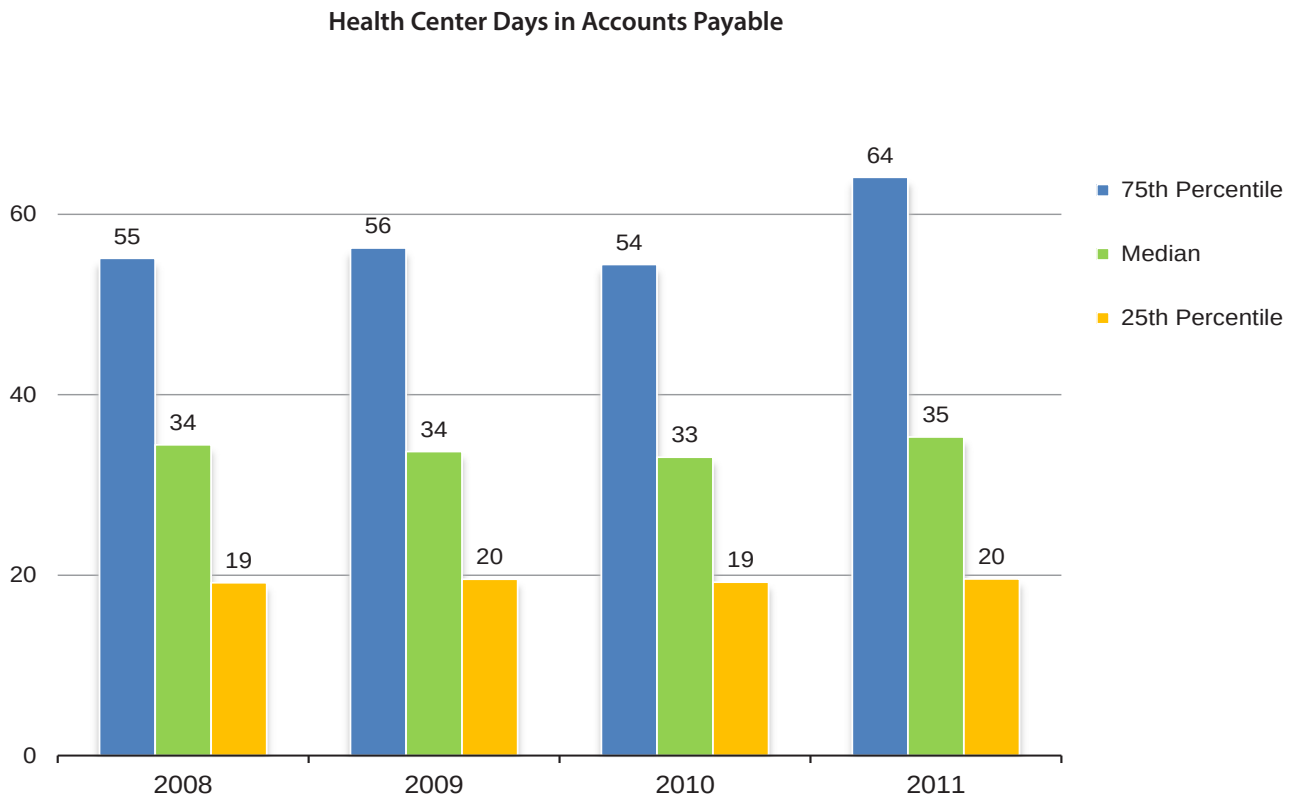


Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

Accounts Payable Days (AP Days)

(Accounts Payable / Total Cash Operating Expense minus Salaries all divided by Number of Days in Period measured)

In most cases, health centers pay their vendors faster than they themselves are paid.



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

Generally, health centers report low accounts payable days, with the median averaging 34 days and the 25th percentile (in this case, the strongest cohort) 19 days or less, indicating that half of the health centers studied paid their bills within 34 days or less of receipt of invoice and 50% of these paid within 19 days or less. Hence, a lower number of days in payables is a positive indication that a health center has the liquidity to pay its bills promptly. While days payable is best measured against the terms under which credit is granted, generally anything over 60 days may be cause for concern. At the 75th quartile AP Days were at or above 64 in 2011, slightly above the high end of the recommended range, indicating that at least 25% of health centers may be having trouble meeting their financial obligations when due.

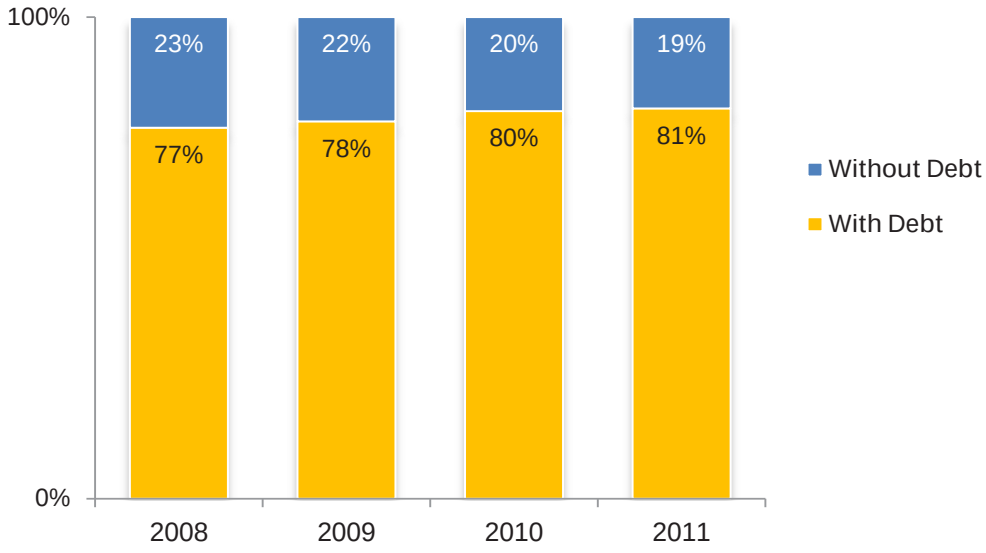
Debt Load and Capital Structure

Total Debt

Historically, health centers have reported relatively low debt levels, with a significant portion of the industry carrying no debt at all. Since health centers have limited cash reserves and a complex and not well understood operating model, they have faced challenges in accessing credit from banks and other sources. However, health centers' general debt aversion has also impacted their willingness to seek significant levels of debt—even when their credit profiles are fairly strong. As a result, the industry as a whole has a limited borrowing track record.

Further, over the study period, the federal government made available $1.37 billion in capital grants for health centers, eliminating at least some of health centers' need to take on debt to fund capital projects. Nevertheless, with the pressure to grow, an increasing proportion of health centers are seeking debt as a way to accelerate and manage their growth. The following chart shows the increasing proportion of health centers with debt[8] —and the declining share of health centers without it. It is likely that this trend will continue now that capital grant funds from HRSA have been fully allocated—and with dim prospects of additional capital grants from the federal government in the future.

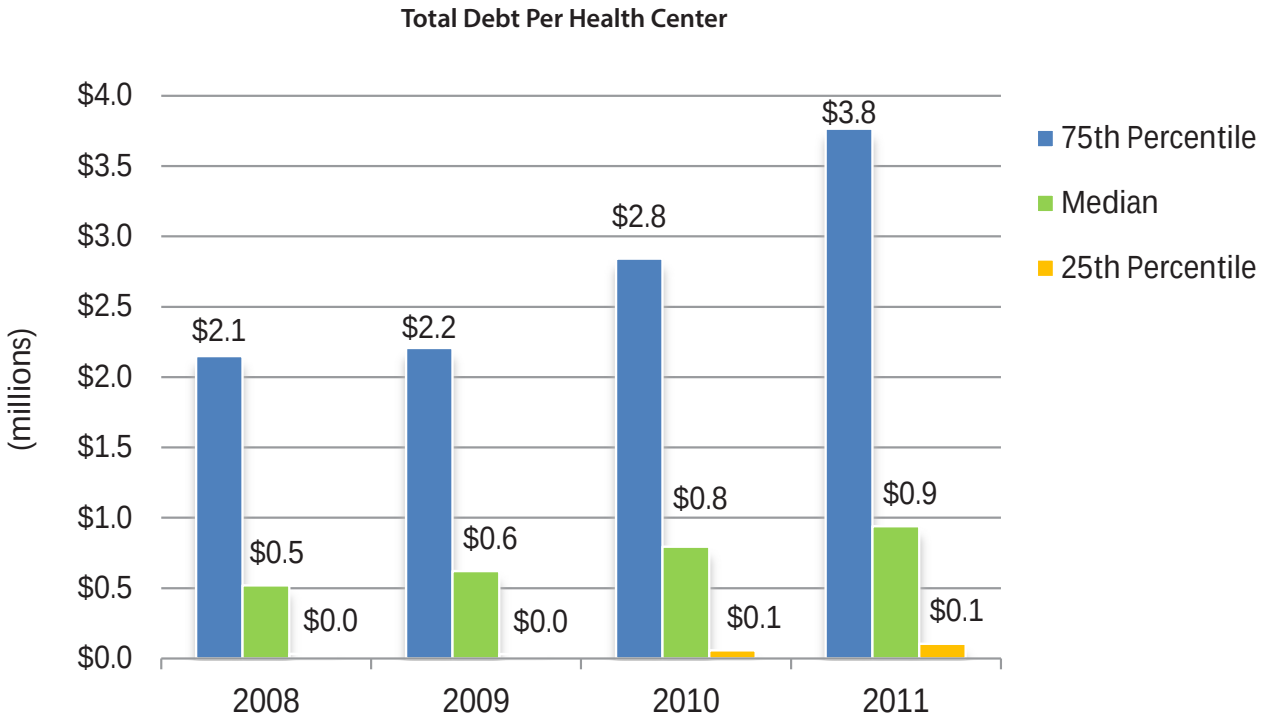
Proportion of Health Centers With and Without Debt



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

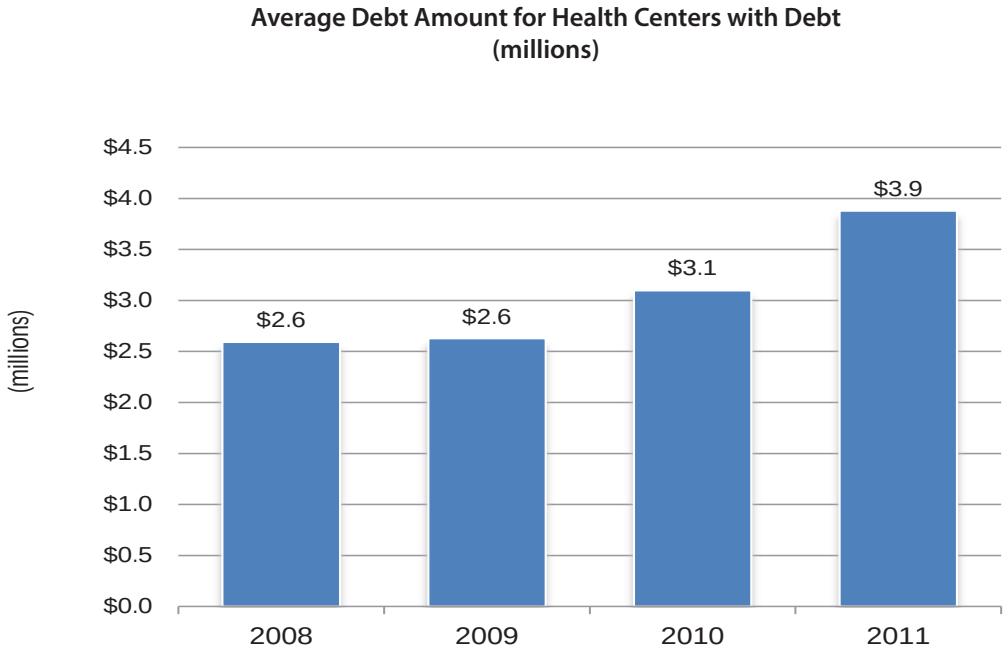
[8]Debt includes short-term and long-term loans, lines of credit and/or short and long-term capital leases.

Even for health centers with debt, the amount of indebtedness is relatively small compared to the size of health center operations. Over the study period, at least 50% of health centers began taking out relatively larger loans, as indicated in the following chart. This trend is anticipated to continue over time as the amount of debt required to complete capital projects increases proportionately with the decline in federal grants. The number of capital projects may decline going forward without the robust government grant support, but those centers strong enough to borrow will likely continue to grow and borrow a higher percentage of the total project cost than they have in the past.



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

This trend is especially apparent looking at the following chart, which shows only health centers with reported indebtedness (~80%) in any given year. This chart shows a 50% increase in average debt over the study period, with growth accelerating in 2010 and 2011.



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

To put this trend into perspective, health center debt at the high end of the scale ranged between $36 million and $57 million over the study period.

Leverage

Leverage ratios measure the amount of debt a company reports on its balance sheet. These ratios focus more on long-term debt while liquidity ratios deal with short-term debt.

There is no correct amount of debt. Leverage varies according to industries, a company's line of business, its stage of development and its ability to generate cash flow sufficient to service debt. Nevertheless, common sense tells us that low debt and high net asset levels in these ratios indicate lower risk. As a whole, the health center industry is relatively underleveraged and appears to be in a position to take on more debt to achieve growth targets.

Total Liabilities to Total Net Assets (Equity)

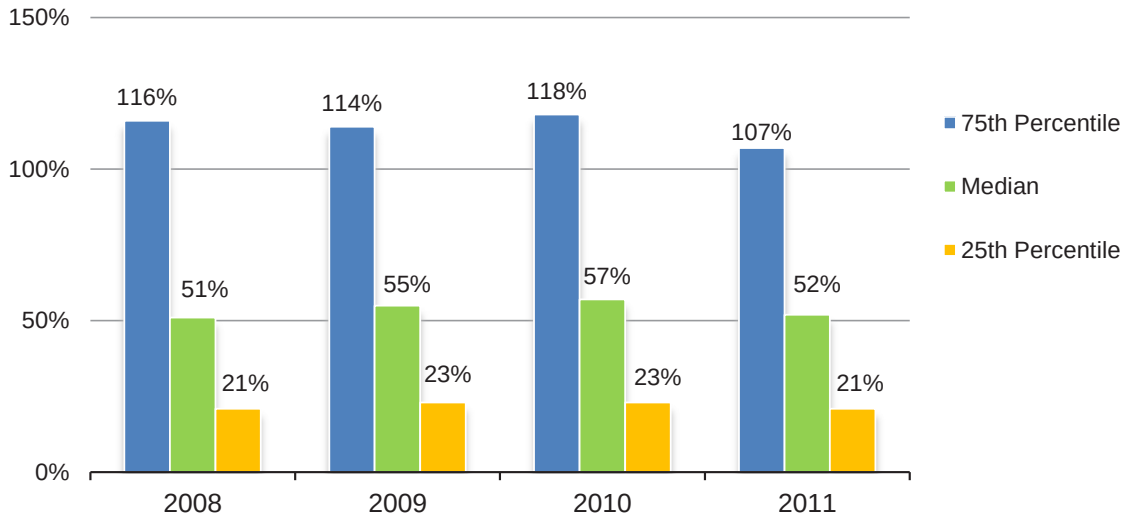
(Total Liabilities / Total Net Assets)

This ratio measures an organization's total liabilities relative to its total net assets (or equity) and reflects how an organization is financing its assets – either by debt, by its net assets (equity) or a combination of both. The lower the ratio, the less leverage an organization is using and the less risk it is assuming.

Given health centers' relatively low levels of debt, their leverage ratios tend to be low. At the median, this ratio averaged 50%, suggesting that half of all health centers have at least $0.50 in total liabilities to every dollar of total net assets. Further, 50% of this group reported an even lower average ratio of only 22%, indicating that these health centers have less than $0.22 in Total Liabilities to every dollar of total net assets. At the higher end, 25% of health centers have at least $1.07 in total liabilities to every dollar of total net assets. Ratios over 100% indicate organizations that carry more debt than net assets (equity) on their balance sheets, reflecting the most leveraged group of health centers, on a relative basis.

Bankers have a general rule of thumb that this ratio should not exceed 300% or, $3 in total liabilities to every dollar of total net assets (equity). While not specific to the medical industry or health centers, this benchmark is useful to put the generally low level of health center debt into perspective. Even at the high side, health centers do not approach this threshold. This finding suggests that there is capacity in the industry to finance future growth through debt, but it will take time for centers to become more comfortable with their ability to service that debt. It seems reasonable to suggest that if the current "cautious optimism" surrounding the potential financial impact of ACA implementation on health centers becomes a reality over the next few years, that result will translate to higher confidence in future cash flows and more comfort with fueling growth through debt.

Health Center Total Liabilities/Total Net Assets (Equity) Ratio



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

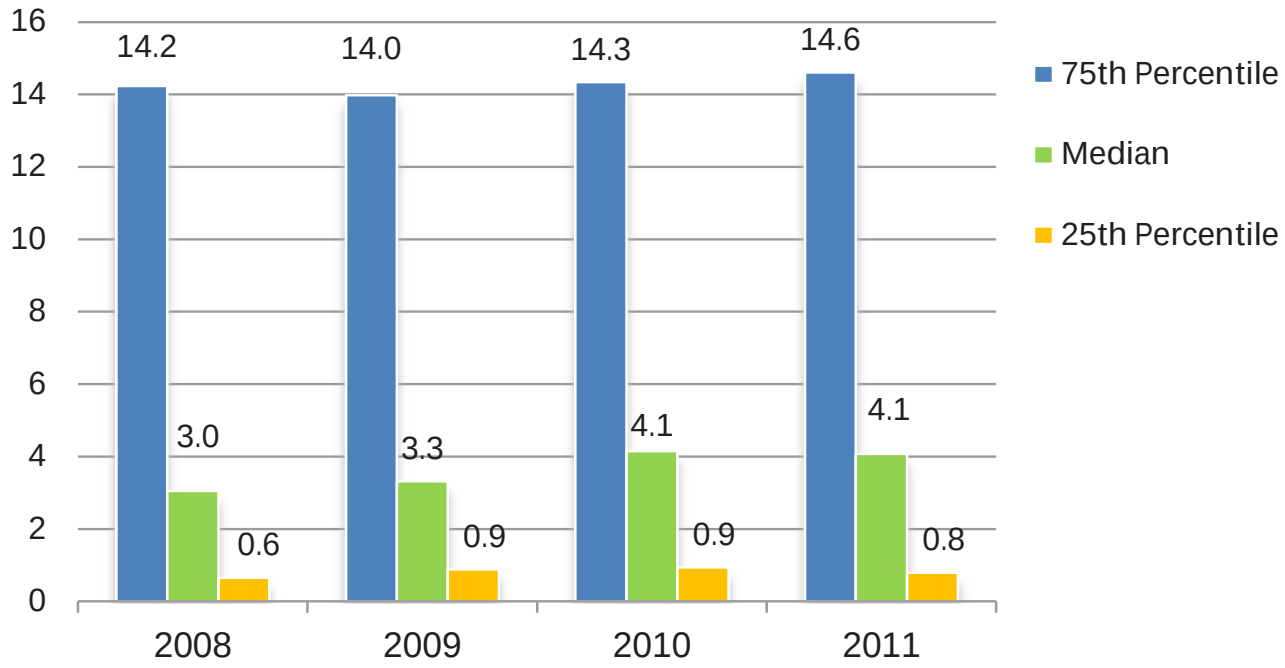
Debt Service Coverage Ratio (DSCR), Operations

(Operating EBIDA / Debt Service for the Period)
EBIDA = Change in Net Assets from Operations before Interest, Depreciation and Amortization Expenses
Debt Service = Interest Expense plus Current Portion of Loan and Capital Lease Payments Due

DSCR measures an organization's ability to service its debt level (including interest, principal and capital lease payments currently due) generally on an annual or fiscal year-end basis. Since this is a coverage ratio, more coverage, or higher, is better. This ratio utilizes change in operating net assets rather than change in net assets as it focuses on ongoing sources of cash earnings available for debt service, rather than including possible one-time, non-operating sources.

The following chart includes data from the subset of health centers that reported debt on their balance sheets, not on the entire health center group. This subset represents approximately 80% of the full set of health centers studied or some 400 - 500 organizations in each year. Reported debt includes: short and long-term loans, lines of credit and/or short and long-term capital leases.

Health Center Debt Service Coverage Ratio, Operating EBIDA



Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

Based on operating EBIDA, the median health center (of the subset with debt) reported a 3.6 times average DSCR for the study period, indicating that half of all health centers studied generated cash from operations sufficient to service their interest, principal and capital lease payments up to 3.6 times. Keeping in mind that health centers have not historically carried much debt, this median ratio reflects ample cash earnings available to service existing debt and/or minimal debt service.

Most lenders require a minimum DSCR of 1.15 – 1.25 times. The 25th percentile health center reported an average .80 times ratio, suggesting cash was insufficient to service debt levels at this percentile and lower. Given that this subset includes only centers already reporting debt on their balance sheets, it suggests that some centers may be struggling to service the debt they have already taken on. If one assumes that this is the same (or very similar) cohort that is producing negative operating margins, then third party lenders may be adding to the urgency management feels to make operational changes to deal with these challenges.

Conclusion

This analysis of the health center industry's operating and financial metrics suggest that the basic business model works and is scalable. At the median, health centers appear to be operationally stable and financially sustainable. However, the "rules of the game" are about to change quite dramatically with the full implementation of the ACA. While ostensibly this change should be a boon to most health centers, it remains to be seen if the industry can adjust to new models of care and new reimbursement systems.

With the maturity of any industry comes a natural stratification of performance at the individual organization level. The audited financial results clearly identify a segment of the health center industry that has achieved scale and is growing. Another significant portion, however, is challenged to consistently produce positive operating margins and as a result has struggled to develop balance sheet stability.

Health center patient and visit growth rates continued to increase for most health centers over the study period, but the pace of growth slowed in 2011 as federal funding remained relatively flat. If the anticipated upside potential of ACA implementation for health centers is fully realized in the near future, centers will need to continue to expand aggressively, but will likely need to look internally for resources (local fund raising and borrowing based on debt service capacity). This scenario will represent a fairly significant change in the drivers of health center growth. For an individual health center operating in an environment where more individuals are insured, growth may take different forms—from acquiring local private practices (or other health centers), to opening new sites and expanding existing ones—and in some cases requiring different types of capital investment.

For the bottom quartile of health centers, adaptation to the upcoming changes in the health care environment may be a matter of survival as opposed to growth. It could be very important for the industry to identify what, if any, common operating problems these centers face in order to ensure that these centers —all of which serve vulnerable patient populations—achieve a sustainable level of operational performance.

Methodology

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

- The Health Resources and Services Administration (HRSA) Uniform Data System (UDS) data, and
- Audited financial statements of community health center organizations.

Uniform Data System (UDS)

Operated and maintained by HRSA, this dataset is derived from annual submissions required of all Section 330-funded FQHCs ("grantees"). During the 2008 – 2011 period under review, only grantees were required to report annually through UDS. Beginning in 2012, all FQHCs, including both grantees and LALs, will be required to report. UDS tracks a variety of core health center-related information, including number and demographics of patients served, service sites, full-time equivalent (FTE) employees and staffing makeup, services provided, encounters/visits, revenues and expenses, clinical indicators, utilization rates, etc. UDS data is collected from grantees and reported at the grantee, state and national levels. This analysis utilized only publically available national roll-up data, from approximately 1,100 health centers annually from 2008-2011.

Capital Link Database of Health Center Audited Financial Statements

Capital Link's proprietary financial database contains independent audits for 50% - 70% (depending on the fiscal year) of all health centers that produced separately audited financial statements over the four-year study period from 2008 - 2011. The majority of audited financials are from Section 330 FQHC grantees, with a small number of FQHC LALs and an even smaller number of "other" clinics that are organized as safety-net providers, but are not FQHCs. Capital Link's database tracks balance sheet and income statement information and facilitates the calculation of financial, profitability, liquidity, leverage, debt, and other measures for comparison purposes.

Capital Link's database was tested vs. the grantee universe and found to be representative in terms of the mix (urban vs. rural) and size of health centers (in revenues) as well as geographic composition, although it was slightly skewed toward larger health centers and states that have completed a higher number of facility projects in recent years.

The final data set for each year included 500 - 662 organizations over the study period as follows:

Fiscal Year	2008	2009	2010	2011
National Sample Size, All Health Centers	662	657	626	500
Health Centers with Debt	510	514	503	405

Statistical and Financial Ratios and Data Sources

The financial ratios used in the analysis were generated using data from independent health center financial audits. These ratios were generated for the full health center data set except as indicated below and included the following:

- Operating Margin
- Bottom Line Margin
- Operating Revenue Growth
- Operating Expense Growth
- Employment-Related Expense/ Operating Revenue
- Net Patient Service Revenue (NPSR)/ Operating Revenue
- Grant and Contract (GC) Revenue/ Operating Revenue
- Days in All Receivables
- Days in NPSR Receivables
- Days in GC Receivables
- Days in Accounts Payable
- Days Cash on Hand (DCOH)
- Current Ratio (CR)
- Total Liabilities to Total Net Assets (Equity)
- Debt Service Coverage Ratio (DSCR)
- Total Debt
- Average Debt (including only health centers with debt)

Health Center and Industry Characteristic Data Sources

The UDS data was used to generate all measures, ratios and trends related to community health centers such as: organizational characteristics, patient demographics, encounters/visits and payer sources. Measures and ratios calculated based on UDS data for the full health center data set includes:

- Number and Growth Rate of Patients by Service Type
- Total Revenues by Type
- Grant and Contract Revenue by Type
- Patient Incomes (compared to FPL)
- Analysis of Payer Mix and Allowances
- Patient Race and Ethnicity
- Employment Statistics including FTEs by Type and Growth Rates
- Provider Productivity
- Revenues vs. Expenses per Patient

Median, 75th Percentile and 25th Percentile

Statistical measures used to describe the financial ratios and trends include the median, the 75th percentile and the 25th percentile.

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

The percentile is the percentage of observations in a distribution that is at or below a given value. The 75th percentile is a value that is equal to or greater than 75 percent of the values. The 25th percentile is a value that is equal to or greater than 25 percent of the values. The 50th percentile is the same as the median value.