

Report on the Financial Condition of 8 Community Health Centers in New Hampshire

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This report examines the financial performance and condition of 8 community health centers (CHCs) in New Hampshire. It focuses on the key indicators of cash flow, profitability, liquidity, and capital structure. It describes key ratios and the variability of those ratios for purposes of trend and comparative analysis during the period 2003 through 2007.

Aggregate Statement of Operations 2003-2007

During the past 5 years, community health centers in New Hampshire have seen a dramatic decrease in operating income. From an aggregate total operating income of \$968,000 in 2003, income declined to a loss of \$663,000 in 2006, but has recovered to show a loss of only \$82,000 in 2007. During this period operating revenue increased 44%, mostly due to increases in net patient revenue, but operating expenses grew 49%, mainly due to large increases in personnel costs. Grant revenue during this period only grew 15%.

Excess of revenue over expense has declined from just over \$1 million in 2003 to a loss of \$435,000 in 2006, but has recovered to show an aggregate profit of \$342,000 in 2007. Thus, the operating loss has been offset by investment income, but this has averaged only \$175,000 annually over each of the 5 years, and most of the investment income has come in the past 2 years. Given the instability of capital markets in 2008, this type of income may not be available in the current and future years.

The aggregate statement of income shown below provides an overall picture of health center profitability, but it is not representative of a typical health center. Financial profiles of individual health centers vary, and there is some variability in profitability as will be described in this report.

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FISCAL YEAR	2003	2004	2005	2006	2007	Compound annual growth rate	2003-2007
OPERATING REVENUES:							
Gross Patient Service Revenues	8,765,541	10,233,082	16,082,696	20,506,011	22,389,423	21%	77,976,753
Free Care	792,000	724,000	1,345,172	895,416	1,511,972	14%	5,268,560
Contractual Adjustments	2,038,477	1,991,047	2,908,666	4,180,511	3,320,560	10%	14,439,261
Bad Debt	482,896	1,033,327	904,026	1,328,606	1,084,621	17%	4,833,476
Net Patient Service Revenues	12,471,998	14,904,617	18,853,199	20,801,012	23,664,390	14%	90,695,216
Other Operating Revenue:							
Donated Goods & Services/ Contributions	1,187,030	2,226,169	3,264,070	738,966	676,301	0%	8,092,536
Grants & Contracts (incl United Way)	14,794,129	15,656,093	16,729,685	15,906,671	17,029,655	3%	80,116,233
Assets Released from Restrictions for Opns	0	519,661	454,982	569,026	542,207	1%	2,085,876
Other Operating Revenue	1,234,942	1,115,884	938,220	886,035	894,430	0%	5,069,511
Total Other Operating Revenues	17,216,101	19,517,807	21,386,957	18,100,698	19,142,593	2%	95,364,156
Total Operating Revenues	29,688,099	34,422,424	40,240,156	38,901,710	42,806,983	8%	186,059,372
OPERATING EXPENSES:							
Salaries, Payroll Taxes & Fringes	19,831,340	22,802,934	27,040,662	29,114,497	31,594,045	10%	130,383,478
Depreciation	511,021	559,666	615,601	596,669	692,491	6%	2,975,448
Interest	175,490	173,477	215,416	183,616	242,249	7%	990,248
Other Operating Expenses	8,210,458	10,043,179	11,979,362	9,170,393	10,360,385	5%	49,763,777
Total Operating Expenses	28,720,403	33,579,256	39,851,041	39,564,278	42,889,170	8%	184,604,148
OPERATING INCOME	967,696	843,168	389,115	(662,568)	(82,187)	0%	1,455,224
NONOPERATING GAINS (LOSSES):							
Investment Income (incl realized gains)	30,248	65,433	125,839	223,577	424,409		869,506
Gains (Losses)	0	10,507	10,176	3,519	(453)	0%	23,749
Other Income (Expense)	56,139	0	0	0	0		56,139
Total Nonoperating Gains (Losses)	86,387	75,940	136,015	227,096	423,956	35%	949,394
EXCESS REVENUES OVER EXPENSES	1,054,083	919,108	525,130	(435,472)	341,769	0%	2,404,618
OTHER GAINS (LOSSES) DUE TO:							
Extraordinary Items/changes in net assets	0	41,505	104,673	(96,725)	145,560		195,013
TOTAL CHANGE IN NET ASSETS	1,054,083	960,613	629,803	(532,197)	487,329	0%	2,599,631

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Cash Flows, 2003 - 2007

The aggregate cash sources for the eight CHC's over the five years 2003-2007 shows that they generated a total of \$9.7 million in cash, of which 61% came from operating activities (excluding working capital, which was a net use of cash). This includes the total change in net assets (equity) of \$2.9 million, plus another almost \$3 million from the noncash expenses (depreciation and amortization). Of the total change in net assets, operating income generated only \$1.5 million or roughly half, and nonoperating revenue another roughly \$950,000.

		% Sources
Total Sources of Cash:		
Total Change in Net Assets	2892011	30%
Depreciation and Amortization	2975448	31%
Issue Longterm debt	2489228	26%
Transfer from Restricted Funds	1324679	14%
Sale of Fixed Assets	31784	0%
 Total Sources	 9713150	

Fourteen percent of total sources, or \$1.3 million, came from restricted funds, which include capital grants provided by foundations and other donors. Finally, 26% of their total cash sources came from borrowing long term debt.

Total Uses 2003-2007 in \$		
	-	
Property Plant and Equipment	4491657	46%
	-	
Repay Longterm Debt	1087998	11%
	-	
Decrease Other Noncurrent Liabilities	1380721	14%
Noncash Revenues	-599696	6%
Net Working Capital	-717035	7%
increase Cash	-532535	5%
Increase Other Noncurrent Assets	-625608	6%
Transfer to other entities	-259861	3%
Increase Trustee-held Investments	-18039	0%
	-	
Total Uses	9713150	

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In terms of cash uses over the period 2003 – 2007, nearly \$4.5 million, or 46% of total uses, went toward property plant and equipment, which is roughly 1.5 times depreciation expense, an amount that is barely sufficient to maintain facilities and equipment. In order to keep up with price increases and changes in medical technology the ratio of capital expenditures to depreciation should be closer to 2. Another 25% went toward repaying debts (long term debt and other noncurrent liabilities). Working capital plus increases in cash absorbed roughly \$1.25 million, or 12% of total cash uses.

The overall picture is one of constrained ability to invest in capital assets, with a heavy reliance on debt and capital donations. However there is significant variability within the eight health centers in terms of the distribution of cash sources and uses.

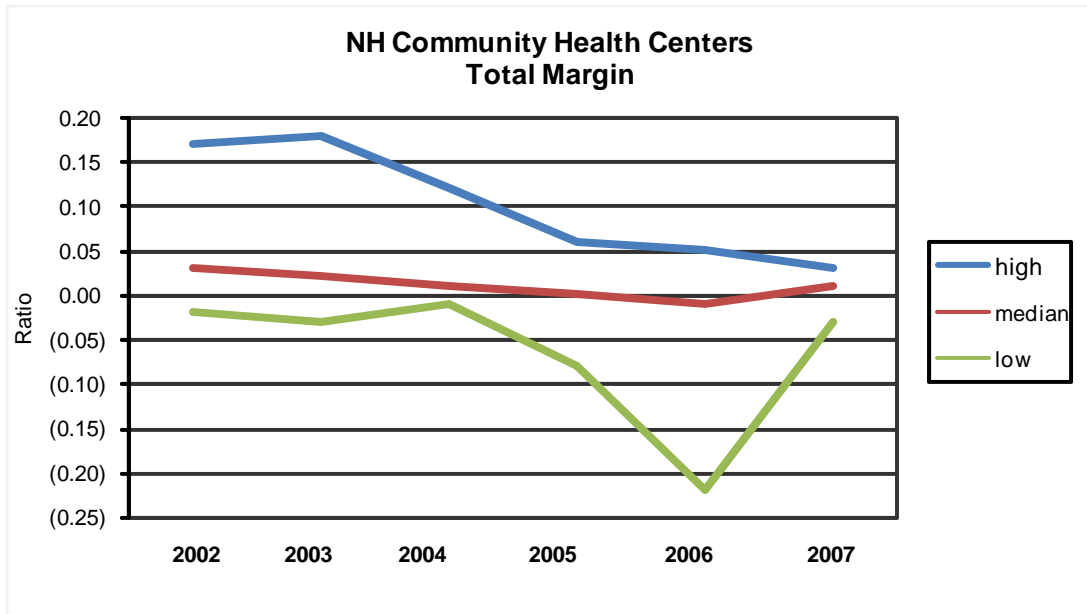
In two of the health centers, cash flows from operations (including changes in working capital) were negative; in three of the health centers the operating cash flows have declined between 2005 and 2007. In addition to difficulties in creating positive cash flows from operations, collections of receivables have contributed to negative cash flows (a requirement to invest scarce cash in working capital).

In most health centers, cash was reinvested in property, plant, and equipment. However, in two health centers, capital expenditures were less than depreciation expense. In one of those health centers, they are saving in a board-designated fund for future capital expansion; in another, there was a purchase of capital assets by a related organization that will merge with the health center in 2008

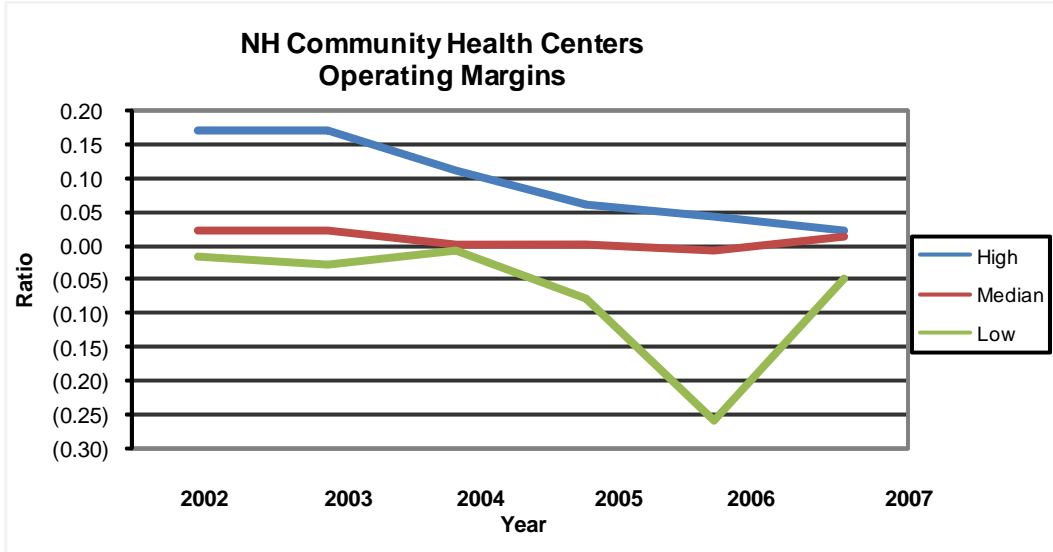
In order to pay for these capital expenditures, health centers borrowed almost \$2.5 million during this period. Regarding long-term debt during the past 5 years, two of the health centers have not issued long-term debt. Two have reported a reduction in long-term debt, but one of these has used an affiliated organization to take on a substantial amount of long-term debt; since the two organizations had not yet merged by the end of 2007, the debt and related purchased capital assets remain off the health center's balance sheet. However the health center is the guarantor of the debt. Four centers have increased their long-term debt, but one has debt owed to a sponsoring organization which is 60% forgivable so long as they continue to operate as a CHC

Profitability

During the past 5 years total margins (which include any investment income) have decreased. In 2003, the median total margin was 2%, while in 2007 it had fallen to only 1%. Two health centers had negative total margins in 2007 and only three were above 1%. This put five of the eight centers in a very unstable situation, especially when the median margins in 2006 and 2005 were -1/2 % and 0%, respectively. Only three of the health centers have had positive total margins in each of the past three years. In almost every health center, expenses grew faster than revenues between 2003 and 2007. By the end of 2007, the variation in total margins among the health centers had shrunk to between -2% and +3%.



Operating margins (excluding investment income) have similarly decreased in the past 5 years. In the aggregate, operating margins have been negative for the past two years



During the period examined, health centers have relied less on grants and contracts and more on third party billing to cover their costs. The median health center was covering about 45% of its operating expenses with net patient service revenue in 2003; that has now grown to 60%. In general, more reliance on third party billing is a good thing, since it is subject to less fluctuation in funding than grants. However, the billing and collection process from third parties is more costly than collecting from the grantor agencies. The accumulation of data for medical claims is usually more time consuming and the processing time by the payors is usually longer than for grants. Health centers did not always report the mix of payors, but from what was reported, Medicare and commercial insurances are billed in addition to Medicaid and individuals.

Not all of the health centers reported details of their grant revenues, but from what was reported, the federal government and the State of New Hampshire were major sources of grant revenue, annually contributing about \$3 million and \$3.4 million respectively. In addition, another \$1.5 million was received from four local hospitals. Of this amount, one hospital provided in excess of \$1 million, while the other three provided just close to \$435,000 combined. Another \$1.2 million was received from sources whose origins were not apparent from the financial statements so it isn't clear whether more than four hospitals provided support to CHC's.

Only two health centers derive significant income (roughly \$100,000 annually) from investments. One health center has an endowment fund of \$1.5 million that was able to earn some income and support the health center operations from this income. Another health center was earning investment income on funds it has set aside for future

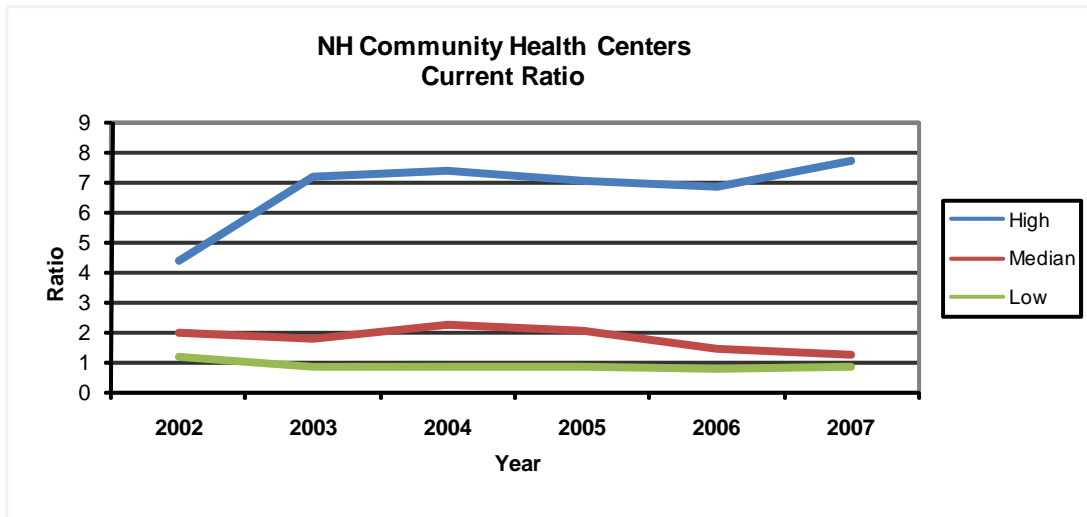
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expansion. Once these funds are expended, investment earnings will disappear. The remaining health centers have less than \$5,000 of investment income annually.

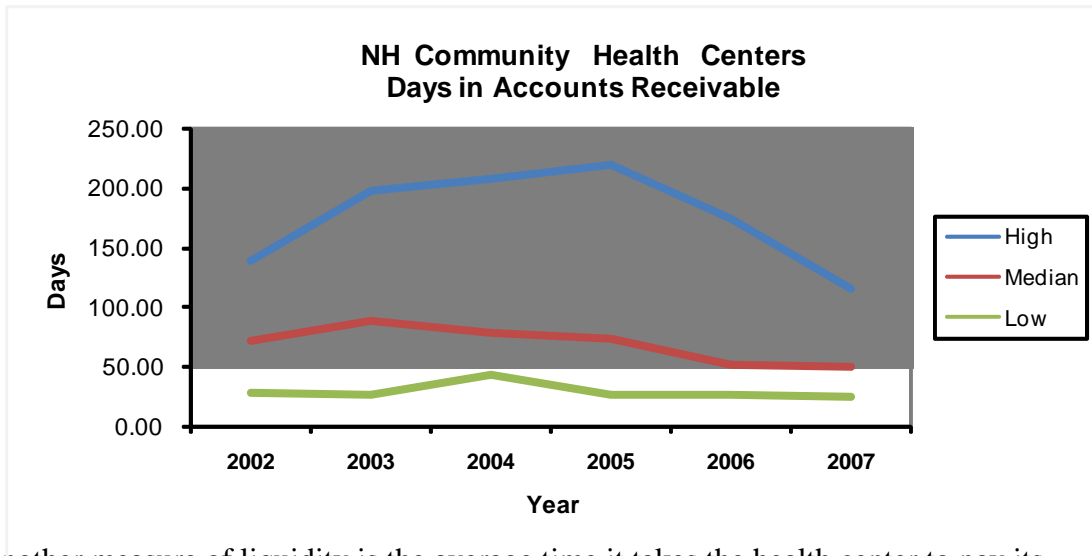
In a similar vein, only five health centers reported any income from contributions and of those, only one reported contributions in excess of \$100,000 annually.

Liquidity

A commonly used measure of liquidity is the current ratio which measures the organization's ability to meet its current financial obligations with current assets. An often cited benchmark is 2, but only two of the health centers met that test in 2007. The median current ratio was 1.25 and there were three health centers that had current ratios below 1, meaning they did not have current assets sufficient to cover their current obligations. The median current ratio for all health centers has decreased from a high of 2.23 in 2004, but there were two health centers below 1 that year. One health center has been below 1 in each of the five years; another has been below 1 in the most recent four years. On the brighter side, two health centers have been above 2 in each of the five years.

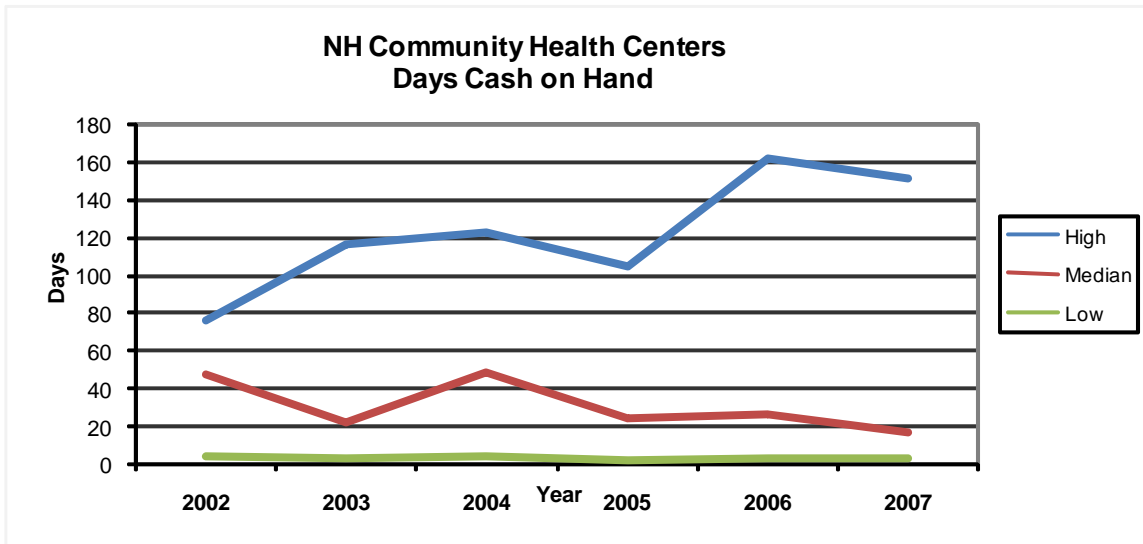


A second measure of liquidity is days in accounts receivable, which measures how quickly the health center is able to collect from third parties. The median over the past five years has improved from 95 days in 2004 to 50 days in 2007. There are three centers that are above the median, but each of them has made significant improvement in the past five years. One health center was able to collect in a very quick 24 days in 2007. Some the differences here may have to do with payor mix or the health center policy with regards to writing off uncollectible accounts.



Another measure of liquidity is the average time it takes the health center to pay its suppliers. In 2007, the median was 29 days, but with one health center taking as long as 41 days. There are three health centers that pay within 8 days. The ideal is to collect receivables faster than you pay suppliers. Since the median collection period was 50 days and the average payment period was 29 days, health centers were dipping into existing cash balances or borrowing on their line of credit.

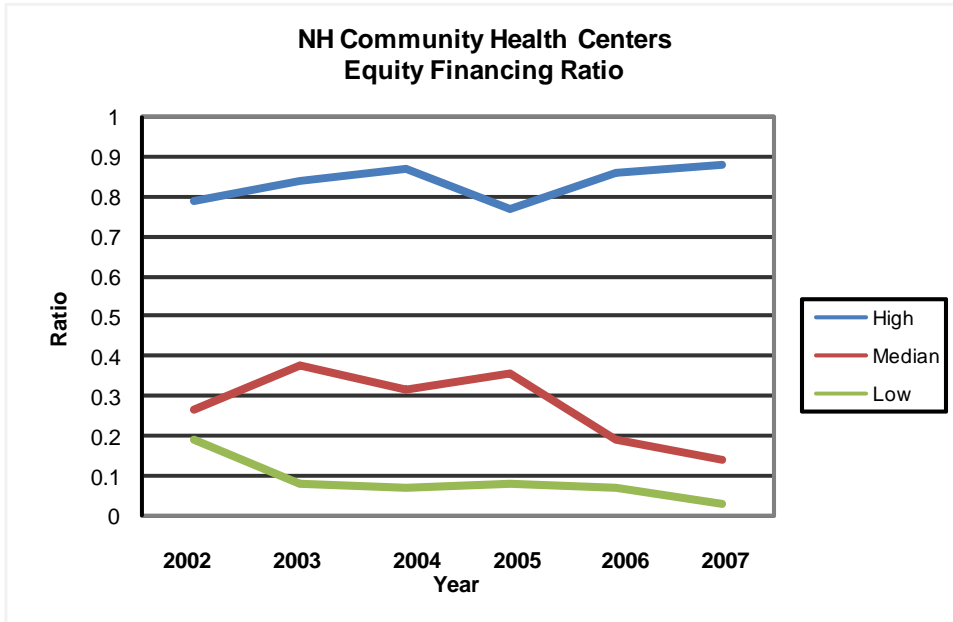
A fourth ratio that we looked at was days cash on hand from all sources. This ratio measures how long the health center could stretch its cash, assuming an average daily rate of spending. In 2007, the median was 21 days, meaning that the health center could pay its expenses for 21 days if no additional cash were received. This is not excessive given that most invoices are due within 30 days and the turnaround on third party payments, assuming all is going smoothly, is 29 days. There were four health centers that held less than 21 days cash and two that were below 10 days. This is a very precarious position. At the other extreme, there is one health center that had 177 days of cash, but that can be explained by the fact that we included in cash any funds set aside by the board of directors for designated purposes. This health center is saving for future capital expansion. Without this board-designated cash, the health center had 75 days cash which would still make it the highest among the health centers we examined.



Capital Structure

The analysis of capital structure had two parts. First, to look at how much the health centers rely on debt to pay for their assets; second, to determine how able the health centers are to meet the debts that they have incurred.

The equity financing ratio measures the amount of equity the health center has used to pay for assets. It is the complement of the debt financing ratio. In 2007, the median equity financing ratio was 18%, meaning that 18% of the asset values were financed from within the health center (and that 82% was financed using outside borrowing). Although a preference for equity over debt may be a management decision, there is often an advantage to using debt rather than the health center's own funds. On the other hand, a health center needs to be healthy enough to convince a bank to lend them funds. It is somewhat startling to see that health centers have been able to borrow as much as they have given their relatively fragile financial condition.



We also looked at the cash flow to debt ratio which measures the amount of cash flow available to pay both short-term and long-term debt. The median in 2007 was 9%, meaning the health centers had cash flow to only pay 9% of the outstanding debt. This ratio median has deteriorated since 2005 when it was 16%. The healthiest ratio was 60% at a center that had no long-term debt. On average, the ratio of current liabilities to long-term liabilities was 1.89 at the end of 2007. Only two health centers had no outstanding long-term debt. The average long-term debt among the remaining six health centers was about \$770,000.

Other

We also looked at the average age of the health center facilities. Although this is a rough estimate that does not take into account that health centers may only rent space and not own it, there is a wide range among the health centers from 1 year at a recently formed health center to 21 years at a health center that is actively saving in order to renovate/purchase new facilities. The median was almost 7 years at the end of 2007 and this has been the median for about three years. As health centers grow, they need additional space for both clinical and administrative activities.

Summary

In general, community health centers in New Hampshire operate with very low margins and, as a result, they are not able to generate funds from patient care to provide a sufficient excess to pay for working capital, and replacement or expansion of facilities. They operate with very limited cash reserves. Health centers do have some grant money available from federal and state sources to help support their activities, but these funds are subject to changes in legislation and appropriations. In order to provide the services needed in the community, health centers have incurred substantial debt in many cases. The requirement to pay back these loans puts additional pressure on profitability and liquidity. The financing of community health centers is a fragile puzzle. Each of the pieces for revenue generation (operations, grants, investments, and contributions), expense control, and capital planning and financing must be in place or the puzzle will not be completed and the health center will be at high risk of financial distress.