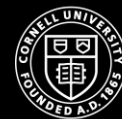


Building the Community Health Equity *Capital Fund*

Care creates capital

April 2026



Johnson
Cornell
SC Johnson College of Business

The Investment Case *in Five Chapters*

01

The Problem

Primary care expansion is stuck **behind a \$21B funding gap**

02

Our Solution

CHECF gives clinics the growth capital **traditional markets do not**

03

Financials

Three income streams turn clinic growth **into investable returns**

04

Risk Profile

Layered capital makes a **hard market financeable**

05

Operations & Scale

Start where the model works, **then scale what proves out**



Inside a Community Health Center: *The Cost of Underinvestment*

Federally Qualified Health Centers are the primary care backbone for 30 million Americans, yet many remain capital-starved to expand

When Demand Shows Up Before the Doors Open

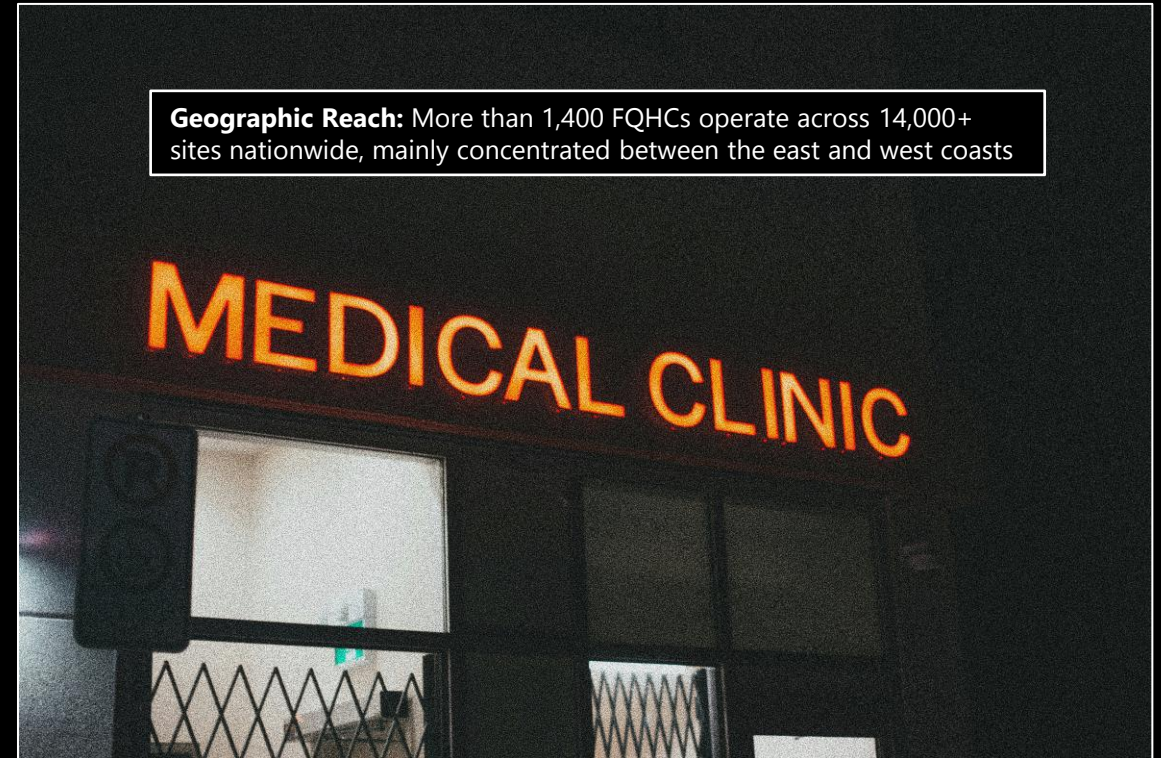
On a Tuesday morning at a Federally Qualified Health Center in rural Kentucky, the waiting room is full by 7:45 a.m. A grandmother with uncontrolled diabetes. A young mother with a feverish toddler. A construction worker who has not seen a doctor in three years

Patients arrive with chronic conditions, delayed care needs, and nowhere else to go, **but the clinic does not have the rooms, staffing, or capital required to grow with the demand already in front of it**

What This Means for Much Needed Care

- Patients wait longer for care
- Conditions worsen before treatment begins
- The system pays more later for avoidable acute care
- Current impact investing efforts don't go far enough

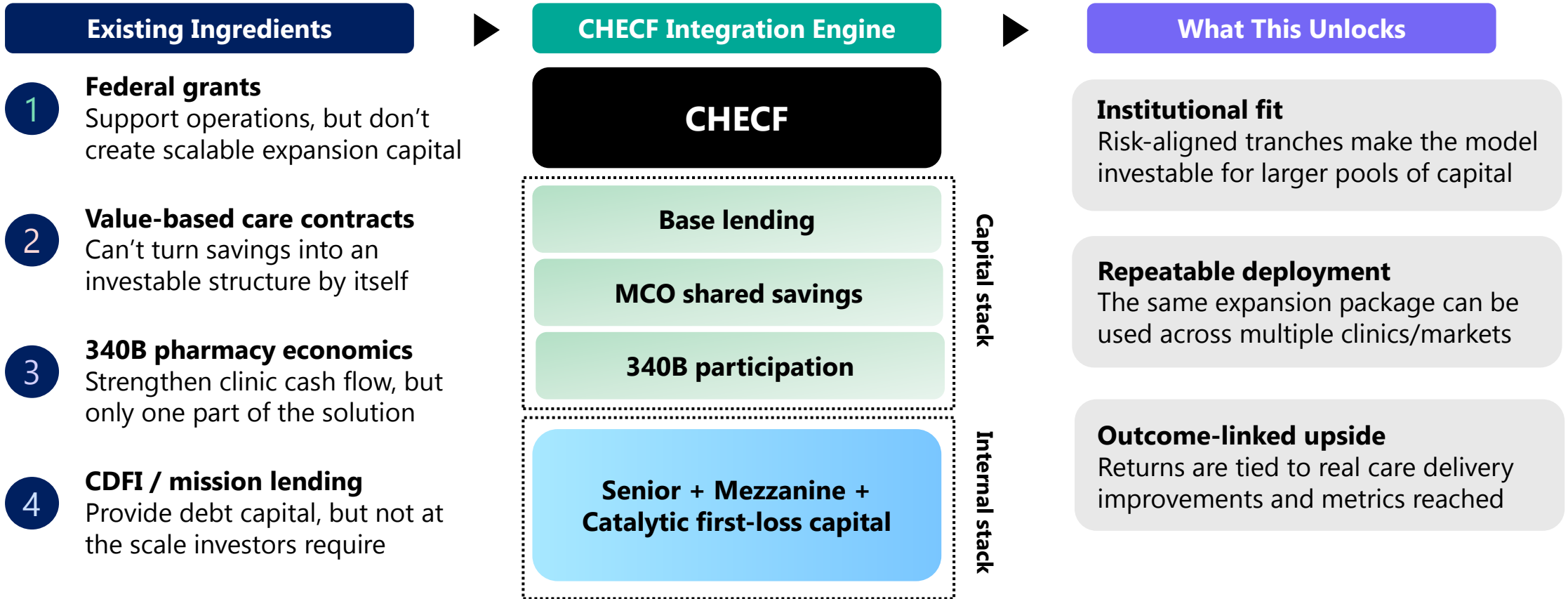
Geographic Reach: More than 1,400 FQHCs operate across 14,000+ sites nationwide, mainly concentrated between the east and west coasts



Federally Qualified Community Health Centers are often the primary care backbone of many rural communities, but many remain too capital-starved to expand

What Makes CHECF Different from *Existing Funding Sources*?

The individual tools already exist in many forms: grants, value-based care, 340B, and mission lending. Our investment approach, the CHECF, Community Health Equity Capital Fund, is the first structure that combines them into one scalable, investable vehicle

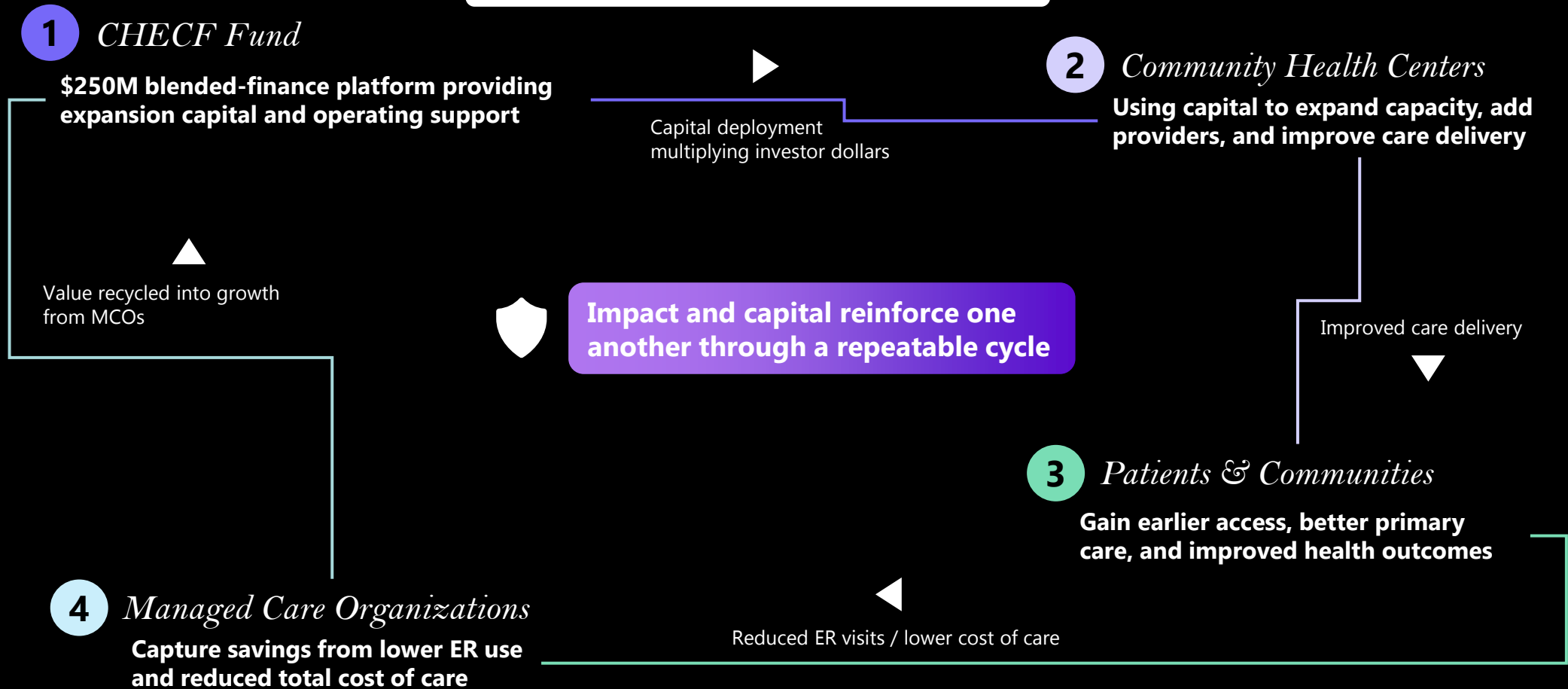


CHECF does not invent new tools. It brings the right ones together in a structure that can finally finance clinic expansion at scale and turn fragmented funding pathways into one repeatable model that brings robust returns to investors

How it Works: *The CHECF Care-and-Capital Loop*

CHECF connects four participants in one continuous cycle: investors fund expansion, clinics improve care, patients avoid higher-cost utilization, and MCOs share in the savings created. This is how better care on the ground becomes a scalable, investable model

How Capital Flows Through the CHECF



Fund Structure, Capital Stack & *Investor Alignment*

CHECF's \$250M blended finance three-tranche structure matches different sources of capital to different levels of risk and return. That alignment is what makes underserved primary care expansion financeable for both catalytic and institutional investors

TRANCHE A

Catalytic / First-Loss

FUND SIZE & SHARE

\$175M

70% of total capital

TARGET RETURN

8.5% IRR

Market-rate, risk-adjusted

INVESTOR PROFILE

Institutional Investors, Pension Funds,
Insurance Companies, Bank CRA Capital

TRANCHE B

Mezzanine Debt

FUND SIZE & SHARE

\$37.5M

15% of total capital

TARGET RETURN

6.0% IRR

Concessionary, impact-first

INVESTOR PROFILE

Impact Investors, Family Offices, High Net
Worth Individuals, Donor-Advised Funds

TRANCHE C

Senior Debt

FUND SIZE & SHARE

\$37.5M

15% of total capital

TARGET RETURN

2.5% IRR

Capital preservation focus

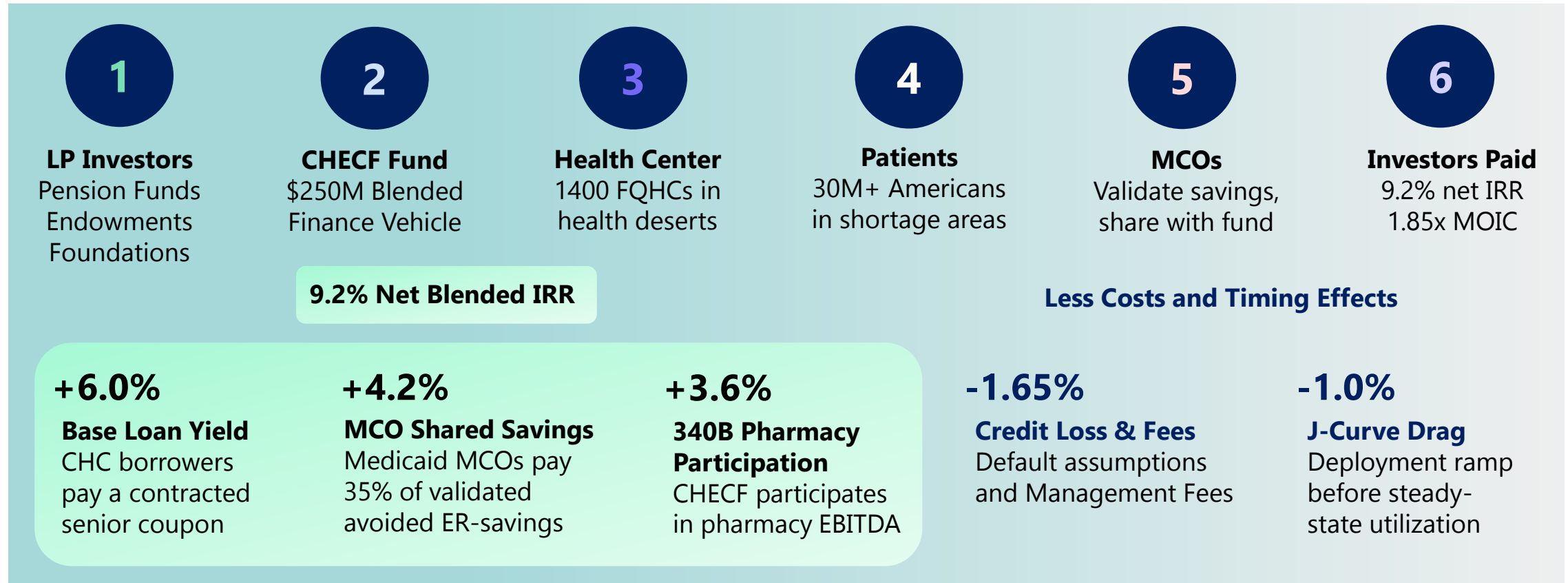
INVESTOR PROFILE

Philanthropic Foundations, Government
Grants, Program-Related Investments

The capital stack is what turns CHECF from a compelling idea into a financeable product. By aligning catalytic, impact, and institutional capital, the structure opens a market that traditional lenders have left behind and creates more opportunity

How CHECF Generates Revenue and *Builds Investable Returns*

CHECF earns returns from three contractable revenue streams, then absorbs losses, fees, and deployment drag before arriving at a resilient net blended IRR. The model works because a contracted base yield is reinforced by two healthcare-linked upside streams



Returns are not built on one fragile assumption. CHECF starts with a contracted base yield, layers in two healthcare-linked upside streams, and still preserves an investable return profile after losses, defaults, fees, and deployment drag

Every Dollar of Return Is Traceable *from Metric to Payment Source*

Each CHECF revenue stream has a named payer, a measurable operating driver, and a defined payment trigger. That structure turns base lending, shared savings, and 340B participation into cash flows that can be monitored, validated, and underwritten

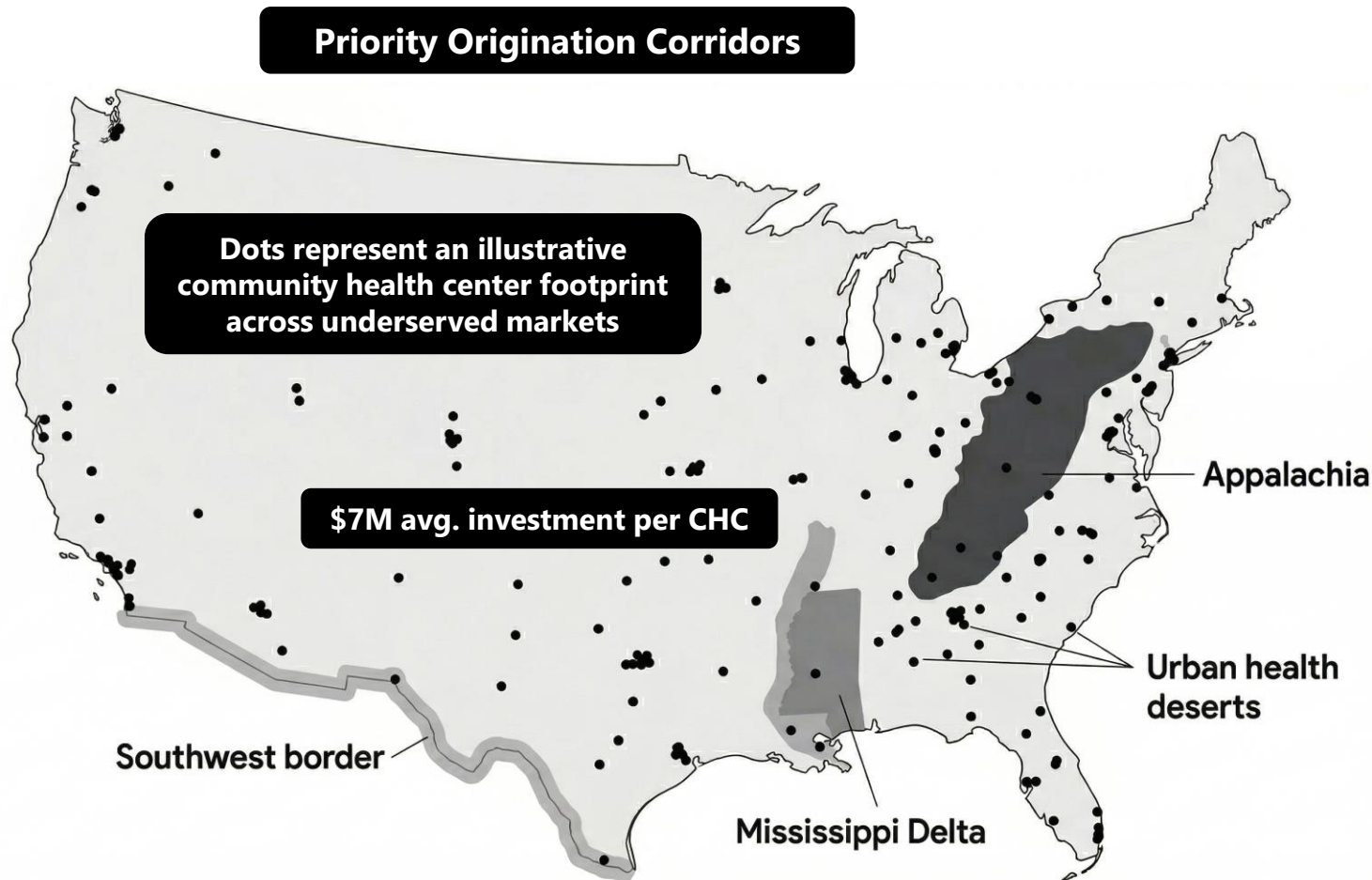
Revenue Stream	What Creates It	Who Pays	When Paid	Proof Point
+6.0% Base Debt Service	<ul style="list-style-type: none"> Senior loan repayment 	<ul style="list-style-type: none"> CHC borrower 	<ul style="list-style-type: none"> Monthly coupon 	<ul style="list-style-type: none"> Contracted from day one
+4.2% MCO Shared Savings	<ul style="list-style-type: none"> Avoided ER visits per 1,000 enrollees 	<ul style="list-style-type: none"> Medicaid managed care organization 	<ul style="list-style-type: none"> 35% of validated savings 	<ul style="list-style-type: none"> Rolling baseline + audit rights
+3.6% 340B Participation	<ul style="list-style-type: none"> 340B-enabled pharmacy EBITDA 	<ul style="list-style-type: none"> Pharmacy economics 	<ul style="list-style-type: none"> Monthly revenue share 	<ul style="list-style-type: none"> Tied to funded expansion

Contract design includes 5-year terms, rolling 12-month baselines, per-clinic floor guarantees, independent audit rights, and payments tied to sustained performance. This helps provide robust measurement over metrics and puts us on the path to returns

CHECF does not rely on abstract upside. Each return stream can be tracked from the operating driver to the payment source to cash realization which makes the model more credible to underwrite and more durable as the portfolio scales

Where CHECF Starts: *High-Need Markets, Diversified Risk*

CHECF prioritizes markets where **provider shortages, unmet demand, and value-based savings potential overlap**. A focused origination strategy creates impact density while a national footprint reduces single-market concentration risk




Why These Markets?

- 1 Need is concentrated**
 Persistent provider shortages, avoidable acute-care use make these markets high-impact starting points
- 2 CHCs are care anchors**
 Community health centers are often the primary care institutions in these regions, making them natural deployment partners
- 3 Diversification = resilience**
 Spreading capital across multiple underserved corridors reduces single-market risk while preserving underwriting logic

Phased Rollout: From Pilot Markets *to National Scale*

Each phase de-risks the next. CHECF starts where contract readiness and clinic economics are strongest, then expands into larger markets using the same underwriting and deployment template, creating a path from pilot proof to repeatable national scale

 CHECF Expansion	Years: 1-3	Years: 3-6	Years: 6-10
	Phase 01 Prove	Phase 02 Expand	Phase 03 Scale
Geographic Focus	Appalachia: WV, TN, KY	Growth States: TX, GA, FL	Mississippi Delta, Southwest border, urban deserts
Why These Markets	High need, existing clinics, strongest proof case	Larger Medicaid markets with similar economics	Same model, broader national scale
Existing Ecosystem	~82 Grantees/ 1,000 Sites	~87 Grantees/ 800 Sites	~200+ Grantees/ 2,000+ Sites
Deployment	20–30 clinics at ~\$5M each	30–40 clinics at \$5–7M each	50+ clinics at \$5–8M each
Success Metrics	ER reduction, 340B activation, signed MCO contracts	Shared savings, pharmacy EBITDA, patient growth	MOIC, LP re-up, less catalytic capital

CHECF scales by repeating the same clinic expansion logic in larger markets once contracts, underwriting, and outcomes are proven. CHECF doesn't jump straight to a national scale; it earns the right to expand by proving the model step by step

What Expansion Capital Actually Buys: *Case Study*

Breathitt County Health Center in Jackson, Kentucky is an illustrative Phase I clinic in a severe shortage market with an HPSA score of 19/25 and ER utilization 3.1x the national baseline, It also sits within a broader Appalachian pipeline of 82 grantees and 1,038 FQHCs

The Patient

Martha Collins, 63*
Breathitt County, KY
Type 2 diabetes, 11 years

Today: No CHECF Capital

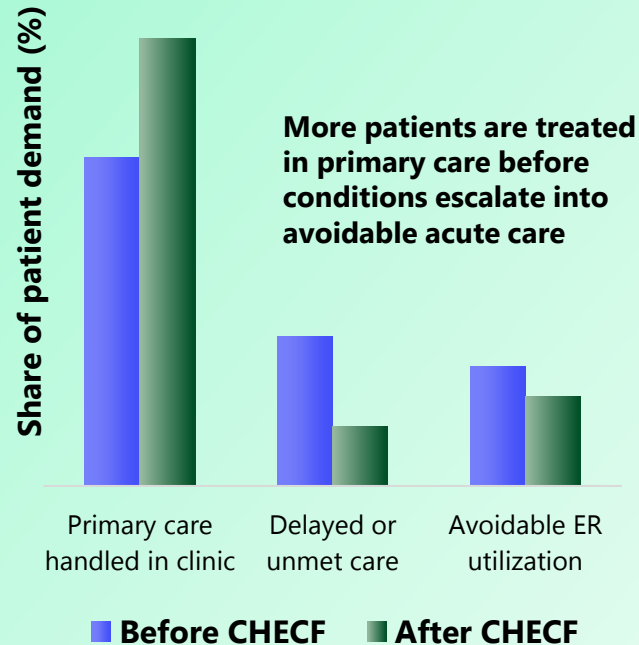
A seven-week wait for primary care and 14 months without an A1C check ended in a 2 a.m. ER visit that **cost Medicaid \$14,200**

After CHECF: Year 2 of Scale

A four-day appointment, quarterly A1C monitoring, kept her out of the ER for 12 months, with **\$2,800 of Medicaid spend** avoiding \$11,400 of acute care

The Clinic

Illustrative Shift in Care Delivery After CHECF-Funded Expansion



The Impact CHECF Brings

- 175,000 Patients Reached**
Earlier appointments and more consistent primary care access
- 3,500 ER Visits Avoided**
More throughput, stronger staffing leverage, and 340B-ready operating scale
- \$21M in Medicaid savings/yr**
Fewer avoidable ER visits and lower downstream cost of care
- 1:2,000 PCP Ratio Target**
A stronger local care anchor that can serve more people earlier and more consistently

*Martha is a composite profile based on HRSA UDS diabetes prevalence data for Breathitt County; clinic-level projections Breathitt County Health Center public profile and standard FQHC expansion economics. Not a committed figure.

How We Acquire Clinics, MCO Partners, *and Investors*

CHECF builds the platform through three parallel channels: clinic origination, payer contracting, and capital formation.

Each channel already has identifiable sources, repeatable templates, and a clear path to scale that can be exponentially grown

Clinic Acquisition

NACHC network

1,400+ member FQHCs create a proprietary borrower pipeline

HRSA + PCA data

Public clinic data primary care associations create qualified leads

Standardized deal template

\$5M expansion case makes origination faster and repeatable

Target: 10 clinics per year in Years 1–3 from the NACHC pipeline alone

MCO Partner Acquisition

Existing NC template

NC's model provides a low-risk contract starting point

Top Medicaid MCOs

Centene, UHC, Molina, etc. are the first target payer set

Proven ROI logic

MCOs keep most of the savings, building on the economic case

Negotiation cost falls materially as templates become standardized

Investor Acquisition

Tranche A capital

Institutional fixed-income and ESG allocators for the senior tranche

Tranche B capital

CDFI intermediaries, DFIs, and impact-oriented family offices

Tranche C capital

Foundations and PRIs to provide catalytic first-loss protection

Catalytic capital is what makes the senior tranche financeable

Why CHECF Wins *Where Existing Tools Stop*

Most existing tools solve one piece of the problem. CHECF is the only structure that combines scalable capital, outcome-linked revenue, and institutional investability in one repeatable model built for clinic expansion at scale

Feature / Model	HRSA Grants	CDFIs	Banks	Healthcare PE	CHECF
Scalable capital	X	X	X	X	✓
Market-rate returns	X	X	X	✓	✓
Outcome-linked upside	X	X	X	X	✓
Repeatable deployment	X	X	X	X	✓
Institutional LP ready	X	X	X	X	✓

Structured for institutional capital: The matrix shows that CHECF is not marginally better; it is structurally different. Healthcare PE is the only adjacent model that reaches market-rate returns, but CHECF is the only one that also delivers returns across all five relevant features

CHECF is not just another funding source. It is the first structure designed to turn fragmented clinic expansion needs into an investable, repeatable healthcare infrastructure strategy; it works by opening a market existing tools cannot fully serve

The CHECF Is the Right Vehicle *for a Broken Market*

CHECF turns a fragmented clinic expansion problem into a practical, scalable solution that works for both communities and capital. The impact goes beyond investing, working to resolve some of our nation's toughest challenges through blended finance



Investable: \$250M Vehicle

Risk-aligned tranches unlocks strong institutional capital and make this market financeable at scale

Repeatable: 100+ Expansions

A standardized expansion model can be deployed across multiple high-need markets with the same logic

Meaningful: Better Access & Care

Earlier primary care improves outcomes, reduces avoidable ER use, and build community health over time

CHECF makes clinic expansion financeable at scale. It brings capital, care, and community impact together in one durable model that can be repeated across markets and deliver value for everyone: individuals, communities, and investors

Meet our Team *and our Faculty Advisors*



Eshan Varma

Hometown: Minnesota
Background: Strategy Consulting, PE/VC



Olivia Kao

Hometown: Taiwan
Background: Post M&A Integration



Nayancie Matthews

Hometown: New York
Background: Healthcare M& IB, Pharmaceuticals



Min Namkoong

Hometown: Korea
Background: GTM, Growth Strategy, Partnership



Advising Faculty



Sanjeev Bhojraj

Alumni Professor in Asset Management
 Academic Co-Director of the Parker Center for Investment Research



Mark B. Milstein

Clinical Professor and Academic Lead of Semlitz Fellowship
 Academic Director of the Center for Sustainable Global Enterprise

Appendix



Terms *and Definitions*

These definitions clarify the core terms behind CHECF's revenue model, capital stack, and operating strategy. Together, they provide a common language for understanding how the structure works in practice and demystify technical terms

Acronym	Definition
CHECF	Community Health Equity Capital Fund
FQHC	Federally Qualified Health Centers are community-based, non-profit clinics that provide comprehensive primary care to underserved populations regardless of ability to pay.
CHC	Community Health Centers
NACHC	National Association of Community Health Centers is the main advocacy and support organization for community health centers
MCO	Managed Care Organizations are healthcare entities that finance and control the delivery of medical services for a defined group of people,

Term	Definition
HPSA	Health Professional Shortage Area is an HRSA designation for places with too few primary care, dental, or mental health providers relative to need
CRA	Community Reinvestment Act is a U.S. law that requires banks to serve the credit needs of the communities they operate in
Section 330 Grant	Federal funds provided by HRSA under the Public Health Service Act to support community health centers.
340B	A U.S. federal drug pricing program that forces pharmaceutical companies to sell outpatient drugs at deep discounts to eligible healthcare providers. It's administered by HRSA under Section 340B of the Public Health Service Act.

Financial Model Drivers & *Base-Case Return Build*

The **base-case model demonstrates how CHECF translates repeatable clinic expansion economics into a resilient blended return profile.** Base yield is enhanced by two healthcare-linked revenue streams, then adjusted for losses and other variables

Core Assumptions

Fund Size	\$250M
Fund term	10 yrs
Invest Period	5 yrs
Avg. Deal Size	\$5M
Number CHCs	50
Default Rate	1.5%
LGD	10%
Fund Expenses	1.5%
J-curve Drag	1.0%

Notes: 5-year deployment period; fully amortizing loans within a 10-year fund structure. The base case assumes 50 CHCs with an average deal size of ~\$5M

Return Build / Yield Bridge

Base Interest	+6.0%
MCO Shared Savings	+4.2%
340B Participation	+3.6%
<hr/>	
Gross Portfolio Yield	+13.8%
Credit Loss	(0.15%)
Fund Expenses	(1.5%)
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Net Portfolio Yield	12.15%
J-Curve Drag	(1.0%)

Base-Case Blended IRR	9.2%
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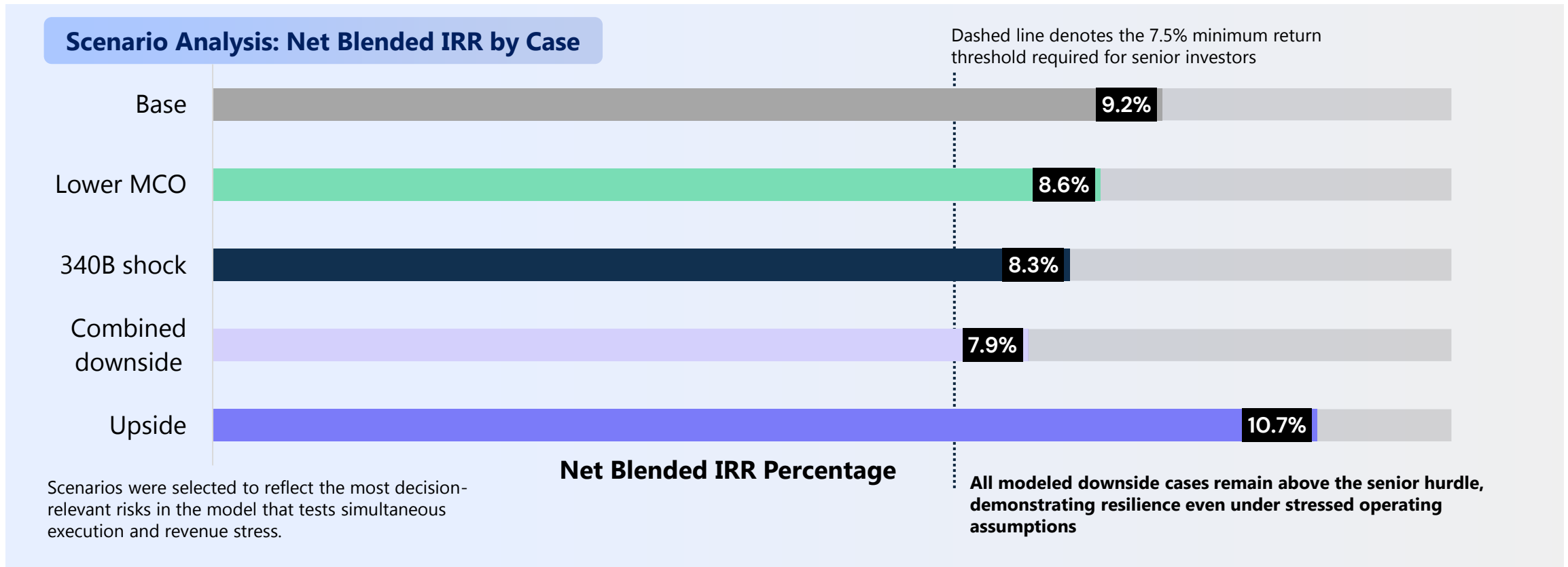
Base-Case Outputs

Gross Yield	+13.8%
Net Yield	+12.15%
Base IRR	+9.2%
TR. A hurdle	+7.5%
Downside IRR	+7.9%
Blended MOIC	1.85x

The model is supported by several reinforcing levers rather than one fragile input. That layered structure helps preserve the base case even after incorporating defaults, fund expenses, and deployment drag

Stress-Tested Returns *Remain Above the Senior Hurdle*

Even under imperfect execution and revenue pressure, the fund preserves an investable return profile and continues to clear the minimum senior return threshold, demonstrating resilience across realistic downside cases

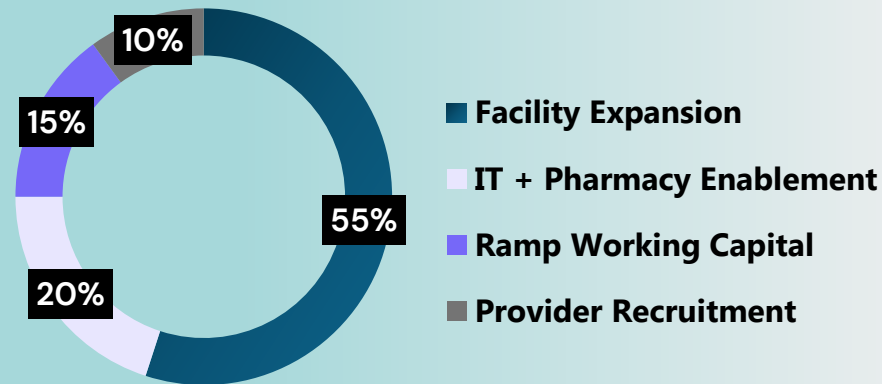


The base case is attractive, but the more important result is that downside scenarios still preserve an investable return profile. This shows the model is not dependent on perfect execution to deliver acceptable outcomes for senior capital

The Unit Economics Work *at a Clinic Level*

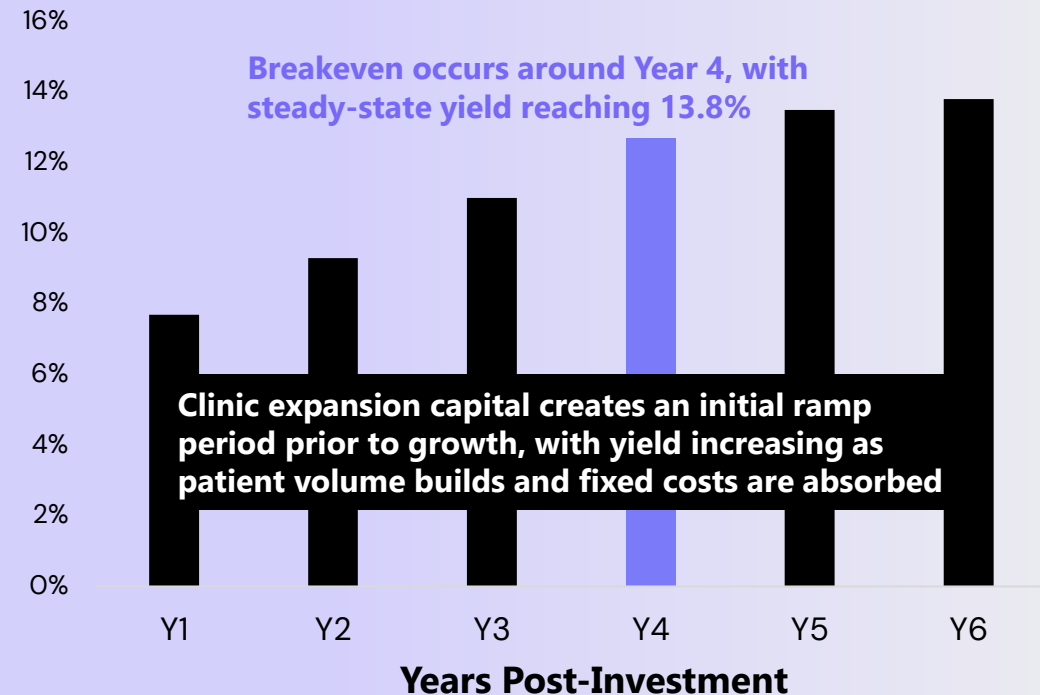
The model is underwritten from the ground up: capital funds clinic expansion which builds towards sustainable coverage that provides a solid pathway towards the steady state from where returns can be generated on a self-sustained basis

Illustrative use of Funds



Use of funds is concentrated in site-level capacity expansion rather than passive balance-sheet support. The spend mix is designed to increase patient throughput, strengthen operations, and accelerate the clinic's path to breakeven

Clinic Yield Ramp to Steady State



This is not a top-down portfolio story alone; the economics work because each clinic can convert targeted capital into sustainable operating performance. That clinic-level proof point underpins both repayment resilience and portfolio-scale

A Transparent, Disciplined Path *to a 9.2% Blended Net IRR*

A senior-loan core with contracted upside participation transforms community health center lending into a market-rate return profile. The structure preserves downside protection while lifting Tranche A investors to a 9.2% blended net IRR

Return Bridge Components

Base Interest 5–6% interest on CHC senior loans	+6.0%
MCO Shared Savings 35% capture of avoided ER visits/clinic/yr	+4.2%
340B Pharmacy Revenue 20% participation in ~\$900K EBITDA/clinic	+3.6%
Credit Loss & Fees 1.5% default rate; 1.5% management fee	-1.65%
J-Curve Drag Years 1–3 deployment ramp	-1.0%
Net Blended IRR XIRR on 10-year cash flows	9.2%

Fund Summary

FUND SIZE \$250M	FUND TERM 10 Years
TARGET CHCS 30–40	AVG. INVESTMENT \$7M
GROSS YIELD 13.8%	NET BLENDED IRR 9.2%
MANAGEMENT FEE 1.5%	CARRIED INTEREST 15% > 8% hurdle

Stress Test: Base case: 1.5% default (340B reserve). Stress: 25% 340B margin compression reduces IRR to ~7.8%. Geographic diversification across states provides a stable floor

Layered Defenses Preserve Portfolio Yield

Even as defaults rise and MCO capture compresses, the model retains a meaningful cushion above the senior hurdle because returns are supported by multiple underwriting and structural buffers, keeping the overall return profile robust

Net portfolio yield sensitivity

	1.0% def	1.5%	2.0%	2.5%	3.0%
2.5% MCO	10.5%	10.4%	10.4%	10.3%	10.3%
3.0% MCO	11.0%	10.9%	10.9%	10.8%	10.8%
3.5% MCO	11.5%	11.4%	11.4%	11.3%	11.3%
4.2% MCO	12.2%	12.2%	12.1%	12.1%	12.0%
5.0% MCO	13.0%	12.9%	12.9%	12.8%	12.8%

This sensitivity table tests two of the model's most material risks: lower MCO savings capture and higher portfolio defaults. **Even under simultaneous stress, net portfolio yield remains above the senior return threshold**, indicating that downside compression is manageable rather than thesis-breaking

Defense stack

- 1 Contractual base yield**
 Senior loans generate a recurring yield floor before any performance-based upside is realized
- 2 Multiple return levers**
 Returns are supported by more than one driver, with MCO shared savings and 340B economics
- 3 Conservative underwriting**
 Losses, fees, and ramp drag are incorporated upfront; downside is priced in from day one
- 4 Diversified portfolio construction**
 Cross-clinic and cross-market exposure reduces concentration risk.

The model does not rely on one fragile assumption to clear the senior hurdle. Instead, contractual yield, diversified upside drivers, conservative underwriting, and portfolio diversification work together to preserve the investable return profile

Regulatory Risk Assessment: *Mitigation Strategies*

We assume regulatory scrutiny upfront and redesign the structure accordingly rather than treat it as an afterthought. The goal is to preserve an investable return profile while removing the elements most likely to create Anti-Kickback or 340B-related exposure

Primary Risk

Anti-Kickback Statute Exposure

Core concern: Shared savings flowing to the fund could be viewed as a referral-linked incentive, triggering AKS scrutiny

340B exposure: External investors capturing 340B-derived value may conflict with program intent

Safe harbor: Current structure does not clearly fit an existing safe harbor without significant legal structuring

OIG Advisory Opinion: Useful validation tool for Fund II — time-intensive for the pitch stage

Structural Solution

Fixed Returns + Infrastructure Economics

Remove: MCO shared savings to fund — eliminates AKS referral-linked incentive entirely

Replace with: Fixed 6% loan returns + infrastructure lease income (fund owns clinic buildout, leased to FQHC at fixed rent) as well as other flexible plans

340B restructure: Fund receives fixed fee for 340B build out financing — not revenue participation. Removes program exposure

IRR impact: ~7.5–8.0% net IRR — below primary case, above Tranche A hurdle. Senior investors remain fully protected from possible risk

Base-Case 10-Year Cash Flow *and Investor Return Pathway to 9.2%*

The base-case model demonstrates how CHECF translates the repeatable economics of clinic expansion into a resilient blended return profile. Base yield is enhanced by two healthcare-linked revenue streams, then adjusted for losses and other variables

How the Model Scales Through Time	Deployment (Year 1 – Year 5)					Harvest (Y6 – Y10)					Total
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	
Capital Deployed	\$50M	\$62.5M	\$62.5M	\$50M	\$25M	-	-	-	-	-	\$250M
Gross Revenue	\$3.5M	\$10.8M	\$17.9M	\$23.1M	\$25.1M	\$23.3M	\$20.0M	\$17.2M	\$14.8M	\$12.8M	\$168M
Net Fund Income	(\$0.4M)	\$6.6M	\$13.5M	\$18.5M	\$20.4M	\$18.7M	\$15.5M	\$12.8M	\$10.5M	\$8.6M	\$124.7M
Net Yield (%)	(1.7%)	8.5%	10.5%	11.1%	11.3%	11.2%	10.9%	10.5%	10.1%	9.6%	9.2%
Tranche A Distr.	(\$0.4M)	\$3.5M	\$5.8M	\$7.5M	\$8.1M	\$7.5M	\$6.4M	\$5.5M	\$4.7M	\$4.0M	\$52.6M
340B Reserve	\$0.2M	\$0.9M	\$2.1M	\$3.6M	\$5.2M	\$6.7M	\$8.0M	\$9.1M	\$10.0M	\$10.8M	-

Year 1: Expected J-Curve

\$50M deployed; net fund income is **(\$0.4M)** as fees hit before full ramp

Year 3: Scaling up

Net fund income rises to **\$13.5M**, and net yield reaches 10.5%

Year 5: Fully Deployed

The fund reaches full deployment, with net yield at 11.3% and **\$8.1M** of Tranche A distributions

Years 6+: Harvest Period

Cash flow converts into steady distributions as net yield holds between **9.6%–11.2%**

Why This Can Scale Beyond a *One-Off Impact Fund*

Each CHECF revenue stream has a named payer, a measurable operating driver, and a defined payment trigger. That structure turns base lending, shared savings, and 340B participation into cash flows that can be monitored, validated, and underwritten

How Replication Works

- 1 **Target the same market profile:** Invest in shortage markets with high Medicaid exposure and clear unmet demand
- 2 **Finance the same expansion case:** Fund repeatable clinic upgrades like exam rooms, telehealth, staffing, and 340B readiness
- 3 **Aggregate into the same portfolio logic:** Combine small clinic financings into a scalable, diversified asset pool

CHECF is designed to turn fragmented clinic expansion needs into a repeatable, institutionally scalable healthcare infrastructure strategy

What makes this repeatable

1400+
FQHCs

14,000+
Sites

4
Phase I
Corridors

Investment Criteria

FQHC / HRSA Fit	HRSA-designated FQHCs in MUA/HPSA market
Payer Mix	High Medicaid/uninsured mix and clear unmet access need
Operating Case	Path to breakeven after expansion and staffing ramp
Ancillary Monetization	340B eligible or operationally ready for activation

The ambition is not just a fund. It is a replicable health-infrastructure asset class that is sustainable long-term

Three Named States *Where Contracts Already Exist*

We do not start everywhere. We start where execution risk is lowest, and the model can be proven fastest, using three named states that together validate contract readiness, operating economics, and impact density before broader expansion

1**North Carolina**

Existing MCO shared-savings contract template
89% MCO penetration | 450+ FQHC sites | 12–15 target clinics
Lowest contract-negotiation risk in Phase I

Contract proof point

Great market for shared-savings execution with the lowest negotiation risk

2**Massachusetts**

Proven FQHC ACO model
94% MCO penetration | 280+ FQHC sites | 8–10 target clinics
Strongest evidence base for shared-savings assumptions

Template proof point

Robust evidence base for underwriting the model against proven FQHC economics

3**Kentucky / Appalachia**

Highest-need impact corridor
78% MCO penetration | 380+ FQHC sites | 10–13 target clinics
Largest savings opportunity per dollar deployed

Impact proof point

Highest-need corridor, where each dollar deployed has the clearest savings

The phased rollout is designed to prove more than demand. It shows that targeted clinic expansion can turn capital into reliable operating performance, supporting both repayment resilience and a model that can scale across future market

Traction, Validation, and the *Path to Long-Term Impact*

Each phase de-risks the next by turning early case studies, contract templates, legal clarity, and capital demand into proof points for scale. Fund I proves the model, Fund II expands it across markets, and Fund III mainstreams it into a broader institutional asset class

Case Studies

Early traction matters because it shows the model is not hypothetical; the contracts, economics, and capital pathways already exist

Healthy Opportunities
Pilots confirm 30–40%
MCO capture rates –
Contracts exists

MA FQHC ACO
program: 5+ years of
shared savings data
validating our yield
assumptions

AHA v. Becerra
(SCOTUS 2022)
permanently locks 340B
pharmacy revenue for
FQHCs

Orrick LLP engaged,
regulatory risk mapped,
fallback structure
defined (7.5–8.0% IRR)

\$500B+ ESG
institutional capital
pool actively seeking
impact-aligned credit at
scale

PHASE 01 · Years 1–5 Prove | Fund I — \$250M

30–40 FQHCs

3+ states

- Deploy to 30–40 pilot clinics in 3 named states
- Execute first MPPN shared savings contracts (NC)
- Build standardized underwriting template
- Validate 340B reserve — target \$9M by Year 5
- Prove 10% ER reduction at portfolio level

Track record created. MCO contracts bankable
Deal origination cost: \$75K → \$20K

PHASE 02 · Years 3–8 Scale | Fund II — \$1B

100–150 FQHCs

3+ states

- Catalytic layer shrinks: 15% → 8%
- Expand to 5+ state MCO programs
- Aggregate clinics into securitizable portfolio
- NACHC partnership provides proprietary deal flow
- Adjacent markets: dental safety net, mental health

Fund II IRR: ~9.8%
Catalytic need halved. LP universe doubles

PHASE 03 · Years 6–15 Mainstream | Fund III — \$3B+

500+ FQHCs

12+ states

- Catalytic layer <3% — near fully market-rate
- Securitize: CHECF Loan Trust ABS issuance
- Credit rating achieved — opens insurance co. capital
- Health REIT: own clinic infrastructure, lease to FQHCs
- CHC Expansion Module becomes institutional asset class

Health REIT: \$10B+ AUM
Fully market-rate. No philanthropic capital needed

Market Size: A \$21B *Annual Gap*

The U.S. primary care safety net serves millions of patients but remains structurally undercapitalized, creating one of the largest unfunded infrastructure gaps in American healthcare. That gap is not theoretical: it shows up in unmet demand across the FQHC network

Market Opportunity

\$21B+

Annual capital need

Expansion, IT & workforce
across 1,400+ FQHCs

<1%

Currently funded

By grants, CDFIs, and
traditional lenders combined

TAM — TOTAL ADDRESSABLE

\$21B

 annual FQHC capital need nationally

SAM — SERVICEABLE ADDRESSABLE

\$8–10B

 in HPSA-designated FQHCs with MCO

SOM — FUND I TARGET

\$250M

 across 30–40 Phase 1 clinics

Legal Structures

30M

Americans served

The only primary care option
in 7,000+ shortage areas

1:3,500

Provider ratio

PCPs to residents in target
health desert markets

2022 AHA v. Becerra (SCOTUS)

Affirmed 340B pricing integrity for FQHCs. It significantly reduces legislative risk and secures our primary pharmacy revenue stream

2023 MCO VBC Contracts Scale

NC Healthy Opportunities Pilots & MA FQHC ACOs prove 30–40% shared savings capture. Our contract template exists

2024 \$500B+ in ESG Capital

Institutional ESG fixed income pool reaches record size pension funds and endowments actively seeking impact-aligned credit

Stress-Tested Across Scenarios, *Structurally Flexible by Design*

Returns remain above the senior hurdle across every modeled downside case, showing that the fund is not dependent on perfect execution or a single optimistic assumption. The structure can fall back to simpler fixed-return economics and still protect senior investors

Scenario	Net IRR	vs. 9.2%	Investor Impact
Base Case	+9.4%	+0.2%	All tranches paid. GP carry ~\$11M. Reserve \$10.8M at maturity
MCO -20%	+8.6%	-0.6%	Tranche A (7.5%) still met. Floor guarantee activates
340B Reform -25%	+8.3%	-0.9%	Above hurdle. AHA v. Becerra protects FQHCs. Reserve activated
Defaults 2.5%	+8.9%	-0.3%	Above hurdle. AHA v. Becerra protects FQHCs. Reserve activated
Combined Downside	+7.9%	-1.3%	Tranche A barely met. No carry. All senior principal returned
MCO Floor Only	+7.5%	-1.7%Re	Worst case: contractual floor activates. A hurdle exactly met

7.5% Tranche A Hurdle

Regulatory Risk

- Potential Issue:** shared saving payments may attract AKS (Anti-Kickback Statue) review
- Why we are protected:** Top tier counsel, Orrick LLP, validated structure; Revenue-tied to infrastructure expansion; not referrals; independent contractual framework
- If regulation tightens:** fall back to loan + lease income model. Senior investors protected with 7.5%-8% expected returns

Defense Stack

Contractual Base
Yield Floor

Multiple return levers
(MCO + 340B)

Conservative 1.5%
Default Rate

12+ States Geographic
Diversification

Existing Ecosystem and *a 6,000+ Site Pipeline Sequenced by Phase*

Each phase has a quantified pipeline and a distinct strategic role, allowing CHECF to scale from proof of concept to broader market expansion without losing selectivity. Phase I selects fewer than 1% of available Appalachian sites and then expands using the same logic

Region	Grantees	Sites	Role in Rollout	Strategic Evaluation
Appalachia	390+	~3,500	Phase 01: Prove <i>Years 1–3</i>	Strongest Proof Case: Highest social need creates the clearest data for ER reduction metrics
Texas (Border+)	26	312	Phase 02: Expand <i>Years 3–6</i>	EBITDA Engine: High-volume Medicaid markets; ideal for \$5–7M deployment per clinic
Georgia / Florida	61	488	Phase 02: Expand <i>Years 3–6</i>	Contract Readiness: Mature MCO environments allow immediate shared-savings participation
Mississippi Delta	71	830+	Phase 03: Scale <i>Years 6–10</i>	Deep Impact: Most complex social determinants — model must be fully mature before entry
Urban Health Deserts	~200+	1,800+	Phase 03: Scale <i>Years 6–10</i>	Density & 340B Volume: Maximum 340B pharmacy volume; drives Fund I MOIC and re-up signal

Fund I starts with deliberate concentration, not broad reach. It selects 30–40 clinics from the ~3,500-site Appalachian pipeline, then applies the same underwriting template across 6,000+ sites in later phases growing across the care ecosystem

Year 10 Exit: *Self-Liquidating* by Design

CHECF requires no exit event. FQHC loans amortize across the 10-year term. Principal flows back via scheduled repayment — the structural advantage of private credit over PE for impact at scale

Year 10 Outcomes

~70%

Clean Self-Liquidation

All FQHC loans fully amortize by Year 10. Final distributions paid. Fund dissolves. LPs receive 1.85x MOIC

~20%

Tail Loan Extension

LPA 2-year extension option exercised for loans originated in Years 4–5. Collections continue; final wind-down at Year 12

~10%

Secondary Sale

Remaining loan book sold at par to CDFI, bank CRA desk, or successor impact credit fund. Clean close at Year 10

How Principal Flows Back

Deploy

Yrs 1–5



\$250M deployed
Capital out

Harvest

Yrs 5–8



Interest + savings + 340B
Yield returns

Wind-down

Yrs 8–10



Principal amortization
Principal back

Key Mechanics

- 7–10 yr amortizing loans — principal returns on schedule
- No liquidity event required (unlike PE)
- \$10.8M 340B reserve cushions tail defaults
- LPA allows 2-yr extension if tail loans remain

Fund I closes, but the platform continues: by Year 10, Fund II is in harvest and Fund III is deploying. Individual funds self-liquidate on schedule; CHECF compounds as infrastructure grows creating a care-based feedback loop that

Maximizing What We Have: *Monetize Unused Capacity*

Instead of physician recruitment which is costly and inefficient, CHECF's opportunity is to monetize capacity by financing throughput expansion **using exam room construction, increasing NPs PAs workforce pipelines**, and throughput focused workforce model design

How does CHECF maximize capacity

1 Exam Room Expansion:
Fund the construction of 10 more exam rooms to increase patient capacity

2 Nurse Practitioners & Physician Assistants Recruitment: NPs and PAs earn about 60% of what physicians earn and can handle a large volume of primary care cases. Lower cost, higher efficiency

3 Primary Care Talent Pipeline Development:
Leveraging NHSC loan repayment, full tuition funded NHSC Scholars, and J-1 Visa Waivers programs to create talent pipeline in the resource shortage area

NHSC Loan Repayment

NHSC Scholars

J-1 Visa Waivers

4 Throughput-Focused Workforce Model Design: Using team-based care: 1 MD supervises 3–4 NPs. This provides 4× patient throughput at 60% of physician cost. This is an already standard FQHC operating practice

Go-to-Market: *Three* Parallel Pipelines

CHECF builds three acquisition engines simultaneously. Each has a named channel, a quantified pipeline, a conversion assumption, and a Year 1–3 target grounded in comparable fund benchmarks which gives our fund maximum flexibility across operations

Clinic Origination

NACHC member network

1,400+ FQHCs; proprietary borrower pipeline via State Primary Care Associations

HRSA UDS + Section 330 data

Public data identifies HPSA-designated, Medicaid-heavy clinics with expansion readiness

Regional PCA partnerships

KY, NC, MS PCAs provide warm introductions; reduce CAC by 40–60%

Target: Y1: 10 clinics | Y2: 12 | Y3: 12

~15% of qualified leads → closed deal (CDFI comparable: 10–20%)

MCO Partnerships

North Carolina template

Healthy Opportunities Pilots provides closest analog; modeled as Medicaid Performance Participation Note

Top 5 Medicaid MCOs

Centene, UnitedHealth, Molina, Anthem, Humana — cover 70%+ of Medicaid MCO lives nationally

State Medicaid agencies

Direct engagement in NC, MA, KY to secure template endorsement

Target: 3 MCO contracts signed by Y2 end

9-month avg sales cycle; drops to 4-6 months by contract #5

LP Capital Formation

Tranche A: Institutional

Pension funds, insurance, ESG fixed-income allocators — 8 target LPs identified

Tranche B: Mission-aligned

CDFI intermediaries, DFIs, impact-oriented family offices — 12 target LPs

Tranche C: Catalytic

Foundations, PRIs, gov't guarantees — Kresge, Ford, MacArthur precedents

Target: First close \$100M by Q2 2026; final close \$250M by Q4 2026

Catalytic-first sequencing unlocks senior commitments