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Evaluating Funding Structures of Federally Qualified Health Centers (FQHCs) in Metropolitan Atlanta: A Basis for Public Policy

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***Abstract*:**

Health care costs in the United States are generally unaffordable; however, Federally Qualified Health Centers (FQHCs) have the prime mission to offer affordable services to the communities they serve. This paper evaluates the funding structures over a two-year period of an FQHC in Metropolitan-Atlanta which the Atlanta Regional Commission Agency determines to have the following eleven counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale, and the City of Atlanta. After a comparative review of the clinical and non-clinical aspects, recommendations will be made on how the specific Atlanta FQHC studied could increase their revenue or other performance measures such as best practices.

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Author's Statement Page

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Signature of Author

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

1 Introduction

In the current healthcare system of the U.S., healthcare insurance plans are widely unaffordable not only because of their high deductible and premium rates but also because of the high cost of health services. As a means of providing more affordable healthcare to millions of uninsured or underinsured Americans, Federally Qualified Health Care Centers (FQHCs) and other safety net organizations, were established by the Health Resources and Services Administration (HRSA), a part of the Department of Health and Human Services (HHS) (Uberoi, 2016). This federal program is authorized in Section 330 of the Public Health Service Act (PHSA) and supports four types of health centers: community health centers, health centers for the homeless, health centers for residents of public housing, and migrant health centers. Every year, FQHCs receive these section 330 grants in addition to revenue generated through private and public insurance, philanthropic proceeds, self-pay options for patients, and private grants.

As determined by the Atlanta Regional Commission Agency, Metropolitan Atlanta area is composed of eleven counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale, and the City of Atlanta. Currently, there are approximately 23 FQHCs in the Metro-Atlanta area (Rural Hub FQHC Map). Each FQHC offers different types of services, specifically focusing on which services would benefit the community they serve the most. A concern is that the financial instability of these organizations may be a result of the fact that these clinics rely too heavily on federal funding. The purpose of this paper is to evaluate the funding structures over a two-year period of an FQHC in metropolitan Atlanta, and after reviewing the clinical and non-clinical aspects, recommend potential ways to increase revenue and ensure sustainability.

2 Background

2.1 What are FQHCs/How do FQHCs Function?

FQHCs are primarily outpatient clinics that serve the underserved, uninsured, and underinsured. While FQHCs accept various types of health insurance, each insurance will have a different premium and cover different services. Government supported insurances that are commonly accepted include Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). The majority of the patients that seek health care at FQHCs have Medicaid (Kaiser Family Foundation, 2018). The socioeconomic status of individuals that are eligible for Medicaid have a socioeconomic status that falls below or within a designated range of the federal poverty line. Certain medical conditions can render an individual eligible for additional Medicaid coverage. This includes but is not limited to pregnancy, disability, needing nursing home care, being legally blind, or if an individual is a child or is over the age of 65 and older. With Medicaid, an individual can get care that includes the following services: hearing evaluations, immunizations and vaccinations, mental health assessments and counseling, preventative care, prenatal and maternity care, vision care. For children and pregnant women, comprehensive dental care is also available (CMS, 2018).

After Medicaid, the second largest insurance payor-type at FQHCs is Medicare, which patients use as supplemental health coverage. Individuals who qualify for Medicare are those who are 65 or older, deemed medically disabled, or have end-stage renal disease (ESRD). Individuals with Medicare coverage can have four different types of coverages: 1)

hospital insurance which is used primarily for inpatient care; 2) supplemental medical insurance used primarily for outpatient services and medical equipment; 3) medicare advantage plus which gives the first two parts some supplemental benefits; and/or 4) prescription drug plans. Patients have several plans that they can choose from and accommodate it to what they need. The primary coverage type for children is through the Children's Health Insurance Program (CHIP), sometimes referred to as "State Children's Health Insurance Program". (S)CHIP was established in 1997 to expand coverage to children whose family income requirements are not Medicaid eligible (CMS, 2018). Pediatric patients that are covered by CHIP receive comprehensive care similar to Medicaid, but the coverage of service is expanded to include a broader range of services, such as hospital care, laboratory studies, x-rays, and well-child examinations, which includes immunizations and physical screenings, and comprehensive preventive dental services and most therapeutic dental services. (CMS, 2018).

Private insurance coverage depends on the insurance plan selected by the patient. While the patient has access to all the services offered by the facility, the type of service that will be covered by the insurance depends on the amount and type of coverage provided by the insurance carrier this is true for Medicare as well. If there is a service that is not covered or a service that is not covered at 100%, the patient will be expected to pay the difference. In the event that the patient cannot afford to pay the difference in cost for the specified service, the patient can apply for the Sliding Fee Scale Program (SFS). The SFS is a requirement for Health Resources and Services Administration (HRSA) Health Center Programs to be able to treat all patients regardless of their inability to pay. FQHCs have a schedule of fees and payments for services that are consistent with locally prevailing rates

and will cover costs of operations (Health Center Compliance Manual, 2008). The sliding fee discount schedule is applied to the payment and is adjusted on the patient's household size and the patient's income level. The FQHC must give a full discount to individuals with annual incomes at or below 100% of the federal poverty line. No discount is given to individuals who have annual incomes greater than 200% above the federal poverty line (Health Center Compliance Manual, 2008). Individuals that are uninsured are also eligible for the sliding fee scale.

FQHCs provide many ways to obtain healthcare services in the communities they serve. However, most of their revenue is generated from governmental assisted healthcare insurances which have a strong possibility of changing due to the political influence on them. For example, in order to receive federal funding for Medicaid and Medicare, the states agree to certain terms, such as having no enrollment cap and not being able to charge for premiums or copayments for anyone earning less than 150% of the federal poverty line (CMS, 2018). Some states decline the terms and conditions, thus removing healthcare coverage for those states' citizens. Due to these influences, FQHCs should work on becoming sustainable by generating their revenue through patient services so they do not have to not rely on federal grants to operate.

2.2 Healthcare Reforms and their Impact on FQHCs

Comprehensive national healthcare reform was paused until President Barack Obama presented the Affordable Care Act (ACA), also known as Obama Care. Prior to the implementation of the ACA, 16% of Americans (42 million people) had no health insurance;

14% of Americans received some form of public health care; and 70% had private health insurance (Uberoi, 2016). Medicare covered 49 million Americans and Medicaid covered 58 million people (Uberoi, 2016). With the ACA's implementation, there was also a transition from a fee-for-service (FFS) reimbursement system or volume-based system to a value-based reimbursement system. The current system of volume-based reimbursement (VBR) focuses on the amount of services rendered which can create an incentive for providing healthcare services that may not be essential to the patient's treatment plan at that time. The value-based system asserts that providers receive compensation based on clinical outcomes and patient satisfaction. The system discourages inappropriate or excessive healthcare services.

Value-based care has been a long-standing idea; however, it has only been used as a method of cost containment and has not been universally attempted in the United States (Sultz, 2014). One example of a cost containment pilot program is Medicaid's drug rebate program and its practice of switching from brand name drugs to generic drugs. In this example, the cost containment is immediate. However, if the reimbursement system is universally implemented, the initial costs for a hospital system would be high but they will decrease in the long run. The implementation of value-based care will result in hiring additional staff, increasing resources such as hospital beds and IT services, developing new workplace systems, and integrating comprehensive care for patients. Medicaid expansion would further support this with Accountable Care Organizations (ACOs) synching information, primary care medical homes, and bundled payments. Primary care medical homes would dedicate themselves to improving the patient's health by providing case managers and adherence counselors. Value-based systems encourage doctors' efforts in

incorporating preventive care into the patient's treatment plan and supports them to be more responsible with the amount and type of services rendered (Sultz 2014). Overall, it is better care for individuals and communities, and it results in lower healthcare costs and improved health outcomes.

From the beginning, FQHCs aimed to focus on providing comprehensive and affordable healthcare to the communities they serve. These clinics are not only federally funded, but they have the ability to offer a wide variety of resources, such as pharmaceuticals, pediatrics, family medicine, obstetrics and gynecology, dental, mental health, and even certain specialties like podiatry. While some FQHCs currently operate on a fee-for-service reimbursement payment method, others offer certain services that come in bundled packets. The bundle packets are part of the prospective payment system (PPS) and reflect the cost for services associated with primary care visits. These services do not have to occur on the same day and stand -alone visits are evaluated for certain services. Bundle services are classified into specific payment codes describing the services provided (CMS FQHC PPS, 2017). With some services being bundled and still a part of the fee-for-service system, FQHCs make a profit while still being affordable for the communities they serve. If FQHCs can become more sustainable and not rely heavily on federal grants, then they have the potential to offer communities a wider variety of affordable options.

3 Methodology

3.1 Study Design: Programmatic Cost Analysis Model

The purpose of conducting an economic evaluation approach is to identify and compare the costs and consequences of different facilities that have similar programs. A programmatic cost analysis is one way to determine how resources are required to implement an intervention or program and how the costs associated with the use of those resources can be assessed (CDC). A type of analysis is also known as a cost-minimization analysis or a cost consequence analysis and can be assessed alongside program evaluations (CDC). There are two ways in which a programmatic cost analysis can be conducted, prospectively and retrospectively. A prospective analysis is conducted while the program is being evaluated for effectiveness, and retrospective analysis is conducted after a program has already established effectiveness trials (CDC). A retrospective analysis will be applied to this study to determine how costs vary across FQHCs in the Metro-Atlanta area. This begins with inputting resources such as labor, equipment, supplies, and space to function. From inputting resources, a facility can be established to produce changes in health outcomes such as morbidity, mortality, and health disparities (CDC). In FQHCs, this would appear in the form of income made based on the number of services provided and the number of patients seen.

The first step in this economic evaluation is to determine the costs and resources of the FQHC. The costs are defined as the value of resources used to promote the services at the facility. Resources are defined as the people, facilities, equipment, and supplies used by

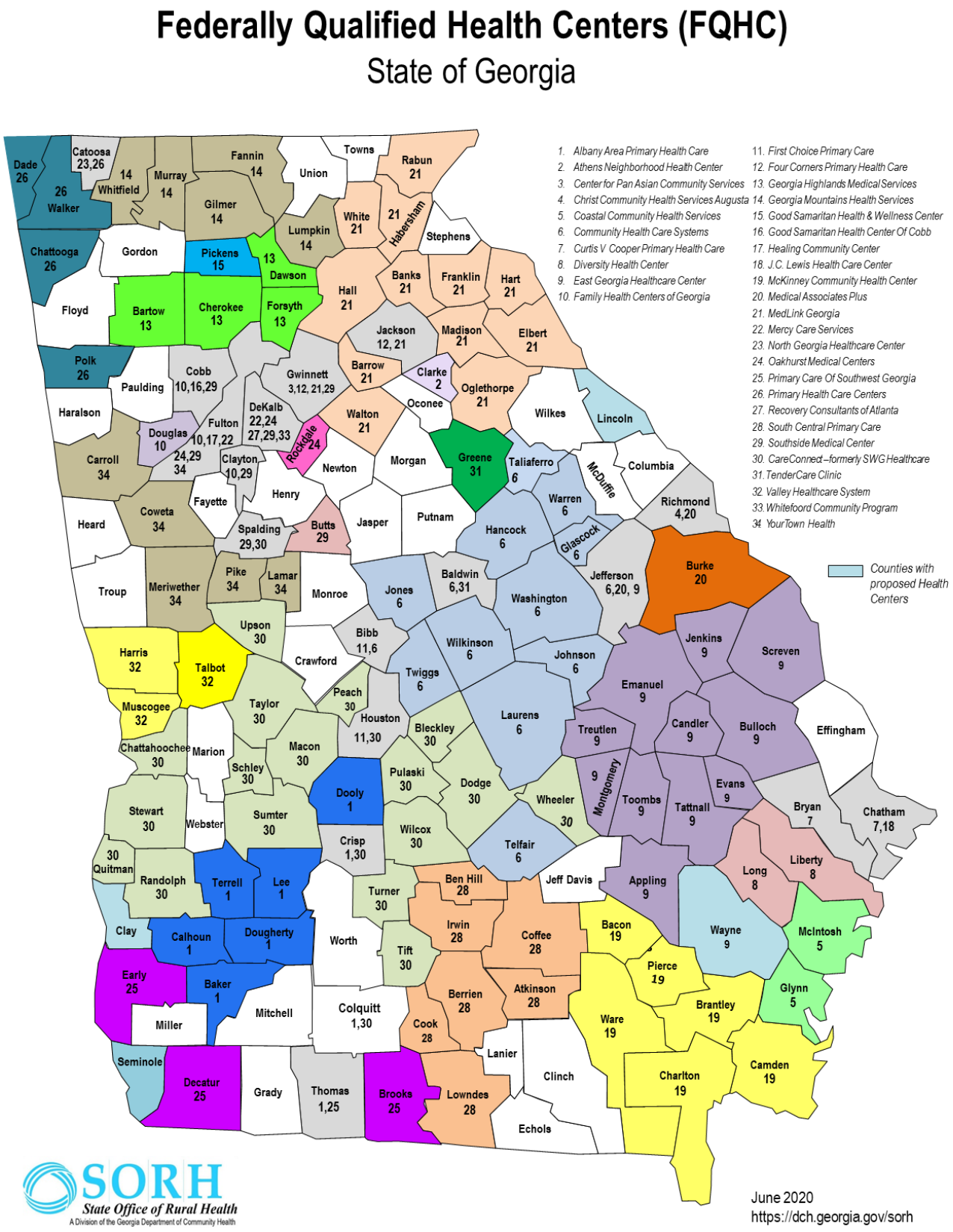
the facility. When assessing these costs, it is important to take into account any financial and opportunity costs (CDC). Financial costs would include the costs with running the facility, such as administrative and supply costs. Opportunity costs take into account the value of a good or service. This would include any volunteers or time that is donated at a facility because it can save the facility costs without incurring any further costs. The second step in programmatic cost analysis is to find how costs should be collected by developing a classification system that categorizes cost groups (CDC Programmatic Costs Analysis, 2017, p. 12). Although categorizing costs can be done in many different ways, they typically fall within the following framework of direct costs, indirect costs, client administrative activity costs, and program administrative activity costs (CDC Programmatic Costs Analysis, 2017, p.15). This classification method can show where funds are being more actively used. These steps have already been simplified for this study's use as the study will be looking at the income tax forms of the FQHCs. Specific study variables are discussed in section 3.3.

Another way to assess programmatic costs is through the calculations of average and marginal costs. Average costs are the total cost of the facility divided by the outcome of the interest, and marginal costs are the costs of additional resources required to continue services (CDC Programmatic Costs Analysis, 2017, p. 22).

3.2 Study Participants & Setting

Prior to the analysis, it is necessary to identify the scope and volume of services FQHCs in the eleven counties: Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, and Rockdale had in fiscal years 2017 and 2018.

Figure 1: Overview of Atlanta FQHCs



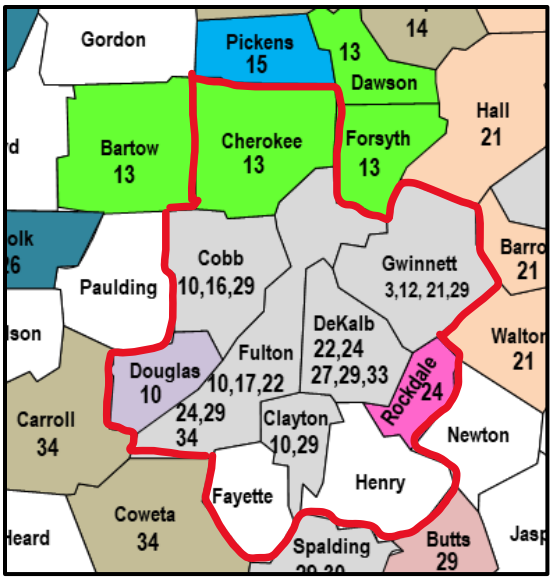


Figure 2: Overview of Atlanta FQHCs, the Metro-Atlanta Area. The red line outlines the Metro-Atlanta area. Note: The City of Atlanta is included in Fulton County.

A focus will be placed on the FQHCs that have an adult primary care center, a women's center or gynecology department, a dental department, and a pharmacy. These services have been selected as a specific criteria for FQHCs to meet because the primary Atlanta FQHC being studied uses these departments to generate revenue through their services. After similar FQHCs have been found, then the patient volume and financial trends and patterns will be analyzed.

In conjunction with evaluating financial reports, it is also necessary to observe how a facility operates on a day-to-day basis. This would include:

- Assessing space utilization for non-clinical and clinical services.
- Observing patient involvement in obtaining services.
- Observing non-clinical staff interactions with each other and with established and new partners.

This non-clinical observation occurred from August 2019 to May 2020 and will be used to provide insight on the recommendations to how FQHCs can be more sustainable.

3.3 Study Variables & Data Analysis

Various components of the tax forms will be analyzed to identify any performing trends of the FQHCs. Specific study variables that will be looked at are growth and expansion, payor mix, financial performance and condition, utilization, and productivity. These study variables can be found by taking a look at the following sections in the tax forms:

- Tax Summary
- Statement of Revenue
- Independent Contractors
- Statement of Functional Expenses
- Balance Sheet
- Reconciliation of Net Assets
- Land, Buildings, and Equipment Form

From these statements, comparative trends will be analyzed.

3.4 Expected outcomes of the study

If FQHCs become more sustainable, the communities they serve can continue to obtain affordable health care and not have to rely on government funding to use for operational expenses. Recommendations will be made to, specifically, the primary Atlanta FQHC being studied, the Healing Community Center, on how they could improve their

sustainability. However, these recommendations can be used by other FQHCs on how they could add to their sustainability.

4 Results

4.1 Selecting FQHC Sites

Out of the 23 FQHC organizations in the Metro-Atlanta area, only six FQHC organizations, including the primary Atlanta FQHC, have an adult primary care center, a women's center or gynecology department, a dental department, and a pharmacy (Table 1a). Out of these six FQHCs, three FQHCs were removed from further analysis due to insufficient or unavailable tax data from 2017 and 2018. The remaining three FQHCs are the Healing Community Center, the Southside Medical Center, and the Oakhurst Medical Center (Table 1b). Whilst the Healing Community Center only has one location in Fulton county, Southside Medical Center and Oakhurst Medical Center both have facilities in Dekalb, Fulton, and Gwinnett counties. Southside Medical Center has additional counties in Cobb and Clayton counties. Tables 1a and 1b show the narrowing of facilities based on services and tax data availability.

National patient characteristics from the uniform data system by HRSA (Table 2a) shows that, on average, 91% of patients are at or below 200% of the federal poverty line while an average of 68.5% fall below the 100% federal poverty line throughout 2017, 2018, and 2019. Out of these patients, an average of 22.7% are uninsured, 48.9% have Medicaid, 9.6% have Medicare, 3.8% are dually eligible for Medicare and Medicaid, and 18.7% are other third-party patients. A specific observation is that out of the total number of patients, 57.6% of the patient population is composed of female patients and 30.9% is composed of pediatric patients. Similarly, a comparison of all the demographics for the five counties,

involved with these FQHCs shows that females are the majority population in each county (Table 2b).

Table 2b compares the demographic data of the five counties and is compiled from neighborhood nexus, a regional information system that derives their fact sheet data from the American Community Survey (ACS). Fulton has the largest total population with Gwinnett following behind, and Clayton County has the smallest total population. Dekalb and Cobb County are similar in size. Overall, Cobb County has the least amount of poverty levels at 9.1% while the highest poverty level is in Clayton County. Cobb County has the least reliance on supplemental security income and food stamp/SNAP benefits while Clayton County has the highest reliance in those categories. Cobb County also has the highest median household income at $77,932 while Clayton County has the lowest at $47,864. Fulton County has the largest household income differences with 14.1% earning more than $200,000 or more a year (Neighborhood Nexus, 2019).

Table 2c shows the health insurance coverage throughout the five counties the three FQHC organizations are located in. Throughout all five counties, over 80% of civilians not institutionalized have health insurance coverage. 53% to 74% of those individuals have private health insurance coverage, and 22% to 35% have public health insurance coverage. 10% to 18% of individuals do not have health insurance coverage. Out of the five counties, Fulton County has the least percentage (10%) of individuals that do not have health insurance coverage while Clayton County has the highest percentage at 18%. Overall, there are a significant number of individuals that could benefit from the services of FQHCs.

4.2 Financial Trends

The Tax Form 990 is a publicly available form and provides an easy way for donors and other individuals to get a synopsis of an organization. It states the facility's mission and accomplishments and can provide information on the cash reserves, top paid employees, and a list of the board members. Various components of the IRS 990 tax form for each organization were analyzed to identify financial trends at the FQHC. Financial performance and condition, utilization, and productivity were measured by analyzing the tax summary, statement of revenue, independent contractors, statement of functional expenses, balance sheet, and the reconciliation of net assets. The tax form portion that was used specifically to analyze growth and expansion is the land, buildings, and equipment form.

Oakhurst Medical Center

From the tax summary (Table 4a), Oakhurst Medical Center has an overall positive net asset of fund balances. However, the increase in net asset of fund balances dropped from 21.8% from 2016 to 2017 to 1.5% from 2017 to 2018. The total revenue percentage had an above 10% increase each year. On the other hand, the total expenses increased each year with an above 20% increase in other expenses and an above 5% increase in employee benefits and salaries. On a closer look at the statement of functional expenses (Table 4b), the facility had a 26.7% increase in expenses in program services compared to management and general services, which cut down on costs by 6.6%. The largest increases in expenses, with over a 100% change, were in pension plan accruals/contributions; advertising and promotion; and occupancy. The most notable decrease in expenses was in travel and all other expense costs with savings greater than 10%.

The Reconciliation of Net Assets form (Table 4d) shows that there was a 13.6% increase in revenue from 2017 to 2018, but the total expense cost was higher than the total revenue by 8.4%. The facility also had a positive unrealized gain in 2017 but a significant decrease in 2018. Net assets at the end of the 2017 year show a savings of 21.8% throughout the year. However, net assets at the end of the 2018 year has a percent change of 1.5%, with the 22% higher expense difference but with no significant change in total revenue, there is an indication that the facility has lost funds through program services. A closer look at the balance sheet (Table 4c), shows that the organizations' savings decreased by 161% by the end of 2018.

The facility did not use any independent contractors in 2017 or 2018 (Table 4f). For growth and expansion, the land, building, and equipment form (Table 4e) show a total change of a negative 2% change in the book value. This negative change primarily stems from the increase in accumulated depreciation in buildings, leasehold improvements, and equipment. Overall, the Oakhurst Medical Center increased their total revenue from each year, but they also experienced greater expenses which did not allow them to sustain a larger net revenue.

Southside Medical Center

The Southside Medical Center has an overall positive net asset of fund balances by 1.3% (Table 5a). In addition to the major decrease in the other revenue category in funds from 2017 to 2018, expenses also increased consistently in salaries and other expenses. The statement of functional expenses (Table 5b) shows that there is a total of a 6.6% increase in expenses from 2017 to 2018 with most expenses being from management and

general expenses. Most notably in management and general expenses, there is a significant decrease in expenses in repairs and maintenance, and pension plan accruals while the largest increase in expenses, above 100%, being in legal fees; advertising and promotion; and all other expenses category. The most notable increase in program services expense with an above 30% change occurred in other employee benefits; advertising and promotion; and interest expenses. Significant savings, above 30%, occurred in travel and all other expense costs. Overall, from 2017 to 2018, the most increase in expenses stem from advertising and promotion with a 128.5% increase, and from legal fees that had a 111.4% increase. From the end of the 2017 fiscal year to the end of the 2018 fiscal year, the balance sheet (Tabel 5c) shows a 144% decrease in assets from other security investments. However, even with this large decrease in assets, the organization was still able to increase its total asset percentage by 4.6%. Liabilities show that there was a 112.8% increase in secured mortgages and notes payable. Otherwise, there were multiple areas in which liability expenses decreased. Most notably, is that tax-exempt bond liabilities had a consistent above 25% decrease in expenses in 2017 and 2018. Overall, there was an increase in liabilities primarily due to the secured mortgage and notes payable expense.

This facility hires independent contractors to allocate some responsibilities (Table 5f). While there was over a 20% decrease in compensation for patient appointments and professional services, there was over a 25% increase in compensation for billing and pharmacy services. Overall, there is a 21% increase in compensation for independent contractors from 2017 to 2018. The liabilities section of the balance sheet indicates that in 2018 the organization may have expanded at a current location or set up a new location. The land, buildings, and equipment form (Table 5e) confirms this by having a 62.4%

increase in building book value. Overall, the Southside Medical Center had an increase in both revenue and expenses with the difference between each being less than 1%. With most savings coming from decreasing liability expenses, the organization was able to net a 10.6% increase in net assets by the end of the 2018 fiscal year.

Healing Community Center

In 2018, the Healing Community Center experienced an overall 83.6% increase in net assets of fund balances compared to the 2017 fiscal year (Table 3a). However, a closer look at the tax forms reveals that, in 2018, the organization reduced expenses by cutting back on salaries and employee benefits by 30.9%. The revenue generated also underwent an 11.4% decrease compared to the previous year. The organization also cut expenses by another 30.5% in other expenses. As a result, even with the decrease in revenue, the organization was able to make up for its decrease in funds by reducing expenses. The statement of functional expenses (Table 3b) shows that 59.4% of the decreases in salaries and wages came from management and general while a 35.6% decrease came from program services. However, there was also a 53.1% increase in change in the compensation of current key employees in management and general. The organization also pays no payroll taxes in management and general. Other notable changes in expenses include a significant decrease to zero for accounting and conference expenses and an increase in legal and other expenses. The facility also increased expenses in advertising and promotion by 383% from the previous year. However, two of the most notable changes come from over a 2,117% decrease in insurance and a 329% decrease in other itemized expenses. On the other hand, the balance sheet shows that the organization underwent a

significant loss in revenue in 2017 primarily due to a reduction in cash non-interest bearing and the amount received in pledges and grants. In 2018, the organization was able to increase its non-interest bearing cash by 458% from 2017. However, pledges and grants continued to decrease by another 151.6%. At the end of the 2018 fiscal year, the organization was able to sum its total assets and liabilities to an increase of 13.9% from 2017 (Table 3c). Overall, the Healing Community Center had an 11.4% decrease in total revenue and a 20.8% decrease in expenses. With the downsizing, the organization was able to increase its net assets by 83.6% from 2017 to 2018 (Table 3d).

The facility did not use any independent contractors in 2017 or 2018 (Table 3f). For growth and expansion, the land, building, and equipment form (Table 3e) show a total change of a negative 30.9% change in the book value. This negative change comes primarily from the increase in accumulated depreciation in equipment and other property.

4.3 Comparison of all 3 FQHC Organizations

After reviewing all three FQHCs separately, the FQHCs were compared to each other. From the statement of revenue form, the contributions from grants and other sources of revenue can be assessed. The Healing Community Center had a 3.8% decrease in grant funds from 2017 to 2018. The facility's second largest funding source comes from private foundations which decreased by 46.2% in 2018. The facility's net patient services revenue also decreased by 6.7% from 2017 to 2018. On the other hand, Oakhurst Medical Center received almost triple the amount of grant funding compared to the Healing Community Center. The Oakhurst Medical Center received a consistent amount of funds from federated campaigns; increased their grant funds by 9.2% from 2017 to 2018; and

received funds from additional contributions and grants. However, even with receiving double the amount of federal funds, the facility's largest generating revenue source is their pharmacy which accounted for 45.3% of the facility's total revenue. Out of all three organizations, the Southside Medical Center received the largest amount of funds from federal grants, 307.8% more than the Healing Community Center. The Southside Medical Center was also able to increase its net patient services revenue by 9.8% from 2017 to 2018. Overall, roughly 50% of the Southside Medical Center's revenue is generated by patient services while the other 50% is from grants and other investments.

Combining this information with other organization characteristics, the following can be summarized. The Healing Community Center has only one location where they downsized in order to make a profit in 2018. The facility receives most of its funds from federal funding, which is twice the amount that they can generate from patient services. On the other hand, Oakhurst Medical Center has three locations that generate 610.5% more from patient services than from federal funds. Finally, the Southside Medical Center has five different locations and receives the largest amount of federal grants than the other two organizations. However, the facility is still able to generate more revenue from patient services.

4.4 Non-clinical Observations

Non-clinical observations were only completed at the Healing Community Center as it is the primary Atlanta FQHC being studied and the observations will be used as insight to

provide specific recommendations for the clinic. From August 2019 to May 2020, the Healing Community Center's daily operations were observed with specific attention towards the utilization of space, patient involvement in obtaining services, and non-clinical staff interactions with each other and outside partners.

While there is no physical data for this, the ease with which patients visited the clinic and requested certain services was casual. The clinic's environment was open and approachable. The metro railway station-MARTA, was close by and there were key accessible points for bus stops. The building area was handicap accessible and parking was provided for free. The building entrances were monitored by security guards who kindly directed you to where you needed to be as there were multiple health care departments including a pediatric clinic by a separate organization on the bottom floor. Pharmacy services, by a separate organization, were also provided on-site.

Most observations occurred in the dental department as it is the highest revenue generating department at the Healing Community Center. The execution of services was observed in the non-clinical areas. Although the clinic is currently transitioning into becoming paperless, there is still quite a large use of office supply services. Patient administration and services were provided adequately and in a timely fashion. Recommendations were made for patients that may be interested or needed additional services or assistance. Finally, non-clinical staff interactions with each other and with established and new partners were also observed. Interactions remained professional in a relaxed atmosphere. Communication was encouraged and continuous between departments. However, it is unknown as to how efficient the communication was. These

general non-clinical observations will be used to provide insight on the recommendations on how FQHCs can be more sustainable.

5 Discussion

Affordable services in a prime location attract a stable patient source that can utilize as many different services as they can in one location. Currently, all three FQHC organizations offer family primary care, women's gynecology services, pediatrics, and dental services. All three FQHC organizations also offer additional various services through patient outreach services that will attract more patients to utilize their facilities. The Oakhurst Medical Center offers the most programs and services while the Healing Community Center offers the least amount among these three FQHC organizations. After data and observational analyses, three recommendations that have the potential to expand the Healing Community Center: adding an obstetrics department to the clinic, creating a resource center, and active management. These three recommendations have the potential to not only tie the community together by having a center that offers more services at one location but to also be able to generate revenue by bringing in obstetric patients and their families.

5.1 Addition of Obstetric Department

The Oakhurst Medical Center also generates most of its revenue from its pharmacy department. However, many other factors come into place, especially if stronger medications are involved. Currently, the primary Atlanta FQHC, the Healing Community Center, provides adult primary care and gynecology services for women, but it does not provide any services for obstetric patients. Based on the demographics of the five counties, the majority of the total population is comprised of females while 25% to 20% of the population falls below 19 years of age (Table 2b). According to the World Health Organization (WHO), the average reproductive age falls between 15 to 49 years of age. With

the majority of the population being female, an assumption can be made that at least half of this population is of childbearing age. By not providing prenatal and postnatal care, the center is less ideal for women looking specifically for maternity care and for women who want to continue their adult primary/gynecology care at the facility even when they need maternity care. Furthermore, obstetric patients have the potential to increase patient volume as they may have other children who need healthcare services. If the clinic has an obstetrics department, and the parents can see that they can obtain care for themselves at the same location, they are more likely to obtain care for their child at the same location since it would save them time and energy.

The primary Atlanta FQHC has some space that is unused or not used to its full capacity, so the remaining space has the potential to save on new overhead costs. Table 6 shows the average preliminary costs that would be associated with expanding the gynecology department to include obstetrics. The preliminary cost assessment includes all the expected costs that are associated with the addition of the obstetrics department except for overheard costs. The total cost comes out to $650,000. Since we are expecting an increase in patient volume, we need to be aware of the increase in services these patients may obtain at the clinic. In other words, these patients may also be obtaining services in other departments of the clinic causing the revenue of those departments to rise. The number of new patients that these departments receive as a consequence of the addition of the OB department will be a positive health outcome for the clinic. The other health outcomes that will also increase are the total number of new patients that were treated at the OB department, and the financial increase in payer types. The collection of this health

outcome data can be useful to the FQHC in enhancing measures that can cater to the population that obtains their services.

5.2 Resource center with support services

During the questionnaire portion that Udow-Phillips (2016) conducted in Michigan FQHCs, it was revealed that those who were still uninsured had some common reasons including health care insurance still being unaffordable for them, not being aware of their coverage options, or needing assistance with applications and waivers. The results show that the demographics in the five counties vary in socio-economical status and in health insurance coverage. A general association from Table 2b, demographic comparison of the five counties, and Table 2c, health insurance coverages in the five counties, show that as income falls, health insurance coverage decreases. This trend skews when there is a wide discrepancy or outlier in houshold income. It is imperative to address these concerns as it will not only ensure that all demographics have been accounted for, but that health equities are addressed and health disparities are lowered.

The observational results show that some means are provided in having access to care, such as having a culturally aware staff, having means of transportation available nearby, and having information for additional resources available. However, it may not be enough to adequately address the social determinant of health Udow-Phillips points out. In 'Taking action on the social determinants of health in clinical practice: a framework for health professionals,' Andermann identifies concrete ways in which clincians can use to address the social determinants of health in their routine clinical work. Andermann first recommends to identify social challenges a patient may be facing (Andermann, 2016).

Table 2b shows that a range of 9.1% to 18.6% in the five counties lives below the federal poverty line. A larger range of households receives various types of income either from social security, retirement, supplemental security, or food stamp/SNAP benefits. Understanding what is available to certain patients, can allow the clinician to have some insight on how the patient can realistically continue care for themselves. Andermann's second recommendation after a social evaluation is to connect patients with support resources that can assist the patients with where can continue some form of their care whether it is a housing advocacy group or a referral to an affordable pharmacy (Andermann, 2016). By providing continual care options, as a healthcare industry, we can encourage patients to have health advocacy for themselves by not delay their care, and to guide them to the correct facilities for chronic illness management.

One way in which the primary Atlanta FQHC can accomplish both of Andermann's recommendations are through the evidence-based community health worker (CHW) program which plays a unique role as the link between the community and the healthcare system. The goal of the CHW program is to help interpret information, address socioeconomic needs, provide connections to resources, and develop trusting relationships with populations that have greater needs and face barriers to entry into the healthcare system. More specifically, this concern can be addressed at the primary Atlanta FQHC with a computer station to assist individuals in receiving the benefits they need. This could include the community health worker helping individuals learn why preventative care matters and how insurance can help access that, having walk-throughs on how to sign up for specific benefits, information on healthcare insurance, and addressing similar concerns.

Making an effort to address the concerns regarding administrative paperwork for patients has a strong potential to be able to collect payments in the future; thus, increasing revenue. Furthermore, the CHW program aligns itself with the missions of FQHCs and impacts individual and community capacity by increasing self-sufficiency and health knowledge of community members through empowerment, education, outreach, counseling, social support and, advocacy (WHO, 2014).

5.3 Active Management

Under the Health Resource and Services Administration (HRSA), an FQHC's key management staff may include a president or chief executive director (CEO), chief operating officer (COO), chief financial officer (CFO), chief medical officer (CMO), and a chief information officer (CIO). The key management staff makes up the FQHC's c-level structure. The management team needs to be appropriate for the size and complexity of the health center. The management team should work cohesively to set up new departments or programs, making resources available, ensuring that the budget with income and expense is on track, and ensuring there are plenty of intervention strategies in place to make the FQHC sustainable (Ch. 11, Health Center Compliance Manual).

The primary Atlanta FQHC complies with all of the HRSA's management criteria, but it is always a necessity to mention the need to have an active management team because good communication especially with accurate feedback can produce results that serve the clinic and the community. Comparing to the Oakhurst Medical Center, which generated the largest patient services revenue that was significantly more than they obtained from federal funding, it can be seen that because the facility was able to document their payor

sources in their statement of revenue form, their organization focuses on proper documentation and proper billing procedures to collect revenue from patients and their insurance companies. An active management team at the Healing Community Center can facilitate the compliance of proper documenting and billing procedures.

With the proper data and feedback obtained from each department head, the c-level management team can properly address concerns regarding services, finances, public relations. More specifically, the chief executive officer should lead the team towards independent sustainability in which the clinic's operating expenses are not covered by grants. The chief executive officer or the chief financial officer should apply for a grant to accommodate the preliminary costs of the obstetrics department addition. This would lessen the financial pressure on the clinic's operating budget and allow the clinic to focus on proceeding with generating revenue through the new addition. The chief financial officer and chief operating officer, along with their general duties, should also continue to find ways where expenses could be reduced whether this is finding supplies that are less costly or by increasing ways to ensure that collection of payments will be received without hindering a department's ability to function adequately. This is where recommendation two, information desk with support services, can play a significant part because promoting a service that is not a direct medical service but contributes significantly towards the operations of healthcare systems in general needs more attention especially in areas where access to healthcare insurance information is limited.

The chief information officer or public relations team will need to actively promote the new services at the facility: the addition of the resource center and the obstetrics

department. With the influx of patient volume and additional revenue, the chief executive officer, chief financial officer, and the chief operating officer should keep detailed information regarding health outcomes to ensure there is good data collection from the additional resources. The management team should evaluate the new additions biannually and develop an evaluation plan to monitor the transition of the services into the clinic.

5.4 Limitations & Future Research

Some public data may not be sufficient or updated to be utilized in this study. More specifically, not enough information was available to find exact payor source types or the amount of patient volume for each facility. The only available information present for payor source types are national, state, and the Healing Community Center data. Furthermore, observations were only made at the Healing Community Center. Accurate observation methods would involve observing the other organizations as well. Only the resources that were available were used in this study.

To improve this capstone, future research should address having data for payor source types and the revenue generated per patient volume seen. Another year of data for each organization to fortify a trend in finances should also be included.

6 Conclusion

Federal funding has the potential to be unstable due to the fluctuating nature of political opinions towards the allocation of funds towards health care resources. The implementation of the Affordable Care Act was able to increase access to care, but millions of individuals were still not able to receive access to care. This lack of coverage and access to care continued into the Trump administration, which responded by making changes to the ACA, inadvertently continuing and limiting access to care. The current Biden administration has an objective to increase access to quality healthcare and address disparities by strengthening and expanding ACA provisions. So far each administration's goals have been the same-to provide people with access to care. However, it is uncertain when this will occur. As a result, FQHCs that rely heavily on federal funding need to find sustainable measures to continue their operations.

The results provide insight into the financial trends of FQHCs while the non-clinical observations of the primary Atlanta FQHC offers insight on daily operations. While there are fluctuations through the fiscal years of 2017 to 2018, there have been many physical changes at the clinic as well, such as the expansion of services by adding additional services and attempts to cover more patients. Currently, the generated income of the primary Atlanta FQHC is roughly a quarter of its overall functional expenses. To increase the generated income, three recommendations are proposed. The addition of an obstetrics department has a strong potential to bring in a larger patient volume to the clinic. The addition will also prioritize the clinic's limited resources. Furthermore, the implementation of a community health worker program at the FQHC has a strong potential to link the community the FQHC serves with proper healthcare insurance coverage as well as other

resources that can increase the likelihood of a patient being able to properly pay for the services they receive at the FQHC. Lastly, key management personnel must have a similar vision for each of the projects they would like to occur. Effective and efficient communication between upper management can ease the process of new programs being implemented or evaluated. These three recommendations are given generally and should be considered after a needs assessment has been conducted for a facility. By utilizing these recommendations, the FQHC will have a higher likelihood of generating more income than in previous years.

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Appendix A: FQHC Site Links.

Good Samaritan Health Center of Cobb: https://goodsamcobb.org/portal/get-ready.html

Southside Medical Center: https://southsidemedical.net/pediatrics-and-teen-health8203/

Family Health Centers of Georgia: https://www.fhcga.org/primary-healthcare

Canton Family Health Center: https://www.ghms-inc.org/locations/canton-family-health-center/

Healing Community Center: https://www.healingcommunitycenter.org/additionalservices

Whitefoord: https://www.whitefoord.org/healthcare-programs

Recovery Consultants of Atlanta: https://www.recoveryconsultants.org/services

Medcura Health, formerly known as Oakhurst Medical Center: https://medcura.org/services/additional-services/

Mercy Care: https://mercyatlanta.org/services/

Appendix B.

Table 1a: FQHCs in the Metro-Atlanta Area with Similar Services to Primary Atlanta FQHC[1].

Georgia FQHCs with Similar Services to the Healing Community Center						
FQHC	**Georgia Highlands Medical Services**	**Family Health Centers of Georgia**	**Southside Medical Center**	**Oakhurst Medical Services**	**Healing Community Center**	**YourTown Health**
County	CHEROKEE	CLAYTON COBB DOUGLAS FULTON	CLAYTON COBB DEKALB FULTON GWINNETT	DEKALB FULTON GWINNETT	**FULTON**	FULTON
Services	Family Practice/Adult Medicine	Family Practice/Adult Medicine	Family Practice/Adult Medicine	Family Practice/Adult Medicine	**Family Practice/Adult Medicine**	Family Practice/Adult Medicine
	Women's Health/GYN	Women's Health/GYN	Women's Health/GYN	Women's Health/GYN	**Women's Health/GYN**	Women's Health/GYN
	Pediatrics	OB	Infectious Diseases	OB	**Dental**	OB
	Behavioral Health	Pediatrics	Pediatrics	Pediatrics	**Behavioral**	Prenatal
	Dental	Behavioral Health	Substance Abuse	Behavioral	**Health Education**	Pediatrics
	Vision	Dental	Dental	Dental	**Specialties in Cardiology & ENT**	Behavioral
	Pharmacy	Vision	Vision	Vision	**Pharmacy**	Dental
	Family Planning	Pharmacy	Pharmacy	Podiatry		Geriatrics
	On-Site Laboratory	Family Planning	Health Education	Infectious Diseases		Chronic Disease Management
	Healthcare Marketplace Assistance			Gastroenterology		Laboratory Services
				Pharmacy		Pharmacy
				Health Education		Care Coordinator
				Right from the Start Medicaid (RSM)		
				Pregnancy Center		

[1] Data obtained from Rural Health Hub and individual FQHC organization websites.

Table 1b. Georgia FQHCs with Similar Services to the Healing Community Center & Available Tax Data. based on Tax Data Availability.[2]

Georgia FQHCs with Similar Services to the Healing Community Center			
FQHC	**Southside Medical Center**	**Oakhurst Medical Services**	**Healing Community Center**
County	CLAYTON COBB DEKALB FULTON GWINNETT	DEKALB FULTON GWINNETT	**FULTON**
Services	Family Practice/Adult Medicine	Family Practice/Adult Medicine	**Family Practice/Adult Medicine**
	Women's Health/GYN	Women's Health/GYN	**Women's Health/GYN**
	Infectious Diseases	OB	**Dental**
	Pediatrics	Pediatrics	**Behavioral**
	Substance Abuse	Behavioral	**Health Education**
	Dental	Dental	**Specialties in Cardiology & ENT**
	Vision	Vision	**Pharmacy**
	Pharmacy	Podiatry	
	Health Education	Infectious Diseases	
		Gastroenterology	
		Pharmacy	
		Health Education	
		Right from the Start Medicaid (RSM)	
		Pregnancy Center	

[2] Data obtained from Rural Health Hub and individual FQHC organization websites.

Table 2a: National Patient Characteristics from UDS HRSA.

National Patient Characteristics From UDS HRSA			
Patient Characteristics	**2017**	**2018**	**2019**
Income Status (% of patients with known income)			
Total Patients with Known Income (Denominator)	19,498,453	20,373,081	21,353,559
% Patients at/below 200% of Federal Poverty Guideline	91.48%	91.33%	91.06%
Patients at/below 200% of Federal Poverty Guideline	17,836,567	18,607,652	19,445,538
% Patients at/below 100% of Federal Poverty Guideline	69.15%	68.23%	67.97%
Patients at/below 100% of Federal Poverty Guideline	13,483,840	13,899,913	14,514,557
Insurance Status (% of total patients)			
% None/Uninsured Patients	22.88%	22.62%	22.74%
None/Uninsured Patients	6,216,811	6,419,472	6,783,710
% None/Uninsured Children (<18 years)	12.70%	12.52%	12.98%
None/Uninsured Children (<18 years)	1,066,596	1,093,990	1,194,385
% Medicaid/CHIP Patients	49.64%	49.00%	48.20%
Medicaid/CHIP Patients	13,490,591	13,905,805	14,380,852
% Medicare Patients	9.40%	9.66%	9.81%
Medicare Patients	2,555,311	2,741,037	2,927,781
% Dually Eligible (Medicare and Medicaid)	3.82%	3.74%	3.77%
Dually Elgible (Medicare and Medicaid)	1,038,609	1,062,522	1,125,689
% Other Third-Party Patients	18.07%	18.72%	19.25%
Other Third-Party Patients	4,911,659	5,313,366	5,744,270
Total Patients	27,174,372	28,379,680	29,836,613
% Children (<18 yearss)	30.89%	30.78%	30.85%
Children (<18 years)	8,395,134	8,736,509	9,204,942
% Adults (18-64 years)	60.41%	60.05%	59.55%
Adults (18-64 years)	16,416,970	17,041,599	17,767,170
% Older Adults (Age 65 and over)	8.69%	9.17%	9.60%
Older Adults (Age 65 and over)	2,362,268	2,601,572	2,864,501
Special Populations			
% Homeless Patients	5.01%	4.98%	4.98%
Total Homeless Patients	1,361,675	1,413,256	1,459,446
% Total Agricultural Workers or Dependents	3.58%	3.51%	3.46%
Total Agricultural Workers or Dependents	972,251	995,232	1,031,049
% Public Housing Patients	12.75%	15.56%	17.31%
Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site	3,466,074	4,415,160	5,165,074
% School-Based Health Center Patients	2.95%	2.89%	2.97%
School-Based Health Center Patients	802,630	819,177	885,553
% Veterans Patients	1.31%	1.36%	1.34%
Veterans Patients	355,648	385,222	398,788
Number of Female Patients (ages 15-44)	7,014,487	7,262,983	7,560,990
% of Female Patients under 15	22.20%	22.14%	22.21%
Number of Female Patients under 15	3,483,223	3,623,192	3,809,299
% of Female Patients (ages 15-64)	68.86%	68.46%	67.98%
Number of Female Patients (ages 15-64)	10,802,779	11,201,800	11,661,973
% of Female Patients over 65 years	8.94%	9.39%	9.81%
Female Patients over 65 years	1,401,777	1,536,363	1,682,905
Total Female Denominator	15,687,779	16,361,355	17,154,177

Table 2b: County Demographic Data from 2015 to 2019.[3]

COUNTY DEMOGRAPHIC DATA (2015-2019)					
	CLAYTON	**COBB**	**DEKALB**	**FULTON**	**GWINNETT**
Total Population	283,538	751,218	749,323	1,036,200	915,046
Male	46.8%	48.4%	47.3%	48.4%	48.8%
Female	53.2%	51.6%	52.7%	51.6%	51.2%
Under 19 years	30.8%	26.4%	25.7%	25.3%	29.8%
20 to 34 years	22.7%	21.1%	23.1%	24.0%	19.8%
35 to 54 years	26.4%	28.6%	27.6%	28.2%	29.4%
55 to 64 years	11.0%	12.0%	11.7%	11.2%	11.4%
65 to 84 years	8.4%	10.7%	10.6%	10.2%	8.9%
85 years and over	0.7%	1.1%	1.3%	1.2%	0.8%
Median age (years)	32.5	36.7	35.8	35.5	35.3
Income (All Households)	94,279	280,374	282,436	410,576	293,330
Less than $10,000	6.9%	4.0%	5.9%	6.7%	4.2%
$10,000-$24,999	16.7%	8.0%	12.1%	12.0%	8.8%
$25,000-$34,999	12.0%	7.6%	9.5%	7.6%	8.3%
$35,000-$49,999	16.8%	11.2%	12.9%	11.2%	12.3%
$50,000-$74,999	21.4%	17.3%	17.5%	15.7%	19.0%
$75,000-$99,999	12.3%	13.8%	12.3%	11.2%	15.0%
$100,000-$149,999	10.2%	17.7%	14.1%	14.3%	17.6%
$150,000-199,999	2.4%	9.7%	6.4%	7.3%	7.7%
$200,000 or more	1.4%	10.7%	9.1%	14.1%	7.2%
Median household income	47,864	77,932	62,399	69,673	71,026
Household income with Social Security income	23.0%	22.5%	23.5%	21.6%	20.7%
Household income with retirement income	16.7%	16.0%	16.5%	14.0%	13.7%
Household income with Supplemental Security income	7.2%	2.8%	4.2%	4.4%	3.1%
Household income with Food Stamp/SNAP benefits in the past 12 months	21.7%	6.8%	13.0%	11.4%	7.4%
People Below Poverty Level					
All People	18.6%	9.1%	15.1%	14.4%	10.7%
Under 18 years	27.9%	12.5%	23.5%	21.5%	15.1%
18 to 64 years	15.4%	8.4%	13.0%	12.5%	9.2%
65 years and over	11.3%	6.0%	9.9%	11.0%	7.7%

[3] Data compiled from Neighborhood Nexus, 2019.

Table 2c: County Health Insurance Coverage from 2015-2019.[4]

County Health Insurance Coverage (2015-2019)					
	CLAYTON	**COBB**	**DEKALB**	**FULTON**	**GWINNETT**
Civilian Noninstitutionalized Population	279,870	746,238	743,368	1,026,404	910,143
With Health Insurance Coverage	81.6%	87.7%	86.0%	89.7%	83.5%
With Private Health Insurance Coverage	53.5%	74.4%	65.3%	72.3%	66.3%
With Public Health Insurance Coverage	35.4%	22.2%	29.0%	25.5%	24.1%
No Health Insurance Coverage	18.4%	12.3%	14.0%	10.3%	16.5%
Civilian Noninstitutionalized Population Under 19 years	83,816	190,008	183,015	245,356	260,817
No Health Insurance Coverage for Population under 19 years	10.0%	8.2%	7.7%	5.4%	9.8%
Civilian Noninstitutionalized Population 19 to 64 years	170,884	468,587	472,639	665,394	562,270
No Health Insurance Coverage for Population 19 to 64 years	29.7%	20.2%	22.5%	17.0%	29.9%

[4] Data compiled from Neighborhood Nexus, 2019.

HEALING COMMUNITY CENTER TAX INFORMATION[5]

Table 3a: Healing Community Center Tax Form 990, Summary. Note: The pink color indicates an increase and the blue color indicates a decrease. The analysis will alter depending on whether expenses or assets are being analyzed.

Healing Community Center FQHC Summary					
Activities & Governance	**2016**	**2017**	**% Change from 2016 to 2017**	**2018**	**% Change from 2017 to 2018**
Number of Voting members	-	13	-	13	0
Number of Independent members	-	13	-	13	0
Number of Employees	-	68	-	59	9
Number of Volunteers	-	0	-	0	0
Total Unrelated Business Revenue	-	0	-	0	0
Net Unrelated Business Taxable Income	-	0	-	0	0
Revenue					
Contributions & Grants	2,367,054	2,725,636	15.15	2,624,896	3.84
Program Service Revenue	1,397,898	1,430,419	2.33	1,107,183	29.19
Investment Income	0	0	0	208	
Other Revenue	0	0	0	0	0
Total Revenue	3,764,952	4,156,055	10.39	3,732,287	11.35
Expenses					
Grants & Similar Amounts Paid	0	0	0	0	0
Benefits Paid to/for Members	0	0	0	0	0
Salaries/Employee Benefits	2,613,026	3,301,651	26.35	2,522,490	30.89
Professional Fundraising Fees	0	0	0	0	0
Other Expenses	1,212,566	1,255,720	3.56	962,102	30.52
Total Expenses	3,825,592	4,557,371	19.13	3,484,592	30.79
Revenue Less Expenses	-60,640	-401,316	84.89	247,695	
Net Assets of Fund Balances					
Total Assets	1,023,230	719,707	42.17	819,837	13.91
Total Liabilities	325,649	423,442	30.03	275,876	53.49
Net Assets of Fund Balances	697,581	296,265	135.46	543,961	83.61

[5] Tax form data available from Guidestar by Candid (2020).

Table 3b: Healing Community Center Tax Form 990, Statement of Functional Expenses. Note: The pink color indicates an increase in expenses and the green color indicates a decrease in expenses.

Healing Community Center Statement of Functional Expenses									
	Total Expenses			Program Service Expenses			Management & General Expenses		
	2017	2018	% Change	2017	2018	% Change	2017	2018	% Change
Compensation of Current Key Employees	198,732	304,331	53.14	0	0	0	198,732	304,331	53.14
Compensation to Disqualified Persons	0	0	0	0	0	0	0	0	0
Other Salaries & Wages	2,781,618	1,949,711	42.67	1,858,942	1,370,985	35.59	922,676	578,726	59.43
Pension Plan Accruals/Contributions	0	0	0	0	0	0	0	0	0
Other Employee Benefits	99,163	101,292	2.15	0	557		99,163	100,735	1.59
Payroll Taxes	222,138	167,156	32.89	200,405	167,156	19.89	21,733	0	
Fees for Services (Non-employees)									
Management	0	0	0	0	0	0	0	0	0
Legal	0	3,246		0	0	0	0	3,246	
Accounting	28,419	0		0	0	0	28,419	0	
Lobbying	0	0	0	0	0	0	0	0	0
Professional Fundraising Services	0	0	0	0	0	0	0	0	0
Investment Management Fees	0	0	0	0	0	0	0	0	0
Other	0	451,770		0	197,298		0	254,472	
Advertising & Promotion	731	3,532	383.17	617	532	15.98	114	3,000	2531.58
Office Expenses	395,036	328,037	20.42	160,487	107,981	48.63	234,549	219,117	7.04
Information techology	0	0	0	0	0	0	0	0	0
Royalties	0	0	0	0	0	0	0	0	0
Occupancy	619,941	52,624	1,078.06	255,933	5,173	48,474.77	364,008	47,451	667.12
Travel	25,249	24,660	2.39	5,715	3,879	473.32	19,534	20,781	6.38
Conferences/Meetings	5,945	0		2,938	0		3,007	0	
Interest	9,625	11,538	19.88	0	0	0	9,625	11,538	19.88
Payments to Affiliates	0	0	0	0	0	0	0	0	0
Depreciation/Depletion/Amortization	74,461	72,407	2.84	42,296	37,613	12.45	32,165	34,794	8.17
Insurance	43,414	1,958	2,117.26	7,775	1,958	297.09	35,639	0	
Other Itemized Expenses	52,899	12,330	329.03	10,340	12,330	19.25	42,559	0	
Medical Supplies & Drugs	-	-	-	-	-	-	-	-	-
Licenses/Dues/Subscriptions	-	-	-	-	-	-	-	-	-
Bad Debt	-	-	-	-	-	-	-	-	-
Repairs & Maintenance	-	-	-	-	-	-	-	-	-
All other expenses	-	-	-	-	-	-	-	-	-
Total Functional Expenses	4,557,371	3,484,592	30.79	2,545,448	1,905,462	33.59	2,011,923	1,578,191	27.48

Table 3c: Healing Community Center Tax Form 990, Balance Sheet. Note: In the assets section, the pink color indicates a decrease. In liabilities, the pink color indicates an increase in expenses and the blue color indicates an increase in expenses.

Healing Community Center Balance Sheet						
	2017			2018		
ASSETS	**Beginning of Year**	**End of Year**	**% Change**	**Beginning of Year**	**End of Year**	**% Change**
Cash non interest bearing	138,318	40,962	237.67	40,962	228,651	458.20
Savings/Temporary Cash Investments	0	0	0	0	0	0
Pledges & Grants Receivable	161,148	9,308	1,631.28	9,308	3,700	151.57
Accounts Receivable	367,211	352,428	4.19	352,428	342,090	3.02
Notes & Loans Receivables	0	0	0	0	0	0
Inventories for Sale/Use	0	0	0	0	0	0
Prepaid Expense & Deferred Charges	17,108	9,908	72.67	9,908	10,702	8.01
Land/Building/Equipment Cost	339,445	307,101	10.53	307,101	234,694	30.85
Investments-publicly traded securities	0	0	0	0	0	0
Investments-other securities	0	0	0	0	0	0
Investments-program related	0	0	0	0	0	0
Intangible Assets	0	0	0	0	0	0
Other Assets	0	0	0	0	0	0
Total Assets	1,023,230	719,707	42.17	719,707	819,837	13.91
LIABILITIES						
Accounts Payable & Accrued Expenses	249,652	342,995	37.39	342,995	195,950	75.04
Grants Payable	0	0	0	0	0	0
Deferred Revenue	21,932	0		0	0	0
Tax-exempt bond liabilities	0	0	0	0	0	0
Escrow/Custodial Account Liability	0	0	0	0	0	0
Loans & Other payables to key staff/ disqualified person	0	0	0	0	0	0
Secured Mortgages & Notes Payable	40,000	74,391	85.98	74,391	74,000	0.53
Unsecured Notes & Loans	0	0	0	0	0	0
Other Liabilities	14,065	6,056	132.25	6,056	5,926	2.19
Total Liabilities	325,649	423,442	30.03	423,442	275,876	53.49
NET ASSETS OF FUND BALANCES						
Unrestricted Net Assets	364,623	-10,835		-10,835	9,267	
Temporarily Restricted Net Assets	332,958	307,100	8.42	307,100	234,694	30.85
Permanently Restricted Net Assets	0	0	0	0	300,000	
Capital Stock/Trust Principle/Current Funds	0	0	0	0	0	0
Paid-In/Capital Surplus	0	0	0	0	0	0
Retained Earnings	0	0	0	0	0	0
Total Net Assets/Fund Balances	697,581	296,265	135.46	296,265	543,961	83.61
Total Liabilities & Net Assets/Fund Balances	1,023,230	719,707	42.17	719,707	819,837	13.91

Table 3d: Healing Community Center Tax Form 990, Reconciliation of Net Assets.

Healing Community Center Reconcilliation of Net Assets			
	2017	2018	% Change
Total Revenue	4,156,055	3,732,287	11.35
Total Expenses	4,557,371	3,484,592	30.79
Revenue less expenses	-401,316	247,695	-161.72
Net Assets @ Beginning of Year	697,581	296,265	135.46
Net unrealized gains on investments	0	0	0
Donated Services/Facility Use	0	0	0
Investment Expenses	0	0	0
Prior Period Adjustments	0	0	0
Other Changes in Net Assets	0	1	
Net Assets @ End of Year	296,265	543,961	83.61

Table 3e: Healing Community Center Tax Form 990, Land, Buildings, and Equipment. Note: The red color indicates a decrease in value and the blue color indicates an increase in value.

Healing Community Center Land, Buildings, and Equipment											
	Cost/Investment		Cost/Other			Accumulated Depreciation			Book Value		
Property Description	2017	2018	2017	2018	% Change	2017	2018	% Change	2017	2018	% Change
Land	-	-	0	0	0	0	0	0	0	0	0
Buildings	-	-	0	0	0	0	0	0	0	0	0
Leasehold Improvements	-	-	340,000	340,000	0	200,416	215,000	7.28	139,584	125,000	11.67
Equipment	-	-	406,477	406,477	0	243,670	300,567	23.35	162,807	105,910	53.72
Other	-	-	231,486	231,486	0	226,776	227,702	0.41	4,710	3,784	24.47
Total									307,101	234,694	30.85

Table 3f: Healing Community Center Tax Form 990, Independent Contractors.

Healing Community Center Independent Contractors		
	Compensation	
Description of Services	2017 Year	2018 Year
Billing Services	NONE	NONE
Pharmacy Services		
Patient Appt Services		
Billing Services		
Professional Services		

OAKHURST MEDICAL CENTER TAX INFORMATION [6]

Table 4a: Oakhurst Medical Center Tax Form 990, Summary. Note: The pink color indicates an increase and the blue color indicates a decrease. The analysis will alter depending on whether expenses or assets are being analyzed.

Oakhurst Medical Center FQHC Summary					
Activities & Governance	**2016**	**2017**	**% Change from 2016 to 2017**	**2018**	**% Change from 2017 to 2018**
Number of Voting members	-	11	-	10	-1
Number of Independent members	-	11	-	10	-1
Number of Employees	-	125	-	133	8
Number of Volunteers	-	10	-	16	6
Total Unrelated Business Revenue	-	0	-	0	0
Net Unrelated Business Taxable Income	-	0	-	0	0
Revenue					
Contributions & Grants	5,362,092	5,296,237	1.24	5,741,881	8.41
Program Service Revenue	24,252,949	30,135,970	24.26	34,669,456	15.04
Investment Income	10,457	24,954	138.63	26,001	4.20
Other Revenue	90,726	456,440	403.10	326,118	39.96
Total Revenue	29,716,224	35,913,601	20.86	40,793,456	13.59
Expenses					
Grants & Similar Amounts Paid	0	0	0	0	0
Benefits Paid to/for Members	0	0	0	0	0
Salaries/Employee Benefits	6,388,211	6,863,925	7.45	7,217,248	5.15
Professional Fundraising Fees	0	0	0	0	0
Other Expenses	21,184,596	26,317,671	24.23	33,286,363	26.48
Total Expenses	27,572,807	33,181,596	20.34	40,503,611	22.07
Revenue Less Expenses	2,143,417	2,732,005	27.46	289,845	842.57
Net Assets of Fund Balances					
Total Assets	15,678,093	20,413,313	30.20	20,357,312	0.28
Total Liabilities	3,081,769	5,068,293	64.46	4,785,086	5.92
Net Assets of Fund Balances	12,596,324	15,345,020	21.82	15,572,226	1.48

[6] Tax form data available from Guidestar by Candid (2020).

Table 4b: Oakhurst Medical Center Tax Form 990, Statement of Functional Expenses. Note: The pink color indicates an increase in expenses and the green color indicates a decrease in expenses.

Oakhurst Medical Center Statement of Functional Expenses									
	Total Expenses			Program Service Expenses			Management & General Expenses		
	2017	2018	% Change	2017	2018	% Change	2017	2018	% Change
Compensation of Current Key Employees	731,278	782,535	7.01	584,202	625,150	7.01	147,076	157,385	7.01
Compensation to Disqualified Persons	0	0	0	0	0	0	0	0	0
Other Salaries & Wages	5,314,355	5,490,437	3.31	4,245,522	4,223,156	0.53	1,068,833	1,267,281	18.57
Pension Plan Accruals/Contributions	42,997	101,735	136.61	34,349	78,630	128.91	8,648	23,105	167.17
Other Employee Benefits	363,840	401,118	10.25	290,664	310,019	6.66	73,176	91,099	24.49
Payroll Taxes	411,455	441,423	7.28	328,702	341,171	3.79	82,753	100,252	21.15
Fees for Services (Non-employees)									
Management	0	0	0	0	0	0	0	0	0
Legal	26,263	34,772	32.40	0	0	0	26,263	34,772	32.40
Accounting	57,557	59,718	3.75	0	0	0	57,557	59,718	3.75
Lobbying	0	0	0	0	0	0	0	0	0
Professional Fundraising Services	0	0	0	0	0	0	0	0	0
Investment Management Fees	0	0	0	0	0	0	0	0	0
Other	9,597,876	13,955,848	45.41	6,778,324	11,792,566	73.97	2,819,552	2,163,282	30.34
Advertising & Promotion	7,897	42,772	441.62	7,107	38,495	441.65	790	4,277	441.39
Office Expenses	172,870	221,794	28.30	163,527	211,572	29.38	9,343	10,222	9.41
Information techology	0	0	0	0	0	0	0	0	0
Royalties	0	0	0	0	0	0	0	0	0
Occupancy	172,436	449,565	160.71	155,192	404,608	160.71	17,244	44,957	160.71
Travel	24,630	21,381	15.20	12,506	9,732	28.50	12,124	11,649	4.08
Conferences/Meetings	102,911	100,690	2.21	52,256	45,830	14.02	50,655	54,860	8.30
Interest	34,186	34,216	0.09	30,767	30,794	0.09	3,419	3,422	0.09
Payments to Affiliates	0	0	0	0	0	0	0	0	0
Depreciation/Depletion/Amortization	362,580	432,817	19.37	326,322	389,535	19.37	36,258	43,282	19.37
Insurance	84,731	84,387	0.41	58,408	64,052	9.66	26,323	20,335	29.45
Other Itemized Expenses									
Consumable Medical Supplies & Drugs	13,211,974	15,037,113	13.81	13,123,530	14,938,246	13.83	0	98,867	
Other Expenses	0	1,189,003		0	998,238		0	190,765	
Bad Debt	897,674	0		897,674	0		0	0	0
Donated Vaccines	687,548	885,145	28.74	687,584	885,145	28.73	0	0	0
Repairs & Maintenance	0	0	0	0	0	0	0	0	0
All other expenses	876,538	737,142	18.91	737,142	737,142	0	139,988	0	
Total Functional Expenses	33,181,596	40,503,611	22.07	28,513,150	36,124,081	26.69	4,668,446	4,379,530	6.60

Table 4c: Oakhurst Medical Center Tax Form 990, Balance Sheet. Note: In the assets section, the pink color indicates a decrease. In liabilities, the pink color indicates an increase in expenses and the blue color indicates an increase in expenses.

Oakhurst Medical Center Balance Sheet						
	2017			2018		
ASSETS	**Beginning of Year**	**End of Year**	**% Change**	**Beginning of Year**	**End of Year**	**% Change**
Cash non interest bearing	2,137,360	3,569,861	67.02	3,569,861	3,405,088	4.84
Savings/Temporary Cash Investments	2,501,713	4,008,868	60.24	4,008,868	1,535,812	161.03
Pledges & Grants Receivable	51,311	176,687	244.35	176,687	289,776	64.01
Accounts Receivable	2,738,932	4,324,485	57.89	4,324,485	6,300,915	45.70
Notes & Loans Receivables	0	0	0	0	0	0
Inventories for Sale/Use	0	0	0	0	0	0
Prepaid Expense & Deferred Charges	86,753	101,013	16.44	101,013	120,470	19.26
Land/Building/Equipment Cost	6,528,446	7,306,225	11.91	7,306,225	7,162,016	2.01
Investments-publicly traded securities	537,165	576,575	7.34	576,575	1,024,811	77.74
Investments-other securities	0	0	0	0	0	0
Investments-program related	0	0	0	0	0	0
Intangible Assets	0	0	0	0	0	0
Other Assets	1,096,413	349,599	213.62	349,599	518,424	48.29
Total Assets	15,678,093	20,413,313	30.20	20,413,313	20,357,312	0.28
LIABILITIES						
Accounts Payable & Accrued Expenses	1,764,715	3,750,161	112.51	3,750,161	3,519,466	6.55
Grants Payable	0	0	0	0	0	0
Deferred Revenue	99,570	96,612	3.06	96,612	64,722	49.27
Tax-exempt bond liabilities	678,182	538,140	26.02	0	0	0
Escrow/Custodial Account Liability	0	0	0	0	0	0
Loans & Other payables to key staff/ disqualified person	0	0	0	0	0	0
Secured Mortgages & Notes Payable	953,340	902,238	5.66	902,238	844,739	6.81
Unsecured Notes & Loans	0	0	0	0	0	0
Other Liabilities	0	0	0	0	0	0
Total Liabilities	3,081,769	5,068,293	64.46	5,068,293	4,785,086	5.92
NET ASSETS OF FUND BALANCES						
Unrestricted Net Assets	12,596,324	15,345,020	21.82	15,345,020	15,572,226	1.48
Temporarily Restricted Net Assets	0	0	0	0	0	0
Permanently Restricted Net Assets	0	0	0	0	0	0
Capital Stock/Trust Principle/Current Funds	0	0	0	0	0	0
Paid-In/Capital Surplus	0	0	0	0	0	0
Retained Earnings	0	0	0	0	0	0
Total Net Assets/Fund Balances	12,596,324	15,345,020	21.82	15,345,020	15,572,226	1.48
Total Liabilities & Net Assets/Fund Balances	15,678,093	20,413,313	30.20	20,413,313	20,357,312	0.28

Table 4d: Oakhurst Medical Center Tax Form 990, Reconciliation of Net Assets.

Oakhurst Medical Center Reconcilliation of Net Assets			
	2017	2018	% Change
Total Revenue	35,913,601	40,793,456	13.59
Total Expenses	33,181,596	40,503,611	22.07
Revenue less expenses	2,732,005	289,845	842.57
Net Assets @ Beginning of Year	12,596,324	15,345,020	21.82
Net unrealized gains on investments	16,691	-62,639	-475.29
Donated Services/Facility Use	0	0	0
Investment Expenses	0	0	0
Prior Period Adjustments	0	0	0
Other Changes in Net Assets	0	0	0
Net Assets @ End of Year	15,345,020	15,572,226	1.48

Table 4e: Oakhurst Medical Center Tax Form 990, Land, Buildings, and Equipment. Note: The red color indicates a decrease in value and the blue color indicates an increase in value.

Oakhurst Medical Center Land, Buildings, and Equipment											
	Cost/Investment		Cost/Other			Accumulated Depreciation			Book Value		
Property Description	2017	2018	2017	2018	% Change	2017	2018	% Change	2017	2018	% Change
Land	-	-	947,275	948,175	0	0	0	0	947,275	948,175	0.10
Buildings	-	-	6,576,729	6,575,829	0	1,026,149	1,285,610	25	5,550,580	5,290,219	4.92
Leasehold Improvements	-	-	178,267	185,426	4	26,291	36,904	40	151,976	148,522	2.33
Equipment	-	-	1,915,388	2,247,057	17	1,345,015	1,507,757	12	570,373	739,300	29.62
Other	-	-	86,021	35,800	140	0	0	0	86,021	35,800	140.28
Total									7,306,225	7,162,016	2.01

Table 4f: Oakhurst Medical Center Tax Form 990, Independent Contractors.

Oakhurst Medical Center Independent Contractors		
	Compensation	
Description of Services	2017 Year	2018 Year
Billing Services	NONE	NONE
Pharmacy Services		
Patient Appt Services		
Billing Services		
Professional Services		

SOUTHSIDE MEDICAL CENTER TAX INFORMATION [7]

Table 5a: Southside Medical Center Tax Form 990, Summary. Note: The pink color indicates an increase and the blue color indicates a decrease. The analysis will alter depending on whether expenses or assets are being analyzed.

Southside Medical Center FQHC Summary					
Activities & Governance	**2016**	**2017**	**% Change from 2016 to 2017**	**2018**	**% Change from 2017 to 2018**
Number of Voting members	-	10	-	11	1
Number of Independent members	-	10	-	11	1
Number of Employees	-	301	-	324	23
Number of Volunteers	-	12	-	11	-1
Total Unrelated Business Revenue	-	-216,041	-	-109,027	
Net Unrelated Business Taxable Income	-	-215,573	-	-109,027	
Revenue					
Contributions & Grants	10,320,283	10,864,532	5.27	11,718,182	7.86
Program Service Revenue	13,297,031	14,946,178	12.40	16,406,189	9.77
Investment Income	71,522	103,242	44.35	98,882	4.41
Other Revenue	-61,863	-57,284	7.40	-500,699	88.56
Total Revenue	23,626,973	25,856,668	9.44	27,722,554	7.22
Expenses					
Grants & Similar Amounts Paid	0	0	0	0	0
Benefits Paid to/for Members	0	0	0	0	0
Salaries/Employee Benefits	12,784,550	13,548,973	5.98	14,391,536	6.22
Professional Fundraising Fees	0	0	0	0	0
Other Expenses	10,320,200	11,111,349	7.67	11,893,512	7.04
Total Expenses	23,104,750	24,660,322	6.73	26,285,048	6.59
Revenue Less Expenses	522,223	1,196,346	129.09	1,437,506	20.16
Net Assets of Fund Balances					
Total Assets	17,149,713	18,210,976	6.19	20,172,029	10.77
Total Liabilities	4,764,871	4,671,636	2.00	5,195,183	11.21
Net Assets of Fund Balances	12,384,842	13,539,340	9.32	14,976,846	10.62

[7] Tax form data available from Guidestar by Candid (2020).

Table 5b: Southside Medical Center Tax Form 990, Statement of Functional Expenses. Note: The pink color indicates an increase in expenses and the green color indicates a decrease in expenses.

Southside Medical Center Statement of Functional Expenses									
	Total Expenses			Program Service Expenses			Management & General Expenses		
	2017	2018	% Change	2017	2018	% Change	2017	2018	% Change
Compensation of Current Key Employees	718,189	809,532	12.72	277,317	331,951	19.70	440,872	477,581	8.33
Compensation to Disqualified Persons	101,447	95,584	6.13	101,447	95,584	6.13	0	0	0
Other Salaries & Wages	10,803,346	11,281,033	4.42	8,825,369	9,175,685	3.97	1,977,977	2,105,348	6.44
Pension Plan Accruals/Contributions	69,510	54,339	27.92	48,159	43,737	10.11	21,351	10,602	101.39
Other Employee Benefits	1,002,600	1,255,962	25.27	700,208	938,168	33.98	302,392	317,794	5.09
Payroll Taxes	853,881	895,086	4.83	679,910	719,844	5.87	173,971	175,242	0.73
Fees for Services (Non-employees)									
Management	0	56,947	+	0	0	0	0	56,947	+
Legal	47,166	99,700	111.38	0	0	0	47,166	99,700	111.38
Accounting	95,935	0	-	0	0	0	95,935	0	-
Lobbying	0	0	0	0	0	0	0	0	0
Professional Fundraising Services	0	0	0	0	0	0	0	0	0
Investment Management Fees	0	0	0	0	0	0	0	0	0
Other	3,833,471	4,044,939	5.52	3,292,233	3,394,874	3.12	541,238	650,065	20.11
Advertising & Promotion	25,281	57,765	128.49	10,768	19,563	81.68	14,513	38,202	163.23
Office Expenses	593,086	593,404	0.05	399,879	374,933	6.65	193,207	218,471	13.08
Information techology	0	0	0	0	0	0	0	0	0
Royalties	0	0	0	0	0	0	0	0	0
Occupancy	751,962	722,195	4.12	710,329	656,526	8.20	41,633	65,669	57.73
Travel	188,886	165,331	14.25	81,604	61,249	33.23	107,282	104,082	3.07
Conferences/Meetings	91,362	110,634	21.09	48,349	61,203	26.59	42,013	49,431	17.66
Interest	60,024	82,150	36.86	48,011	71,204	48.31	12,013	10,946	9.75
Payments to Affiliates	0	0	0	0	0	0	0	0	0
Depreciation/Depletion/Amortization	521,090	559,432	7.36	419,353	445,270	6.18	101,737	114,162	12.21
Insurance	206,811	185,846	11.28	156,830	133,214	17.73	49,981	52,632	5.30
Other Itemized Expenses									
Medical Supplies & Drugs	2,650,447	3,030,367	14.33	2,650,447	3,030,367	14.33	0	0	0
Licenses/Dues/Subscriptions	1,121,241	1,301,382	16.07	988,238	1,049,885	6.24	133,003	251,497	89.09
Bad Debt	578,830	578,829	0.00	578,830	578,829	0.00	0	0	0
Repairs & Maintenance	334,286	286,300	16.76	219,252	247,635	12.95	115,034	28,665	301.30
All other expenses	11,471	18,291	59.45	7,162	4,449	60.98	4,309	13,842	221.23
Total Functional Expenses	24,660,322	26,285,048	6.59	20,243,695	21,434,170	5.88	4,416,627	4,850,878	9.83

Table 5c: Southside Medical Center Tax Form 990, Balance Sheet. Note: In the assets section, the pink color indicates a decrease. In liabilities, the pink color indicates an increase in expenses and the blue color indicates an increase in expenses.

Southside Medical Center Balance Sheet						
	2017			2018		
ASSETS	**Beginning of Year**	**End of Year**	**% Change**	**Beginning of Year**	**End of Year**	**% Change**
Cash non interest bearing	907,826	1,702,605	87.55	1,702,605	1,792,363	5.27
Savings/Temporary Cash Investments	552,057	1,029,146	86.42	1,029,146	1,646,222	59.96
Pledges & Grants Receivable	672,966	838,032	24.53	838,032	775,966	8.00
Accounts Receivable	1,476,300	1,206,643	22.35	1,206,643	1,115,538	8.17
Notes & Loans Receivables	6,999,000	6,999,000	0	6,999,000	6,999,000	0
Inventories for Sale/Use	176,390	116,716	51.13	116,716	191,358	63.95
Prepaid Expense & Deferred Charges	101,208	139,446	37.78	139,446	231,953	66.34
Land/Building/Equipment Cost	4,531,283	4,641,472	2.43	4,641,472	6,347,211	36.75
Investments-publicly traded securities	338,311	366,206	8.25	366,206	396,697	8.33
Investments-other securities	950,198	860,432	10.43	860,432	352,670	143.98
Investments-program related	0	0	0	0	0	0
Intangible Assets	0	0	0	0	0	0
Other Assets	444,174	311,278	42.69	311,278	323,051	3.78
Total Assets	17,149,713	18,210,976	6.19	18,210,976	20,172,029	10.77
LIABILITIES						
Accounts Payable & Accrued Expenses	2,966,201	3,065,069	3.33	3,065,069	2,934,189	4.46
Grants Payable	0	0	0	0	0	0
Deferred Revenue	0	0	0	0	0	0
Tax-exempt bond liabilities	678,182	538,140	26.02	538,140	394,189	36.52
Escrow/Custodial Account Liability	0	0	0	0	0	0
Loans & Other payables to key staff/ disqualified person	0	0	0	0	0	0
Secured Mortgages & Notes Payable	760,502	701,242	8.45	701,242	1,492,449	112.83
Unsecured Notes & Loans	359,986	367,185	2.00	367,185	374,529	2.00
Other Liabilities	0	0	0	0	0	0
Total Liabilities	4,764,871	4,671,636	2.00	4,671,636	5,195,183	11.21
NET ASSETS OF FUND BALANCES						
Unrestricted Net Assets	11,624,016	13,111,493	12.80	13,111,493	14,627,737	11.56
Temporarily Restricted Net Assets	760,826	427,847	77.83	427,847	349,109	22.55
Permanently Restricted Net Assets	0	0	0	0	0	0
Capital Stock/Trust Principle/Current Funds	0	0	0	0	0	0
Paid-In/Capital Surplus	0	0	0	0	0	0
Retained Earnings	0	0	0	0	0	0
Total Net Assets/Fund Balances	12,384,841	13,539,340	9.32	13,539,340	14,976,846	10.62
Total Liabilities & Net Assets/Fund Balances	17,149,713	18,210,976	6.19	18,210,976	20,172,029	10.77

Table 5d: Southside Medical Center Tax Form 990, Reconciliation of Net Assets.

Southside Medical Center Reconcilliation of Net Assets			
	2017	2018	% Change
Total Revenue	25,856,668	27,722,554	7.22
Total Expenses	24,660,322	26,285,048	6.59
Revenue less expenses	1,196,346	1,437,506	20.16
Net Assets @ Beginning of Year	12,384,842	13,539,340	9.32
Net unrealized gains on investments	0	0	0
Donated Services/Facility Use	-41,848	0	0
Investment Expenses	0	0	0
Prior Period Adjustments	0	0	0
Other Changes in Net Assets	0	0	0
Net Assets @ End of Year	13,539,340	14,976,846	10.62

Table 5e: Southside Medical Center Tax Form 990, Land, Buildings, and Equipment. Note: The red color indicates a decrease in value and the blue color indicates an increase in value.

Southside Medical Center Land, Buildings, and Equipment											
	Cost/Investment		Cost/Other			Accumulated Depreciation			Book Value		
Property Description	2017	2018	2017	2018	% Change	2017	2018	% Change	2017	2018	% Change
Land	-	-	1,333,128	1,486,358	11.49	-	-	0.00	1,333,128	1,486,358	11.49
Buildings	-	-	2,900,132	4,016,350	38.49	1,322,824	1,455,494	10.03	1,577,308	2,560,856	62.36
Leasehold Improvements	-	-	339,977	388,467	14.26	90,889	118,374	30.24	249,088	270,093	8.43
Equipment	-	-	6,102,154	6,532,370	7.05	5,049,751	5,377,231	6.49	1,052,403	1,155,139	9.76
Other	-	-	429,545	874,765	103.65	-	-	0.00	429,545	874,765	103.65
Total									4,641,472	6,347,211	36.75

Table 5f: Southside Medical Center Tax Form 990, Independent Contractors.

Southside Medical Center Independent Contractors			
	Compensation		
Description of Services	2017 Year	2018 Year	% Change
First Billing Services	687,264	865,350	25.91
Pharmacy Services	452,939	680,315	50.20
Patient Appt Services	308,374	240,943	27.99
Second Billing Services	185,347	245,096	32.24
Professional Services	139,539	113,908	22.50
Total	1,773,463	$2,145,612	20.98

Table 6: Preliminary Cost Assessment to add an Obstetrics Department.

Preliminary Cost Assessment	
Cost Category	**Annual Cost**
Staff Personnel: -OB Physician -OB Nurse	$250,000
Imaging/Ultrasound -Includes maintenance costs	$200,000
Supplies	$50,000
Additional Malpractice Insurance	$100,000
Contingency	$50,000