Financial Performance of Community Health Centers in New Hampshire

Kane Consulting Group

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1. Executive Summary

This report assesses the financial performance of nine federally qualified health centers (FQHC's) in New Hampshire between 2010 and 2014. Our analysis of these nine FQHC's financial performance focuses on overall profitability, liquidity, solvency, and capital investment. This report builds off a similar analysis of nine FQHC's in New Hampshire during the period 2007 – 2011 (Rivenson and Loucks 2013).

In 2014, New Hampshire's FQHC's reviewed in our analysis (FQHCs)provided care for roughly almost 84,000 patients, up 27% from 2010. Racial/ethnic mix was 85% White, 8% Latino/Hispanic, and roughly 3% each African American or Asian. 23% were children, and 15% were adults at or above 65 years old. 77% of patients lived at or below 200% of the federal poverty level and 48% lived below 100% of the federal poverty level, which is similar to prior years. What has changed, particularly in 2014, is the insurance mix: 19% were uninsured, which is down from 32% in 2010 and 29% in 2013. Medicaid/SCHIP covered 30% of the patients, up from 23% in 2010 and 25 in 2013). [1] This change occurred before New Hampshire implemented ACA-related Medicaid expansions in September, 2014 (most FQHC 2014 fiscal years ended in June, 2014).

[1] Data is from HRSA web site: http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014&state=NH

Overall, the health centers experienced improving profitability over the period, after reporting aggregate operating and total losses in 2011 and 2012. Patient service revenue, a higher "quality" source of revenue than grants and contracts, grew from 57% to 60% of total revenues. However significant variation in profitability characterized the sector, with the range of total margins often exceeding 20 percentage points between the minimum and maximum values. No one center always had the minimum or maximum value; rather, most showed considerable volatility in profitability over time. Only one had a positive total margin in all five years, while two reported negative total margins in three of the five years.

In terms of liquidity, the median ratios for current ratio, days to collect receivables, days to pay payables, and days cash on hand reflected barely adequate levels throughout the period. Again, performance varied widely among the centers, with the minimum current ratio below 1 (technical bankruptcy) throughout the period. Five centers experienced a current ratio below 1 at least once during the period. As of 2014, aggregate days cash on hand was roughly 32 days, not a big change from 27 days in 2010, and a fairly thin cushion for protection against a potential slowdown in collection of receivables, which in 2014 was 48 days for the sector, up from around 40 in 2010.

Solvency for the centers improved significantly with the arrival of large capital grants and donations, particularly in 2011. This improved the sector's major solvency metrics, with the aggregate equity financing going from 40% in 2010 to just over 50% in 2014, and debt service coverage ratios rising from 1.17 in 2011 to 4.54 in 2014.

Although plant age did not dramatically change over the period, capital expenditures for the sector exceeded depreciation expense by 2.8 times, representing a significant upgrade in facilities and equipment in the sector.

The challenge ahead is for the centers to stabilize profitability, and to generate adequate cash flow for growing debt service, capital investment, and working capital needs without the capital infusions provided by the ARRA and the ACA. The potential infrastructure needs (information technology, ability to absorb financial risk, need to build new programs to manage chronic disease and population health) are likely to become even greater as the health sector adapts a more accountable and integrated model of health care delivery.

2. Methodology

To assess the financial performance of New Hampshire's federally qualified health center sector, the most recent 5 years of audited annual financial statements (2010 – 2014) were collected from 9 FQHC's. Data from these financial statements was standardized for comparability both across years and across centers and manually inputted into an Excel template. A comprehensive analysis of key financial ratios was conducted for each individual health center, as well as for the sector as a whole.

List of New Hampshire FQHC's [2]
Ammonoosuc Community Health Services (ACHS)
Avis Goodwin Community Health Center (AGCHC)

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Coos County Family Health Services
Families First of the Greater Seacoast (FFGS)
Health First Family Care Center (HFFCC)
Indian Stream Health Center (ISHC)
Lamprey Health Care
Manchester Community Health Center (MCHC)
Mid-State Health Center (MSHC)

3. Results

Overall Financial Performance - Profitability

The aggregate statement of income in Table 1 combines the statement of operations and changes in net assets for all nine FQHC's over the period 2010 – 2014. The aggregate cumulative operating *loss* over the five years was $3.1 million, while excess revenues were a positive $ 4.4 million due primarily to contributions and donated goods/services[3]. The only year of positive operating profit during the period was 2014. In that year, the health centers experienced a 19% increase in number of patients, with an improvement in insurance coverage as well: a 35% reduction in the percentage of uninsured patients and a 20% increase in the percentage of patients covered by Medicaid.

The primary driver of increases in net assets (equity) were the capital donations and grants that totaled close to $14 million over the period, with the largest amount awarded in 2011 ($11 million). As this money was invested in facilities and equipment, capital expenses (depreciation and interest) rose. As Table 1 indicates, the average annual increase in depreciation expense was over 12%, and interest expense, 8.6%. While the rise in depreciation expense depressed operating income, since it

[3] We did our best to separate out contributions for operating purposes from capital contributions. It is possible that some of the operating contributions identified here may be capital in nature, which would have lowered the total margins. The reporting of capital contributions was not uniform or always clearly specified among the health centers.

is a noncash expense (representing the writing-off of capital assets as they are "used"), it did contribute to a significant increase in the cash-flow-adjusted margins in 2013 and 2014 (see Table 2 below).

Table 1: Aggregate Statement of Operations and Changes in Net Assets, 2010 – 2014

	Dollars in Thousands					Aggregate	Average Annual
Fiscal Year	**2010**	**2011**	**2012**	**2013**	**2014**	**2010-2014**	% Change
Net Patient Service Revenues	31,334	30,935	31,659	36,125	40,569	170,623	7.37%
Grants & Contracts	21,337	20,147	17,202	16,572	19,084	94,342	
Assets Released from Restrictic	1,095	1,600	1,311	1,254	2,035	7,295	
Other Operating Revenue	1,553	2,096	5,371	6,694	5,567	21,281	
Total Other Operating Revenue	23,985	23,843	23,884	24,519	26,687	122,919	2.82%
Total Operating Revenues	55,319	54,778	55,543	60,644	67,256	293,541	5.39%
Salaries, Payroll Taxes, Fringes	40,417	41,653	40,203	42,804	46,607	211,685	3.83%
Depreciation	1,120	1,360	1,733	1,711	1,671	7,596	12.29%
Interest	403	611	686	681	542	2,923	8.60%
Other Operating Expenses	14,229	13,771	13,724	15,871	17,479	75,075	5.71%
Total Operating Expenses	55,767	56,785	56,708	61,067	66,300	296,627	4.72%
OPERATING INCOME	-448	-2,007	-1,165	-423	957	-3,086	
Investment Income (incl realize	156	88	9	18	5	275	
Gains (Losses	22	-86	107	148	0	191	
Donated Goods & Services/ Co	1,471	1,130	623	1,454	1,731	6,410	
Other Income (Expense	168	97	107	110	124	607	
Total Nonoperating Revenue (L	1,818	1,229	847	1,730	1,861	7,484	
EXCESS REVENUES OVER EXPEI	1,370	-777	-318	1,307	2,817	4,398	
Capital Additions and other	1,330	11,275	315	599	608	14,126	
Unrealized gains/losses	522	544	-25	108	14	1,163	
Other Changes in Net Assets	0	0	-155	0	0	-155	
Change in total net assets	3,222	11,042	-183	2,013	3,439	19,532	

Table 2 shows the trend in key margins over the period. While operating and total margins were positive in 2014, the aggregate ratios combined over the years show a total margin of only 1.5% - not enough by itself to finance the expansion of services and facilities expected as demand is fueled by increased insurance coverage. Adding depreciation back to operating income generated a "cash-flow-adjusted" total margin that improved steadily from 2011 – 2014, due primarily to the rapid rise in depreciation expense over the period, and generating a total cash from operations (excess revenue plus depreciation expense) of almost $12 million over the period.

Bad debt represented roughly 5 – 6% of net patient service revenue throughout the period; it might be expected to rise in the future as newly insured patients with subsidized or unsubsidized individual coverage experience deductibles that they may not be able afford[4]. As of 2014, 32% of FQHC patients had insurance "other than" Medicare or Medicaid.

Table 2: Aggregate Indicators of Profitabilty and Revenue Sources

						Aggregate
	2010	**2011**	**2012**	**2013**	**2014**	**Ratios**
Total Margin	0.024	-0.014	-0.006	0.021	0.041	0.015
Operating Margin	-0.008	-0.037	-0.021	-0.007	0.014	-0.011
Cash-Flow Adjusted Total Marg	0.044	0.010	0.025	0.048	0.065	0.040
Bad Debt % NPSR	0.049	0.060	0.064	0.060	0.054	0.057
NPSR/TOR	0.566	0.565	0.570	0.596	0.603	0.581
Grants & Contracts/TOR	0.386	0.368	0.310	0.273	0.284	0.321
Nonop Rev/Excess Rev	1.327	-1.581	-2.659	1.324	0.660	1.702

Balance sheets showed improved aggregate metrics over the period. Table 3 shows the aggregate balance sheet in 2010 and 2014; Table 4 shows key aggregate balance sheet ratios.

Table 3 shows very little growth in current assets (the source of liquidity), but significant growth in noncurrent assets, specifically property, plant and equipment. Current liabilities also show very little change over time, while the biggest change is a large increase in net assets, which grew mostly because of the large capital asset grants received under the ARRA and the ACA.

[4] On the Exchanges, the "Bronze Plan" has the lowest premium but includes a $5,000 deductible; at the next level up, the "Silver Plan" has a $2000 deductible. Lower income residents are eligible for some cost-sharing subsidies.

Table 3: Aggregate Balance Sheet, 2010 and 2013

					2014 minu
Fiscal Year		**2010**	**2014**		**2010**
Current Assets:					
Cash & Short-Term Investmen		3990	5449		1458
Other current assets		10057	11316		1259
Total Current Assets)		14048	16765		2718
Noncurrent Assets:					
Gross PP&E)		25613	49139		23527
Accumulated Depreciation)		9554	15000		5446
Net PP&E)		15879	33943		18065
Other Noncurrent Assets)		2107	2712		605
Total Noncurrent Assets)		7499	36768		21207
TOTAL UNRESTRICTED ASSETS)		31481	53532		22052
Current Liabilities:					
Current Portion Long-Term Debt)		407	589		182
Notes Payable/ Line of Credit)		684	601		-84
Accounts Payable & Accrued Expenses)		5520	6060		540
Other Current Liabilities)		3565	4595		1030
Total Current Liabilities)		10176	11843		1667
Noncurrent Liabilties:					
Long-term Debt)		8339	13006		4668
UNRESTRICTED NET ASSETS)		12966	28683		15717
Total Unrestricted Net Assets and					
Liabilties		31481	53532		22052

Table 4 summarizes key aggregate ratios based on the balance sheet or a combination of the balance sheet and statement of operations. As is discussed more fully in the detailed ratio sections below, the liquidity-related ratios do not show much improvement, while the solvency ratios do show sector improvement, again largely due to the capital grants received over the period. Plant age, somewhat paradoxically, does not change by very much over the period.

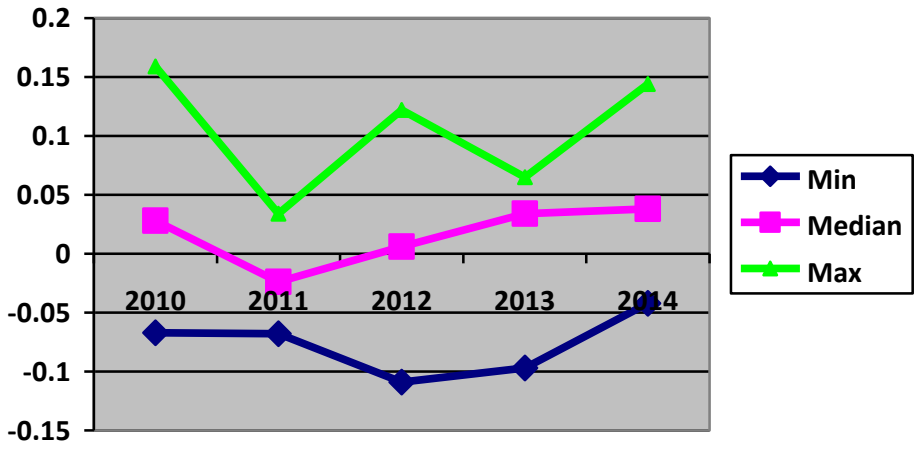
Table 4 Key Aggregate Balance Sheet Ratios 2010 – 2014

	2010	2011	2012	2013	2014
Days Cash on Hand	27	26	31	31	32
Days in AR	40	48	38	37	49
Days in AP	37	41	33	33	34
Current ratio	1.38	1.30	1.24	1.33	1.42
Equity Financing	0.41	0.52	0.51	0.53	0.51
Debt Service Coverage		1.17	1.53	3.09	4.54
Plant Age	8.53	7.87	6.95	7.99	8.97

Ratio Distribution

Profitability Total Margin reflects health center net income (income after expenses) as a percentage of total revenue, and includes both operating income and nonoperating revenues. Figure 1 shows the distribution of values for total margin for the nine FQHCs, using minimum and maximum instead of 25th and 75th quartiles to capture the full range, as only 2 centers would be represented in most quartiles.

Figure 1 Total Margin

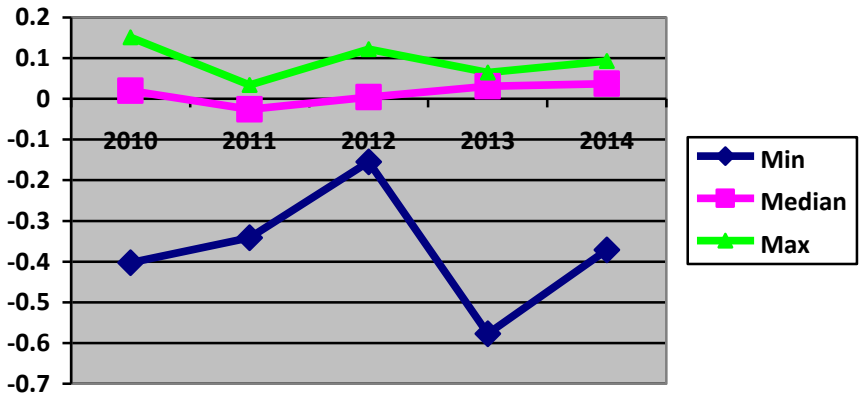


The median total margin improves considerably in 2013 and 2014 after a loss in 2011 and breakeven in 2012. Within the sector, some health centers did much better than did others.

Three health centers reported positive margins in at least four of the five years; two health centers reported negative margins in 3 of the five years. The annual variation in margins for most health centers showed few trends, but large year –to-year fluctuations.

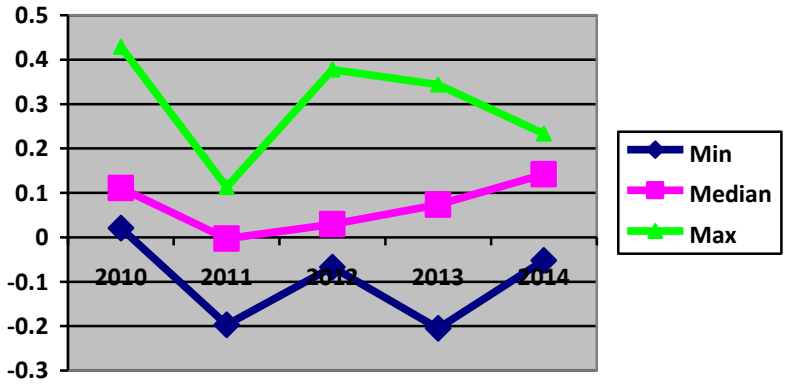
Figure 2 shows the distribution of values for the operating margin. The minimum value reflects one health center that was heavily reliant upon private contributions to meet its operating expenses; private contributions are classified as nonoperating revenue in our standardization model, so the operating margin excluded these contributions. The median operating margin hovers around breakeven, while the maximum value shows the wide and erratic fluctuations also noted in the total margin values.

Figure 2 Operating Margin



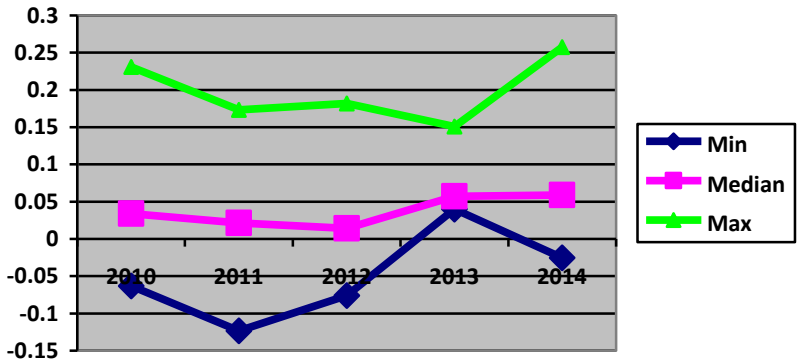
Operating Revenue Growth rates, as seen in Figure 3, reflect the year-to-year change in revenues related to mostly net patient service revenues, grants and contracts. One FQHC saw revenues decline in three of the five years, and one experienced revenue growth in all five years. Most of the rest experienced revenue declines in one year. As the median trend line suggests, over 50% of the FQHC"s experienced rapid revenue growth in 2013 and 2014.

Figure 3 Rate of Growth in Operating Revenues



In Figure 4, the distribution of growth in Operating Expenses is shown. As the trend in the median shows, growth in operating expenses also accelerated in 2013 and 2014. Three FQHC's saw positive growth in all five years; two FQHC's saw negative growth in two of the five years. The others had positive growth in four of the five years. Expense growth exceeded revenue growth about 30% of the time.

Figure 4 Rate of Growth in Operating Expense



Net Patient Service Revenue (NPSR) as a percentage of Total Operating Expenses reflects the percentage of expenses covered by patient service revenue; a greater percentage generally is a favorable development, as it is a sustainable source of support earned by providing services to

patients, compared to grants and contracts, which are subject to being cancelled or ending without renewal. As seen in Figure 5, the median has drifted upward from 53% to closer to 60% over the period.

Figure 5 Net Patient Service Revenue as Percentage of Total Revenues

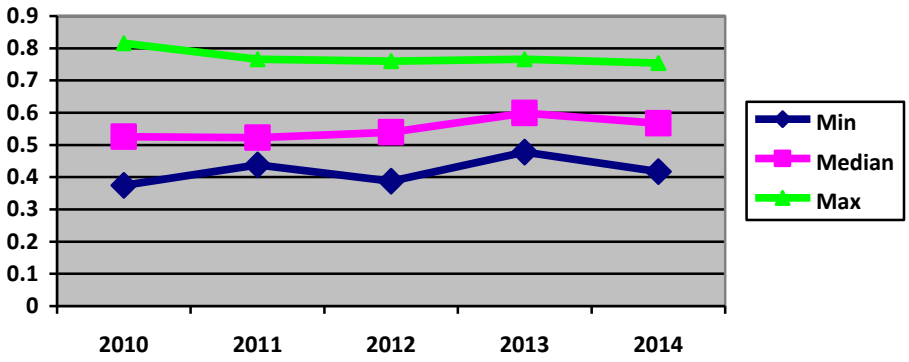
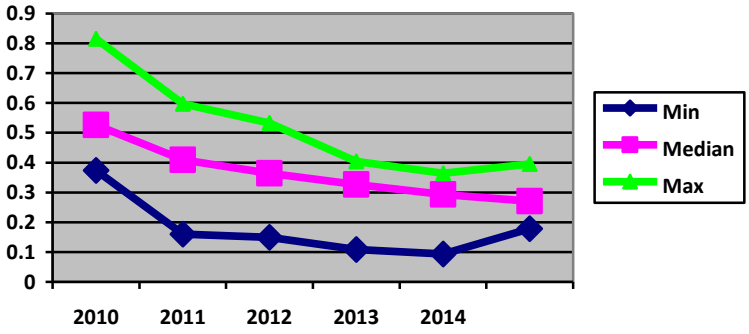


Figure 6 shows trends in the ratio Grants and Contracts as a Percentage of Total Operating Revenue. Clearly, as Net Patient Service Revenue has grown as a percentage of Total Operating Revenue, Grants and Contracts have declined, from close to 50% of revenue to less than 30%. The balance after these two sources of revenues is "Other" Operating Revenues, the elements of which are not generally specified in the audited financial statements.

Figure 6: Grants and Contracts as a Percentage of Total Operating Revenues

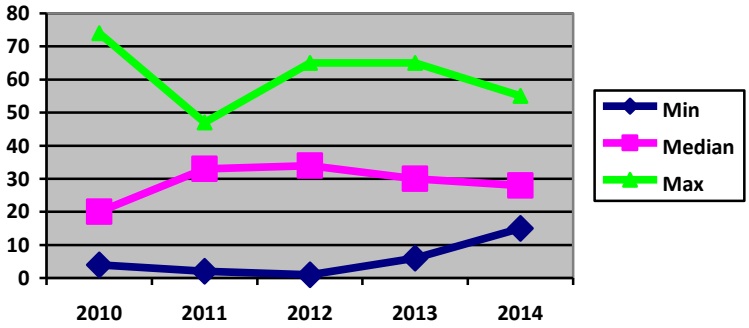


Liquidity

Liquidity assesses an organization's ability to meet its current financial obligations with its current assets. Collectively, the FQHCs experienced fairly stable liquidity, with the median days in collections between 36-42, the median days payable between 32 and 36, and 20-34 days cash on hand throughout the period. However, as the minimum and maximum values show, there was wide variation among the centers in each year.

Days Cash On Hand , shown in Figure 7, measures the number of days a health center can continue operations with its available cash. Available cash includes marketable securities or board-designated funds that can be utilized for short-term needs, although they may be reported as "noncurrent" on the balance sheet. As Figure 7 shows, the maximum value ranged from 47 – 74 days; the minimum value range was 1 – 15 days, and the median value ranged from 20 - 34, roughly one month of operating expense. Thus roughly half of the centers had cash on hand that would cover them for one month or less, which is an adequate but not very generous reserve.

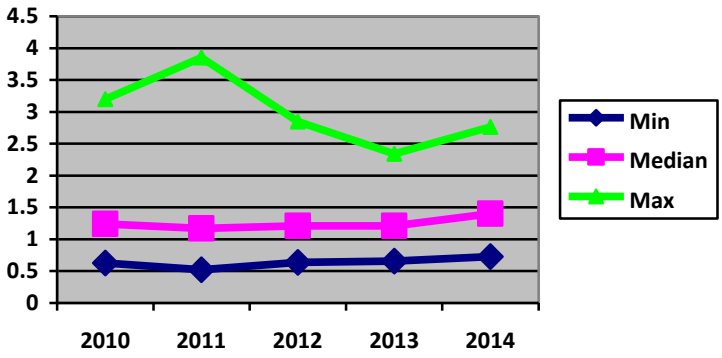
Figure 7 Days Cash On Hand, All Sources



Another commonly used measure of liquidity is the current ratio which measures the organization's ability to meet its current financial obligations with current assets. The health centers show a slight upturn in 2014 but at least 50% of them had current ratios below 1.5, which

suggests tight liquidity. The minimum ratio was below 1 the entire period; four different centers experienced current ratios below 1 during the period; they had problems making payroll and paying outside vendors, and often had to rely on short – term lines of credit to make ends meet.

Figure 8 Current Ratio



Days in Account Receivables reflect a health center's ability to collect revenues due from payers. Alternately, Average Pay Period assesses its ability to pay employees and vendors. For both ratios, typically the lower the values the better, although from a cash management perspective, it can be good practice to hold off paying bills to conserve cash. As shown in Figure 9, the median Days in Account Receivables hovered around 35 – 40 days throughout the period, a little over a month from billing to collection. However the maximum value ranged between 67 and 127 days – two to four months to collect, which can mean a substantial delay that may require debt financing and extra interest cost to already financially fragile organizations. Three different centers experienced days in accounts receivable greater than 60 days at various times over the period.

Figure 10 shows that, the median Average Pay Period decreased slightly during the period, but remained within a range of 32 – 36 days, slightly shorter than the median days to collection. However the maximum values ranged between 47 – 62 days, which could indicate problems with

vendors. Interestingly, one of the two centers with the fastest payment period had some of the slowest receivable collection periods, which could indicate that their vendors were demanding cash up front after waiting too long in prior periods to be paid.

Figure 9. Days in Accounts Receivable

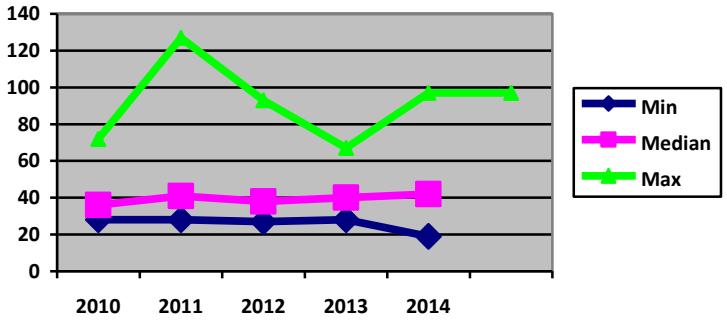
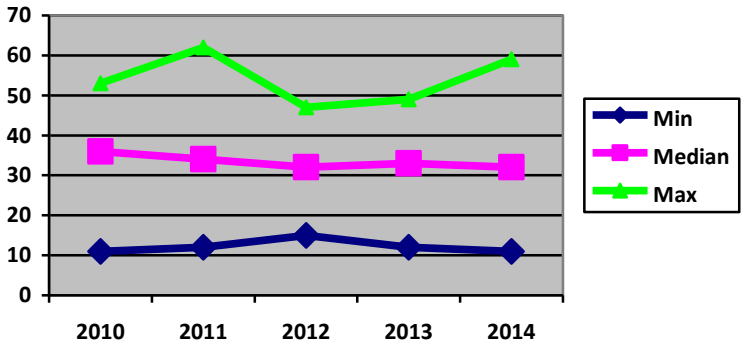


Figure 10 Average Pay Period

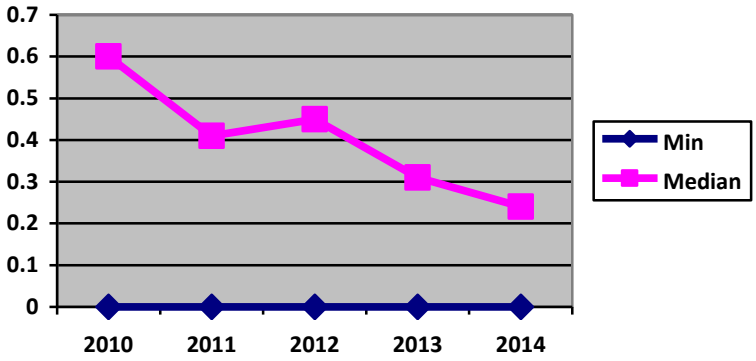


Capital Structure: Long-term Financing Performance

The analysis of capital structure has two objectives: first, to measure the extent to which health centers rely on debt to pay for their assets, and second, to determine whether the health centers are able to pay the debt service on the level of debt that they have incurred.

Health centers adopted various long-term financing strategies. The general trend for 2010 – 2014 reverses the 2007-2011 trend by reducing reliance on long-term debt to meet long-term financing needs. The Long-term Debt to Equity(Figure 11) is one indicator for a health center's overall debt leverage. The median dropped from .60 in 2010 to .24 in 2014. The maximum value (not shown in Exhibit, as it is such a high value that the median trend cannot be discerned) dropped from 35 X equity to only 3 X equity in 2014; these represent two different health centers with very high long-term debt burdens relative to their equity. Their ability to repay the debt (measured by the Debt Service Coverage ratio) improved throughout the period, and as of 2014, were at healthy levels. Though there is often an advantage to using debt rather than the health center's own funds, a health center needs to be financially healthy enough to secure a loan and to generate the cash flow necessary to repay it.

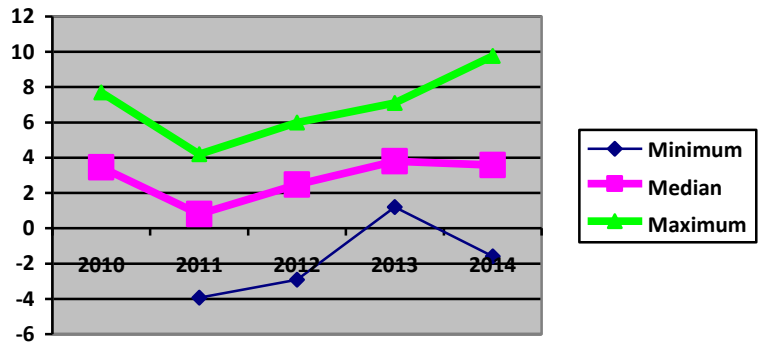
Figure 11 Long Term Debt to Equity



Debt Service Coverage (Figure 12) indicates the ability of a health center to meet its debt obligations. Between 2010 and 2014, the median was between 2.5 and 4 (except for 2011), indicating healthy coverage of debt service obligations for at least half of the centers. The minimum ratio shows largely negative coverage ratios as operating losses were much greater than the depreciation and interest expense components of the ratio; three health centers at

various times had negative coverage ratios, only one of which was negative for more than one year.

Figure 12 Debt Service Coverage



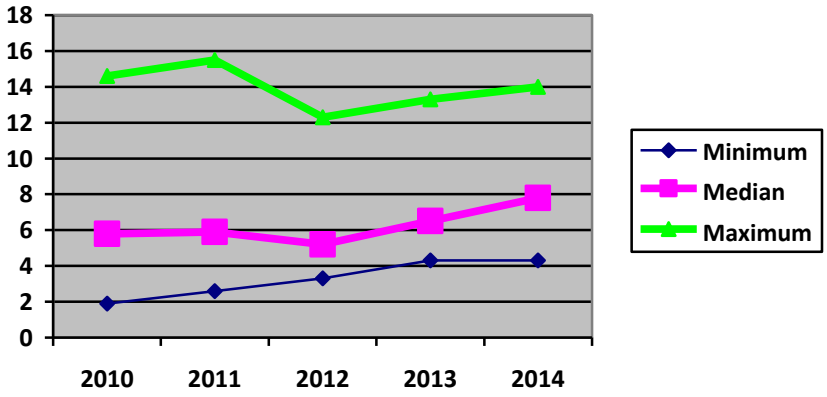
Plant Age

Average Age of Plant is a rough estimate of how old the property, plant, and equipment are for a health center. It does not take into account PP&E that is rented rather than owned; for these centers, several rent rather than own their facilities. Lower values of plant age are "favorable" in that they indicate "newer" facilities and equipment. Figure 13 indicates that the median and minimum ages got slightly older during this time, while the maximum hovered around 12 – 14 years throughout the period. The largest ARRA grants were received in 2011; while three of the five with large ARRA grants subsequently reduced plant age by from 1 – 3 years after 2011, two of the five show rising plant age (by 2 – 3 years) after receiving a large ARRA grant. Thus plant age does not appear to be a fair indicator of the level of investment in plant over this period. This could be because the slower-depreciating assets such as buildings are often rented rather than owned in this sector, while the faster-depreciating assets like equipment are more likely to be owned. Maintaining equipment age requires a more frequent investment, and a higher investment relative to the asset's total value (1/3 to 1/5 may depreciate in one year,

compared to a building which may depreciate over 20 years) to maintain equipment age compared to maintaining building age.

A better indicator of the adequacy of capital spending for this sector is the ratio of total capital expenditures to depreciation expense. Total capital expenditures over the period 2010 – 2014 were $28 million, which was roughly 2.8 X depreciation expense, indicating significant capital investment to upgrade/expand facilities. This capital spending was supported by $14.65 million in capital grants/donations, especially in 2011 and 2012 from the federal ARRA program. Longterm debt increased by only about $4.8 million over the period; the balance of capital spending was financed internally from the $12 million in operating cash flow generated over the period.

Figure 13: Average Age of Plant



4. Conclusion

The FQHCs show improving profitability and solvency over the period, although the solvency improvement is mostly due to one-time capital grants and donations generated by the ARRA and ACA. Patient volume and payer mix changes are also going in a good direction, with higher volume, fewer uninsured, and more Medicaid patients in 2014 than in the previous four years.

Capital investment has fueled capacity expansions as spending reached 2.8 times depreciation expense across the sector.

The good times are not evenly distributed among the various centers, however. Six of the nine centers spent between 2 and 7 million on capital expenditures, while three spent less than a million over the period. Profitability is erratic and highly dependent on private contributions to reach positive margins. Liquidity remains tight, and some health centers are in technical bankruptcy with current ratios below 1.

The next few years will be critical for many of the centers as they seek to attract more insured patients while continuing to serve those remaining uninsured, in a marketplace that increasingly requires more coordination, integration, and potentially, some financial risk related to accountable care and changing payment mechanisms. Close monitoring of this sector will be important over the next few years, as these centers provide critical primary care and care coordination services to the most vulnerable citizens.