

March 2014

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

Prepared by: **Capital Link and Community Health Center Capital Fund**



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The views expressed in this report are those of its authors and do not necessarily reflect the views of the Federal Reserve Bank of San Francisco or the Federal Reserve System.

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.



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Executive Summary

This report provides an operational and financial overview of the community health center industry for the years 2008 – 2011. Prepared with the goal of increasing the information available to lenders and investors on community health centers nationwide, this document is the second of a series of studies supported by Citi Foundation, which will further illuminate the financial and operational trends of this group of organizations. The term “community health center” is defined and discussed in detail in the Introduction. This report will often refer to these organizations simply as “health center(s).”

Key Findings

Rapid Growth Fueled by Recent Federal Investments

For more than 45 years, health centers have demonstrated their staying power with successful operations through both good and bad economic cycles. Most recently, during the prolonged national economic downturn that began in 2008—and despite the ongoing challenge of relatively tight margins and limited cash reserves—the industry has sustained consistent growth.

This growth was significantly spurred by federal investments related to the American Recovery and Reinvestment Act (ARRA) of 2009 and the Patient Protection and Affordable Care Act (ACA) of 2010. With increased federal operating and capital grant support totaling approximately \$2.2 billion over the four-year study period, health centers leveraged this investment by adding more than \$1.6 billion in revenues from other sources, for overall revenue growth of 38%.

Health Centers Are Poised to Grow Significantly with the Implementation of the ACA

Going forward, health centers are well positioned to play a major role in a post–health reform landscape. The ACA, a catalyst driving towards a more integrated healthcare delivery system, positions health centers to play a critical role in America’s future health care system.

The report demonstrates the critical role health centers have played over the study period in providing services to low-income and uninsured residents in their communities—providing care to a disproportionate share of racial and ethnic minorities and a significant portion of the current Medicaid-eligible and uninsured populations. Under the ACA, Medicaid coverage will be expanded to all individuals under 65 years of age with incomes up to 133% of the Federal Poverty Level (FPL) guidelines, within those states opting for this expanded eligibility. Since Medicaid is the preferred payer for health centers, this increase in Medicaid-eligible patients (coupled with an expected decrease in uninsured patients as some of these become Medicaid-eligible) positions health centers for further growth going forward.

Consistent Financial Performance within Quartiles

Health centers operate with significant overall variability in financial results across the industry, with operating margins ranging from an average of negative 1.4% at the 25th percentile to 7% at the 75th percentile. However, within each quartile, results are fairly consistent from year to year, with relatively small variations across the study period. The gap between the financially strongest cohort and the financially weakest cohort as compared to the median in both cases appears to be widening across almost all measures, especially in 2010 and 2011—suggesting that a cohort of health centers has been able to take advantage of the increased investments at the federal level more successfully than their weaker counterparts, some of whom are struggling to cover their costs and maintain adequate liquidity.

Comments on Financial Trends

Industry-wide, both cash and operating margins are tight, but at the same time, leverage is low and the cash available for debt service is relatively untapped, suggesting additional debt capacity for at least half of the health centers studied. Finally, the strongest cohort has consistently performed well above the median, reflecting the financial stability of this group of health centers.

The analysis and findings are presented in five 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 discusses their origins, longevity, models of care, organizational structure and 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.

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

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

Key Ratio Summary

Key Ratio	Report Page	Quartile Metrics: 2011	
		Percentile/Quartile	Metric
Operating Margin	26	75th	7.9%
		Median	2.1%
		25th	(1.6%)
Bottom Line Margin	27	75th	11.2%
		Median	4.8%
		25th	0.6%
Days Unrestricted Cash on Hand (DCOH)	28	75th	90
		Median	44
		25th	19
Current Ratio (CR)	29	75th	4.1
		Median	2.4
		25th	1.5
Accounts Receivable Days: All (AR)	30	75th	66
		Median	44
		25th	31
Accounts Receivable Days: NPSR	30 - 31	75th	69
		Median	45
		25th	30
Accounts Receivable Days: GCR	31	75th	54
		Median	21
		25th	0
Accounts Payable Days	32	75th	64
		Median	35
		25th	20
Total Liabilities to Total Net Assets	36	75th	107%
		Median	52%
		25th	21%
Debt to Capitalization	37	75th	94%
		Median	75%
		25th	41%
Debt Service Coverage Ratio (DSCR)	38	75th	14.6
		Median	4.1
		25th	0.8
Debt to EBIDA	39	75th	69%
		Median	30%
		25th	10%
Annual Debt Service to Total Operating Revenue	40	75th	3%
		Median	1%
		25th	1%
Cushion Ratio	41	75th	26.2
		Median	8.1
		25th	1.7
Unrestricted Cash to Debt	42	75th	184%
		Median	58%
		25th	20%

Figure Guide

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Section I: Introduction

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,¹ and are poised to play a major role in the implementation of the Affordable Care Act (ACA). However, very little information about this industry’s financial and operational profile is available on a consistent basis to lenders and investors, who will play an increasingly important role in fueling the industry’s growth as it continues to mature in an environment of health reform. This document is a starting point to fill this knowledge gap. Subsequent publications will seek to build upon this knowledge base with an increasingly nuanced analysis of the financial and operating performance of health centers as they continue to evolve over the coming decade.

Overview of Community Health Centers: Definitions, a Brief History and Factors Affecting Their Longevity

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.”² These references generally denote a type of “safety net” provider that serves primarily low-income and uninsured patients regardless of their financial status. While there are fine points and distinctions among these safety net providers, this document will refer to the group generally as “health centers” unless we are specifically referencing subgroups of this “universe” of providers.

Established as a result of the War on Poverty in the mid-1960s, the first community health centers were organized at Columbia Point in Boston, Massachusetts and in Mound Bayou, in Northwest Mississippi, as part of a demonstration project funded through President Johnson’s Office of Economic Opportunity. Since that time, they have expanded to comprise a network of almost 1,200 corporate entities offering a range of primary and preventive health care services through almost 9,000 sites nationwide.

¹2001 – 2011 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

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

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

Patient-Centered Care

Health centers developed a holistic model of care that responded to the needs and gaps in care at the community level. Today, most health centers provide a combination of primary and preventive health care, dental and behavioral health care, with wrap-around “enabling services”³ geared toward eliminating barriers to care. As the originators of the concept of “one stop shopping” in health care, health centers provide a model of care that is convenient for patients and creates continuities and better care coordination, helping patients navigate the health system more efficiently. Today, other providers are seeking to replicate the model of care that health centers invented more than 45 years ago.

Community Control

Located almost equally in urban and rural areas, health centers provide care that is responsive to local needs. A hallmark of health centers is that they are almost exclusively organized on a tax-exempt basis and governed by a board of community stakeholders. At least 51% of the members of a Federally Qualified Health Center’s board must be patients of the health center. This unique feature assures community responsiveness and control and keeps health centers very close to the markets they serve. It can also create challenges in raising private dollars to support the system of care—since health center patients may have more limited connections to wealthy donors. What they lack in connections to communities of wealth, however, they generally make up in their commitment to the communities they serve. When a health center is “owned” by its community, it has very long staying power. Many health centers have operated successfully in both strong and weak economies.

Engines of Economic and Social Empowerment

With roots in the Civil Rights Movement, health centers have always emphasized community empowerment as much as access to health care. At their founding, they were concerned not only with providing high quality health care to community residents regardless of their ability to pay, but they also saw themselves as providing jobs and economic opportunity in low-income communities. Today, health centers employ more than 138,000 people⁴ and are often the largest employers in their predominantly low-income communities, providing a range of relatively high paying jobs and job ladders for the communities they serve.

³Per 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 but rather enable individuals to access health care and improve health outcomes. Enabling services include case management, referrals, translation/interpretation, transportation, program eligibility assistance, health education, environmental health risk reduction, health literacy and outreach.

⁴2011 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

Low-Cost, High Quality Providers

Because health centers have served historically as the “safety net,” they learned to “make do” with limited resources. Diligent advocates for funding for community-based care, they have managed to maintain and increase their public support in a bipartisan fashion by producing excellent results with limited funding. Today, the average cost of care for patients served at health centers is approximately 24% lower than care provided in other primary care settings—with quality measures that equal or exceed many other providers.⁵

Beyond the Exam Room

Health centers have always known that although health is influenced in important ways by access to the health care system, many factors other than the ability to see a doctor affect the health and longevity of populations. From their early days, health centers have served as a platform for addressing the multiple challenges associated with living in poverty, including:

- addressing poor access to quality food to combat obesity;
- focusing on improving literacy rates and early childhood learning; and
- advocating for improvements to sanitary systems and the quality of housing stock to reduce exposure to environmental toxins.

As a result, health centers have been at the forefront of efforts to address the “social determinants of health.” This broad-based focus on the multiple factors that influence health aligns health centers’ model of care with a growing trend toward rewarding activities that produce positive health outcomes rather than rewarding only fee-for-service generated outputs within a medical setting.

⁵Ku L. et al. *Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs*. GWU Department of Health Policy. Policy Research Brief No. 14. September 2009.

Current Operating Environment of Health Centers

Like all health providers, health centers are functioning in a changing and uncertain operating environment on the eve of the implementation of the Affordable Care Act (ACA), the most important features of which are scheduled to roll out in 2014. 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 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 reliant on Section 330 federal operating grants to subsidize the cost of care provided to uninsured and under-insured families and individuals. Health centers' long history of operating in uncertain funding environments will likely serve them well over the next decade as they navigate the inevitable changes to the health care marketplace. In particular, their positioning as relatively low-cost, high-quality providers for a population that is in many respects difficult to serve should 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 derive from it. Some of these benefits include a cost-based prospective payment system (PPS) for services to patients covered by Medicaid and Medicare and eligibility for free medical malpractice insurance through the Federal Tort Claims Act. This experience operating within a highly regulated system should provide health centers a competitive advantage—or at least a head start on their competitors—as they navigate the new and uncharted waters of the ACA.

While the industry continues to grow through the expansion of existing health centers and the addition of new sites, the industry as a whole is maturing and has achieved an operating scale that reflects its evolution from a small “movement” to a sizable industry group that has the capacity for a greater volume of private investment than has been the case in the past. The sections that follow provide a broad overview of the health center industry, particularly with respect to health centers' operational model, financial trends, and drivers of the business model. It is written for an audience of lenders and investors who are generally familiar with financial metrics and terms, but who have limited knowledge of the health center sector.

Section II: Operational and Financial Overview of the Community Health Center Industry

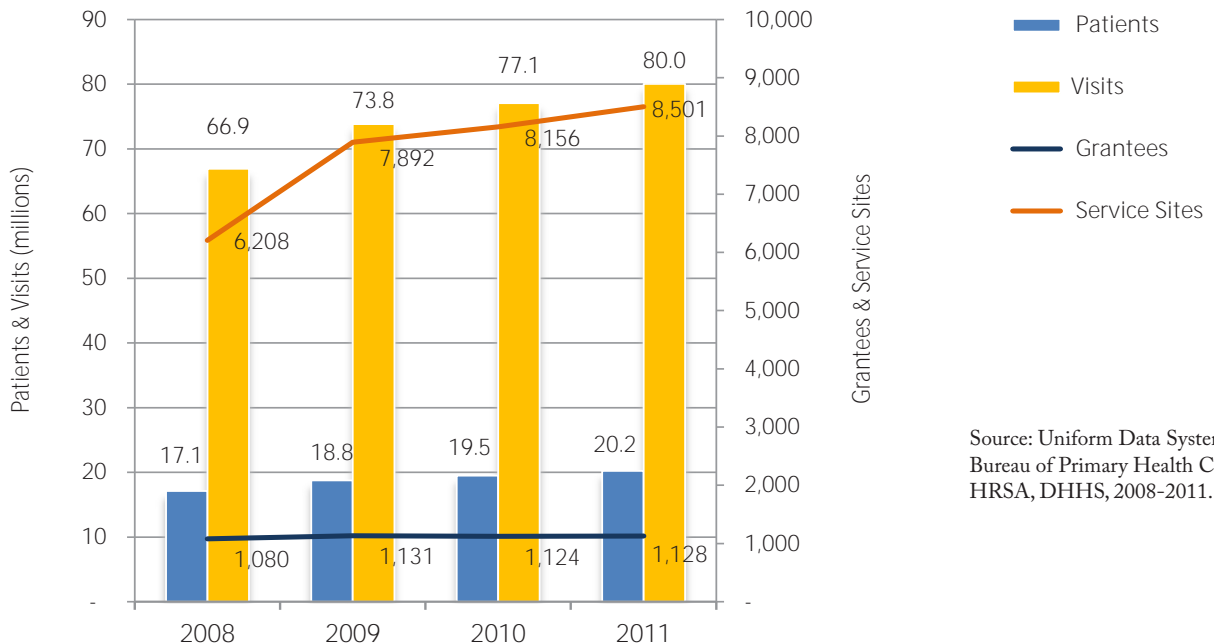
Health Center Industry Profile and Growth Trends

By 2011, Section 330 health centers served more than 20 million patients through 80 million visits annually. Including estimates for Look-Alikes, the National Association of Community Health Centers (NACHC) estimates that almost 1,200 FQHCs in total served approximately 22.3 million patients through 88.3 million visits at close to 9,000 sites.⁶

Four-Year Growth

Despite the prolonged national economic downturn that began in 2008, health centers experienced strong growth over the study period. While patients and visits grew rapidly at 18% and 20%, respectively, 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)⁷ to expand or establish new sites in underserved areas.

**Figure 1. Health Center Four-Year Growth Trends:
Patients, Visits, Grantees & Service Sites**



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

⁶NACHC Infographic, “Who Do Community Health Centers Serve?”, February 2013.

⁷The Health Resources and Services Administration is an agency of the U.S. Department of Health and Human Services.

Beginning in 2009 and continuing in 2010, HRSA offered several rounds of “New Access Point” and “Increased Demand for Services” funding opportunities through the American Recovery and Reinvestment Act (ARRA). In addition, the Patient Protection and Affordable Care Act (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, including \$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 exceeding \$13.88 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 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.

Figure 2. Health Center Total Revenues



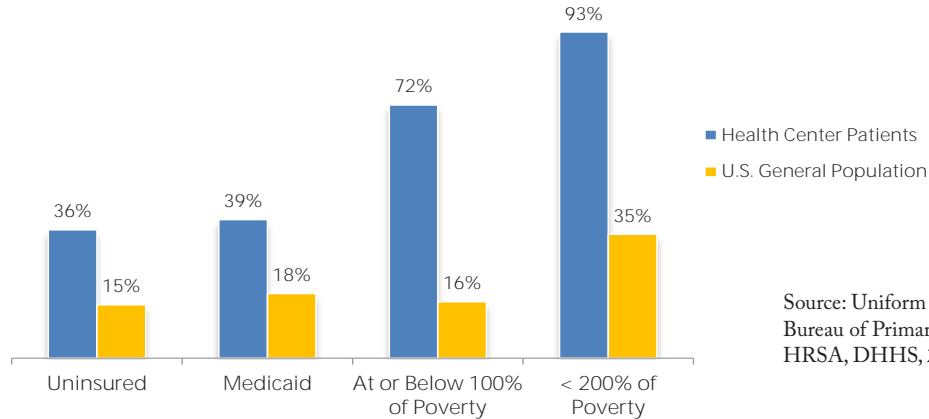
Capital Grants include ARRA, ACA and other capital grants.
 Operating Grants include Section 330 Operating Grants, ACA and ARRA operating grants.
 Other includes other federal, state, local, private and foundation grants as well as other revenue.

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

Health Centers' Patient Base

Health centers serve a highly diverse patient base, most of whom have income levels below 200% of the federal poverty level (FPL) guidelines. These guidelines are issued annually by the Department of Health and Human Services⁸ for administrative purposes—for instance, to determine whether a person or family is eligible for assistance through various federal programs. 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.⁹

Figure 3. Health Center Patients Compared to U.S. Population: Income & Insurance Status, 2011

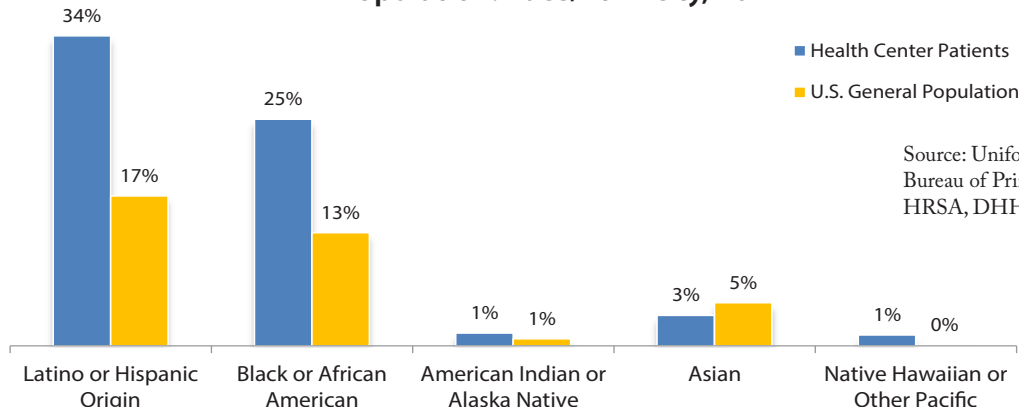


Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2011.

Race/Ethnicity

As shown in the chart below, health centers serve a higher proportion of racial and ethnic minorities as compared to the population of the country as a whole.¹⁰ It should be noted that the health center data are 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.

Figure 4. Health Center Patients Compared to U.S. Population: Race/Ethnicity, 2011



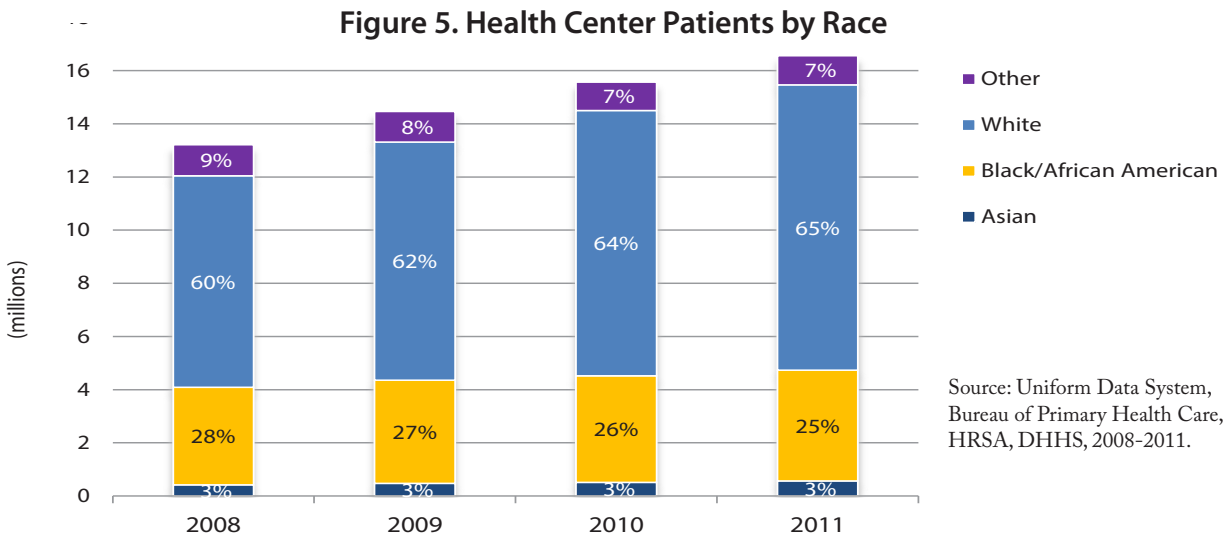
Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2011.

⁸The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

⁹Data Sources: 2011 UDS National Roll-Up; US Census, American Community Survey, 2011 Estimates; CMS 2011 Medicaid Enrollment Report.

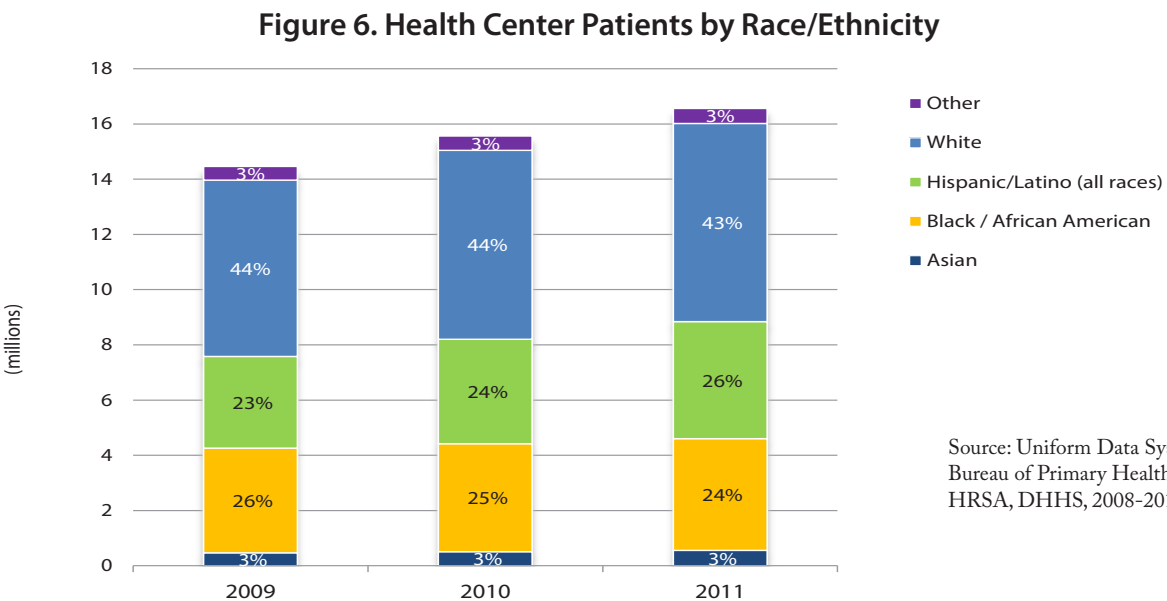
¹⁰Data Sources: 2011 UDS National Roll-Up; US Census, American Community Survey, 2011 Estimates.

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.



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

Consistent with the overall U.S. 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 following chart details the growth of the Hispanic/Latino population regardless of race, as compared to non-Hispanic/Latino populations.

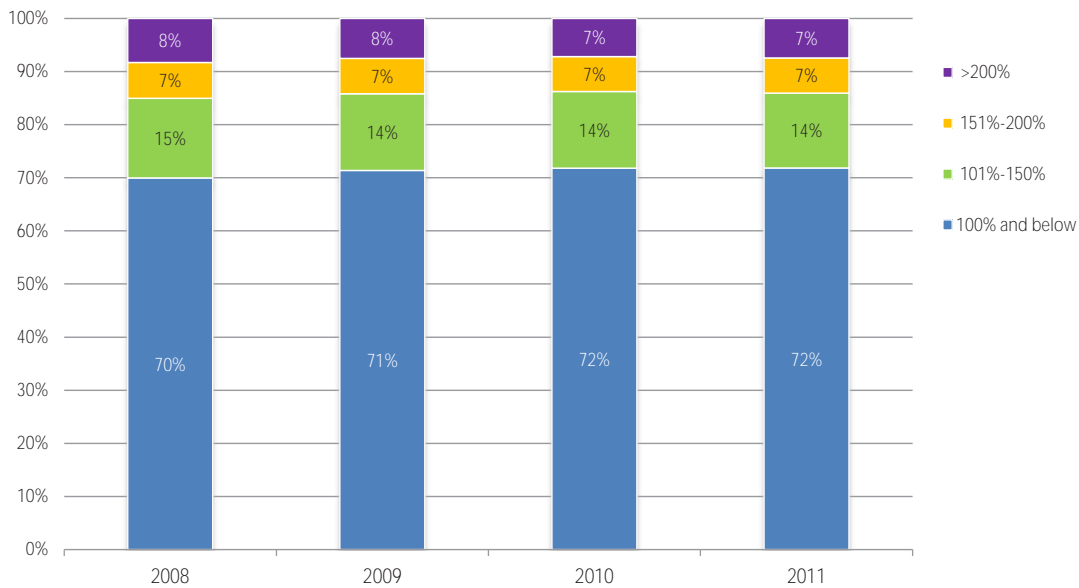


Excludes patients for which race/ethnicity is not known.
Other includes Hawaiian/Pacific Islander - 1%, American Indian - 1% and those patients reporting more than one race - 1%.

Income Status of Health Center Patients

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

Figure 7. Health Center Patients by Income Compared to Federal Poverty Level



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

Over the review period, the number and proportion of extremely low income patients (<100% FPL) increased 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.

Figure 8. Federal Poverty Level: Four Person Family

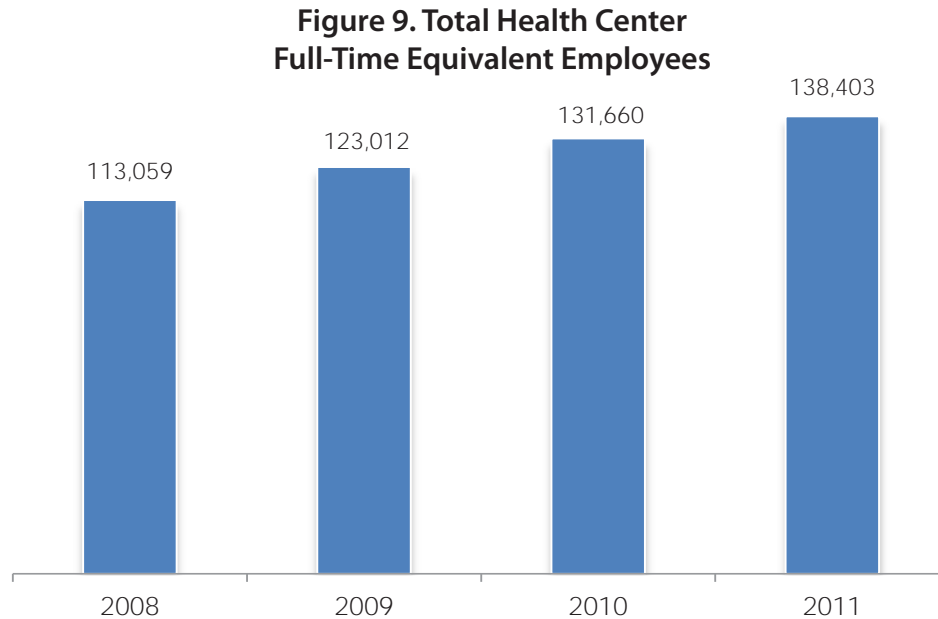
Year	100% FPL	133% FPL	150% FPL	200% FPL
2008	\$21,200	\$28,196	\$31,800	\$42,400
2009	\$22,050	\$29,327	\$33,075	\$44,100
2010	\$22,050	\$29,327	\$33,075	\$44,100
2011	\$22,350	\$29,726	\$33,525	\$44,700

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

Understanding the income status of the health center patient base—and the payer sources that fund their care—is the key to understanding the health center financial operating model. 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

Health centers have grown to become significant employers across the United States. They added more than 25,000 jobs over the last four years (on a full-time equivalent basis), which is especially notable given that this period overlaps with the economic recession.¹¹



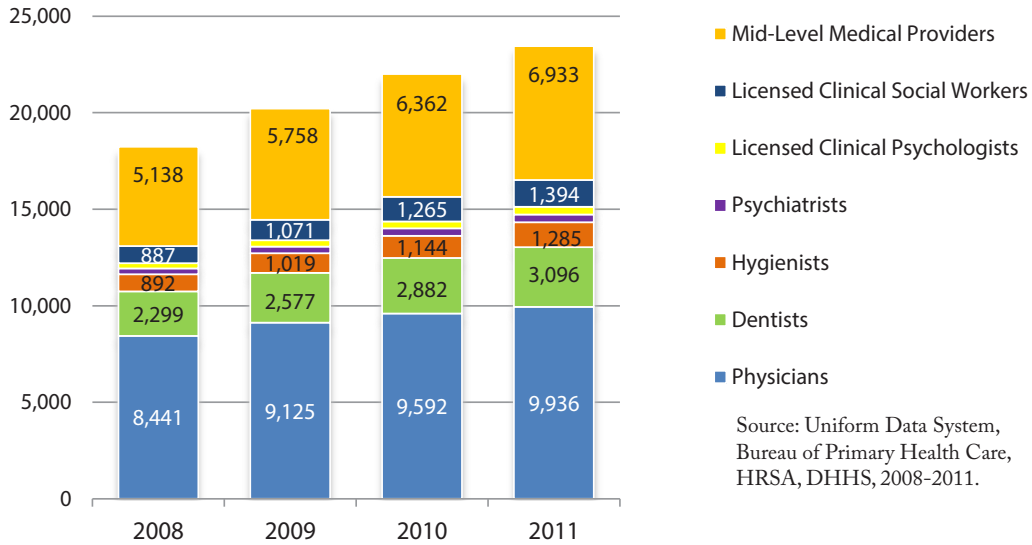
Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Of particular note, the vast majority of those jobs were created in the low-income communities in which health centers typically operate and most come with fringe benefits such as medical insurance, paid sick leave and vacation. Furthermore, health center management generally encourages staff to develop their skill sets and provides opportunities for education and training, another benefit not often found in jobs typically available to low-income persons.

As health centers grow, they face challenges recruiting and retaining primary care practitioners, who are in short supply nationally. While health centers have succeeded in attracting and retaining a significant number of physicians to their practices, they are also recruiting a higher proportion of mid-level personnel (Nurse Practitioners, Physician Assistants and Certified Nurse Midwives, typically referred to as “mid-levels”) as “physician extenders” to round out their increasingly team-based practice models. Two areas of growth over the study period include the addition or expansion of dental and behavioral health services, as HRSA has placed a stronger emphasis on the 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.

¹¹Full-time equivalent (FTE) is a unit that indicates the workload of an employed person in a way that makes workloads comparable across various contexts. An FTE of 1.0 means that the person is equivalent to a full-time worker, while an FTE of 0.5 signals that the worker is only half-time.

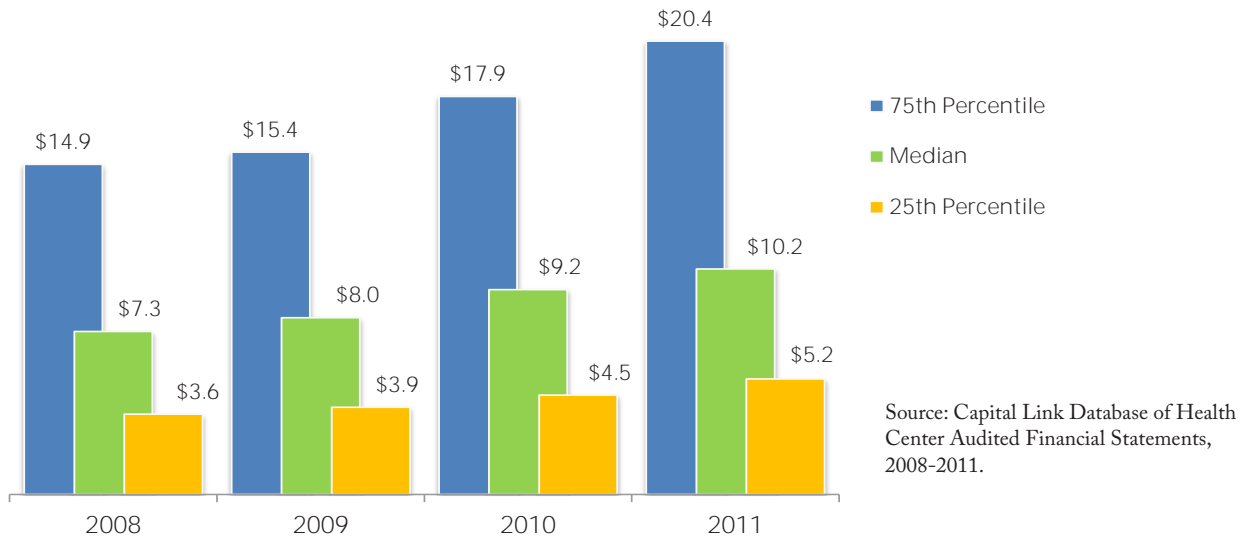
Figure 10. Health Center Full-Time Equivalent Employees by Provider Types



Overview of Operating Revenues: Annual Totals by Quartile, Growth

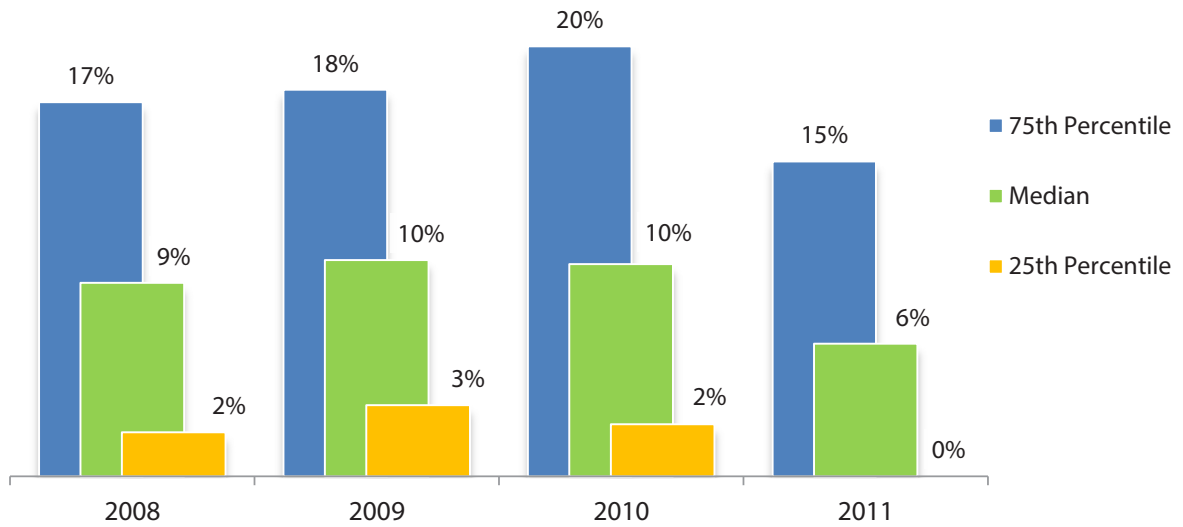
In 2011, health centers ranged in revenue size from small organizations with under \$100,000 in annual revenues to large organizations with close to \$134 million in revenue. As shown in the chart below, the median health center had just over \$10 million in operating revenues in 2011. The bottom 25%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

Figure 11. Total Operating Revenues by Health Center Quartile (millions)



Over the study period, health centers at all levels experienced significant revenue growth, with median growth averaging 9% annually. At the 75th percentile, growth was especially strong, averaging 18% annually, while growth averaged 2% at the 25th percentile.

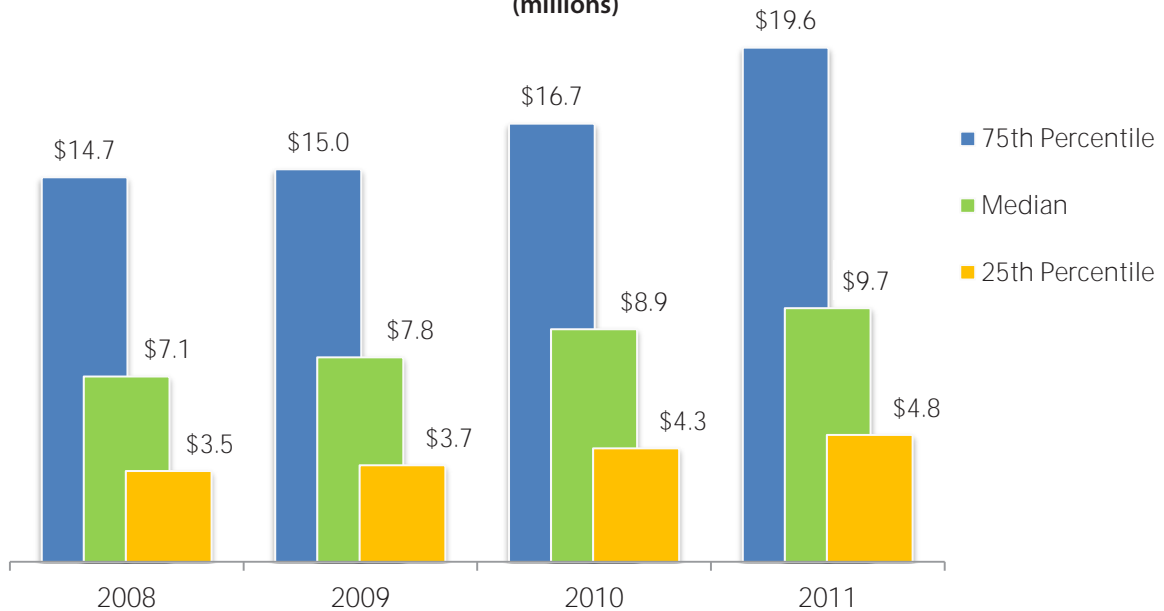
Figure 12. Operating Revenue Growth by Health Center Quartile



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

Overview of Operating Expenses: Annual Totals by Quartile, Growth

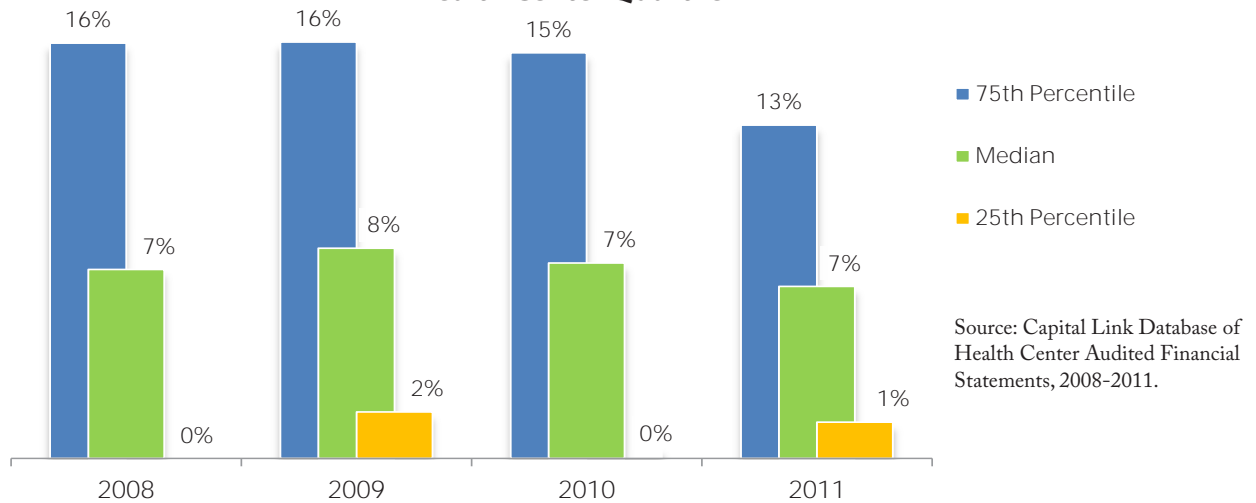
Figure 13. Total Operating Expenses by Health Center Quartile (millions)



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

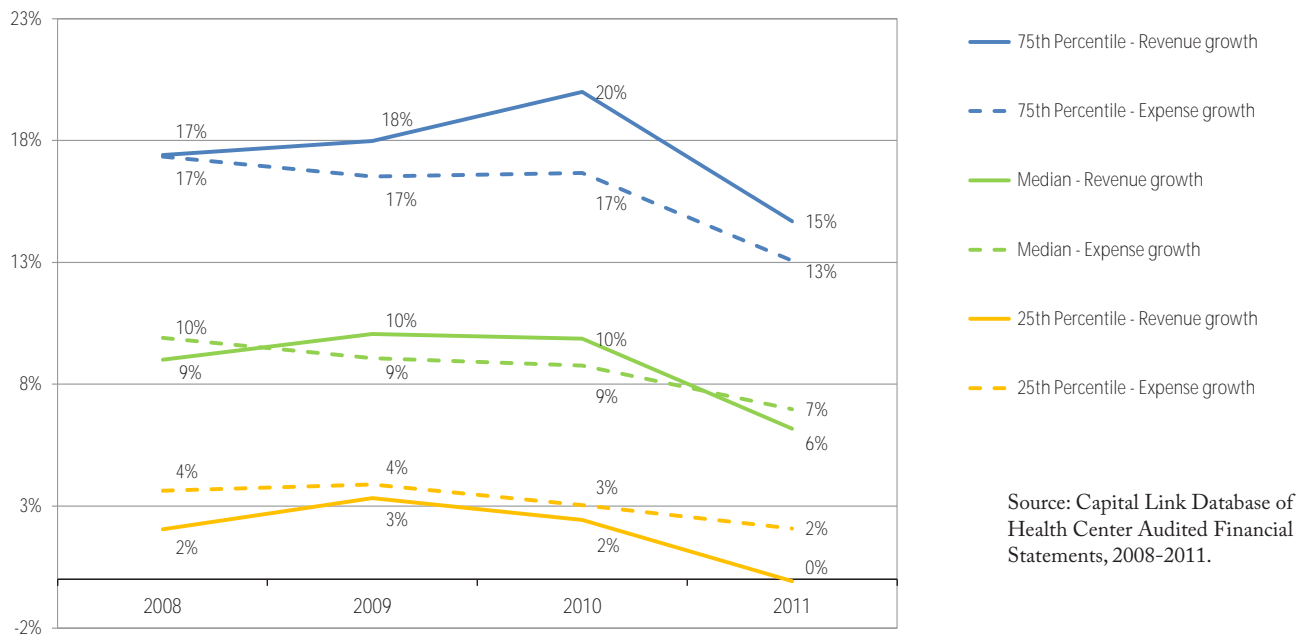
The median health center saw average annual operating expenses grow 9% over the study period, comparable to revenue growth. Health centers at or above the 75th percentile averaged 16% annual expense growth over the study period, lower than the average growth in operating revenues of 18%. These comparative rates indicate that the upper 50% 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.

Figure 14. Operating Expense Growth by Health Center Quartile



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

Figure 15. Comparison of Operating Revenue and Expense Growth by Health Center Quartile



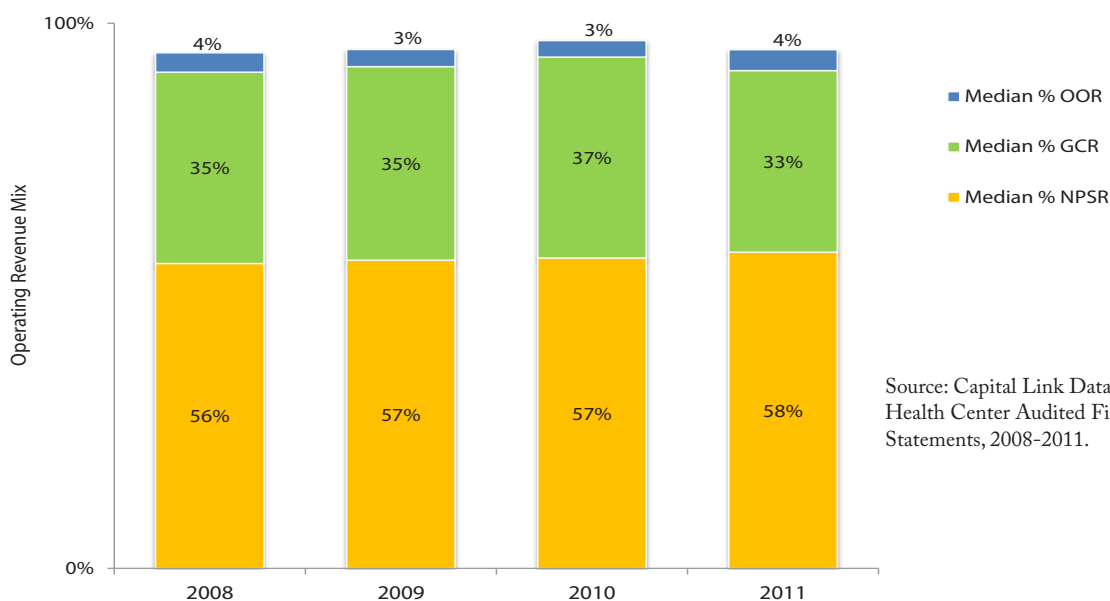
Section III: Health Center Revenues and Expenses Detailed Analysis

This section delves more deeply into the revenue and expense structure of health centers. 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 (NPSR) and Grants and Contracts Revenues (GCR). Trends for the median health center across the study period are shown below.

Figure 16. Revenue Composition for the Median Health Center



NPSR, derived from patient or medical insurance payments, represented nearly 60% of the median health center’s operating revenue in all years, increasing slightly over the study period. GCR, composed of public and private grants and contracts from federal, state and local sources, provided approximately 35% of operating support each year, with a slight decline in 2011. The remaining less than 5% of revenues consisted of “other operating revenue” (OOR) including in-kind and cash donations as well as 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 they typically leverage two dollars from other sources.

NPSR and GCR have both grown significantly over the study period for most health centers. The median health center reported 9% average annual growth in NPSR with 6% average growth in GCR. The 75th percentile average annual growth rate for both NPSR and GCR was 20%, while the 25th percentile saw average annual growth of only 2% and negative 3% in these two categories, respectively. After three years of relatively strong year-over-year growth in GCR, 2011 experienced a slow-down in grant funding with actual declines in this funding category for the 25th percentile and below.

Figure 17. Health Center Net Patient Service Revenue Growth

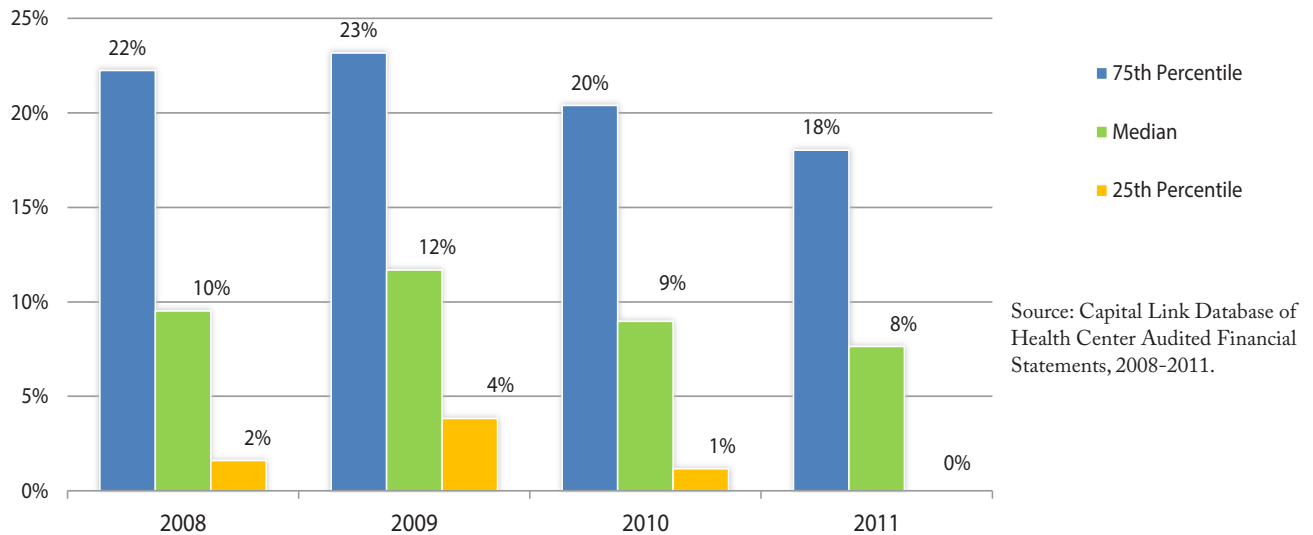
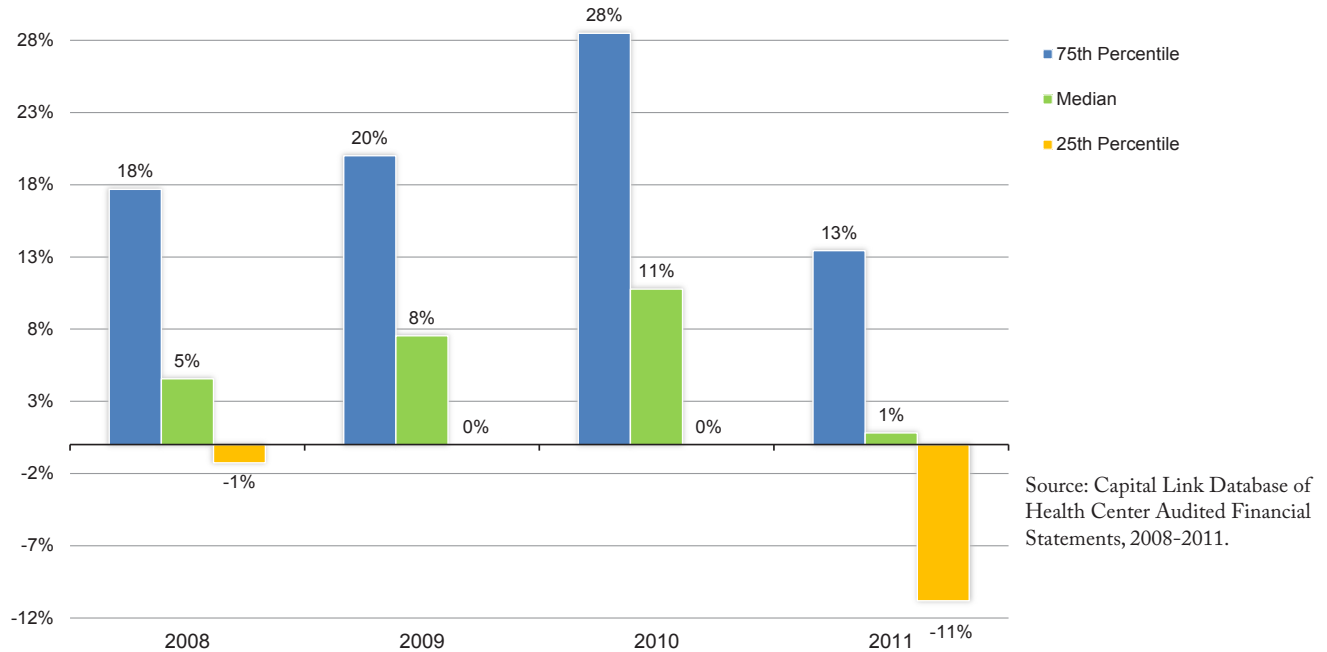


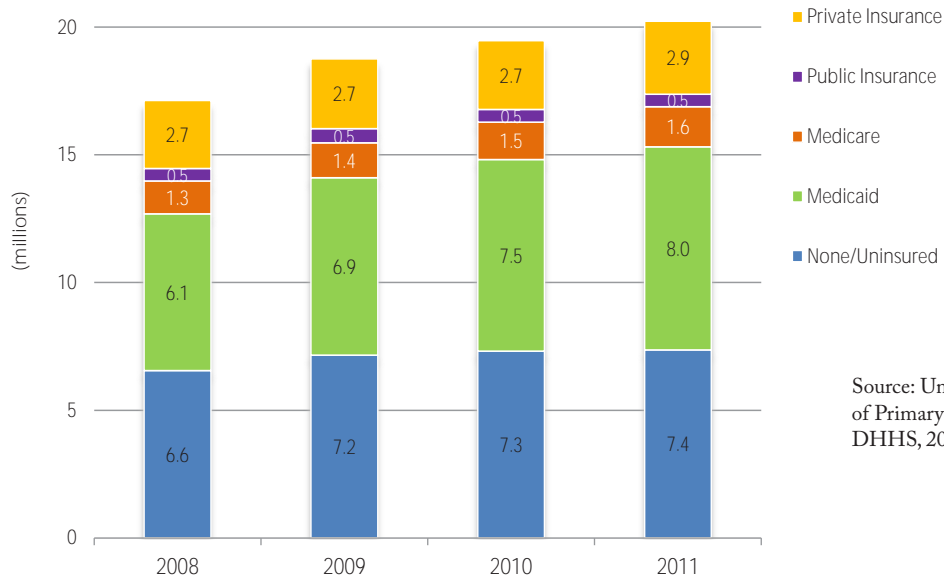
Figure 18. Health Center Grants and Contracts Revenue Growth



Net Patient Service Revenue – Payer Mix

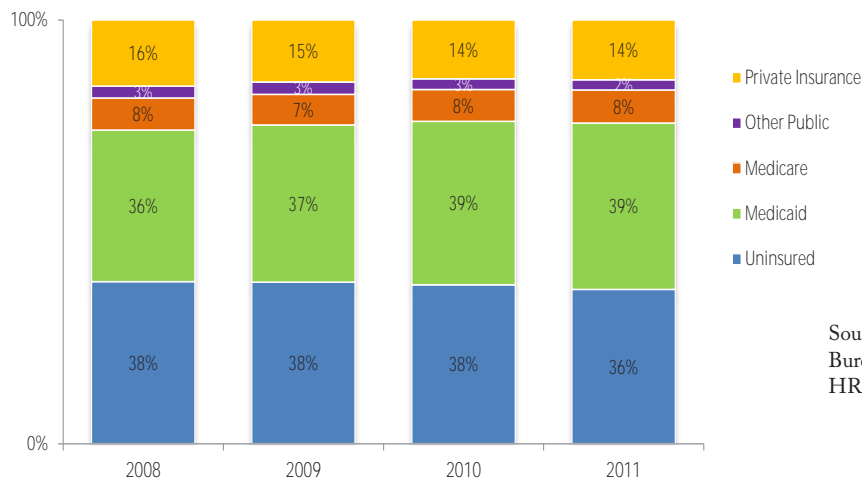
A health center's payer mix is the combination of revenues received by all payer types for patient services provided. As shown in the chart below, health center patients have grown significantly across all payer classes. In 2011, 20.2 million patients received services at a Section 330 health center; including almost 8 million receiving Medicaid-reimbursed services and about 7.4 million who were uninsured.

Figure 19. Health Center Patients by Payer



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

Figure 20. Health Center Patients Payer Mix



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

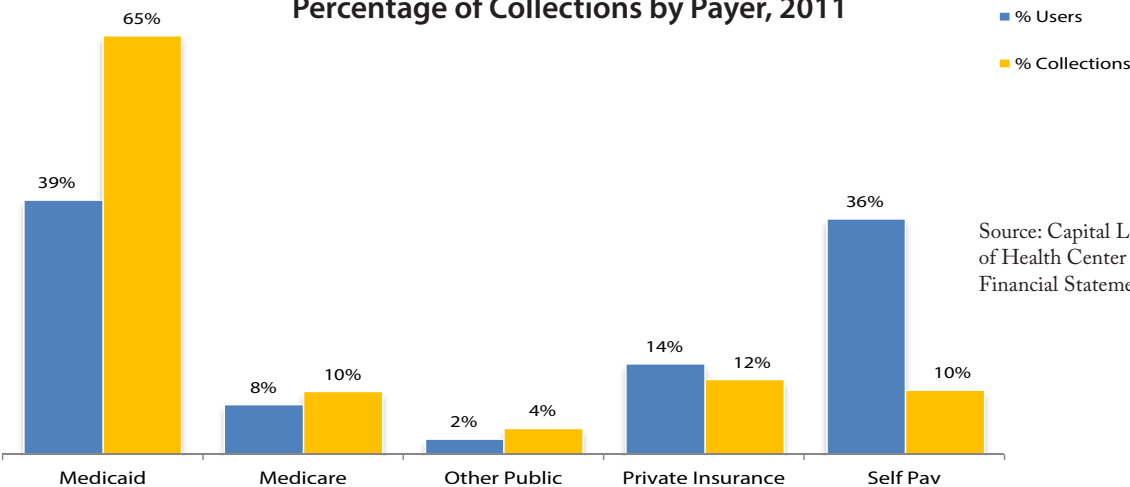
As these charts indicate, health center patients are primarily the uninsured and those on Medicaid (collectively over 70% in every year). The two most significant payer mix trends for health centers over the four-year study period are the notable increase in the percentage of patients covered by Medicaid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

One potential cause of these shifts could be that more of the uninsured may 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 during a time of fiscal austerity to support health centers’ services. As the country proceeds with the 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 users as compared to net patient service revenue collections and does not include grant and contract revenue, which is often specifically designated to cover the cost of care for the uninsured.

Figure 21. Percentage of Patients vs. Percentage of Collections by Payer, 2011



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

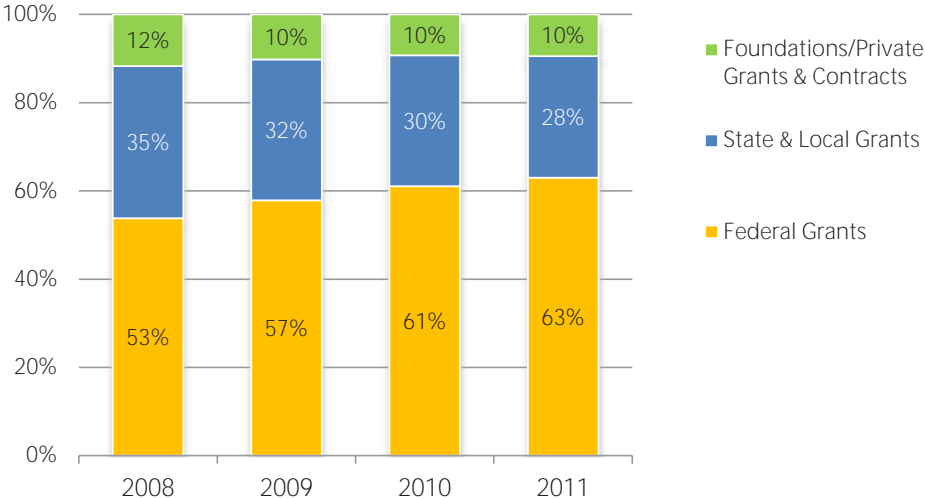
This kind of analysis is useful for understanding how health centers view various payers. They prefer payers whose collection percentage exceeds their user percentage (the orange column is higher than the blue). By this measure, Medicaid is clearly the best payer for health centers—generating positive 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 (PPS rate). This requirement could result in a further financial benefit to health centers as a result of the full implementation of the ACA.

Grants and Contract Revenue—Payer Mix

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.

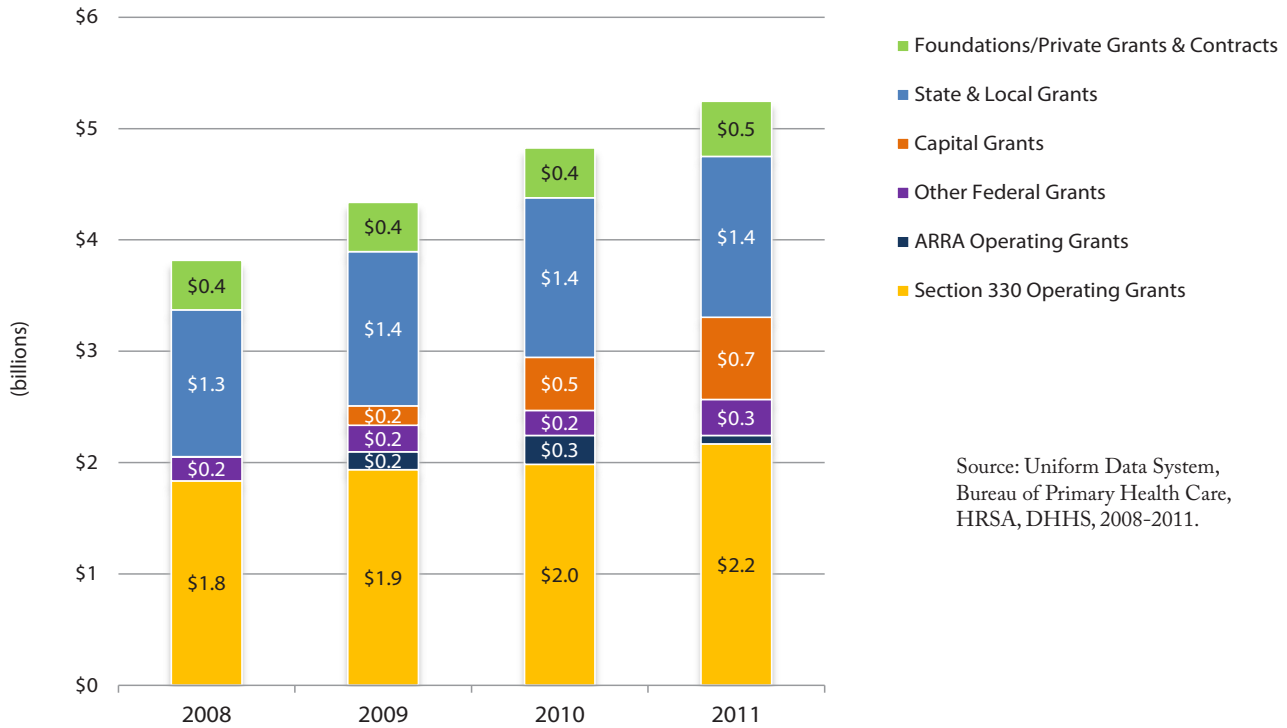
Figure 22. Health Center Grants & Contracts: Major Sources



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

While state and 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 below 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 will continue until at least 2015 and bodes well for health center finances.

Figure 23. Health Center Grants & Contracts Funding



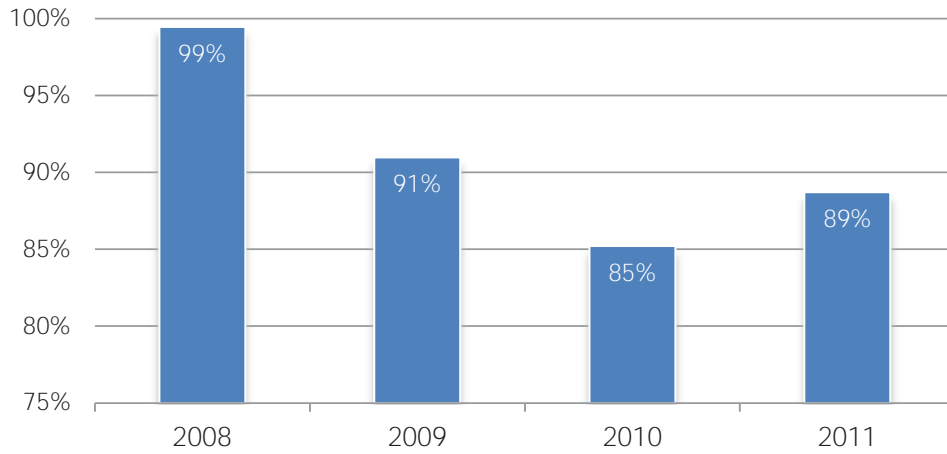
Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

Capital Grants includes ACA, ARRA, and Other.

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 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.

Figure 24. Health Center Section 330 Grant Revenue as Percent of Sliding Fee Discounts



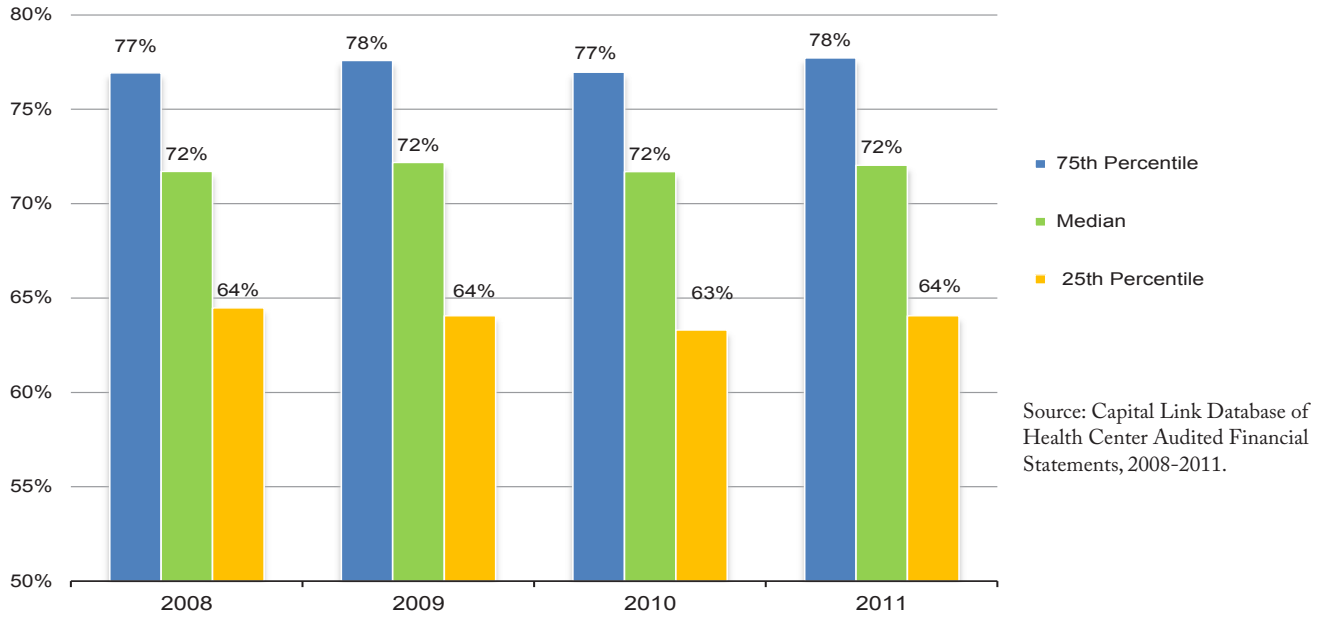
Source: Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS, 2008-2011.

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.

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 these spent 64% or less, affording this group the most flexible operating model. 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.

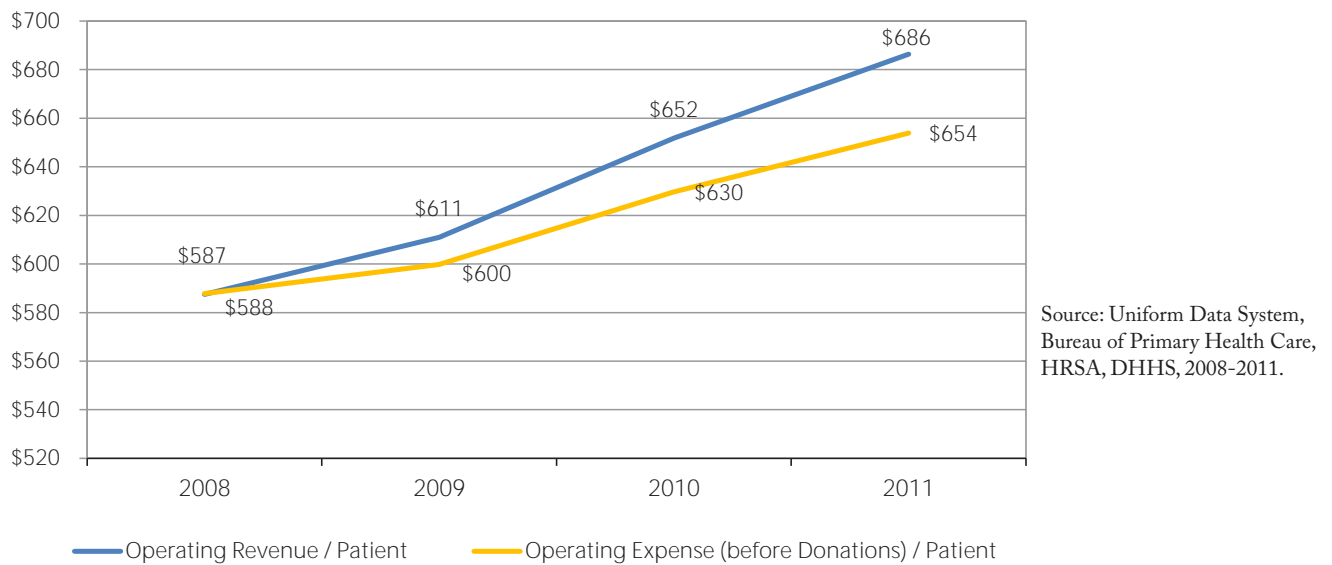
Figure 25. Health Center Employment-Related Expense as a Percent of Operating Revenue



Average Annual Revenues vs. Expenses per Patient

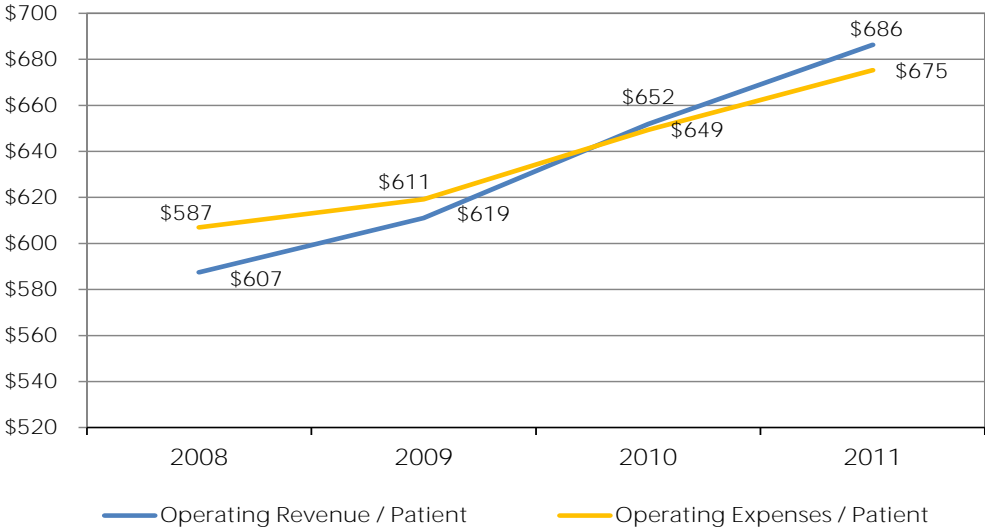
The health center industry as a whole operates with a relatively narrow margin between average revenues and expenses per patient. The following chart offers a window on the average revenues collected per patient versus the average amount spent in providing services per patient. The UDS data indicates 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.

Figure 26. Health Center Operating Revenue and Expense per Patient (Before Cost of Donated Expenses)



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.

Figure 27. Health Center Operating Revenue and Expense per Patient (After Cost of Donated Expenses)



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

This data, however, 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.

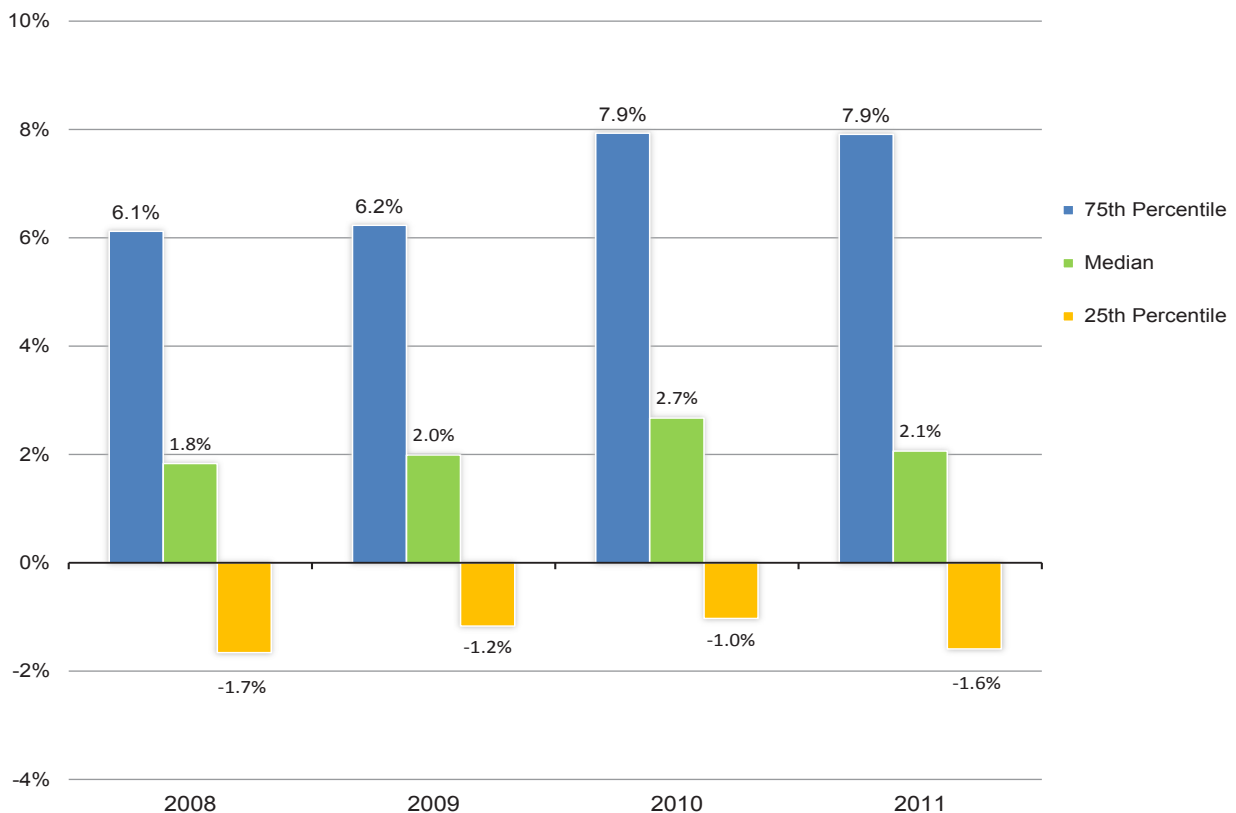
Profitability Measures

Operating Margin

(Change in Net Assets from Operations / Operating Revenue)

The 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.

Figure 28. Health Center Operating Margin



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

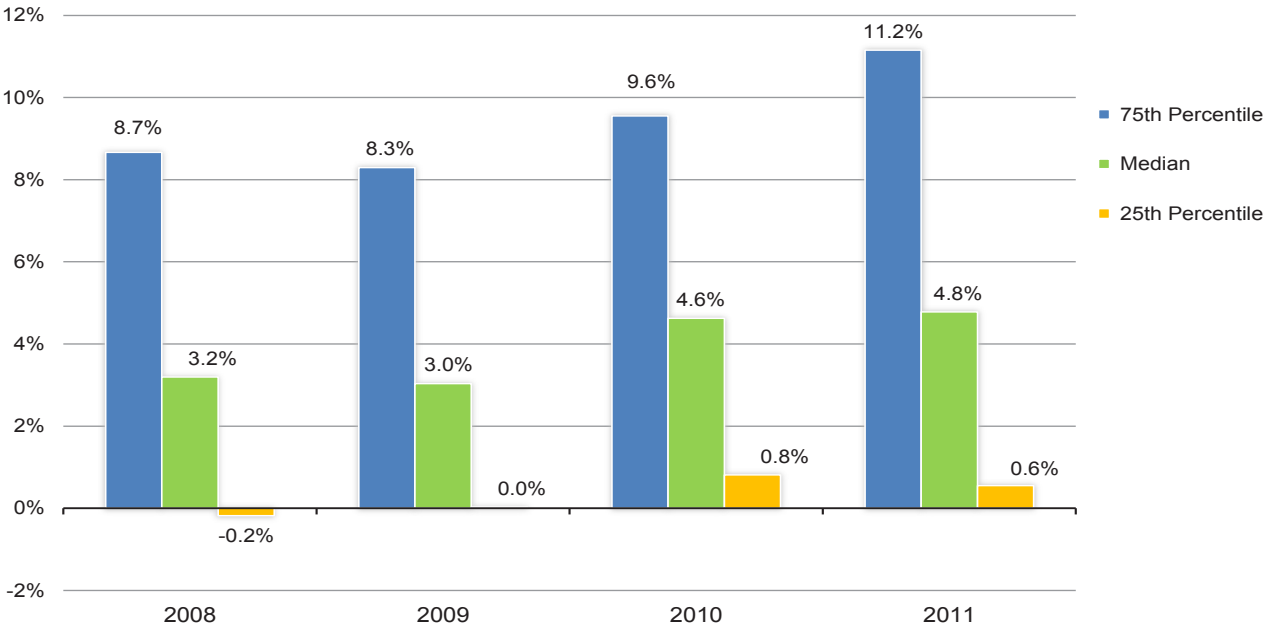
At the median, health centers operated with relatively tight margins as reflected by the 2% average median operating margin over the four-year period. At the 75th percentile, health centers generated an average 7% operating margin, while at the 25th percentile, health centers generated operating margins that averaged 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.

Bottom Line Margin

(Change in Net Assets / Operating Revenue)

The bottom line margin measures the proportion of change in net assets or, net income, after taking into account all revenues and expenses, to operating revenue. Most health centers do not have significant non-operating income as few have endowments from which to generate investment 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.

Figure 29. Health Center Bottom Line Margin



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

Liquidity Measures

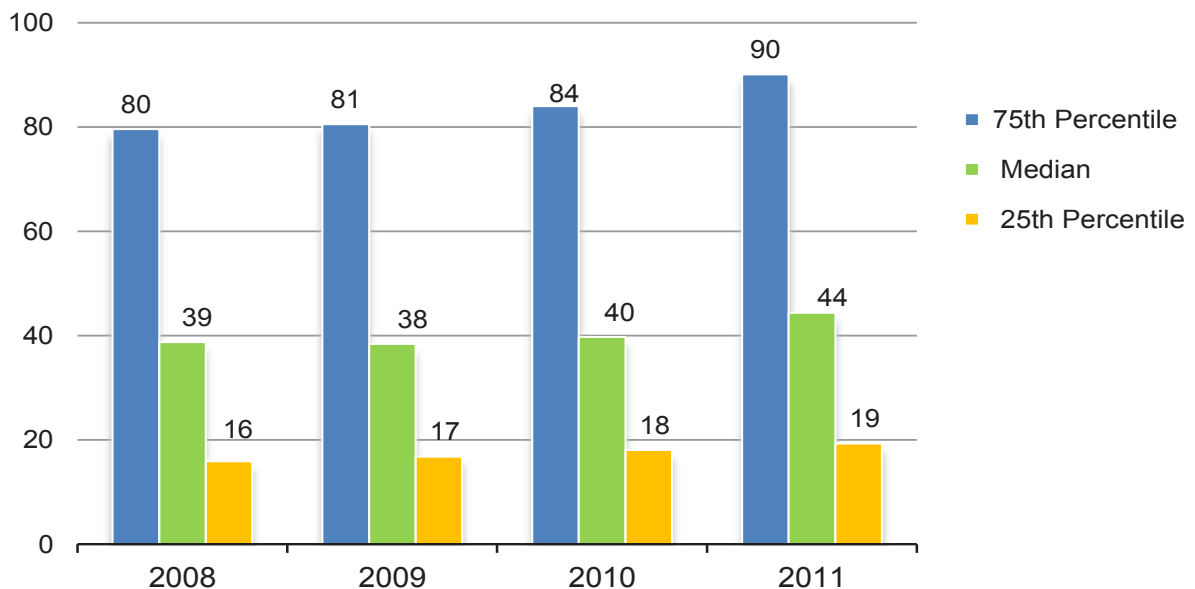
Days Unrestricted Cash on Hand (DCOH)

(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/investments refers to those funds not restricted by time or purpose that are available for general operating uses.

Relative to other provider types, health centers tend to have more limited cash reserves. Due to the income ranges and medical insurance status of the patients they serve, health centers operate with relatively narrow operating margins, which limits their ability to generate significant cash reserves.

Figure 30. Health Center Days Cash



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

Over the four-year study period, average health center DCOH ratios remained very stable for all quartiles, reflecting consistent liquidity levels. At the median, DCOH averaged 40, indicating that health centers at or above this quartile reported cash available to meet at least one month's worth of operating expenses. The 25th percentile, however, had a more constrained liquidity position with only 18 DCOH available on average to fund their operations. On the positive side, one quarter of health centers had 80 or more DCOH in all years.

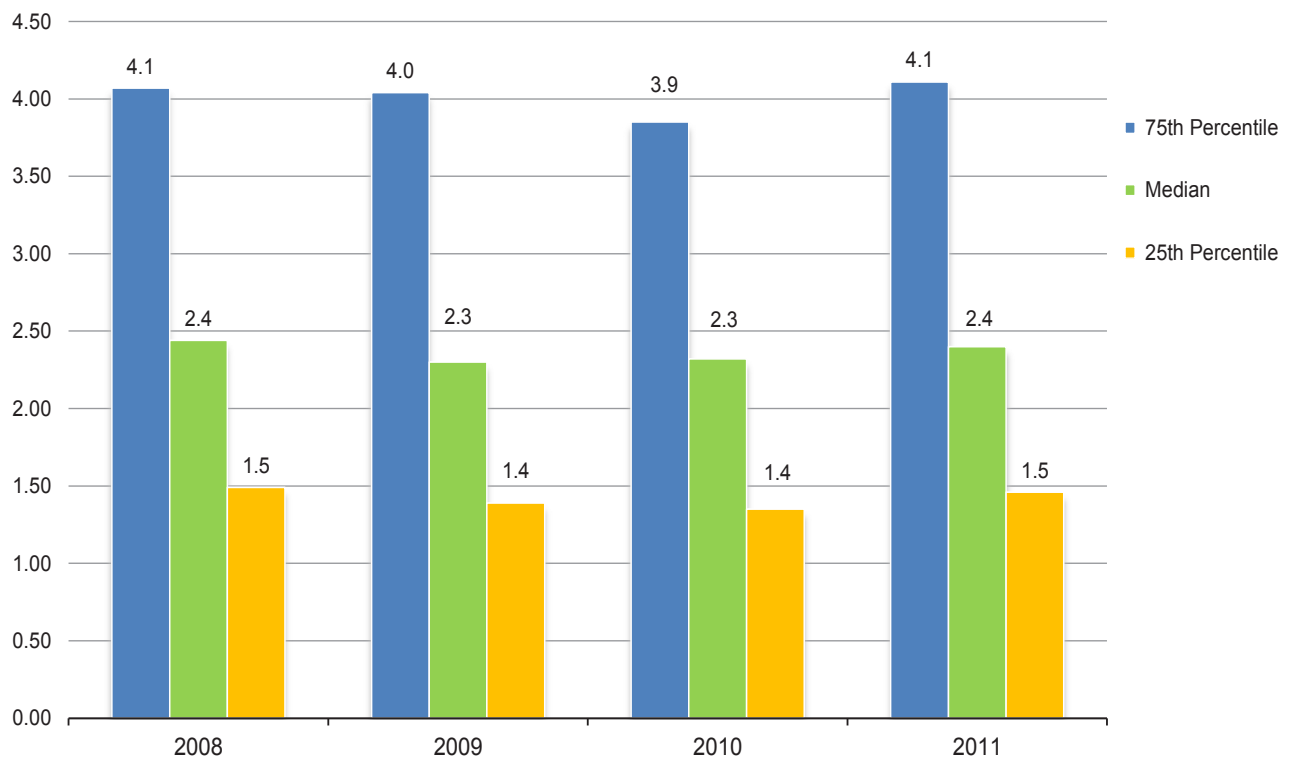
Current Ratio (CR)

(Current Assets / Current Liabilities)

Another liquidity ratio, the current ratio (CR) 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. As such, this 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 at least half of health centers. Notably, health centers at or above the 75th percentile reported strong CRs of 4 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 receivables, which can be challenging given the myriad of payers that health centers usually bill.

Figure 30. Health Center Current Ratio



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

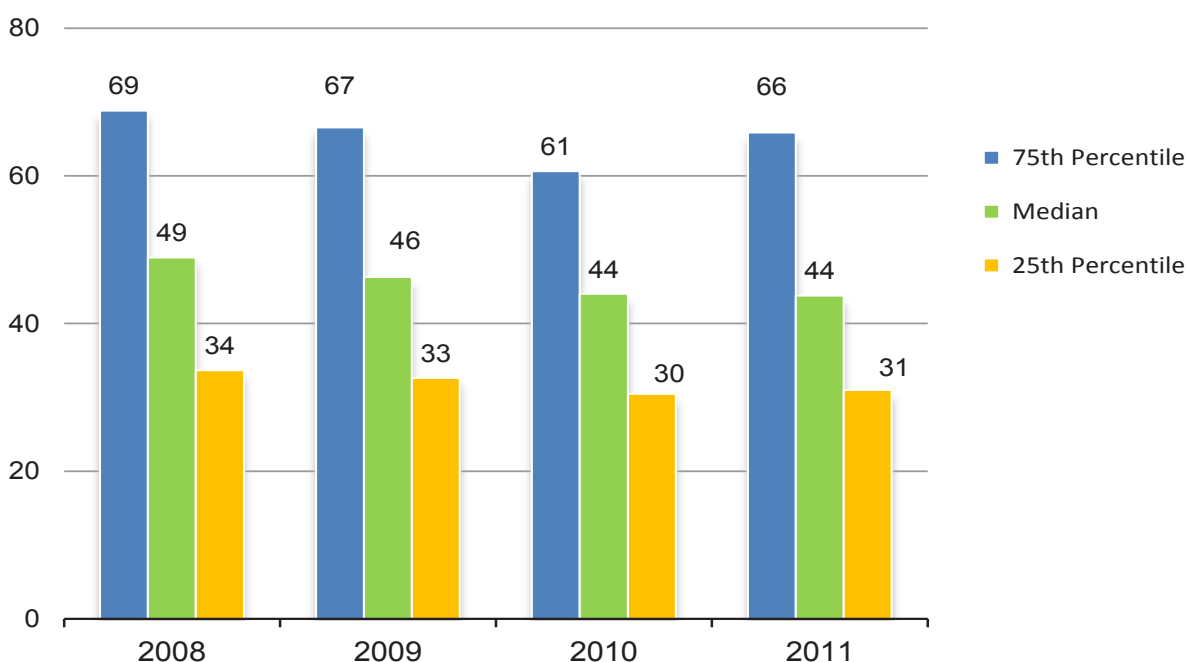
All Receivables Days: (Total Receivables / Total Operating Revenue divided by Number of Days in Period measured)

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, accounts receivables (AR) 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 57%, on average, of all health center revenue, it drives all receivables days, which averaged 46 days at the median over the four year period.

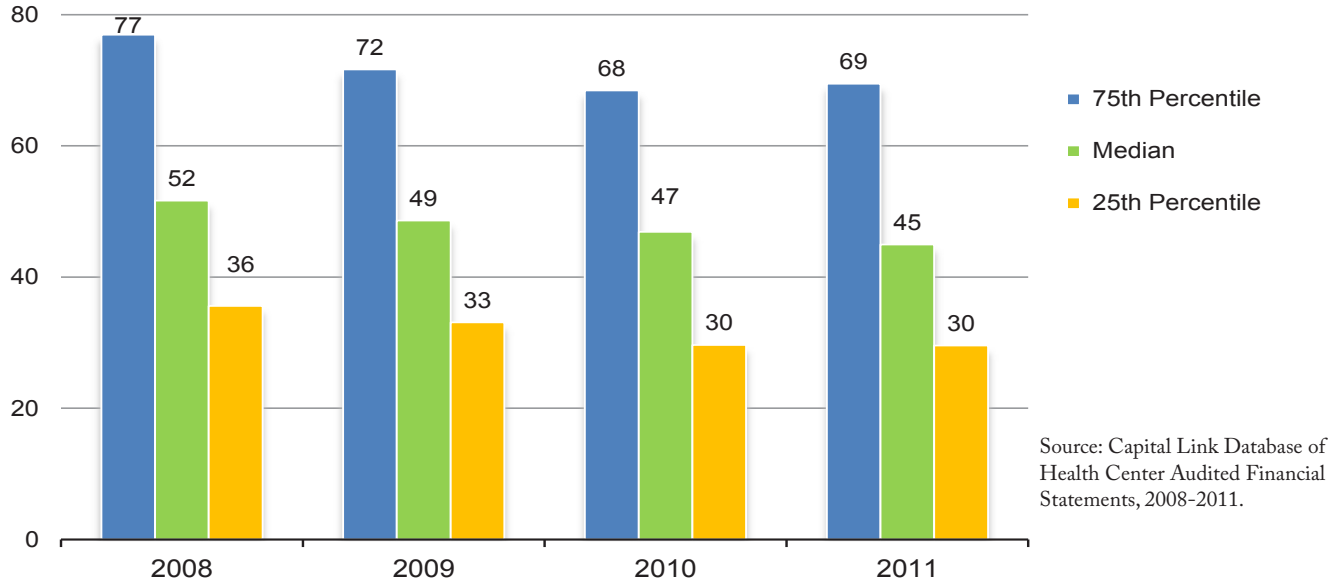
Figure 31. Health Center Days in All Accounts Receivables



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

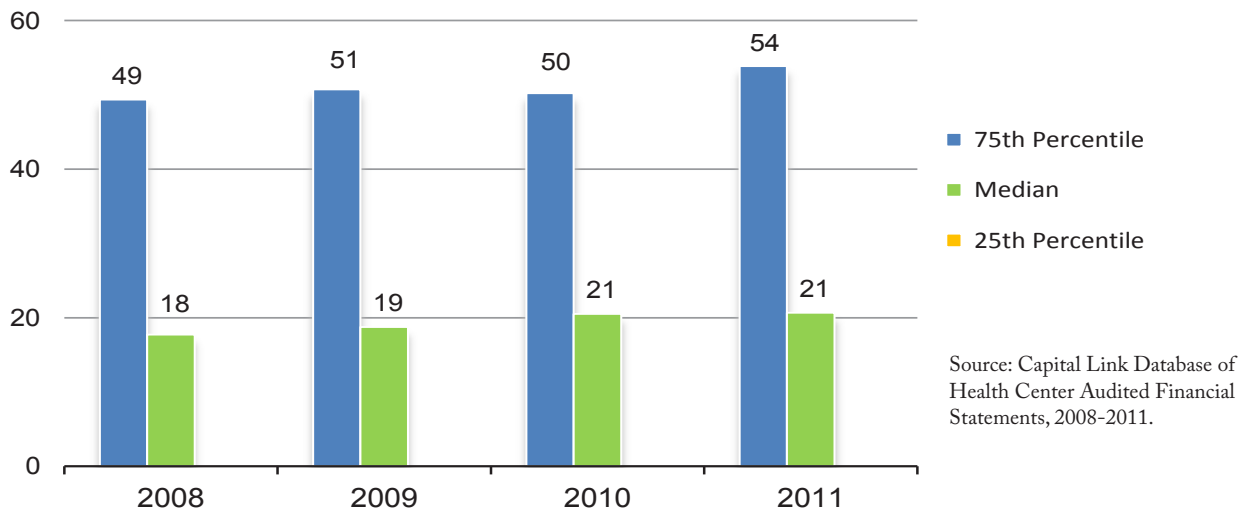
Half of all health centers turned their net patient receivables into cash within 48 days on average, over the four-year study period. Within this group, the strongest cohort collected at 32 days or less, all under the recommended maximum range of 65 – 75 days. The remaining half of health centers reported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

Figure 32. Health Center Days in Net Patient Services Receivables



The days in grants and contracts receivables chart below indicates that: (1) health centers at or below the 25th percentile reported no grant or contracts receivables, hence the 0% ratio for this group; and (2) the lower median and 75th percentile grants and contracts receivables days, when combined with net patient receivables days, lowers all receivables 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.

Figure 33. Health Center Days in Grants and Contracts Receivables



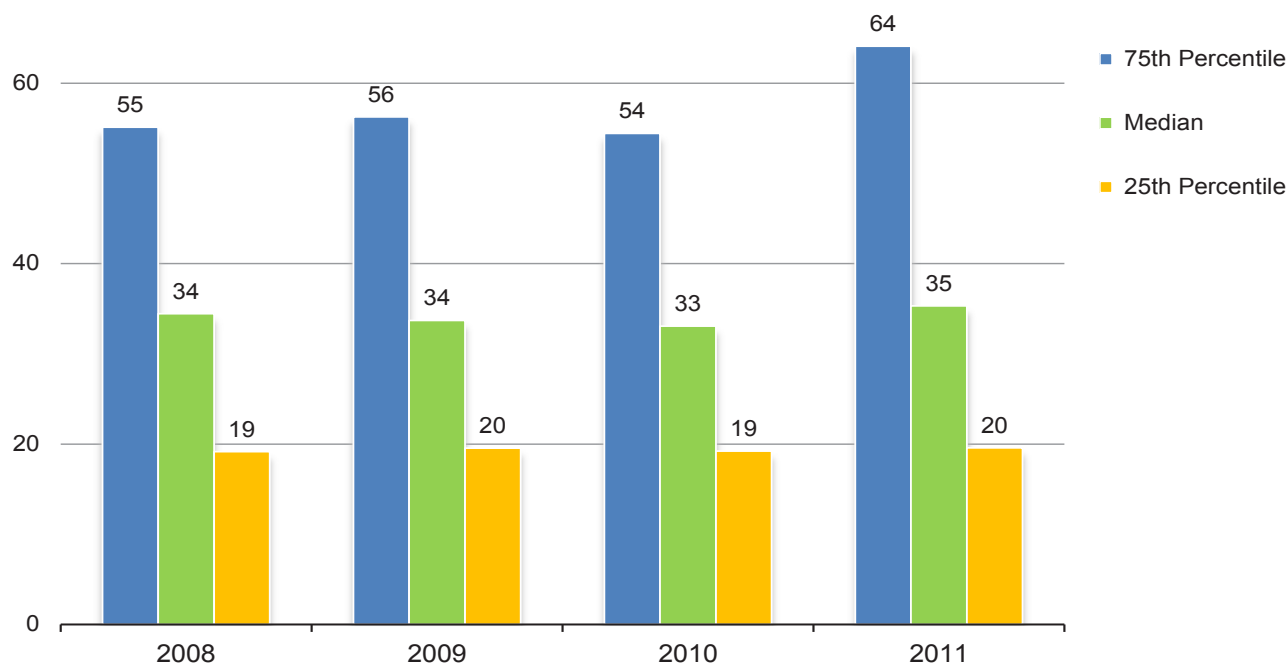
Overall, receivables days, in total and for the two major revenue categories, have been fairly consistent over the study period.

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.

Figure 34. Health Center Days in Accounts Payable



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.

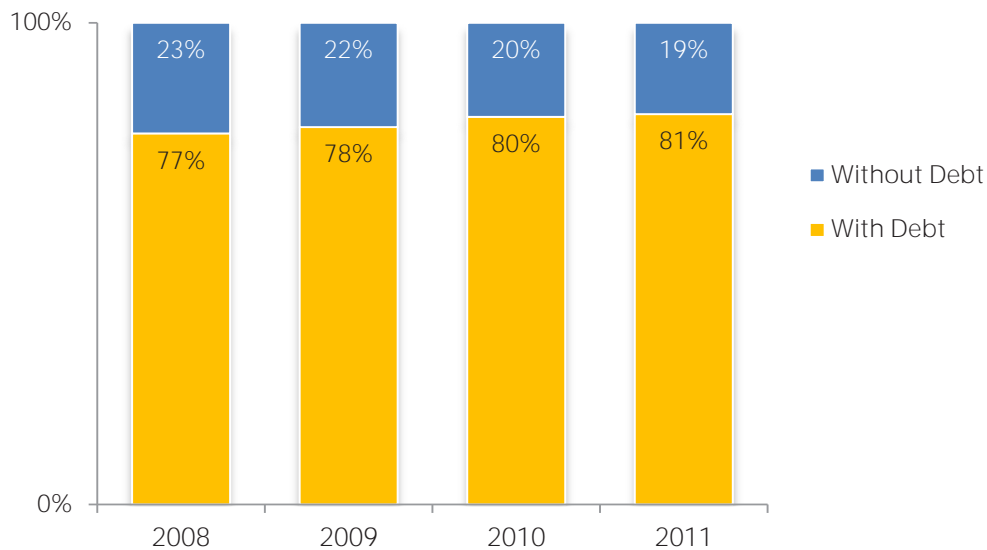
Debt Load and Capital Structure

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 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—and the declining share of health centers without it.¹² 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.

Figure 35. Proportion of Health Centers With and Without Debt

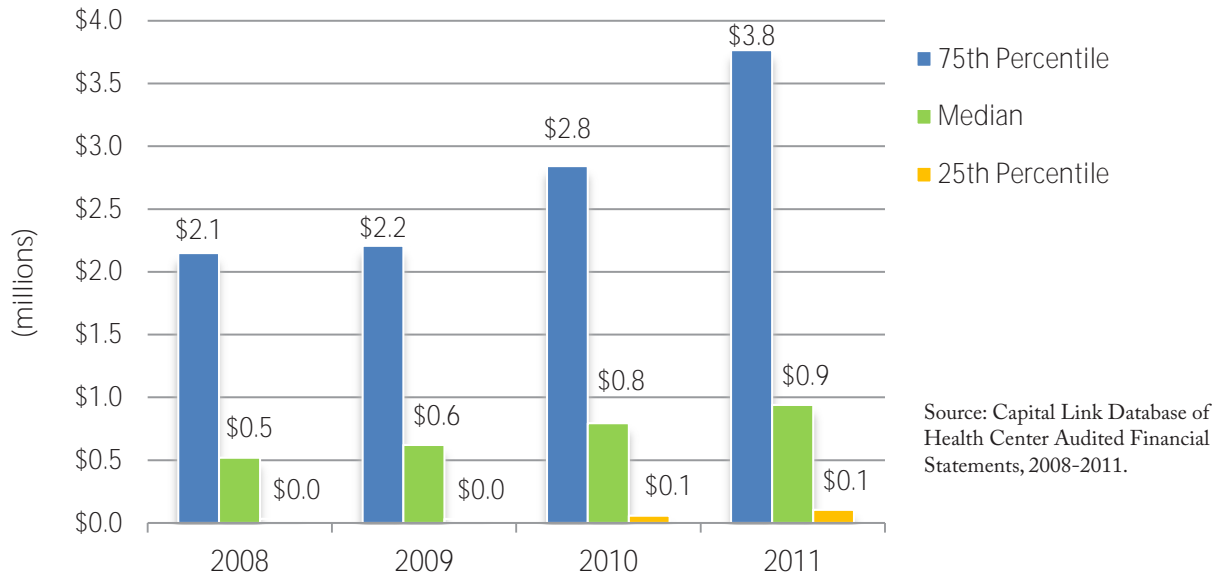


Source: : Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

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.

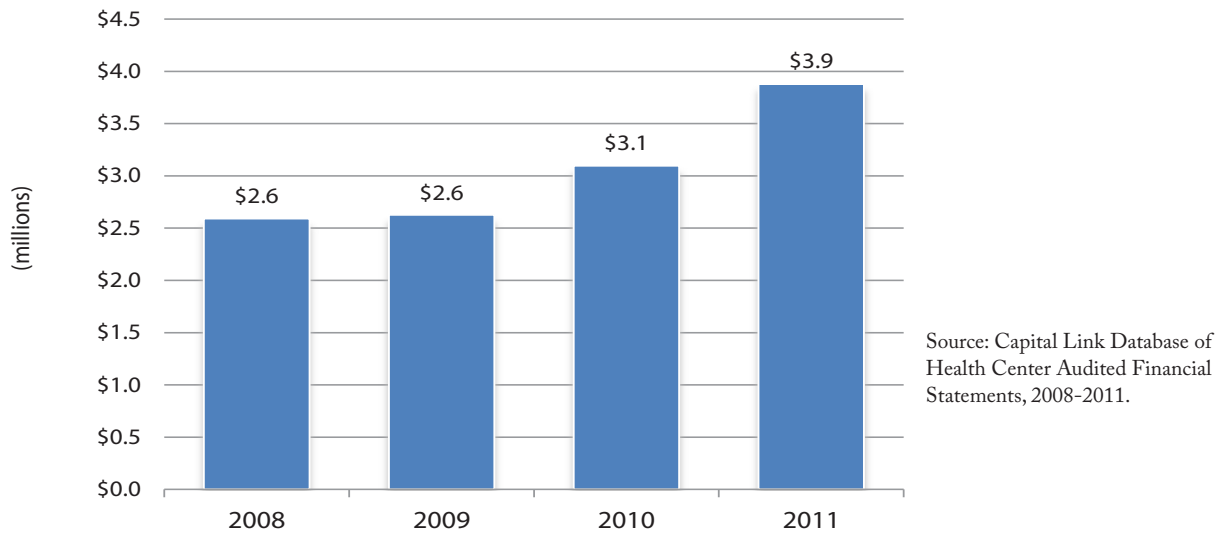
¹²Debt includes short-term and long-term loans, lines of credit and/or short and long-term capital leases.

Figure 36. Total Debt Per Health Center (For All Health Centers)



This trend is especially apparent looking at the following chart which includes 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.

Figure 37. Average Debt Amount for Health Centers with Debt



At the high end, the subset of health centers with indebtedness showed between \$36 million and \$57 million of long term debt on their balance sheets 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. This report highlights six leverage ratios, all discussed on the following pages.

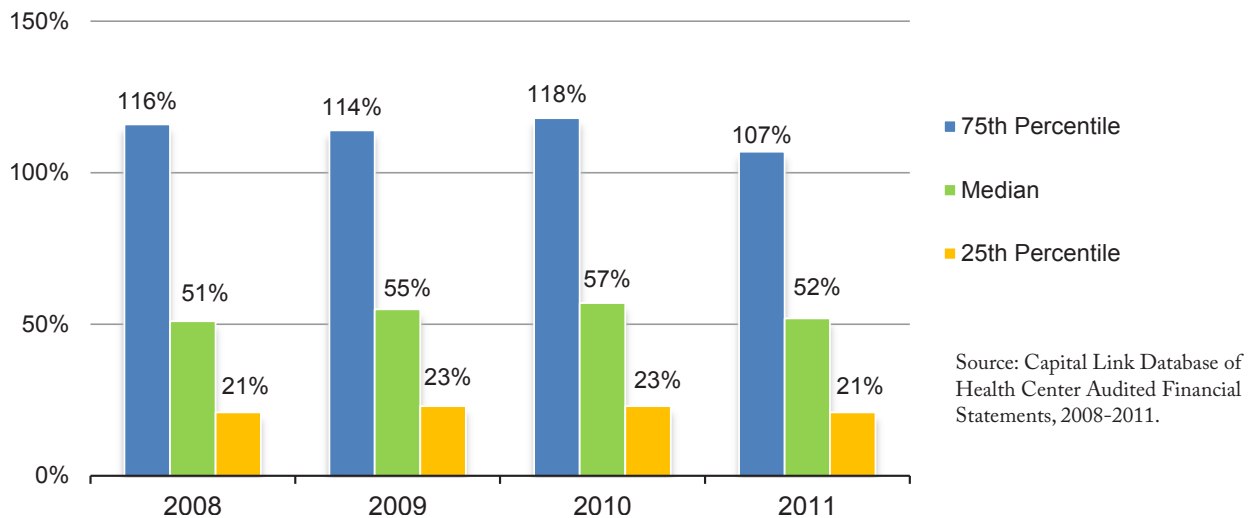
There is no right amount of debt. Leverage varies according to industry, a company's line of business, and its stage of development. Nevertheless, common sense tells us that low debt and high net asset levels in these ratios indicate lower risk. As a whole, the health center industry is relatively underleveraged 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.

Figure 38. Health Center Total Liabilities to Total Net Assets (Equity)



At the median, this ratio exceeded 50%, suggesting that half of all health centers have, on average, 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.

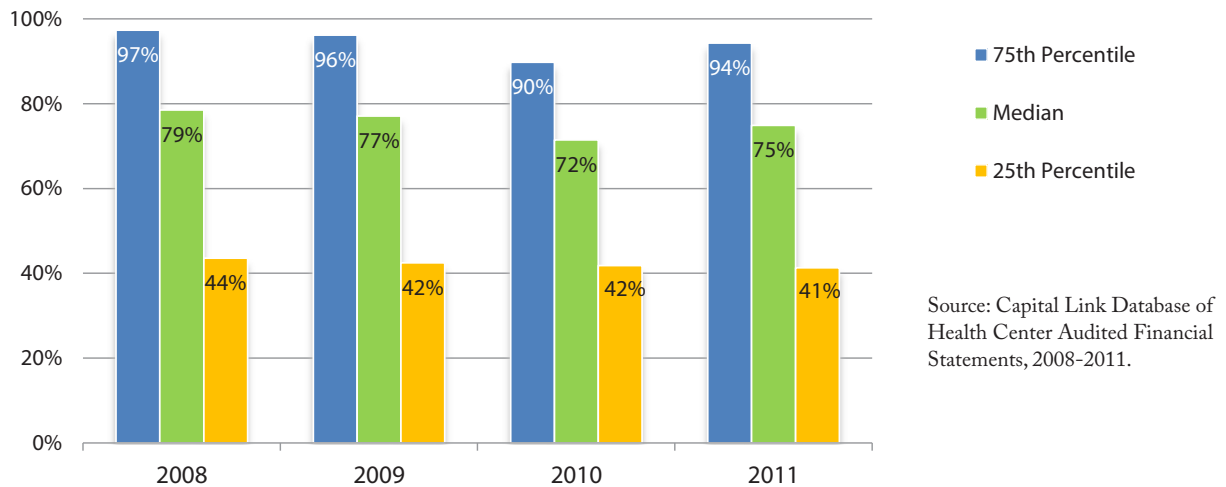
Other Debt-Related Ratios

The ratios and charts that follow were based on the subset of health centers that reported debt on their balance sheets, and not on the entire health center group. This subset represents approximately 80% of the full set of health centers studied, or about 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.

Debt-to-Capitalization

(Total Long Term Debt / Total Long Term Debt + Total Net Assets)

Figure 39. Health Center Debt to Capitalization



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

This ratio was very stable and consistent, with the median health center (of the subset with debt) reporting a 76% average over the four-year period. As the table below indicates, half of the health centers with debt carried approximately \$100 in long term debt for at least every \$32 in net assets.

Percentile	Debt/Capitalization	Long Term Debt	Net Assets	Capitalization
75th	94%	\$100	\$4	\$104
Median	76%	\$100	\$32	\$132
25th	42%	\$100	\$138	\$238

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

Debt Service Coverage Ratio (DSCR), Operations

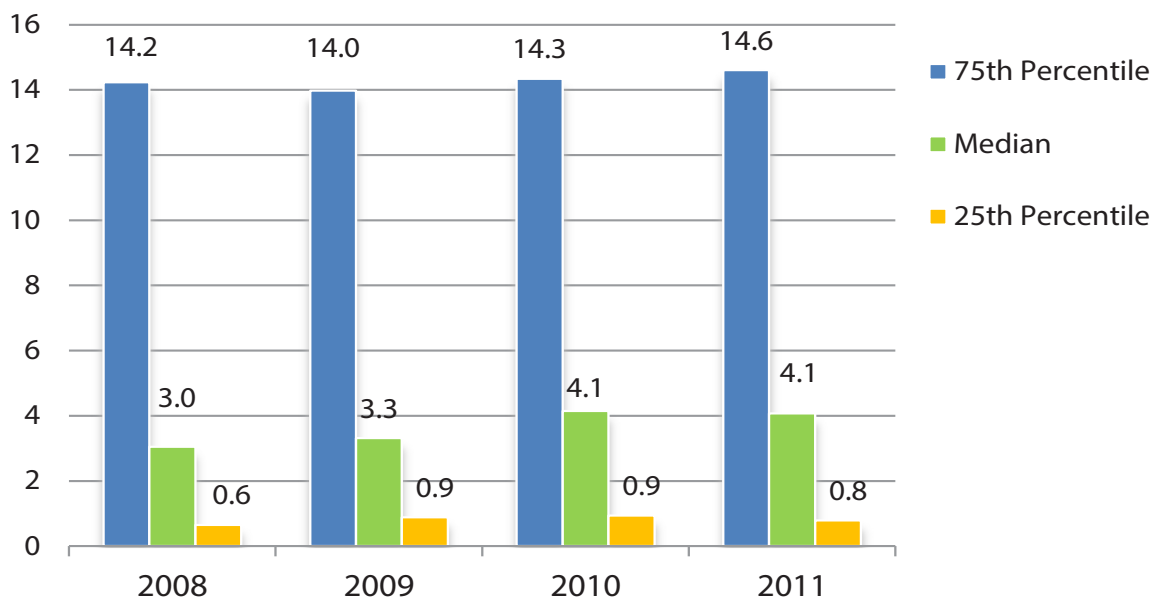
(Operating EBIDA / Debt Service for the Period)

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 both interest and principal payments currently due. 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.

Figure 40. Health Center Debt Service Coverage Ratio, Operating EBIDA



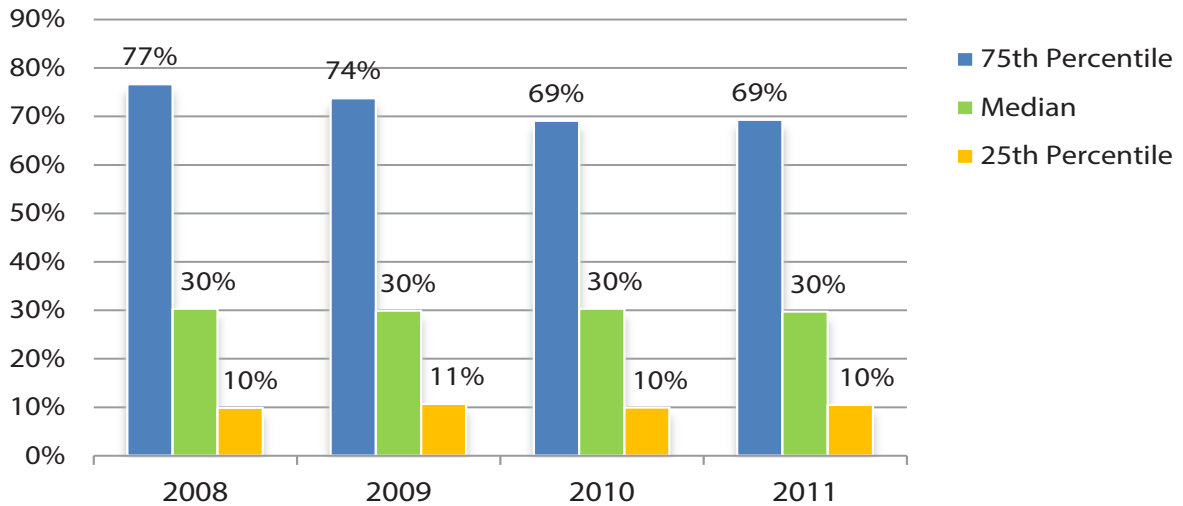
Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

Based on operating cash flow, the median health center (of the subset with debt) reported a 3.6x average DSCR for the study period. 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. However, the 25th percentile health center reported an average 0.80x ratio, suggesting cash was insufficient to service debt levels for at least 25% of health centers.

Debt-to-EBIDA
(Total Debt / EBIDA)

By comparing the financial obligations of an organization, specifically its debt, to its actual annual cash earnings, this ratio measures the approximate number of years that would be needed to pay off all debt, assuming no additional inflows or outflows of cash. Lower debt-to-EBIDA ratios indicate that an organization can fully pay off its debt in less time than organizations with higher ratios.

Figure 41. Health Center Debt to EBIDA



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

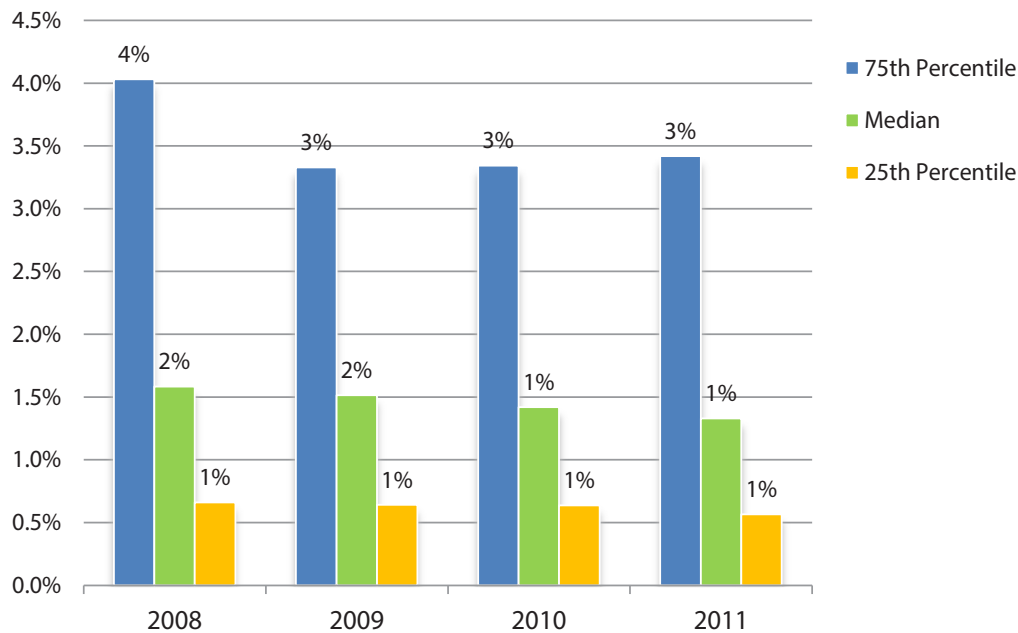
The 30% average ratio over the study period for the median health center suggests that it could take approximately four months of cash earnings to fully pay off its debt commitments. With all quartiles reporting below 100% historically, this ratio and chart indicate that health centers had limited debt and/or adequate cash flow to fully pay off their debt utilizing less than one year's cash earnings. Moreover, this ratio suggests that many health centers have the ability to service more debt than they currently carry.

Annual Debt Service to Total Operating Revenue

(Annual Debt Service / Annual Operating Revenue)

This ratio indicates the relative burden of debt service (interest, principal and capital lease payments) to operating revenues on an annual basis. Lower percentages indicate more room for variances in operating results. As such, it is another ratio used to gauge financial stability and solvency. As the chart below indicates, all quartiles reported extremely low ratios—less than 4% for all years studied, and half of all health centers reported below 2% in all years. This low ratio is consistent with all the previous debt-related ratios in that they reflect low debt levels and/or strong sources of debt repayment.

Figure 42. Health Center Annual Debt Service to Total Operating Revenue



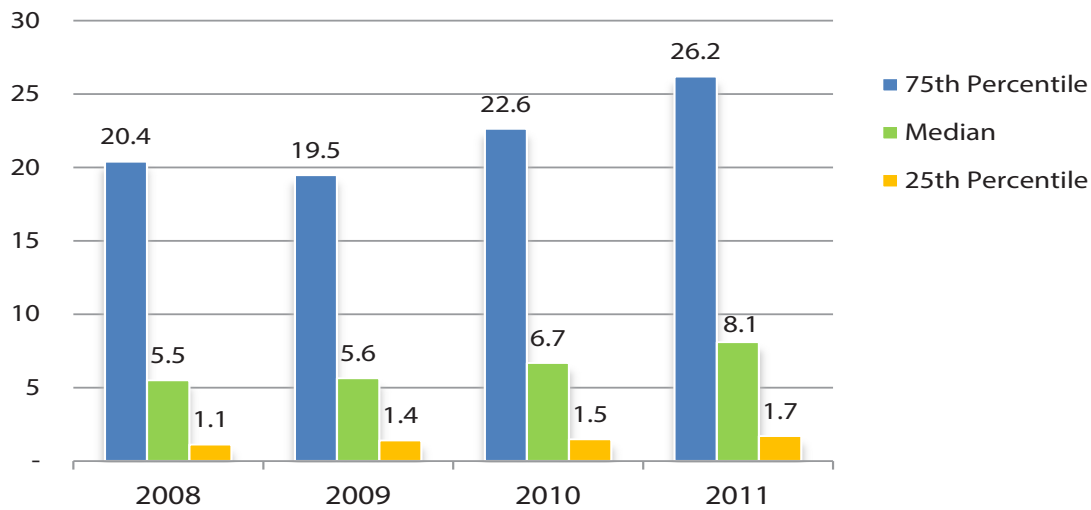
Source: Capital Link Database of Health Center Audited Financial Statements, 2008-2011.

Cushion Ratio

(Unrestricted Cash and Investments / Annual Debt Service)

A financial “cushion” is the amount of unrestricted cash or other highly liquid assets available in the event of a short-term liquidity crunch. The cushion ratio measures the liquidity cushion, represented by unrestricted cash and investments, currently held by an organization relative to its debt service (assuming debt service is constant over time). The higher this ratio, the more easily an organization can avoid potential negative consequences related to its debt position in the event of a liquidity crunch.

Figure 43. Health Center Cushion Ratio



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

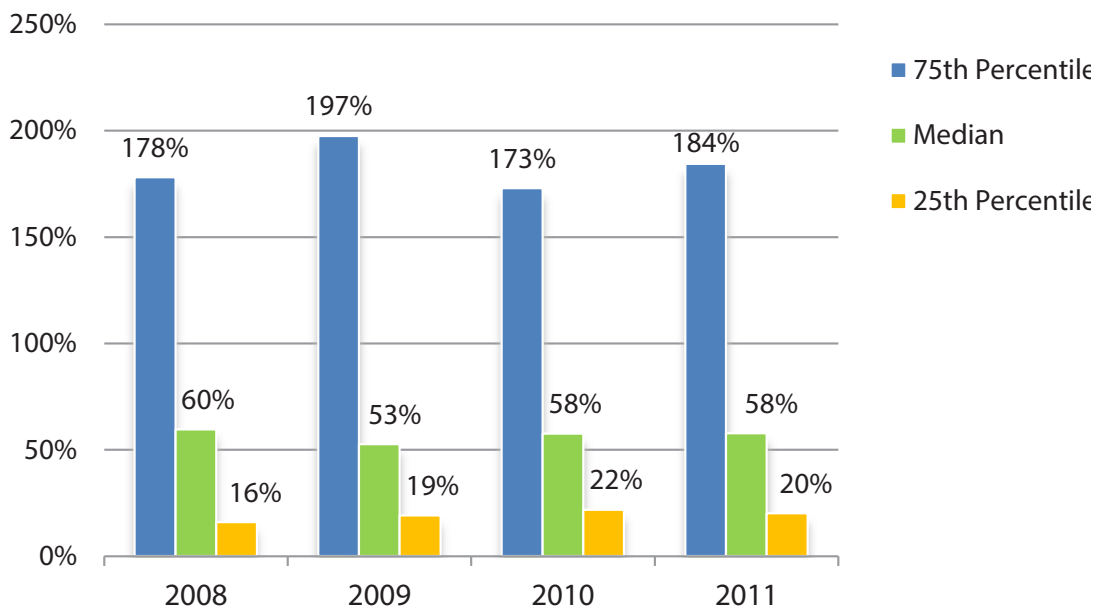
Half of all health centers reported a financial cushion (unrestricted cash and/or other highly liquid assets) that was at least 5 to 8 times greater than the amount of their debt service in a particular year. Additionally, half of the health centers within this group reported a high financial cushion that was at least 20 to 26 times greater than their debt service. These median and 75th percentile results are consistent with other ratios related to understanding relative debt levels in that both quartile ratios reflect good liquidity relative to debt service. However, at and below the 25th percentile, health centers reported a smaller financial cushion representing less than two times annual debt service, reinforcing the tight liquidity position for health centers within this quartile.

Unrestricted Cash-to-Debt

(Unrestricted Cash and Investments / Total Debt)

Lastly, cash-to-debt examines an organization's total unrestricted cash position at a given point in time relative to its total debt burden. While somewhat similar to the cushion ratio, which compares cash to debt service, cash-to-debt attempts to quantify the degree to which unrestricted liquidity/cash is able to cover total debt outstanding or how many times cash can "pay off" total debt.

Figure 44. Health Center Unrestricted Cash-to-Debt



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

Half of all health centers studied had cash positions large enough to pay off at least 57%, on average, of their total debt burden and half of this group had sufficient cash to pay off their debt burdens almost two times or, 183% cash to total debt. This additional view of liquidity reinforces the finding that a significant proportion of health centers had relatively light debt burdens overall, whether compared to their cash reserves, cash earnings or net assets (equity).

The above ratios reflect, on a consistent basis, the relative differentials between the quartile groups studied. For most ratios, the differential between the median and 75th percentile was at least twice that of the differential between the median and the 25th percentile; this suggests that health centers at the 75th percentile and above are performing well above the median on a consistent basis across all indicators, have significantly greater capacity to take on more debt than they have in the past and are, as a group, financially strong and stable. At the same time, many health centers at the 25th percentile are financially vulnerable.

Appendix A

Summary of Obligations and Benefits of FQHC Status¹³

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

¹³This summary is provided as an overview only and is necessarily incomplete. For complete requirements for FQHC certification, see www.bphc.hrsa.gov.

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

Federally Qualified Health Center

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

Federally Qualified Health Center

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

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 the Health Resources and Services Administration (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 Look-Alikes, 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 audit 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 Look-Alikes 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
- Debt Service to Operating Revenue
- Days Cash on Hand (DCOH)
- Current Ratio (CR)
- Leverage
- Debt to Capitalization (*included only health centers with debt*)
- Debt Service Coverage Ratio (DSCR) (*included only health centers with debt*)
- Debt to EBIDA (*included only health centers with debt*)
- Cushion Ratio (*included only health centers with debt*)
- Unrestricted Cash to Debt (*included only health centers with debt*)

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 of Patients and Encounters by Service Type
- Total Revenues by Type
- Growth Rate of Patients by Service 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
- Grant and Contract Revenue by Type
- 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.

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