Financing Community Health Centers

Underwriting CHCs

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CDFI FUND CAPACITY BUILDING INITIATIVE

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Underwriting Challenges for CHCs

- CHCs primary challenges include, but are not limited to:
  - Relying on public funding (Medicaid, Medicare, grant funding) that are subject to cuts and deferrals
  - Operating with slim operating margins and having to constantly control their costs
  - Relying on significant annual fundraising to support operations
  - Lack of succession planning
  - Being debt averse and cost sensitive
  - Community boards can require extra education on lending process

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Primary CHC Underwriting Components

- Management
- Social Impact
- Financial Statements – liquidity and leverage
- Collateral
- Encounters growth & payer mix
- Debt capacity & cash flow analysis
- Market/Competition

Encounters Growth and Payer Mix

- CHCs are almost always operating at capacity
  - Most financing is to increase efficiency and/or capacity
- Look closely at payer mixes
  - Is the composition typical – yes or no?
  - Ask for payer mix by year
- Beware of declining encounters
  - Understand why
- Be conservative in projecting encounter growth
  - Ramp up takes time and money!
- New 330 grantees require some time to operate at capacity

Financial Statements – Liquidity & Leverage

- CHCs typically have between 30-90 days of cash on hand
- Watch for unplanned decreases in cash reserves
- Generally CHCs are debt averse, but most will carry:
  - Short-term lines of credit (LOCs)
  - Long-term (facility financing) debt
- Look-alikes/non-330 grantees are financially weaker
- State payment delays or deferrals may equate to:
  - Strained cash flow
  - Reduced reserves
  - Older A/R

Debt Repayment Sources – Cash Flow

- Debt Service Coverage Ratio (DSCR)
  - EBIDA / Debt Service
  - Primary revenue streams
    - Patient services revenues
    - Government services and contracts
    - Grants and other types of fundraising
- Debt Service
  - Interest Expense + Principal Annual Payments

Debt Repayment Sources - Collateral

- Real estate
  - Appraisal required with a minimum Loan-to-Value (LTV)
- Reserves
  - Debt service reserve account
  - Maintenance reserve accounts
- Credit-enhancements (public or private)
- Guarantees (public or private)

Management

- Many CHCs have long-term leadership
- Be cautious with CHCs (non-330s) that lack a CFO or Finance Director/Controller
- Chief Medical Officer or Clinical Director is another key position
- Board members should represent varied backgrounds
- Any expertise with planning and facilities management is a plus!

Market/Competition

- Importance of assessing the market impacted by the CHCs project
- Direct competition is minimal, but patients often pursue other options. By definition, the vast majority of CHCs are in medically underserved areas (MUAs) so most patients have few or no other options for primary care.
- CHCs do benefit from partnerships with
  - Local hospitals
  - Private/specialty practices
  - Other CHCs

Social Impact Measurements

Outputs	Outcomes
•Patients •Encounters •Uninsured •Medicaid-eligible •Sliding scale	•Infant mortality •Chronic disease management •ER diversions •Other social determinants: •decent housing •financial stability •access to fresh foods

Ratio Analysis

Financial Ratios Typical Ranges	Lending Ratios Typical Ranges
•Operating Margin •1% - 3% •Net Margin •2% - 4% •Cash DOH •≥ 30 days •A/R aging •≤ 90 days (majority of CHCs) •cost reconciliations can increase delay	•Debt Service Coverage Ratio •≥ 1.10x •Current Ratio •≥ 1.25x •Debt-to-Net Asset Ratio •≤ 4.0x