SAN JOAQUIN GENERAL HOSPITAL San Joaquin County Clinics	Department of AMBULATORY CARE SERVICES	Page 1 of 10
	Effective Date September 25, 2018	Date Replaces NEW
Title of Policy/Procedure **QUALITY IMPROVEMENT / QUALITY ASSURANCE PLAN**		

PURPOSE:

The purpose of the Quality Improvement Plan is to provide a planned, systematic, organization-wide approach to designing, measuring, assessing, and improving organizational performance at San Joaquin County Clinics (SJCC). Quality is defined as doing the right things to meet or exceed customer expectations and is also defined by the ability of the organization to deliver sound clinical care. The Quality Improvement Plan is operationalized through performance improvement activities which are defined as ongoing process improvement. The performance improvement activities shall be a coordinated, comprehensive, and ongoing effort to assess the effectiveness of the care, treatment, and services provided. The goals and objectives shall be to strive, within all available resources, for optimal outcomes with continuous, incremental improvements which are consistently representative of a high standard of cost-effective practice in the community, minimizing risk to both the patient and the facility.

POLICY:

I. SCOPE: The Quality Improvement Plan applies to all SJCC sites, employees, contracted employees and volunteers. The intent of the plan is extended to providers of contracted services, and those organizations/individuals may be included in the SJCC performance improvement initiatives as applicable.

II. FUNDAMENTALS:

1. Facilitate institution-wide performance improvement activities.
2. A Quality Improvement Committee (QIC) that meets monthly.
3. Indicator development, implementation, and measurement.
4. Setting and re-setting of performance improvement activities.
5. Identification of high volume, high risk, problem-prone, and high cost issues.
6. Collection of data, use of analysis to transform the data into information for the use of improvement activities and reducing risk.
7. Promoting a data driven process to be used in decision making.
8. Identification of the need for and provision of education related to quality and performance improvement.
9. Assisting the organization in providing evidence of compliance with quality and safety rules, regulations, and standards. Note that much of the compliance reporting burden is shared with and deferred to the Office of Standards and Compliance at San Joaquin General Hospital by means of the co-applicant agreement.

III. OBJECTIVES: The primary goal of the SJCC Quality Improvement Plan is, through performance improvement activities, to implement the ongoing monitoring and assessing of approved improvements of key functions and processes relative to patient care, treatment, and services. The objectives for meeting this goal are:

1. Evaluate existing communication channels to stay abreast of current and proposed rules, regulations, and standards related to accreditation, national, and state quality initiatives.
2. Effectively communicate accreditation, national, and state quality rules, regulations and standards updates to providers and staff.
3. Whenever feasible, implement and maintain comprehensive and electronic systems to concurrently and retrospectively abstract the data reporting mandated by accreditation/national/state agencies, communicate to the organization analysis of said data, and upload data per established schedules to relevant authorities per the quality initiative participation guidelines.
4. In collaboration with identified leaders, create comprehensive reports for key institutional patient-related functions depicting the aggregate measurement, analysis, and improvements within that function.
5. In collaboration with identified leaders, create indicator improvement plans, audit tools, and aggregate reports on specific processes that focus on high risk, high volume, problem prone, and high cost patient issues.
6. Establish a process for effective communication of performance improvement reporting up and down the organization's hierarchy.
7. Provide comparative data, best practices, and community standards whenever feasible.
8. Create and maintain a retrievable documentation history of performance improvement activities designed to meet evidence of compliance requirements of accreditation/national/state agencies.
9. Annually, for the Board of Director's review, evaluate the previous 12 months of performance improvement activities and present an annual report to include quality priorities for the next year.

IV: ORGANIZATION AND RESPONSIBILITY: The responsibilities in relation to the Quality Program of the SJCC Board of Directors, executive administration, committees, providers, and staff are outlined as follows:

A. SJCC Board of Directors: The SJCC Board of Directors has, by means of the co-applicant agreement, shared accountability with the SJGH Medical Executive Committee (MEC) for ensuring that SJCC maintains an effective Quality Program. This includes annual approval of the Quality Improvement Plan and an annual evaluation of overall program effectiveness. Additionally, the SJCC Board of Directors reviews and provides feedback (through approval or recommendation) to the Quality Improvement Committee (QIC) on information regarding performance measurement, analysis and improvement. The SJCC Board of Directors authorizes the Quality Sub Committee to meet independently and delegates all decision making, motion and policy changes to this committee. The Quality Sub Committee will report periodically to the SJCC Board of Directors.

B. SJCC Executive Director/CEO: The Board of Directors delegate to the Executive Director/CEO the authority to oversee implementation of the Quality Program, including:

1. Accountability for the adequate resources to support an ongoing Quality Program.
2. Provides direction in setting quality priorities based upon SJCC mission, values, and philosophy.
3. Review and revision authority of all quality reports prior to submission for provider and organizational review and approval.
4. In collaboration with the Chief Medical Officer and the Chief Medical Information Officer, reprioritize performance improvement activities to adjust to changing needs of the organization in response to unusual/urgent events.
5. Establish, in collaboration with the QIC, an organizational culture which supports commitment to quality and performance improvement.
6. Review and approve annual quality priorities.

C. Chief Medical Officer (CMO): The CMO is responsible for working collaboratively with the Chief Medical Information Officer in the planning, assessing, implementation, evaluation, and education of SJCC providers and staff. The role of the CMO is integral as the Medical Staff liaison and an administrative peer in the provision of quality patient care, treatment, and services as well as implementation of evidence-based medicine. The CMO also co-chairs the QIC.

D. The Chief Medical Information Officer (CMIO): The Executive Director/CEO delegates the responsibility and accountability for the design, implementation, evaluation, and daily operations of the Quality Program to the CMIO who will provide leadership, coaching, and consultation to the organization with respect to the philosophy, principles, and techniques in relation to quality, with a special focus on the use of advanced applied information technologies to achieve quality objectives. The duties of the CMIO include but are not limited to:

1. Co-chair the QIC.
2. Evaluate the effectiveness of the Quality Program annually and make recommendations for annual quality goal(s) and objective(s).
3. Work collaboratively with the CMO to annually review and, as needed, modify for Board of Directors' approval, the Quality Improvement Plan.
4. Report on a quarterly basis to the Board of Directors any substantive findings related to identified organizational quality and patient safety of care activities and improvements.
5. Provide oversight, direction, and support to leaders of approved performance improvement teams, task forces and projects.
6. Per a quality reporting schedule, receive aggregate reports related to quality and collate reports into comprehensive, informative communication packets for stakeholder review and approval.

7. Determine budget implications of the organization's Quality Program and performance improvement activities and make recommendations to the Executive Director for allocation of resources to support approved activities. Maintain a knowledge of current and projected requirements and make recommendations to the Executive Director on future implications for resource allocations relative to the Quality Program.
8. Ensure that the important internal functions, processes, and activities related to safe quality patient care, treatment and services are continuously and systematically measured, assessed and improved within available resources.
9. Determine the educational and training needs of the organization related to quality and performance improvement and make recommendations to the Executive Director on activities to meet those needs.
10. Work cohesively with the remaining executive leadership and SJCC Providers to maintain a comprehensive Quality Program.

E. Providers: The Providers are responsible for the provision of safe, appropriate, high quality care through the sound execution of approved clinical processes and services, identification of important opportunities for performance improvement, and the ongoing provision of patient care, treatment, and services. The Providers (through representation on the QIC) further provide, through peer chart reviews, an effective mechanism to monitor the clinical performance of all individuals with delineated clinical privileges.

F. SJCC Clinic Managers: Managers are responsible for the practice of and the participation in ongoing performance improvement activities. They are further expected to provide leadership and accountability in the developing, measuring, analysis, and reporting of performance improvement functions and indicators respective to their areas of responsibility. These Leaders are responsible for ensuring that their staff has a working knowledge of the organization's Quality Improvement Plan and the performance improvement activities by which the program is operationalized.

G. SJCC Staff: Staff is expected to participate in performance improvement activities through the development of an understanding of key processes in their respective departments, make recommendations for the design and improvement of processes, assist with data collection as assigned, and serve as members of performance improvement teams at the direction of their Manager.

H. The Quality Improvement Committee (QIC): The QIC is a formal, multidisciplinary committee comprising SJCC executive leadership, providers, operational managers, and front-line staff. The QIC has the responsibility for operationalizing the Quality Program. The planning and decision-making activities of this committee will be based on organizational mission, philosophy and values. The QIC has general responsibility for organization-wide design and implementation of the Quality Improvement Plan. The QIC functions as a clearinghouse for all performance improvement activities and as a review and feedback body for all quality reporting. Additionally, the QIC makes recommendations on the

initiation, prioritization, progress, and/or closure of performance improvement activities. The functions of the QIC include:

1. Develop and update organizational-wide policies and procedures.
2. Establish the organizational Performance Improvement Model.
3. Determine and prioritize annual initiatives.
4. Review and prioritize recommendations for improvement.
5. Submit quarterly reports to the Board of Directors summarizing performance improvement activities/projects and findings.
6. Participate in development and review of the annual Quality Improvement Plan.
7. Monitor and evaluate clinical processes and patient outcomes.
8. Evaluate clinical indicators for monitoring and evaluation.
9. Assist with design of data collection and data analysis tools.
10. Review results of monitoring activities, develop action plans, report findings.
11. Refer identified provider performance issues to the Medical Director, as appropriate.
12. Make recommendations to Administration for the development and/or revision of policies and procedures.
13. Review of relevant data driven analysis of compliance with and progress on various quality initiatives including UDS, PRIME, NCQA HEDIS, NCQA PCMH, Meaningful Use, Joint Commission, and others as prescribed by the SJCC Board of Directors, the Quality Sub Committee and the SJCC executive team.

The QIC membership is comprised of the following key members:

- Co-Chairperson: SJCC Chief Medical Officer
- Co-Chairperson: SJCC Chief Medical Information Officer
- SJCC Associate Medical Directors or provider designees from each SJCC site
- SJCC Administrators, Clinic Managers, and Key Middle Management Staff
- SJGH Standards and Compliance representative
- Designated Front Line Staff (medical assistants, registration clerks)

The QIC will meet at least bi-monthly. Meeting minutes shall be recorded and maintained in a binder in the SJCC administrative office.

I. Professional Practice Sub-Committee (PPSC): The PPSC is a subcommittee of the QIC that is responsible for monitoring and evaluating the clinical practice of all Providers across all SJCC sites, to ensure it is consistent with the standards and guidelines of this organization, as well as all applicable laws, mandates, healthcare industry standards and professional practice guidelines. The PPSC assures the integration and coordination of all Provider performance improvement activities into the organization's overall Quality Program through the periodic random selection and review of provider chart documentation. Each Provider's chart reviews will be conducted by the PPSC on a quarterly basis.

The PPSC will conduct chart reviews on a monthly basis (see attachment). A rotating schedule will ensure that each SJCC provider's charts are audited for compliance with standards set by the QIC no less frequently than quarterly. The SJCC Associate Medical Directors will be responsible for sharing results of the specialty-specific (OB/GYN and pediatric) chart reviews with their respective SJCC provider staffs.

J. Performance Improvement Teams: The Quality Sub Committee or QIC will charter small teams dedicated to undertaking specific performance improvement projects in pursuit of processes or outcomes that have been identified as high priorities for improvement. These teams use the organizations' model for improvement to guide their activities. QIC chairs will assign a Performance Improvement Team when an investigation, analysis, and improvement is required as a result of an unusual event and/or a high priority process issue is identified. These teams document the teams' goal, objectives, and corrective actions on a designated template and submit them to the QIC for review.

V. PROCESSES OF THE PLAN: All performance improvement activities carried out within the organization are to be performed as described in this plan, and as appropriate, will be performed in an interdisciplinary approach utilizing the elements of design, measurement, assessment, and improvement as described below:

A. DESIGN: Whenever the organization is improving an existing process or developing a new process or system, the identification of such processes or systems will be based upon:

- The organization's mission, philosophy and values
- The organization's participation in various strategic projects or QI initiatives
- The needs and expectations of patients, staff, and other customers
- Up-to-date information about processes, including practice guidelines and practice parameters
- Analysis of data regarding the performance of processes and outcomes in the organization and available comparative data

B. MEASUREMENT: The organization has a systematic process in place to collect necessary data, enhanced where possible by the use of automated systems and information reporting tools such as electronic health records, enterprise practice management systems, etc.

1. Processes that are prioritized to be monitored on a continuing basis will include those that either affect a large percentage of patients (high volume) and/or those processes that have been or are likely to be problem prone.
2. In accordance with this QI plan, the organization will also monitor the performance of processes related to functions deemed to be key to overall delivery of patient care, treatment and services. These include but are not limited to:

- Provider Indicators (complications, performance)
- Provision of Care, Treatment and Services
- Department Specific Indicators

3. Data collection will be predicated upon a stated indicator and criteria that provides for timely, unbiased, accurate data of compliance or non-compliance with stated indicator. Frequency of collection, analysis responsibilities, reporting channels, denominators, numerators, targets, and reasonable thresholds will be established prior to data collection.
4. Such data will be used to identify and assess new processes, measure the level of quality and stability of important existing processes, and determine whether process changes made have actually improved performance and/or outcomes.

C. ASSESSMENT: The assessment and interpretation of the collected data is intended to provide the organization with information regarding performance along many dimensions and over time.

1. The assessment phase for any specific process may include any or all of the following elements:

- Statistical techniques
- Review of internal data related to SJCC's process and outcome metrics over time
- The use of information from resources about the design and performance of processes
- The use of practical guidelines and practice parameters
- The use of performance and outcome indicators from other organizations including the use of comparative reference databases when available or applicable
- Peer Review

2. Intensive assessment will be initiated:

- By important single events and by levels, trends, or patterns that adversely or undesirably vary from those expected
- When the organization's performance undesirably varies from that of other organizations or from recognized standards
- When a new project or improvement initiative specifies particular indicators

3. When performance assessment is initiated, the assessment includes:

- Detailed analysis of patterns and trends collected
- Clear declination of identified problems or opportunities to improve care
- Review by peers when analysis of the care provided by an individual practitioner is undertaken

- A record containing conclusions, recommendations and actions of the quality analysis and improvement

4. When the findings of the assessment process are relevant to an individual's performance

- The Professional Practice Subcommittee (PPSC) is responsible for determining the use of information through the peer review process of licensed independent practitioners.
- The Clinic Manager is responsible for determining the use of the information in relationship to the competence appraisal of individuals who are not licensed independent practitioners.

D. IMPROVEMENT

1. Elements of the organizational performance improvement may include:

- Improving existing processes
- Designing new processes
- Reducing variation or elimination of undesirable variation in processes or outcomes

2. SJCC has adopted the PDSA model for performance improvement activities. The models includes:

- PLAN: Plan-Do-Study-Act

  P= Plan the improvement → Plan the implementation of the improvement and any associated continuous data collection requirements
  D= Do the improvement to the process → Make the change and measure any impacts
  S= Study the results → Examine data to determine whether changes led to the expected improvement
  A= Act to hold the gains and continue to improve the process → Develop a strategy for maintaining the improvements and for spread to the remaining SJCC environments

3. In prioritizing processes for improvement activities, the organization will consider the following factors (not necessarily in this order):

- Impact of this process on the mission and philosophy of SJCC
- Impact on strategic aims and the extent to which Triple Aim objectives can be achieved
- Effect on needs and expectations of patient and families
- Impact on regulatory and licensing requirements

- Ease with which the data can be collected
- Ease with which the problem can be solved
- Resources available to make improvements
- Estimated cost savings
- Volume of patients affected or frequency with which problem occurs

4. In developing new or improving existing processes, the organization should follow the principles of design as described in this plan.
5. All process designs should involve the QIC in collaboration with those individuals, professionals, and/or departments that are closely involved with the process or system being improved.
6. When action is taken to improve a process, through successive PDSA cycles, for example, the following elements should occur:

   - The action taken may be tested on a trial basis
   - If the initial action taken is not effective, a new action plan is created and tested
   - The action's effectiveness is assessed
   - Successful actions are implemented organization-wide as applicable

E. COMMUNICATION OF RESULTS: Once the performance improvement results have been evaluated and approved by the QIC, the results will be shared with others in the organization, as applicable, through:

1. SJCC Board of Director's minutes
2. Professional Practice Committee (PPSC) documents
3. SJCC and SJGH Departmental, staff, and committee meetings
4. As appropriate, through internal communications.

F. CONFIDENTIALITY OF INFORMATION: Appropriate safeguards have been established to restrict access to highly sensitive and confidential performance improvement information which is protected against disclosure and discoverability through the California Evidence Codes 1156 and 1157.

G. ANNUAL REVIEW: The Quality Improvement Committee shall develop an annual evaluation of the overall organizational Quality Program. The evaluation should contain information regarding opportunities to improve care identified through the quality improvement process and the effectiveness of actions taken. The annual evaluation should address the success or lack thereof with the quality priorities established for the year as well as establish, for approval, the quality priorities for the coming year. The annual evaluation will be reviewed and approved by SJCC's executive leadership followed by final approval by the SJCC Board of Directors.

RELATED POLICIES: None.

REFERENCES:

Reference 1: Centers for Medicare and Medicaid Conditions of Participation
Reference 2: California Title 22
Reference 3: The Joint Commission Accreditation Manual for Ambulatory Care
Reference 4: BPHC/HRSA Guidelines for FQHC Look Alikes

5b

BYLAWS

SAN JOAQUIN COUNTY CLINICS
(a California nonprofit public benefit corporation)

(AMENDED AND RESTATED ON APRIL 26, 2012 and OCTOBER 29, 2013)

ARTICLE I

OFFICES

The principal office for the transaction of the business of the corporation is fixed and located in French Camp, County of San Joaquin, State of California. The Board of Directors may at any time or from time-to-time change the location of the principal office from one location to another in San Joaquin County.

ARTICLE II

PURPOSE

Section 1. General Purpose: This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the California Nonprofit Public Benefit Corporation Law for charitable purposes.

Section 2. Specific Purposes: The specific and primary purposes of the corporation are:

(a) To provide outpatient primary health service in underserved areas for medically underserved populations as a community health center through a system of freestanding clinics;

(b) To develop, promote, and manage health care facilities, services and programs with emphasis on comprehensive health care, preventative medicine, and health maintenance;

(c) To educate the public in the principles of health care protection and promote projects in the interest of public health;

(d) To provide training and career opportunities for the community's residents as well as continuing education and training for all employees and contracted staff;

(e) To promote mutually acceptable and satisfying relationships between the corporation and other providers of health care so as to develop an efficient and effective delivery of health care;

(f) To participate in and cooperate with any governmental agency or other organization engaged in similar or like activities; and

(g) To engage in such other charitable activities as may be directed by the Board of Directors.

ARTICLE III

DEDICATION OF ASSETS

The properties and assets of this nonprofit corporation are irrevocably dedicated to educational, research, and charitable purposes. No part of the net earnings, properties, or assets of this corporation, on dissolution or otherwise, shall inure to the benefit of any private person or individual or any director of this corporation. On the dissolution or winding up of this corporation, its assets remaining after payment, or provision for payment, of all debts and liabilities of this corporation shall be distributed to a nonprofit fund, foundation or corporation which is organized and operated exclusively for charitable purposes and which has established its tax-exempt status under Section 501 (c) (3) of the Internal Revenue Code.

ARTICLE IV

MEMBERSHIP

Section 1. No Membership: The corporation shall have no members. Any action for which there is no specific provision in the California Nonprofit Public Benefit Corporation Law applicable to a corporation which has no members and which would otherwise require only approval by a majority of all members or approval by the members shall require only the approval of the Board. All rights which would otherwise vest in the members shall vest in the directors.

Section 2. Associates: Nothing in these Bylaws shall be construed as limiting the right of the corporation to refer to persons or organizations associated with it as "members" even though such persons are not members, and no such reference shall constitute anyone a "member" within the meaning of California Corporations Code Section 5056. The corporation may confer, by amendment of its Articles or of these Bylaws, some or all of the rights of a member, as set forth in the California Nonprofit Public Benefit Corporation Law, upon any person, persons, or organizations, but no such person or organization shall be a "member" within the meaning of such Section 5056.

ARTICLE V

BOARD OF DIRECTORS

Section 1. General Powers: Subject to the limitations of the Articles of Incorporation and these Bylaws, the activities and affairs of the corporation shall be conducted, and all the corporate powers shall be exercised by, or under, the direction of the Board. The Board may delegate the management of the activities of the corporation to any person, persons, or committee, provided that the activities and affairs of the corporation shall be managed and all corporate powers shall be exercised under the ultimate direction of the Board. Without prejudice to such general powers but subject to the same limitations, the Board shall have the following powers in addition to the other powers enumerated in these Bylaws:

(a) To select, evaluate, and remove, prescribe powers and duties for, to the extent as may not be inconsistent with the law, the Articles or these Bylaws, and fix the compensation for the Chief Executive Officer;

(b) To conduct, manage, and control the affairs and activities of the corporation, including establishing the priorities of the corporation's clinics, and to make such rules and regulations not inconsistent with the law, the Articles, or these Bylaws, as it deems best;

(c) To borrow money and incur indebtedness for the purposes of the corporation, and to cause to be executed and delivered, in the corporate name, promissory notes, bonds, debentures, deeds of trust, mortgages, pledges, hypothecations, or other evidence of debt and securities; and

(d) To change the principal office or the principal business office of the corporation in California from one location to another, and cause the corporation to be qualified to conduct its activities in any other state, territory, dependency, or county and conduct its activities within or outside California.

Section 2. Specific Duties: In addition to General Powers and responsibilities, the Board shall have the specific responsibility for:

(a) Approval for the selection, annual evaluation, and dismissal of the Chief Executive Officer/Executive Director of the corporation;

(b) Establishing personnel policies and procedures, including selection and dismissal procedures, employee grievance procedures, and equal opportunity practices;

(c) Adopting policies for financial management practices, including arranging for an annual independent audit, a system to assure accountability for corporate resources, approval of the annual corporate budget, corporate priorities, strategic planning,

eligibility for services, including criteria for partial payment schedules, and long-range financial planning;

(d) Evaluating corporate activities, including services utilization patterns, productivity, patient satisfaction, achievement of objectives, and development of process for hearing and resolving patient grievances;

(e) Assuring that the corporation is operated in compliance with applicable Federal, State, and local laws and regulations; and

(f) Adopting health care policies, including scope and availability of services, location and hours of services, and quality-of-care audit procedures.

(g) Approve health center application to HRSA.

(h) Approve grant applications. The Board may delegate submissions of grant applications to the CEO, however, all grants must be ratified by the board at the next available meeting.

Section 3. Number: The Board shall consist of at least nine (9) but no more than twenty-five (25) directors and shall consist initially of eleven (11) directors.

Section 4. Classes of Board Members: Subject to the limits set forth in Section 5 below, Board members shall be categorized into one of the following two categories:

(a) Consumer members: Consumer members are all members of the Board who are served by the corporation and who, as a group, represent the individuals being served in terms of demographic factors, such as race, ethnic background, and gender; and

(b) Community members: Community members shall be all members of the Board, except Consumer members, who are representatives of the community and shall be selected for their expertise in relevant subject areas, such as community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns or social services within the community, provided that no more than one-half of the Community members may derive more than 10 percent (10%) of his or her annual income from the health care industry.

Section 5. Composition of Board: A majority of the Board shall be Consumer members. No more than one-half of the non-Consumer members may derive more than ten percent (10%) of his or her annual income from the health care industry.

Section 6. Additional Qualifications: All Board members shall meet the following additional qualifications:

(a) Board members shall be at least eighteen (18) years old;

(b) No Board member shall be an employee of the corporation, or the spouse or child,

parent, brother, or sister by blood or marriage of an employee of the corporation;

(c) Board members shall participate in appropriate training and educational programs necessary to properly fulfill their responsibilities as members of the Board; and

(d) Board members shall, within 30 days of election, acknowledge their acceptance of their position as a member of the Board either in writing or by attendance at a meeting of the Board.

Section 7. Selection: A nominating committee comprised of the officers of the corporation shall meet and present nominees for directorship at the annual meeting as needed to fill vacancies on the Board. To assure public access to Board positions, the nominating committee shall identify appropriate community users at each clinic location for recommendations. Where appropriate and practical, the committee may interview prospects in order to assure compliance with membership requirements. Nominations may be made from the floor. New directors shall be elected by the full Board.

Section 8. Term: The term of office for members of the Board shall be, except as provided below, three (3) years and until a successor has been designated and qualified. Terms shall end either on June 30 or December 31, whichever date is closer to the director's anniversary. There shall be no limit on the number of terms a director may serve.

Section 9. Resignations: Subject to the provisions of California Corporations Code Section 5226, any director may resign effective upon giving written notice to the corporation, unless the notice specifies a later time for the effectiveness of such resignation. If the resignation is effective at a future time, a successor may be appointed by the Board before such time, to take office when the resignation becomes effective.

Section 10. Removal of Director: The Board may declare vacant the office of a director for any of the following causes:

(a) The director has been declared of unsound mind by a final order of a court of competent jurisdiction;

(b) The director is currently excluded, suspended, or otherwise ineligible to participate in Federal health care programs or in either a Federal procurement or in non-procurement programs, or has been convicted of a criminal offense related to the provision of health care items or services, but has not yet been excluded or otherwise declared ineligible, or has been convicted of a felony, excepting motor vehicle offences;

(c) The director has been found by a final order of any court to have breached any duty arising under Article 3 of the California Nonprofit Public Benefit Corporation Law; or

(d) The director has, without excuse, been absent from regular Board meetings for either two (2) consecutive meetings or four (4) meetings in any twelve (12) consecutive month period.

Section 11. Removal of Director – Without Cause: The Board may remove any director, without cause, by approval of two-thirds of the directors then in office.

Section 12. Conflicts of Interest:

(a) No ~~voting~~ member of the Board of Directors shall be an employee of the corporation, a spouse or child, parent, brother or sister by blood or marriage of an employee.

(b) No more than ten percent (10%) of the persons serving on the Board of Directors at any time may be interested persons. An "interested person" is (i) any person currently being compensated by the corporation for services rendered to it within the previous twelve (12) months, as an independent contractor, or otherwise, or (ii) any brother, sister, ancestor, descendant, spouse, brother–in-law, son-in-law, daughter-in-law, mother-in-law or father-in-law of any such person. No Board member shall be an immediate family member of an employee. However, any violation of the provisions of this Section shall not affect the validity or enforceability of any transaction entered into by the corporation.

(c) The corporation will make no loan of money or other property, or guarantee the obligation of any director or officer of the corporation, except as authorized by Corporations Code Section 5236.

Section 13. Transfer of Membership: No director may transfer a seat on the Board or any right arising from it. All rights of a director cease on the director's death.

Section 14. Property Rights: No director shall have any rights or interest in any of the property or assets of this corporation.

Section 15. Liability: No director of this corporation shall be individually or personally liable for the debts, liabilities, or obligations of the corporation.

Section 16. Compensation: Directors shall serve without compensation from this corporation, but may be reimbursed for actual expenditures on a per diem or other basis as determined from time to time by the Board of Directors, not to exceed applicable U.S. Treasury regulations.

Section 17. Nondiscrimination: No person otherwise qualified shall be denied a seat on the Board or be discriminated against in any manner on account of the race, color, religion, ancestry, national origin, sex or as otherwise mandated by law.

ARTICLE VI

MEETINGS OF BOARD OF DIRECTORS

Section 1. Place of Meeting: All meetings of the directors shall be held at such a place as may be designated by the Board of Directors.

Section 2. Open Meetings: All meetings of the directors will be open to the public, except that the Board may hold closed sessions to consider matters concerning real property negotiations, an individual's private medical information, pending or potential litigation, threats to the security of the corporation's facilities or its personnel or clientele, and personnel matters.

Section 3. Meeting Schedule: Regular meetings of the directors shall be held monthly at such time as the Board may fix by resolution from time to time.

Section 4. Special Meetings: Special meetings of the Board of Directors for any purpose or purposes may be called by the Secretary upon the request of the Chair of the Board, the Chief Executive Officer, or any three (3) or more directors.

Section 5. Notice of Meetings: Except in the case of an emergency, notice of each special meeting shall be given to each director at least five (5) days prior to the day of the meeting. The notice shall specify the place, the day, the hour of the meeting and the agenda on which shall be listed those matters which the Board of Directors, at the time of giving notice, intends to present for action by the directors. If action is proposed to be taken at any meeting for approval of any of the following proposals, the notice also shall state the general nature of the proposal. Any directors' action on such items is invalid unless the notice or written waiver of the notice state the general nature of the proposals:

(a) Removing a director;

(b) Filling vacancies on the Board of Directors;

(c) Amending the Articles of Incorporation; or

(d) Voluntary dissolution of the corporation.

Section 6. Manner of Giving Notice: Notice of any meeting of directors shall be given by prepaid First Class mail, facsimile, or e-mail addressed to each director, either at the address of that director appearing in the files of the corporation or the address given by the director to the corporation for the purpose of notice. If no address appears in the corporation's file and no other has been given, notice shall be deemed to have been given

if either (i) notice is sent to that director by First Class mail to the corporation's principal office, or (ii) notice is published at least once in a newspaper of general circulation in the county where the principal office is located. Election of the method of the notice is at the discretion of the Secretary of the corporation. Notice shall be deemed to have been given at the time when delivered personally or deposited in the U.S. mail or transmitted electronically by facsimile or e-mail.

Section 7. Quorum: A quorum shall consist of a majority of the seated directors. Once a quorum is established, official business may be conducted by majority vote of the directors present. Directors present may continue to conduct business by majority vote after a quorum has been established, even if the withdrawal of some members leaves less than a quorum.

Section 8. Voting: Persons entitled to vote at any meeting of the directors shall be directors as of the record date. Voting may be voice or ballot, provided that any election of directors must be by written ballot if demanded by any director before the voting begins. If a quorum is present, the affirmative vote of a majority of the directors represented at the meeting entitled to vote and voting on any matter shall be the act of the directors. Directors may not take action by unanimous written consent without a meeting and without prior notice.

Section 9: Meetings by Telephone: Any meeting may be held by conference telephone or similar communication equipment, as long as all directors participating in the meeting and the public can hear one another. All such directors shall be deemed to be present in person at such a meeting.

Section 10. Presiding Officer: Meetings of the Board of Directors shall be presided over by the Chair. In the absence of the Chair, the Vice Chair shall preside over the meeting. The Secretary of the corporation shall act as secretary of all meetings of the directors, provided that in the Secretary's absence the presiding officer shall appoint another person to act as secretary of the meeting.

Section 11. Rules of Meetings: Meetings of the directors shall be governed by Robert's Rules of Order, as such rules may be revised from time to time, insofar as any rule is not inconsistent or in conflict with these Bylaws, the Articles of Incorporation, or California law.

Section 12. Prohibition against Voting by Proxy: Directors may not vote by proxy.

Section 13. Policies: The Board shall periodically update these Bylaws, its policies and procedures, revise its mission, goals and objectives, adopt short term and strategic planning, and take responsibility for assuring that the corporation is prepared to succeed in the rapidly changing health care environment.

Section 14. General Responsibilities:

(a) The Board shall evaluate the corporation's achievements and performance of its principal officers and its compliance with community health center requirement at least annually.

(b) The Board is responsible for identifying and assuring that it meets its educational and training needs, including orientation and training of new Board members.

(c) Financial oversight requires control of major resource decisions, monitoring financial viability, and an annual audit of its financial reports.

(d) The Board shall prohibit conflicts of interest or the appearance of conflicts of interest by Board members, employees, consultants, and those who provide services or goods to the clinics.

ARTICLE VII

OFFICERS

Section 1. Responsibility: All officers are subordinate and responsible to the Board of Directors.

Section 2. Number and Selection: The officers of the corporation who shall be members of the Board shall be the Chair, Vice Chair, Secretary, and Treasurer. Officers of the corporation who are not members of the Board shall be the Chief Executive Officer/Executive Director, Chief Financial Officer, and Chief Medical Officer/ Medical Director. The corporation may have such other officers as may be appointed in accordance with the provisions of this section. One person may hold two or more offices, except those of Chair, Vice Chair, and Secretary. For purposes of Corporations Code Section 5213(a), the Executive Director shall be the Chief Executive Officer of the corporation.

The Board of Directors may appoint such other officers as the business of the corporation may require, each of whom shall hold office for such period and have such authority and perform such duties as are provided in the Bylaws or as the Board of Directors may determine.

Section 3. Duties of the Chair: The Chair is the chief Board officer and, subject to approval of Board of Directors, shall exercise general supervision and direction of the affairs of the corporation; shall preside at all meetings of the Board of Directors; and shall have the general powers and duties usually vested in the Chair of the Board of Directors of a corporation as may be prescribed by the Board of Directors or by these Bylaws. The day-to-day management of the corporation invested in a full-time Chief

Executive Officer who shall report to the Board of Directors. The Board of Directors shall complete a performance evaluation of the Chief Executive Officer annually.

Section 4. Duties of the Vice Chair: The Vice Chair will preside over meetings of the Board of Directors in the absence of the Board Chair.

Section 5. Treasurer: The Treasurer is a voting member and an officer of the Board of Directors and shall chair the Finance Committee. The Treasurer shall oversee the financial affairs of the corporation and shall perform such other and further duties as may be required by law or as may be prescribed or required from time to time by the Board of Directors.

Section 6. Duties of the Secretary: The Secretary shall keep or cause to be kept at the principal office of the corporation, or such other place as the Board of Directors may order, a file of minutes of all meeting of the directors. The Secretary also shall keep or cause to be kept at the principal office of the corporation a directors' list containing the names and addresses of each director and, in any case where directorship has been terminated, such fact shall be recorded in the minutes together with the date upon which the directorship ceased. The files also shall include the Articles of Incorporation and Bylaws of the corporation and the notices of meetings of the Board of Directors. The Secretary shall perform such other duties as may be required by law or as may be prescribed or required from time to time by the Board of Directors or the Bylaws. The Secretary shall be a voting member and an officer of the Board of Directors.

Section 7. Chief Executive Officer: The Chief Executive Officer ("CEO") of the corporation shall report directly to and be subject to the control of the Board of Directors, have general supervision, direction and control of the business of the corporation and shall be held responsible for the proper functioning of the corporation. The CEO shall organize the administrative functions of the corporation, delegate duties and establish formal means of accountability on the part of his of her subordinate officers. The CEO shall be an ex-officio non-voting member of all committees unless otherwise determined by the Board of Directors. The CEO shall have the general powers and duties of management usually vested in a chief executive officer and shall have other powers and duties as may be prescribed by these Bylaws. The Chief Executive Officer shall be directly employed by the corporation and shall have a term of office as set by contract.

Section 8. Duties of the Chief Financial Officer: The Chief Financial Officer ("CFO") shall keep and maintain or cause to be kept and maintained adequate and correct accounts of the properties and the business transactions of the corporation, including but not limited to the accounts of its assets, liabilities, receipts, disbursements, gain and losses. The financial records shall at all times be open to inspection by any director of the corporation. The Chief Financial Officer shall be selected by the Chief Executive Officer and shall be directly employed by the corporation. The CFO shall report directly to the Chief Executive Officer and shall have a term of office as set by contract.

Section 9. Chief Medical Officer: The Chief Medical Officer/Medical Director ("CMO") of the corporation shall oversee all medical aspects of the corporation's clinics. The CMO shall have such general powers and duties usually vested in the chief medical officer of a corporation engaged in the delivery of health care services and shall have such other powers and duties as may be assigned by the Chief Executive Officer. The Chief Medical Officer shall be selected by the Chief Executive Officer and be directly employed by the corporation. The CMO shall report directly to the Chief Executive Officer and shall have a term of office as set by contract.

Section 10. Removal of Board Officers: Board officers may be removed with of without cause at any meeting of the Board of Directors by the affirmative vote of a majority of all the directors.

ARTICLE VIII

COMMITTEES

Section 1. Committees: The Board may appoint one or more committees, each consisting of two or more directors and such other persons as the Board may deem appropriate. Such committees shall be advisory only and subject to the approval of the Board of Directors.

Section 2. Standing Committees: Standing committees shall consist of an Executive Committee, Finance Committee, Audit Committee, and a Nominating Committee.

Section 3. Special Committees: Special committees may be appointed by the Chair of the Board with the approval of the Board of Directors for such special tasks as circumstances may warrant. A special committee shall limit its activities to the accomplishment of the task for which it is appointed and shall have no power to act except such as is specifically conferred by action of the Board of Directors. Upon completion of the task for which appointed, such special committee shall stand discharged.

Section 4. Quorum: Where not otherwise prescribed by the Chair, a majority of the members of a committee shall constitute a quorum at any meeting of that committee. Each committee shall meet as often as is necessary to perform its duties. Meetings of any committee shall be held on the call of the Chair of the Board, the committee chairperson, or any two or more committee members.

Section 5. Vacancies: Vacancies in any committee shall be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

Section 6. Executive Committee:

(a) There shall be an Executive Committee consisting of such directors as are appointed by the Board.

(b) The designation of such Executive Committee and the delegation of authority to it shall not operate to relieve the Board of Directors or any individual director of any responsibility imposed by law, by the Articles of Incorporation of this corporation or these Bylaws.

Section 7. Finance Committee: The Finance Committee shall be composed of not less than three (3) members, the majority of whom shall be members of the Board of Directors, one of whom shall be the Treasurer, and others appointed by the Board of Directors. All committee members shall have the right to vote. The duties and responsibilities of the Finance Committee shall be:

(a) To develop and recommend financial policy to the Board of Directors;

(b) To review the corporation's annual budgets and to make recommendations thereon to the Board of Directors;

(c) To review the monthly financial statements of this corporation, evaluate the corporation's operating performance, and make recommendations to the Board of Directors on both current and long term fiscal affairs;

(d) To advise the Board of Directors on methods and procedures which will assure that the financial policies and budgets adopted by the Board of Directors are carried out;

(e) To review and advise the Board of Directors on financial feasibility of corporate projects, acts and undertakings referred to it by the Board of Directors; and

(f) To advise the Board of Directors on the fundraising activities of the corporation.

Section 8. Audit Committee: The corporation shall have an Audit Committee consisting of at least three (3) directors and may include nonvoting advisors. Directors who are officers of the corporation or who receive, directly or indirectly, any consulting, advisory, or other compensatory fees from the corporation (other than for service as director) may not serve on the audit committee. The Audit Committee shall perform the duties and adhere to the guidelines set forth in the corporation's audit policy guidelines as amended from time to time by the board. Such duties include, but are not limited to:

(a) Assisting the Board in choosing an independent auditor and recommending termination of the auditor, if necessary;

(b) Negotiating the independent auditor's compensation;

(c) Conferring with the independent auditor regarding the corporation's financial affairs; and

(d) Reviewing and accepting or rejecting the independent auditor's report.

Members of the Audit Committee may be compensated for their service on the Audit Committee in excess of that provided to directors for their service on the board. If the corporation has a Finance Committee, a majority of members of the Audit Committee may not concurrently serve as member of Finance Committee, and the chair of the Audit Committee may not serve on the Finance Committee.

Section 9. Term of Office: The Chair and each member of a standing committee shall serve until the next election of directors and until his or her successor is appointed, or until such committee is sooner terminated or until he or she is removed, resigns, or otherwise ceases to qualify as a member if the committee. The chair and each member of a special committee shall serve for the life of the committee unless they are removed, resign, or cease to qualify as members of such committee.

Section 10. Vacancies: Vacancies on any committee may be filled for the unexpired portion of the term in the same manner as provide in the case of original appointments.

Section 11. Quorum: At all committee meetings, a majority of the members of the committee shall be necessary and sufficient to constitute a quorum for the transaction of business, except that a majority of the committee members present, whether or not a quorum, may adjourn any committee meeting to another time and place. The act of a majority of the members present at a meeting at which there is a quorum shall be the act of the committee. Notwithstanding the previous provisions of the Section, the members present at a meeting at which a quorum is initially present may continue to transact business, notwithstanding the withdrawal of committee members, so long as any action taken is approved by at least a majority of the required quorum for such meeting.

Section 12. Expenditures: Any expenditure of corporate funds by a committee shall require prior approval of the Board of Directors.

ARTICLE IX

INDEMNIFICATION OF DIRECTORS, OFFICERS, EMPLOYEES, AND OTHER AGENTS

Section 1. Definitions: For the purpose of this ARTICLE IX,

(a) "Agent" means any person who is or was a director, officer, employee, or agent of this corporation or is or was serving at the request of this corporation as a director, officer, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, or other enterprise;

(b) "Proceeding" means any threatened, pending, or completed action or proceeding, whether civil, criminal, administrative, or investigative; and

(c) "Expenses" includes, without limitation, all attorney fees, costs and any other expenses incurred in the defense of any claims or proceedings against an agent by reason of the agent's position or relationship as agent and all attorney fees, costs, and other expenses incurred in establishing a right to indemnification under this Article.

Section 2. Successful Defense by Agent: To the extent that an agent of this corporation has been successful on the merits in the defense of any proceeding referred to in this Article, or in the defense of any claim, issue, or matter therein, the agent shall be indemnified against expenses actually and reasonably incurred by the agent in connection with the claim. If an agent either settles any such claim or sustains a judgment rendered against the agent, then the provisions of Sections 3 through 5 shall determine whether the agent is entitled to indemnification.

Section 3. Actions Brought by Persons Other Than the Corporation: Subject to the required findings to be made pursuant to Section 5 below, this corporation shall indemnify any person who was or is a party, or is threatened to be made a party, to any proceeding, other than an action brought by, or on behalf of this corporation, or by an officer director or person granted related status by the Attorney General, or by the Attorney General on the ground that the defendant director was or is engaging in self-dealing within the meaning of California Corporations Code Section 5233, or by the Attorney General or a person granted related status by the Attorney General for any breach of duty relating to assets held in charitable trust, by reason of the fact that such person is or was an agent of this corporation, for all expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred in connection with the proceeding.

Section 4. Actions Bought by or on Behalf of the Corporation:

(a) Claims Settled out of the Court: It any agent settles or otherwise disposes of a threatened or pending action brought by or on behalf of this corporation without Board approval, the agent shall receive no indemnification for either amounts paid pursuant to the terms of the settlement or other disposition or for any expenses incurred in defending against the proceeding.

(b) Claims and Suits Awarded against Agent: This corporation shall indemnify any person who was or is a party or is threatened to be made a party to any threatened, pending, or completed action brought by or on behalf of this corporation by the reason of the fact that the person is or was an agent of this corporation, for all expenses actually and reasonably incurred in connection with the defense of that action, provided that both of the following are met:

(i) The determination of good faith conduct required by Section 5 below, must be made in the manner provided for in that section; and

(ii) Upon application, the court in which the action has been brought has determined that the circumstances of the case warrant that the agent be entitled to indemnification for expenses incurred. Once the court has determined the agent's right to indemnification, the corporation shall determine the amount of indemnification.

Section 5. Determination of Agent's Good Faith Conduct: The indemnification granted to an agent in Sections 3 and 4 above is conditioned on the following:

(a) Required Standard of Conduct: The agent seeking reimbursement must be found, in the manner provided in (b) below, to have acted in good faith, in a manner the agent believed to be in the best interest of this corporation, and with such care, including reasonable inquiry, as an ordinarily prudent person in a like position would use in similar circumstances. The termination of any proceeding by judgment, order, settlement, conviction, or on a plea of nolo contendre or its equivalent shall not, by itself, create a presumption that the person did not act in good faith or in a manner which the person reasonably believed to be in the best interest of this corporation or that the person had reasonable cause to believe that the agent's conduct was lawful. In the case of a criminal proceeding, the person must have had no reasonable cause to believe that the person's conduct was unlawful.

(b) Manner of Determination of Good Faith Conduct: The determination that the agent did act in a manner complying with paragraph (a) above shall be made by:

(i) The Board of Directors by a majority vote of a quorum consisting of directors other than the director whose good faith is being determined; or

(ii) The affirmative vote (or written ballot in accord with Article VI, Section 8) of a majority of the votes required under Article VI, Section 7.

Section 6. Limitations: No indemnification or advance shall be made under this Article IX, except as provided in Sections 2 or 4 (b)(ii), in any circumstance when it appears:

(a) That the indemnification or advance would be inconsistent with a provision of the Articles, a resolution of the directors, or an agreement in effect at the time of the accrual of the alleged cause of action asserted in the proceeding in which the expenses were incurred or other amount was paid which prohibits or otherwise limits indemnification; or

(b) That the indemnification would be inconsistent with any condition expressly imposed by a court in approving a settlement.

Section 7. Advance of Expenses: Expenses incurred in defending any proceeding may be advanced by this corporation before the final disposition of the proceeding on receipt of an undertaking by or on behalf of the agent to repay the amount of the advance, unless it is determined ultimately that the agent is entitled to be indemnified as authorized in this Article IX.

Section 8. Contractual Rights of Non-directors and Non-officers: Nothing contained in this Article shall affect any right to indemnification to which persons other than directors and officers of the corporation may be entitled by contract or otherwise.

Section 9. Insurance: The Board of Directors may adopt a resolution authorizing the purchase and maintenance of insurance on behalf of any agent of the corporation against any liability asserted against or incurred by the agent in such capacity of arising out of the agent's status as such, whether or not this corporation would have the power to indemnify the agent against that liability under the provisions of this Section.

Section 10. Fiduciaries of Corporate Employee Benefit Plan: This Article does not apply to any proceeding against any trustee, investment manager, or other fiduciary of an employee benefit plan in that person's capacity as such, even though that person may also be an agent of the corporation as defined in Section 1 of this Article. Nothing contained in this Article shall limit any right to indemnification to which such a trustee, investment manager, or other fiduciary may be entitled by contract of otherwise, which shall be enforceable to the extent permitted by applicable law.

ARTICLE X

AMENDMENTS TO BYLAWS

These Bylaws may only be amended by a majority of the directors at a duly noticed meeting of the Board of Directors.

ARTICLE XI

FISCAL YEAR

The fiscal year of the corporation shall begin on the first day of July and end on the last day of June of each year.

ARTICLE XII

CORPORATE RECORDS, REPORTS, ETC.

Section 1. Minutes of Meeting: The corporation shall keep at its principal office or at such other place as the Board may order, a written record of the minutes of all meetings of

the directors, with the time and place of holding, whether regular or special, and if special, how authorized, the notice given, the names of those present at members meetings and the proceedings thereof.

Section 2. Directors: The corporation shall keep a record of its directors, listing their names and addresses, which shall be a public record.

Section 3. Books of Account: The corporation shall keep and maintain adequate and correct accounts of its properties and business transactions including assets, liabilities, receipts, disbursements, gains and losses.

Section 4. Annual Report: The Board shall cause an annual report to be sent to the directors not later than one hundred twenty (120) days after the close of the corporation's fiscal year. This report shall contain the following information in reasonable detail:

(a) The assets and liabilities, including the trust funds of the corporation, as of the end of each fiscal year;

(b) The change in assets and liabilities, including trust fund, during the fiscal year;

(c) The revenue or receipts of the corporation, both unrestricted and restricted to particular purposes, for the fiscal year;

(d) The expenses and disbursement of the corporation for both general and restricted purposes during the fiscal year; and

(e) Any information required by California Corporations Code Section 6322.

Section 5. Checks, Drafts, Etc.: All checks, drafts or other orders for payment of money, notes or other evidence of indebtedness, issued in the name of or payable to the corporation, shall be signed or endorsed by such person or persons and in such manner as from time, to time, shall be determined by resolution of the Board of Directors.

Section 6. Contracts and Agreements: The Board of Directors, except as otherwise provided in these Bylaws, may authorize any officer or officers, agent or agents to enter into any contract or execute any instrument in the name of and on behalf of the corporation, and such authority may be general or confined to specific instances; and unless so authorized by the Board of Directors, no officer, agent or employee shall have any power or authority to bind the corporation by any contract or agreement or to pledge its credit or to render it liable for any purpose or to any amount.

Section 7. Maintenance and Inspection: The corporation shall keep at its principal executive office the original or a copy of the Articles of Incorporation and Bylaws as amended to date, which shall be open to inspection by the directors at all reasonable times during office hours. The accounting books, records and minutes of proceedings of the directors and the Board of Directors shall be kept at such place or places designatedby the Board of Directors, or in the absence of such designation, at the principal executive office of the corporation. The minutes and the accounting books and records

shall be open for inspection on the written demand of any director, at any reasonable time During usual business hours, for a purpose reasonably related to the directors' interest as a director. Inspection may be made in person or by an agent or attorney, and shall include the right to copy and make extracts.

Section 8. Professional Liability: The Board of Directors, on behalf of the corporation and its directors, shall ensure that its directors are protected through the maintenance of insurance, insuring the corporation and its directors against liability for the negligent acts of directors in the performance of any services on behalf of the corporation. The Board of Directors also shall procure and maintain in effect such other insurance as is reasonably necessary to protect the members and the corporation against risk of casualty loss and liability for personal injury and property damage.

ARTICLE XIII

GIFTS TO THE CORPORATION

Section 1. Approval of Gifts: The Board reserves the right to approve the receipt as a gift of any real property, or of any other property which requires the corporation to assume or satisfy any underlying loan secured by the property, or any monetary gifts which are restricted by the donor in a fashion which could place a continuing obligation on the corporation.

Section 2. General: The corporation is authorized to accept and administer gifts made to the corporation by donors who name or otherwise identify the corporation in the instrument of gift or transfer. Gifts shall vest in the corporation upon receipt and acceptance by it (whether signified by an officer, employee or agent or the corporation). "Gifts" includes the transfer of money or other property of any kind, real, personal, or mixed, or any interest in property, and whether made by delivery, grant, conveyance, payment, devise, bequest, or any other method of transfer.

Section 3. Terms of Gifts: Each donor by making a gift to the corporation accepts and agrees to all the terms of the Articles of the Incorporation and these Bylaws and provides that the fund so created shall be subject to the provisions for presumption of donors' intent, for modification or restrictions or conditions for amendments and termination, and to all other terms of the Articles of Incorporation and Bylaws of the corporation, each as from time to time amended.

Section 4. Restricted Gifts: Any donor may, with respect to a gift made by such donor to the corporation, give directions in the instrument of gift or transfer as to (a) specific health care, charitable, educational or scientific purposes or particular charitable health name as memorial or otherwise for a fund given, or addition to a fund previously held, or anonymity for the gift.

Section 5. Power of the Board of Directors: Notwithstanding any provision of these Bylaws or in any instrument of gift or transfer creating or adding to a fund of the

corporation, the Board of Directors shall have the power to modify any restriction or condition on the distribution of funds for any specified charitable purposes or to specified health care organizations, or on the manner of the distribution of such funds, if in the judgment and discretion of the Board of Directors, the purpose, object, restrictions of conditions specified in any donation become incapable or not reasonably susceptible of fulfillment, or not in the best interest of advancing the charitable, educational or scientific purposes of the corporation. Any unusual gifts which require continuing obligations on the part of the corporation or restrictions which, on their face, may be incapable of fulfillment must be approved by the Board of Directors prior to acceptance.

ARTICLE XIV

COMMUNITY GROUPS

Section 1. Community: In recognition of the community's vital role in the corporation's existence, effectiveness and relevance, the Board shall from time to time appoint persons from the community to appropriate roles as may be desirable and/or necessary in the best interest of the corporation and its clinics. The organization, bylaws and functions of all groups shall require Board review and approval.

Section 2. Community Advisory Board: In keeping with the conviction that the corporation is part of a broad community, there may be a Community Advisory Board which shall advise the Board of Directors on the matters of interest to the community to promote the good will of the Clinics. Selected members of such Community Advisory Board may be invited to attend all regular meetings of the Board to advise on matters concerning finance, fund raising, facilities development, long-range planning, government relations, health care, personnel relations, community needs, consumer interests and other items. The Community Advisory Board shall have written bylaws approved by the Board of Directors and reviewed periodically. The Community Advisory Board shall meet as often as necessary to perform its duties.

ARTICLE XV

ADMINISTRATION

Medical Care and Its Evaluation: The Board of Directors, in conjunction with the Chief Medical Officer, shall provide for a continuing review and evaluation of the quality of professional care rendered in the Clinics, whether by contracting for evaluation by an independent contractor or otherwise.

ARTICLE XVI

CONFLICTS OF INTEREST AND COMPENSATION APPROVAL POLICIES

Section 1. Purpose of Conflict of Interest Policy: The purpose of this conflict of interest policy is to protect the tax-exempt corporation's interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of an officer or director of the corporation or any "disqualified person" as defined in Section 4958(f)(1) of the Internal Revenue Code, as amplified by 26 CFR Section 53.4958-3, and which might result in a possible "excess benefit transaction" as defined in Section 4958 (c) (1) (A) of the Internal Revenue Code, as amplified by 26 CFR Section 53.495 8. This policy is intended to supplement, but not replace, any applicable state and federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

Section 2. Definitions:

(a) Interested Person.

Any director, principal officer, member of a committee with governing board delegated powers, or any other person who is "disqualified person" as defined in Section 4958(f)(1) of the Internal Revenue Code and amplified by 26 CFR Section 53.4958-3, who has a direct or indirect financial interest as defined below, is an "interested person".

(b) Financial Interest.

A person has a financial interest if the person has, directly or indirectly through business, investment, or family:

(i) An ownership or investment interest in any entity with which the corporation has a transaction or arrangement,

(ii)A compensation arrangement with the corporation or with any entity or individual with which or with whom the corporation has a transaction or arrangement, or

(iii) A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which or with whom the corporation is negotiating a transaction or arrangement.

"Compensation" includes direct and indirect remuneration as well as gifts or favors that are not insubstantial.

A financial interest is not necessarily a conflict of interest. Under Section 3(b) below, a person who has a financial interest may have a conflict of interest only if the Board decides that a conflict of interest exists.

Section 3. Conflict of Interest Avoidance Procedure:

(a) Duty to Disclose.

In connection any actual or possible conflict of interest, an interested person must disclose the existence of the financial interest and be given the opportunity to disclose all material facts to the directors and members of committees with Board-delegated powers considering the proposed transaction to arrangement.

(b) Determining Whether a Conflict of Interest Exists.

After disclosure of the financial interest and all material facts, and after any discussion with the interested person, the person shall leave the Board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

(c) Procedures for Addressing a Conflict of Interest.

An interested person may make a presentation at the Board or committee meeting, but after the presentation, the person shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement involving the possible conflict of interest.

The chair person of the Board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

After exercising due diligence, the Board or committee shall determine whether the corporation can obtain, with reasonable efforts, a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.

If more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a conflict of interest, the Board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the corporation's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination, it shall make its decision as to whether to enter into the transaction or arrangement.

(d) Violations of the Conflict of Interest Policy.

If the Board or committee has reasonable cause to believe a member has failed to disclose actual or possible conflict of interest, it shall inform the member of the basis for

such belief and afford the member an opportunity to explain the alleged failure to disclose.

If, after hearing the member's response, and after making further investigation as warranted by the circumstances, the Board or committee determines the member has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

Section 4. Records of Board and Board Committee Proceeding: The minutes of meetings of the Board and all committees with board-delegated powers shall contain:

(a) The name of the persons who disclosed or otherwise were found to have a financial interest in connection with actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict was present, and the Board's or committee's decision as to whether a conflict of interest in fact existed, and

(b) The name of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

Section 5. Compensation Approval Policies:

A voting director who receives compensation, directly or indirectly, from the corporation for services is precluded from voting on matter pertaining to that member's compensation.

A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the corporation for services is precluded from voting on matters pertaining to that member's compensation.

No voting director or any committee member whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the corporation either individually or collectively, is prohibited from providing information to any committee regarding compensation.

When approving compensation for directors, officers and employees, contractors, and any other compensation, contract or arrangement, in addition to the complying with the conflict of interest requirements and policies contained in the preceding and following sections of this Article as well as the preceding paragraphs of this section of this Article, the Board or a duly constituted compensation committee of the Board shall also comply with the following additional requirements and procedures:

(a) The terms of compensation shall be approved by the Board or compensation committee prior to the first payment of compensation.

(b) All members of the Board or compensation committee who approve compensation arrangement must not have a conflict of interest with respect to the compensation arrangements as specified in Regulation Section 53.495 8-6(c)(iii), which generally requires that each board member or committee member approving a compensation arrangement between this organization and a "disqualified person" (as defined in Section 495 8(f)(I) of the Internal Revenue Code, as amplified by Regulation Section 53.4958-3):

(i) Is not the person who is the subject of compensation arrangement, or a family member of such person;

(ii) Is not in an employment relationship subject to the direction or control of the person who is the subject of compensation arrangement;

(iii) Does not receive compensation or other payments subject to approval by the person who is the subject of compensation arrangement;

(iv) Has no material financial interest affected by the compensation arrangement; and

(v) Does not approve a transaction providing economic benefits to the person who is the subject of the compensation arrangement, who in turn has approved of will approve a transaction providing benefits to the board or committee member.

(c) The Board or compensation committee shall obtain and rely upon appropriate data as to comparability prior to approving the terms of compensation. Appropriate data may include the following:

(i) Compensation levels paid by similarly situated organizations, both taxable and tax-exempt, for functionally comparable positions. "Similarly situated" organizations are those of a similar size and purpose and with similar resources;

(ii) The availability of similar services in the geographic area of this organization;

(iii) Current compensation surveys compiled by independent firms; and

(iv) Actual written offers from similar institutions competing for the services of the person who is the subject of the compensation arrangement

As allowed by Regulation Section 53.4958-6, if this corporation has average annual gross receipts (including contributions) for its three (3) prior tax years of less than $1 million, the Board or compensation committee will have obtained and relied upon appropriate

data as to comparability if it obtains and relies upon data on compensation paid by three (3) comparable organizations in the same or similar communities for similar services.

(d) The terms of compensation and the basis for approving those terms shall be recorded in written minutes of the meeting of the Board or compensation committee that approved the compensation. Such documentation shall include:

(i) The terms of the compensation arrangement and the date it was approved;

(ii) The members of the Board or compensation committee who were present during debate on the transaction, those who voted on it, and the votes cast by each Board or committee member; and

(iii) The comparability data obtained and relied upon and how the data was obtained.

(e) If the Board or compensation committee determines that reasonable compensation for a specific position in this corporation or for providing services under any other compensation arrangement with this corporation is higher or lower than the range of comparability data obtained, the Board or committee shall record in the minutes of the meeting the basis for its determination;

(f) If the Board or committee makes adjustments to the comparability data due to geographic area of other specific conditions, these adjustments and the reasons for them shall be recorded in the minutes of the Board or committee meeting,

(g) Any actions taken with respect to determining if the Board or committee member had a conflict of interest with respect to the compensation arrangement and, if so, actions taken to make sure the member with the conflict of interest did not affect or participate in the approval of the transaction (for example, a notation in the records that after a finding of conflict of interest by a member, the member with the conflict of interest was asked to, and did, leave the meeting prior to a discussion of the compensation arrangement and a taking of the votes to approve the arrangement), shall be recorded in the minutes of the Board or committee meeting.

(h) The minutes of Board or committee meetings at which compensation arrangements are approved must be prepared before the later of the date of the next Board or committee meeting or 60 days after the final actions of the Board or committee are taken with respect to the approval of the compensation arrangements. The minutes must be reviewed and approved by the Board or committee as reasonable, accurate, and complete within a reasonable period thereafter, normally prior to or at the next Board or committee meeting following final action on the arrangement by the Board or committee.

Section 6. Annual Statement:

Each director, principal officer, and member of a committee with governing board-delegated powers shall annually sign a statement which affirms such person:

(a) has received a copy of the conflicts of interest policy,

(b) has read and understands the policy,

(c) has agreed to comply with the policy, and

(d) understands the corporation is charitable and, in order to maintain its federal tax exemption, must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

Section 7. Periodic Reviews:

To ensure the corporation operates in a manner consistent with charitable purposes and does not engage in activities that could jeopardize its tax-exempt status, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, include the following subjects:

(a) Whether compensation arrangements and benefits are reasonable, based on competent survey information, and the result of arm's-length bargaining.

(b) Whether partnerships, joint ventures, and arrangements with management organizations conform to corporation's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, further charitable purposes, and do not result in inurnment, impermissible private benefit, or in an excess benefit transaction.

Section 8. Use of Outside Experts:

When conducting the periodic reviews as provided for in Section 7, the corporation may, but need not, use outside advisors. If outside experts are used, their use shall not relieve the Board of its responsibility for ensuring periodic reviews are conducted.

ARTICLE XVII

WINDING UP AND DISSOLUTION

Irrevocable Charitable Dedication: The property of the corporation is irrevocably dedicated to charitable purposes. Upon the winding up and dissolution of the corporation, its assets remaining after payment or adequate provision for payment of all debts and obligations of the corporation shall be distributed in accordance with the plan of liquidation to an organization which is organized and operated exclusively for charitable purposes, exempt from federal income tax under Section 501(c)(3) of the Internal

Revenue Code, as the Board of Directors may select. In any event, no assets shall be distributed to any organization if any part of the net earnings of such organization inures to the benefit of any private person or individual, or if a substantial part of the activities of such organization is the carrying on of propaganda or otherwise attempting to influence legislation, or if the organization participates in, or intervenes in any political campaign on behalf of or opposed to any candidate or public office, or if the organization carries on any other activities not permitted to be carried on (a) by a corporation exempt from federal tax under Section 501(c)(3) of the Internal Revenue Code or (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code.

CERTIFICATE OF SECRETARY

The foregoing amendments were duly adopted at a regularly noticed meeting on the 29th day of October 2013.

Attest: _____ 12/9/13___
Rod Place, SJCC Secretary

5d

To: Board of Directors

From: Farhan Fadoo MD & Chuck Wiesen

Re: Providers to recommend for Credentialing and privileges at SJCC – the FQHC

Date: October 30, 2018

The attached list are the providers recommended to be credentialed as providers and given privileges per the Specialty indicated within the FQHC primary care clinics – San Joaquin County Clinic. The Staff categories are:

Active	Full privileges of Specialty
Provisional	Provisional until completion of mentoring requirement
Courtesy	Privileges to see a limited number of patients
Consulting	Consulting Physician in a Surgical or Medical Sub-Specialty
Affiliate	Limited Privileges
Allied Health Provider	Nurse Practitioner, Physician Assistant, LCSW's, Certified Nurse Midwives

Department Section Roster

10/17/18

Name	Staff Category	Specialty
Section: Primary Medicine		
Naihsien, Chen MD	Provisional	Internal Medicine
Garza, Crisoforo MD	Active	OB/GYN
Pant, Meenakshi MD	Active	OB/GYN
Sheth, Chirag MD	Active	Internal Medicine
Elayyan, Ala MD	Provisional	Pediatrics
Hira-Brar Shawnee MD	Provisional	Internal Medicine
Pellecer, Silvia, PA	Provisional	Surgery
Abaray, Maureen, NP	AHP	Family Medicine
Heffernan, Nancy, NP	AHP	Internal Medicine
Silvia Pellecer, PA	Provisional	Orthopedic

Facility: FQHC

Department Section Roster

Name	Staff Category	Specialty
Department: Family Med/PMC		
Section: Primary Medicine		
Baumgarten, Gregory A.,N.P.	Allied Health Provider	Nurse Practitioner
Blau, Nathan M.D.	Active	Internal Medicine
Chander, Harish M.D.	Active	Internal Medicine
Chaudhry, Nidhi S.,M.D.	Provisional	Internal Medicine
Chowdhury, Sukalpa M.D.	Provisional	Family Medicine
Diulio, Jonathon M.D.	Provisional	Family Medicine
Goyal, Megha M.D.	Active	Internal Medicine
Mahajan, Arshian M.D.	Active	Family Medicine
Munagala, Shailaja M.D.	Provisional	Family Medicine
Paz, Jun G.,N.P.	Allied Health Provider	Nurse Practitioner
Seifoddini, Mahnoosh K.,M.D.	Active	Internal Medicine
Singh, Satinder D.O.	Active	Internal Medicine
Starve, Richard N.,M.D.	Active	Family Medicine
Sodavarapu, Soujanya M.D.	Active	Internal Medicine
Tha, Khin Z.,M.D.	Provisional	Family Medicine
Verma, Sunita M.D.	Provisional	Internal Medicine

Facility: FQHC

Department Section Roster

Name	Staff Category	Specialty
Department: Family Medicine		
Abaray, Maureen N.P.	Allied Health Provider	Nurse Practitioner
Bahnam, Ramona V.,M.D.	Provisional	Family Medicine
Bobson, Craig M.,M.D.	Courtesy	Family Medicine
Brown-Berchtold, Lauren K.,M.D.	Provisional	Family Medicine
Burgos, Regina N.P.	Allied Health Provider	Nurse Practitioner
Chapa, Eric M.D.	Consulting	Family Medicine
Chiriboga Hurtado, Juan J.,M.D.	Provisional	Family Medicine
Chiu, Jeff W.,D.O.	Provisional	Family Medicine
Davis, Catherine R.,N.P.	Allied Health Provider	Nurse Practitioner
Fadoo, Farhan M.D.	Active	Family Medicine
Fessler, Jerry D.,M.D.	Consulting	Family Medicine
Jafri, Asma M.D.	Active	Family Medicine
Johl, Randeep S.,M.D.	Provisional	Family Medicine
Kafilmout, Imad T.,M.D.	Active	Family Medicine
Krpan, John B.,D.O.	Provisional	Family Medicine
Morrison, Benjamin B.,M.D.	Consulting	Family Medicine
Okhotin, Helena M.D.	Provisional	Family Medicine
Parsa, Elyas D.O.	Active	Family Medicine
Rabada, John S.,M.D.	Affiliate	Family Medicine
Rowe, Michelle J.,D.O.	Active	Family Medicine
Sodhi, Monish M.D.	Provisional	Family Medicine
Wong, Spencer B.,M.D.	Courtesy	Family Medicine
Wunnava, Bhanu M.D.	Active	Family Medicine
Yep, Johnny K.,D.O.	Active	Family Medicine
Zuniga, Ramiro M.D.	Active	Family Medicine
Section: Licensed Clinical Social Worker		
Helsby, Sherri L.C.S.W.	Allied Health Provider	License Clinical Social Worker
Manuse, Patricia A.,L.C.S.W.	Provisional	License Clinical Social Worker
Section: Primary Medicine		
Alicar, Agnes T.,N.P.	Allied Health Provider	Nurse Practitioner
Nwaoha-Ezekwo, Theresa N.P.	Allied Health Provider	Nurse Practitioner
Section: Psychiatry		
Hira-Brar, Shabneet K.,M.D.	Provisional	Psychiatry
Section: Psychology		
Smith, Andrew R.,PhD	Consulting	Psychology
Section: Public Health		
Heffernan, Nancy J.,N.P.	Allied Health Provider	Nurse Practitioner

Facility: ALL

Department Section Roster

Department: OB/GYN

Name	Staff Category	Specialty
Bass, Jason T.,M.D.	Active	OBGYN
Benavidez-Knight, Tuesday M.,C.N.M.	Provisional	Nurse Midwife
Cefalo, Vivian R.,C.N.M.	Allied Health Provider	Nurse Midwife
Clark, Shannon L.,M.D.	Provisional	Maternal-Fetal Medicine
Davis, Catherine R.,N.P.	Allied Health Provider	Nurse Practitioner
Espinoza, Leslie C.N.M.	Provisional	Nurse Midwife
Field, Nancy M.D.	Consulting	Maternal-Fetal Medicine
Garza, Jr., Crisoforo G.,M.D.	Active	OBGYN
Harris-Stansil, Tonja M.D.	Active	OBGYN
Hernandez, Gerardo M.D.	Active	OBGYN
Hsu, Senzan M.D.	Active	OBGYN
Kennedy, Vanessa A.,M.D.	Consulting	Gynecologic Oncology
Le, Anh H.,M.D.	Active	OBGYN
Lee, Lloyd J.,M.D.	Active	OBGYN
Leiserowitz, Gary S.,M.D.	Courtesy	Gynecologic Oncology
Lim, Louis G.,M.D.	Active	OBGYN
Lindeken, Christopher M.,D.O.	Active	OBGYN
Mitchell, Christine A.,C.N.M.	Allied Health Provider	Nurse Midwife
Morris, Rebecca S.,C.N.M.	Allied Health Provider	Nurse Midwife
Motameni, Mandana C.N.M.	Allied Health Provider	Nurse Midwife
Otteno, Helen M.D.	Provisional	OBGYN
Pant, Meenakshi M.D.	Active	OBGYN
Pottala, Sreelatha M.D.	Active	OBGYN
Rodgers, Bennye D.,M.D.	Active	OBGYN
Ruskin, Rachel M.D.	Provisional	OBGYN
Schrimmer, David B.,M.D.	Consulting	OBGYN
Seacrist, Joan E.,C.N.M.	Allied Health Provider	Nurse Midwife
Sohal, Jeetinder S.,M.D.	Active	OBGYN
Tache, Veronique M.D.	Consulting	Maternal-Fetal Medicine
Tang, Qui N.,C.N.M.	Allied Health Provider	Nurse Midwife
Yera, Ramon E.,M.D.	Consulting	OBGYN
Zarza, Tamira C.N.M.	Allied Health Provider	Nurse Midwife

Facility: ALL

Department Section Roster

Name	Staff Category	Specialty
Department: Pediatrics		
Apolinario, Patricia C.,M.D.	Active	Pediatric
Berquist, William E.,M.D.	Consulting	Pediatric Gastroenterology
Elayyan, Ala M.,M.D.	Provisional	Pediatric
Hipolito, Ronaldo M.D.	Courtesy	Neonatal-Perinatal Medicine
Issa, Antonios M.D.	Courtesy	Neonatal-Perinatal Medicine
Jain, Mamta M.D.	Active	Pediatric
Ksar, Kari J.,N.P.	Allied Health Provider	Pediatric
Li, Walter L.,M.D.	Consulting	Pediatric Cardiology
Lindenberg, Jeffrey A.,M.D.	Active	Neonatal-Perinatal Medicine
Loomba, Ashish M.D.	Active	Pediatric
Moody, Toni C.,M.D.	Active	Pediatric
Rojanavongse, Patara M.D.	Active	Pediatric
Simko, Aaron J.,M.D.	Courtesy	Neonatal-Perinatal Medicine
Troncales, Alfred D.,M.D.	Active	Pediatric
Troncales, Imeline H.,M.D.	Active	Pediatric
Vashishtha, Neha M.D.	Active	Pediatric

PROCEDURE:

1. **Establish Data Integrity and Validation Controls:** Department Managers are responsible for establishing controls that support the completeness, consistency, validity, accuracy, and availability of data. A data integrity risk assessment methodology should be employed to address the limitations and factors that may lead to a loss in data integrity. The assessment must be shared with the appropriate staff. The most common limitations include:
   a. Coverage: not all appropriate data is present.
   b. Capture and collection: measures do not exist to minimize error or omission in data capture.
   c. Partial non-response: records received are not complete.
   d. Data currency: data is not up to date at the time of release.
   e. Data comparability: data is not consistent over time or uses inconsistent conventions.

   See Appendix A for data integrity risk assessment methodology.

2. **Data at Collection Point:** All users must enter the required data fields on the respective applications. Users must enter default values to denote missing data. For example, 1/1/1900 must be entered for date of birth if it is not available at the time of entry. This will flag users later in the workflow to attempt to collect the information from the source (person standing in front of them) or a different source system such as the Medi-Cal eligibility portal. See Appendix B for sample flow diagram.

3. **Maintain Integrity of Collected/Transmitted Data:** San Joaquin County Clinics' processes and practices intended to ensure the integrity of data include the following:
   a. Comprehensive documentation, updated as required, are provided for the guidance of staff on data usage.
   b. Formal records are maintained of any changes to source data.
   c. Permanent secure storage of the original submissions of data are maintained for auditing purposes and conform to County policy.
   d. Data moving from source system to a staging database must include the person who executed the process and when the record was moved to the staging database.
   e. The record must remain untouched. If an update to the record is received the record will be appended to the database table and set as the most current version. The old record will be marked as no longer current.
   f. Logging of data moving from staging to the enterprise data warehouse integration layer must include the source system, the date the record was introduced into the staging table, and the person or system loading the data.
   g. Data audit shall occurred during the process of moving data from source to staging. Missing data must be flagged for review and sent to the responsible person for correction.

PROCEDURE:

1. **Establish Data Integrity and Validation Controls:** Department Managers are responsible for establishing controls that support the completeness, consistency, validity, accuracy, and availability of data. A data integrity risk assessment methodology should be employed to address the limitations and factors that may lead to a loss in data integrity. The assessment must be shared with the appropriate staff. The most common limitations include:
   a. Coverage: not all appropriate data is present.
   b. Capture and collection: measures do not exist to minimize error or omission in data capture.
   c. Partial non-response: records received are not complete.
   d. Data currency: data is not up to date at the time of release.
   e. Data comparability: data is not consistent over time or uses inconsistent conventions.

   See Appendix A for data integrity risk assessment methodology.

2. **Data at Collection Point:** All users must enter the required data fields on the respective applications. Users must enter default values to denote missing data. For example, 1/1/1900 must be entered for date of birth if it is not available at the time of entry. This will flag users later in the workflow to attempt to collect the information from the source (person standing in front of them) or a different source system such as the Medi-Cal eligibility portal. See Appendix B for sample flow diagram.

3. **Maintain Integrity of Collected/Transmitted Data:** San Joaquin County Clinics' processes and practices intended to ensure the integrity of data include the following:
   a. Comprehensive documentation, updated as required, are provided for the guidance of staff on data usage.
   b. Formal records are maintained of any changes to source data.
   c. Permanent secure storage of the original submissions of data are maintained for auditing purposes and conform to County policy.
   d. Data moving from source system to a staging database must include the person who executed the process and when the record was moved to the staging database.
   e. The record must remain untouched. If an update to the record is received the record will be appended to the database table and set as the most current version. The old record will be marked as no longer current.
   f. Logging of data moving from staging to the enterprise data warehouse integration layer must include the source system, the date the record was introduced into the staging table, and the person or system loading the data.
   g. Data audit shall occurred during the process of moving data from source to staging. Missing data must be flagged for review and sent to the responsible person for correction.

h. Secure transmission of data conforms to County policy, including file encryption and secure transmission over the Internet.

4. **Inform Data Users of Their Responsibilities:** Department Managers are responsible for informing all data users of their responsibility to maintain the confidentiality and integrity of the data. Department Managers are also responsible for ensuring all data users complete mandatory information protection and compliance training as required by the County.

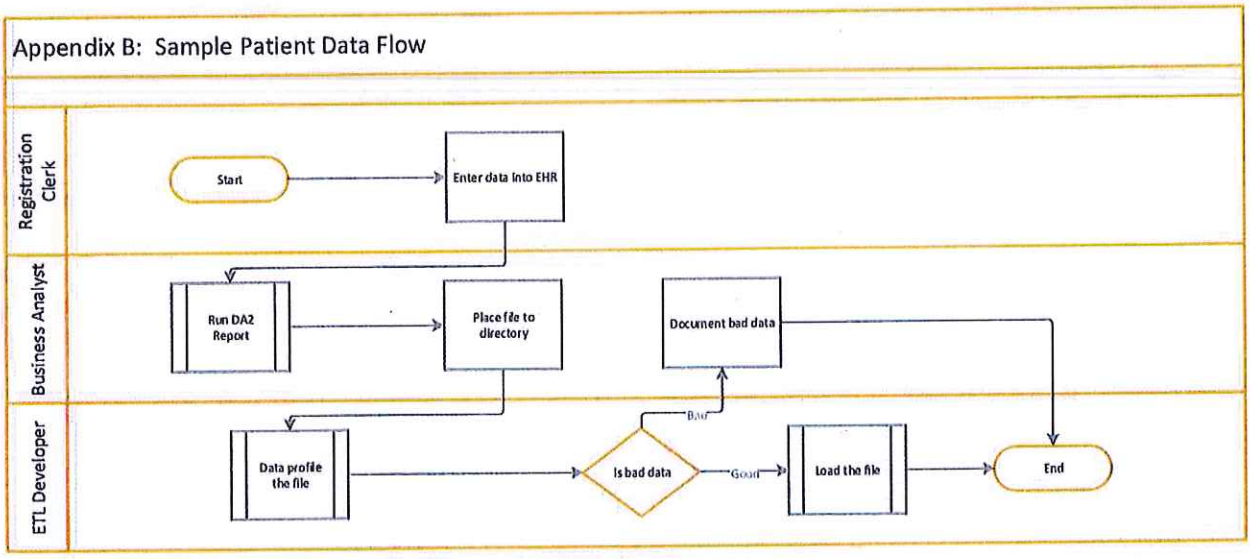
5. **Enterprise Data Warehouse Approach:** The data are moved from source → acquisition →conforming →integration → history → and finally dimension layer. This approach allows the data to be staged as-is from the source. The data are then moved from staging to the conforming layer while being conformed to business logics documented by the organization. The conforming layer uses a truncate and load strategy which keeps only the last load in the system. The conformed data are then loaded to the integration layer where data from all sources reside. Any changes to data must be recorded to the history layer. Data from integration and history layer will be used to build the star schema data model. To ensure data integrity, a row_id from the acquisition layer must follow the data to the integration layer. This will allow users to review data lineage and also troubleshoot when an error was introduced into the data warehouse. The dimension layer will also follow a truncate and load strategy to ensure the latest record is received. See Appendix C for diagram.

6. **Reporting:** The reporting of data will comply with the reporting guidelines provided by the regulatory body. Some of the reporting are PRIME (Public Hospital Redesign & Incentives in Medi-Cal Program), QIP (Quality Incentive Program), EPP (Enhanced Payment Program) to name a few. See Appendix D for informatics architecture.

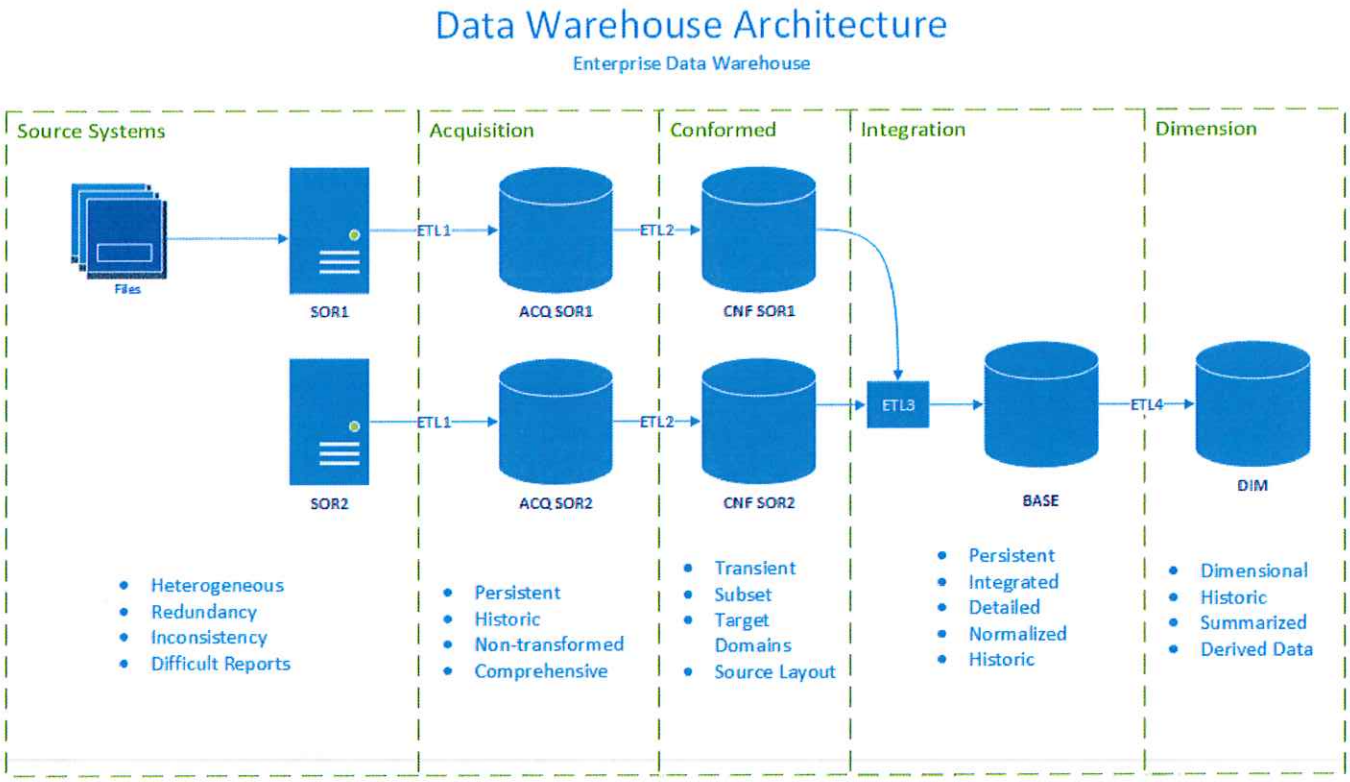
Appendix A: Data Integrity Risk Assessment Methodology

	Limitation Category	Category Definition	Data Integrity Impact: Completeness	Consistency	Validity	Accuracy	Availability
1	Coverage	Not all required data are present	X	X		X	X
2	Capture and collection	Not all data are captured	X	X	X	X	X
3	Partial non-response	Records received are not complete		X	X		
4	Data currency	Data is not up to date at the time release	X	X	X	X	X
5	Data comparability	Data not consistent over time	X	X	X	X	

Appendix B: Sample Patient Data Flow

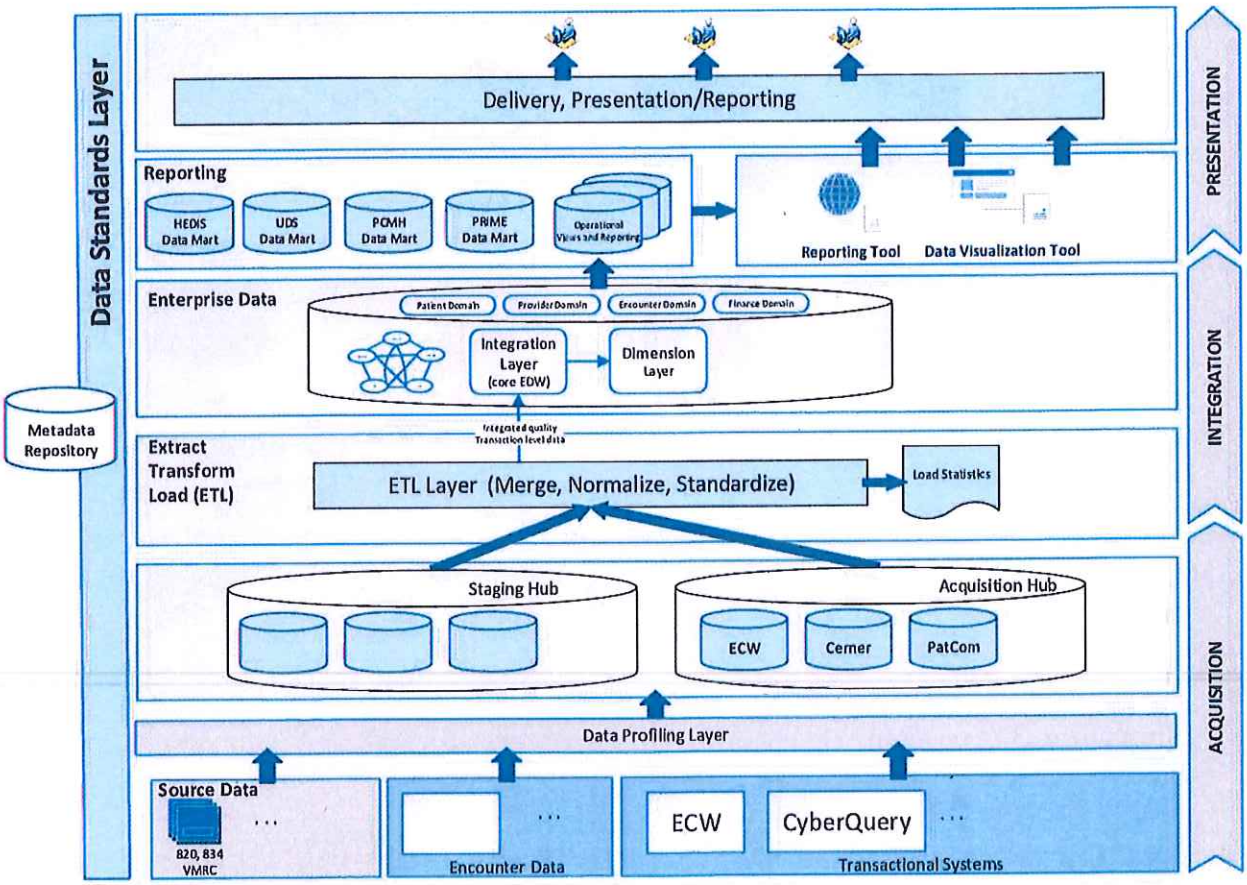


Appendix C: Data Warehouse Approach



Appendix D:

Informatics Architecture



References: PRIME Data Integrity Policy
Authors: Business Intelligence Director
Approvals: FQHC Board
Cc: All departments

WIPFLI LLP
CPAs and Consultants

Wipfli LLP
505 14th Street, 5th Floor
Oakland, CA 94612
510.768.0066
fax 510.768.0044
www.wipfli.com

To: David Culberson
Chuck Wiesen
San Joaquin County Clinics Board of Directors

From: Carlos Jimenez – Senior Manager

Subject: Medi-Cal FQHC Status - Hazelton and Manteca clinic sites

Date: October 30, 2018

For the past three years, I have served as the Project Manager for all the work Wipfli has and is performing for San Joaquin General Hospital (SJGH) and the San Joaquin County Clinics. As noted in various conversations and meetings over the past several months, Wipfli and SJGH staff have received conflicting information as to the FQHC status of the Hazelton and Manteca clinic sites from the Department of Health Care Services' (DHCS) FQHC/RHC Section. In that regard, the following is an update based on discussions I have recently had with Allison Clinton, DHCS' FQHC/RHC Section Chief. Ms. Clinton's unit is responsible for all aspects of Medi-Cal FQHC PPS rate setting.

We have confirmed that both sites are properly enrolled in the Medi-Cal program (Hazelton effective 4/3/17 and Manteca effective 6/21/17). They are currently listed as "County Clinic / Exempt from Licensure" (Provider Type 45) in the state's Provider Master File (PMF).

The enrollment letters were received in December 2017 with the retroactive effective dates noted above. At that time, an Initial Rate Setting Application Package (DHCS Form 3106) should have been submitted for each site. The people who would have been responsible for submission of the initial rate setting packages (at both Wipfli and San Joaquin) are no longer around so there is no way of knowing what did or did not occur at that time.

Upon receipt of a complete and acceptable Form 3106 for each site, DHCS would have changed the Provider Type for each site to 35 (FQHC/RHC) and set up interim payment rates in its system for Traditional Fee-for-Service and Wraparound (Code 18) Medi-Cal FQHC claims.

DHCS has informed us that it has no documentation indicating that rate setting applications for Hazelton or Manteca were ever received and processed. However, the situation is complicated by the fact that there are a significant number of Medi-Cal remittance advices from 2017 and 2018 in which Traditional

and Wraparound (Code 18) claims for Hazelton and Manteca were approved and paid at the same interim rates as San Joaquin's other FQHCs as shown in the tables below:

System: eCW
Dates of Service: 9/19/17 to 3/2/18
Payments posted through: 10/11/18

Decription	Number of Trad / Wrap Paid Claims	Amount of Trad / Wrap Payments	Imputed or Projected Payment Rate
Traditional	222	29,650	133.56
Mgd Care MCal Wrap	1,510	176,240	116.72
TOTAL	1,732	205,890	
Adjustments:			
Traditional @ FFS Rat	222	(8,880)	40.00
PROJECTED IMPACT: WORST-CASE SCENARIO		197,010	

System: Cerner
Dates of Service: 3/3/18 to Present
Payments posted through: 10/11/18

Decription	Number of Trad / Wrap Paid Claims	Amount of Trad / Wrap Payments	Imputed or Projected Payment Rate
Traditional	24	2,879	118.84
Mgd Care MCal Wrap	234	27,285	116.72
TOTAL	258	30,164	
Adjustments:			
Traditional @ FFS Rat	24	(969)	40.00
PROJECTED IMPACT: WORST-CASE SCENARIO		29,195	

Based on normal protocol, there should have been **no** PPS or Wrap payments made to a clinic designated as Provider Type 45. Nevertheless, DHCS has no explanation as to why these payments were made. In our experience, a clinic cannot receive FQHC payments unless it is designated as a Provider Type 35 in the PMF – a status that should be mirrored in the claims processing system. Under these circumstances, we must assume that at some point the Provider Type was changed to 35 in the claims processing system, thus allowing FQHC payment rates to be utilized.

It is unclear what action DHCS may take regarding payments made prior to the effective date of the rate setting applications we will be submitting – particularly because they have declared that there is no retroactivity regarding revised rates. Accordingly, DHCS will need to provide justification for any potential recoupments and depending on how things get processed, there may be subsequent implications for reimbursement and possible recourse on the part of San Joaquin.

We will complete and submit initial rate setting packages for each site at this time. When approved, the new interim rates for each site will be effective prospectively, on a specified date. That date will also determine the fiscal period for the final rate setting cost reports for each site. It is also likely this means that no PPS Reconciliations would be required until the end of the fiscal year in which the interim FQHC rates are established.

Given all the ambiguity, any talk of retroactivity must be taken with a grain of salt. It is not a given that DHCS will make a retroactive adjustment and not clear what justification they would provide in support of such an action. For this reason, we urge caution and patience in attempting to determine the ultimate financial impact of this situation.

Going forward, I will be coordinating the rate setting application process working with Cecilia Murillo in our Oakland office and Debbie Perry at San Joaquin. While others may be asked to contribute information or data, it is important that all communication be routed through myself, Cecilia, and Debbie so that the process can move forward in proper sequence.

6a

Basic Information - Review

00158505: SAN JOAQUIN, COUNTY OF — Due Date: 10/03/2018 (Due In: 5 Days) | Application Status: In Progress

Look-Alike Number: LALCS00158	Original Deadline: 10/03/2018	Created On: 08/05/2018
Project Officer: McCann, Mary	Project Officer Email: MMcCann@hrsa.gov	Project Officer Contact #: (301) 945-5140
Last Updated By: Anderson, Vanessa 9/28/2018 2:18:00 PM	Application Type: Annual Certification	Program Name: Look-Alike Health Center Program

Resources

Cover Page

Applicant Information

Legal Name	SAN JOAQUIN, COUNTY OF
Employer Identification Number (e.g. 53-2079819)	94-6000531
Organizational DUNS	884333345
Mailing Address	P.O. Box 1020 HCS Agency/Benton Hall East, Stockton, CA 95201-

Select Target Population(s)

Select	Target Population Type
[X]	Community Health Centers
[_]	Health Care for the Homeless
[_]	Migrant Health Centers
[_]	Public Housing

Point of Contact (POC) Information

Title of Position	Name	Phone	Email
Point of Contact	Vanessa Anderson	(209) 468-5616	vanderson@sjchcs.org

Authorizing Official (AO) Information

Title of Position	Name	Phone	Email
Authorizing Official	Gregory A Diederich	(209) 468-7031	GDiederich@sjchcs.org

Program Specific Form(s) - Review

00158505: SAN JOAQUIN, COUNTY OF — **Due Date: 10/03/2018 (Due In: 2 Days)**

Look-Alike Number: LALCS00158
Target Population: Community Health Centers
Application Type: Annual Certification
Current Certification Period: 7/1/2018 - 12/31/2018
Current Designation Period: 7/1/2014 - 12/31/2020

Resources

View

LAL AC User Guide | LAL AC Instructions

Form 3 - Income Analysis

As of 10/01/2018 05:54:16 PM
OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

Payer Category	Patients By Primary Medical Insurance (a)	Billable Visits (b)	Income Per Visit (c)	Projected Income (d)	Prior FY Income (e)
Part 1: Patient Service Revenue - Program Income					
1. Medicaid	31896.00	105258.00	$145.38	$15,302,408.04	$10,797,460.00
2. Medicare	3718.00	12268.00	$159.43	$1,955,887.24	$1,380,077.00
3. Other Public	0.00	0.00	$0.00	$0.00	$0.00
4. Private	569.00	1877.00	$24.14	$45,310.78	$31,970.00
5. Self Pay	1107.00	3652.00	$30.67	$112,006.84	$79,042.00
6. Total (Lines 1 - 5)	37290	123055	N/A	$17,415,612.90	$12,288,549.00
Part 2: Other Income - Federal, State, Local and Other Income					
7. Federal	N/A	N/A	N/A	$0.00	$0.00
8. State Government	N/A	N/A	N/A	$0.00	$0.00
9. Local Government	N/A	N/A	N/A	$15,807,203.00	$14,847,540.00
10. Private Grants/Contracts	N/A	N/A	N/A	$0.00	$0.00
11. Contributions	N/A	N/A	N/A	$0.00	$0.00
12. Other	N/A	N/A	N/A	$0.00	$0.00
13. Applicant (Retained Earnings)	N/A	N/A	N/A	$0.00	$0.00
14. Total Other (Lines 7- 13)	N/A	N/A	N/A	$15,807,203.00	$14,847,540.00
Total Income (Program Income Plus Other)					
15. Total Income (Lines 6+ 14)	N/A	N/A	N/A	$33,222,815.90	$27,136,089.00

Comments/Explanatory Notes (if applicable)

Form 3A - Budget Information

As of 10/01/2018 05:54:16 PM
OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

Budget Category	Community Health Centers (CHC - 330(e))	Migrant Health Centers (MHC - 330(g))	Health Care for Homeless (HCH - 330(h))	Public Housing Primary Care (PHPC - 330(i))	Total
1. Expenses					
a. Personnel	$12,958,061.90				$12,958,061.90
b. Fringe Benefits	$5,806,947.00				$5,806,947.00
c. Travel	$16,060.00				$16,060.00
d. Equipment	$518,849.00				$518,849.00
e. Supplies	$973,030.00				$973,030.00
f. Contractual	$4,453,381.00				$4,453,381.00
g. Construction	$0.00				$0.00

Budget Category	Community Health Centers (CHC - 330(e))	Migrant Health Centers (MHC - 330(g))	Health Care for Homeless (HCH - 330(h))	Public Housing Primary Care (PHPC - 330(i))	Total
h. Other	$309,704.00				$309,704.00
i. Total Direct Charges (sum of a through h)	$25,036,032.90	$0.00	$0.00	$0.00	$25,036,032.90
j. Indirect Charges	$8,186,783.00				$8,186,783.00
k. Total Expenses (sum of i and j)	$33,222,815.90	$0.00	$0.00	$0.00	$33,222,815.90
2. Revenue					
a. Applicant	$0.00				$0.00
b. Federal	$0.00				$0.00
c. State	$0.00				$0.00
d. Local	$15,807,203.00				$15,807,203.00
e. Other	$0.00				$0.00
f. Program Income	$17,415,612.90				$17,415,612.90
g. Total Revenue (sum of a through f)	$33,222,815.90	$0.00	$0.00	$0.00	$33,222,815.90

As of 10/01/2018 05:54:16 PM

OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

Form 5A - Required Services

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
General Primary Medical Care	[X]	[_]	[_]
Diagnostic Laboratory	[_]	[_]	[X]
Diagnostic Radiology	[_]	[_]	[X]
Screenings	[X]	[_]	[_]
Coverage for Emergencies During and After Hours	[_]	[_]	[X]
Voluntary Family Planning	[X]	[_]	[_]
Immunizations	[X]	[_]	[_]
Well Child Services	[X]	[_]	[_]
Gynecological Care	[X]	[_]	[_]
Obstetrical Care			
Prenatal Care	[X]	[_]	[_]
Intrapartum Care (Labor & Delivery)	[X]	[_]	[_]
Postpartum Care	[X]	[_]	[_]
Preventive Dental	[_]	[_]	[X]
Pharmaceutical Services	[_]	[_]	[X]
HCH Required Substance Use Disorder Services	[_]	[_]	[_]
Case Management	[X]	[_]	[_]
Eligibility Assistance	[X]	[_]	[_]
Health Education	[X]	[_]	[_]
Outreach	[X]	[_]	[_]
Transportation	[_]	[X]	[_]

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
Translation	[X]	[_]	[_]

As of 10/01/2018 05:54:16 PM
OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

Form 5A - Additional Services

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
Additional Dental Services	[_]	[_]	[_]
Behavioral Health Services			
Mental Health Services	[_]	[X]	[X]
Substance Use Disorder Services	[X]	[_]	[X]
Optometry	[_]	[_]	[_]
Recuperative Care Program Services	[_]	[_]	[_]
Environmental Health Services	[_]	[_]	[_]
Occupational Therapy	[_]	[_]	[X]
Physical Therapy	[_]	[_]	[X]
Speech-Language Pathology/Therapy	[_]	[_]	[_]
Nutrition	[_]	[_]	[_]
Complementary and Alternative Medicine	[_]	[_]	[_]
Additional Enabling/Supportive Services	[_]	[_]	[_]
Other - Health Care Interpreter Network	[_]	[X]	[_]

As of 10/01/2018 05:54:16 PM
OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

Form 5A - Specialty Services

Service Type	Column I - Direct (Health Center Pays)	Column II - Formal Written Contract/Agreement (Health Center Pays)	Column III - Formal Written Referral Arrangement (Health Center DOES NOT Pay)
Podiatry	[_]	[_]	[X]
Psychiatry	[_]	[_]	[_]
Endocrinology	[_]	[_]	[_]
Ophthalmology	[_]	[_]	[_]
Cardiology	[_]	[_]	[_]
Pulmonology	[_]	[_]	[_]
Dermatology	[_]	[_]	[_]
Infectious Disease	[_]	[_]	[_]
Gastroenterology	[_]	[_]	[_]
Advanced Diagnostic Radiology	[_]	[_]	[_]

Form 5B - Service Sites

As of 10/01/2018 05:54:16 PM
OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

Family Medicine Clinic (BPS-LAL-014284)

Action Status: Picked from Scope

Site Name	Family Medicine Clinic	Physical Site Address	500 W Hospital Rd Suite B, French Camp, CA 95231-9693
Site Type	Service Delivery Site	Site Phone Number	(209) 468-6709
Web URL	www.sjgeneralhospital.com		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	751127
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	50
Months of Operation	October, January, April, June, May, July, February, November, September, March, August, December		
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes	95202, 95240, 95330, 95203, 95242, 95215, 95210, 95204, 95231, 95236, 95205, 95376, 95209, 95206, 95366, 95207, 95377, 95337, 95212, 95219, 95336

Primary Medicine Clinic (BPS-LAL-014446)

Action Status: Picked from Scope

Site Name	Primary Medicine Clinic	Physical Site Address	500 W Hospital Rd, French Camp, CA 95231-9693
Site Type	Service Delivery Site	Site Phone Number	
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	0
Months of Operation			
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes	

Children's Health Services (BPS-LAL-014441)

Action Status: Picked from Scope

Site Name	Children's Health Services	Physical Site Address	1414 N California St, Stockton, CA 95202-1515

Site Type	Service Delivery Site	Site Phone Number	
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	0
Months of Operation			
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes

Family Practice Clinic California (BPS-LAL-014285) — **Action Status: Picked from Scope**

Site Name	Family Practice Clinic California	Physical Site Address	1414 N CALIFORNIA ST Suite C, STOCKTON, CA 95202-1515
Site Type	Service Delivery Site	Site Phone Number	(209) 468-9540
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	050167
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	40
Months of Operation	August, July, June, May, December, November, October, September, February, April, March, January		
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes: 95207, 95236, 95215, 95202, 95242, 95376, 95209, 95366, 95219, 95212, 95206, 95210, 95203, 95204, 95337, 95330, 95205, 95240, 95336, 95231, 95377

Family Practice Clinic California (BPS-LAL-014443) — **Action Status: Picked from Scope**

Site Name	Family Practice Clinic California	Physical Site Address	1414 N CALIFORNIA ST, STOCKTON, CA 95202-1515
Site Type	Service Delivery Site	Site Phone Number	
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	

FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	0
Months of Operation			
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes

Hazelton Clinic (BPS-LAL-019320) — **Action Status: Picked from Scope**

Site Name	Hazelton Clinic	Physical Site Address	1601 E Hazelton Ave, Stockton, CA 95205-6229
Site Type	Service Delivery Site	Site Phone Number	(209) 468-6820
Web URL	www.sjcclincs.org		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	2/28/2017	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	
FQHC Site National Provider Identification (NPI) Number	1679023980	Total Hours of Operation	40
Months of Operation	August, July, June, May, December, November, October, September, April, March, January, February		
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes: 95204, 95212, 95210, 95336, 95337, 95231, 95219, 95207, 95206, 95215, 95209, 95377, 95320, 95203, 95202, 95236, 95376, 95240, 95366, 95330, 95242, 95205

Healthy Beginnings California (BPS-LAL-014287) — **Action Status: Picked from Scope**

Site Name	Healthy Beginnings California	Physical Site Address	1414 N California St Suite B, Stockton, CA 95202-1515
Site Type	Service Delivery Site	Site Phone Number	(209) 468-8154
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	050167
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	40
Months of Operation	May, June, July, August, January, February, March, April, November, September, October, December		
Number of Contract Service Delivery		Number of Intermittent Sites	0

Locations	
Site Operated by	Health Center/Applicant

Organization Information

No Organization Added

Service Area Zip Codes	95206, 95205, 95377, 95242, 95203, 95212, 95366, 95210, 95236, 95330, 95376, 95231, 95204, 95219, 95209, 95337, 95202, 95240

Family Medicine Clinic (BPS-LAL-014442) — Action Status: Picked from Scope

Site Name	Family Medicine Clinic	Physical Site Address	500 W Hospital Rd, French Camp, CA 95231-9693
Site Type	Service Delivery Site	Site Phone Number	
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	0
Months of Operation			
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes	

Healthy Beginnings (BPS-LAL-014444) — Action Status: Picked from Scope

Site Name	Healthy Beginnings	Physical Site Address	500 W Hospital Rd, French Camp, CA 95231-9693
Site Type	Service Delivery Site	Site Phone Number	
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	0
Months of Operation			
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes

Children's Health Services (BPS-LAL-014283) — Action Status: Picked from Scope

Site Name	Children's Health Services	Physical Site Address	1414 N California St Suite A, Stockton, CA 95202-1515
Site Type	Service Delivery Site	Site Phone Number	(209) 468-8154
Web URL	www.sjgeneralhospital.com		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	751117
FQHC Site National Provider Identification (NPI) Number	1083955801	Total Hours of Operation	50
Months of Operation	October, January, April, June, May, July, February, November, September, March, August, December		
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes	95202, 95337, 95203, 95204, 95330, 95219, 95376, 95206, 95205, 95377, 95240, 95212, 95210, 95242, 95236, 95231, 95366, 95209

Healthy Beginnings French Camp (BPS-LAL-014286) — Action Status: Picked from Scope

Site Name	Healthy Beginnings French Camp	Physical Site Address	500 W Hospital Rd Suite A, French Camp, CA 95231-9693
Site Type	Service Delivery Site	Site Phone Number	(209) 468-6131
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	751119
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	50
Months of Operation	October, January, April, June, May, July, February, November, September, March, August, December		
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes	95209, 95376, 95204, 95330, 95206, 95212, 95242, 95207, 95219, 95366, 95337, 95336, 95236, 95231, 95210, 95215, 95240, 95205, 95202, 95203, 95377

Healthy Beginnings (BPS-LAL-014445) — Action Status: Picked from Scope

Site Name	Healthy Beginnings	Physical Site Address	1414 N California St, Stockton, CA 95202-1515

Site Type	Service Delivery Site	Site Phone Number	
Web URL			
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	0
Months of Operation			
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes

Manteca Clinic (BPS-LAL-020767) — **Action Status: Picked from Scope**

Site Name	Manteca Clinic	Physical Site Address	283 Spreckels Ave, Manteca, CA 95336-6005
Site Type	Service Delivery Site	Site Phone Number	(209) 468-6820
Web URL	www.sjcclinics.org		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	6/20/2017	Site Operational By	
FQHC Site Medicare Billing Number Status		FQHC Site Medicare Billing Number	921002
FQHC Site National Provider Identification (NPI) Number	1417407636	Total Hours of Operation	50
Months of Operation	October, January, April, June, May, July, February, November, September, March, August, December		
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes: 95320, 95205, 95219, 95210, 95212, 95215, 95230, 95202, 95391, 95207, 95234, 95304, 95236, 95231, 95203, 95220, 95377, 95206, 95330, 95209, 95336, 95258, 95376, 95240, 95237, 95337, 95242, 95204, 95366

Primary Medicine Clinic (BPS-LAL-014288) — **Action Status: Picked from Scope**

Site Name	Primary Medicine Clinic	Physical Site Address	500 W Hospital Rd Suite C, French Camp, CA 95231-9693
Site Type	Service Delivery Site	Site Phone Number	(209) 468-7162
Web URL	www.sjgeneralhospital.com		
Location Type	Permanent	Site Setting	All Other Clinic Types
Date Site was Added to Scope	7/1/2014	Site Operational By	
FQHC Site Medicare Billing Number		FQHC Site Medicare Billing Number	

Status	This site has a Medicare billing number		75750
FQHC Site National Provider Identification (NPI) Number		Total Hours of Operation	50
Months of Operation	October, January, April, June, May, July, February, November, September, March, August, December		
Number of Contract Service Delivery Locations		Number of Intermittent Sites	0
Site Operated by	Health Center/Applicant		

Organization Information

No Organization Added

Service Area Zip Codes	95209, 95207, 95377, 95242, 95376, 95231, 95204, 95205, 95330, 95336, 95236, 95210, 95202, 95219, 95240, 95337, 95206, 95212, 95215, 95366, 95203

Form 5C - Other Activities/Locations

As of 10/01/2018 05:54:16 PM
OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

Activity/Location Information

Type of Activity	Home Visits
Frequency of Activity	The Home visits are done based on patient needs frequently with patients in palliative care and/or where pain in movement is so limiting that the provider decides to see the patient at home.
Description of Activity	The provider makes a regular visit to evaluate and adjust treatment for a patient confined to home or nursing home.
Type of Location(s) where Activity is Conducted	Patient Homes and Nursing Homes.

Activity/Location Information

Type of Activity	Portable Clinical Care
Frequency of Activity	Weekly sick call at an Army base for the participants in a camp for High School aged young people in a six month program.
Description of Activity	Each of the Camp participants is given a Physical at the FQHC center. All of the follow up sick call services are provided by nurses and EMT's. If the needs require a Physician, they are transported to the FQHC for care.
Type of Location(s) where Activity is Conducted	An army base which operates a camp for these young folks.

Activity/Location Information

Type of Activity	Health Fairs
Frequency of Activity	There are usually at least ten events per year but will do more if opportunities become available.
Description of Activity	SJCC provides health education and point of care testing for participants.
Type of Location(s) where Activity is Conducted	The events are scheduled in parks, Community Centers, Business parking lots, San Joaquin Hospital Campus, etc.

Scope Certification

As of 10/01/2018 05:54:16 PM
OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

1. Scope of Project Certification - Services – Select only one below

[X] By checking this option, I certify that I have reviewed my Form 5A: Services Provided and it accurately reflects all services and service delivery methods included in my current approved scope of project.

[ ] By checking this option, I certify that I have reviewed my Form 5A: Services Provided and it requires changes that I have submitted through the change in scope process.

2. Scope of Project Certification - Sites - Select only one below

[X] By checking this option, I certify that I have reviewed my Form 5B: Service Sites and it accurately reflects all sites included in my current approved scope of project.
[ ] By checking this option, I certify that I have reviewed my Form 5B: Service Sites and it requires changes that I have submitted through the change in scope process.

As of 10/01/2018 05:54:16 PM
OMB Number: 0915-0285 OMB Expiration Date: 12/31/2016

Program Narrative Update - Environment and Organizational Capacity

Environment

Discuss the major changes at the community level, as well as state and/or regional level changes, over the past year that have directly impacted the progress of the designated project, including changes in:

- **Service area demographics and shifting target population needs;**
- **Major health care providers in the service area;**
- **Key program partnerships; and**
- **Changes in insurance coverage, including Medicaid, Medicare and the Children's Health Insurance Program (CHIP).**

Recent California law requires Medi-Cal Managed Care Plans to provide non-emergency medical transportation for their enrollees, if needed, to access medical appointments. The majority of SJCC patients are enrolled in Medi-Cal Managed Care and our staff help patients access this benefit. One of the major political topics of the nation for "Repeal and Replace" the Affordable Care Act has created much uncertainty in the region, community and organization. If eventually successful, this action could leave millions of Californians uninsured. The repeal of the individual mandate included in the 2017 tax reform legislation may lead to increased premiums, consequently forcing some to opt out of the coverage market, thereby increasing the number of uninsured. It is too early to measure any impacts, if any, to SJCC related to this reform. Other than SJCC, the only non-county owned and operated primary care clinics located in the service area are CMC (a FQHC grantee) and two school-based primary care clinics owned and operated by Delta Health Care and Management Services Corporation, and Golden Valley Health Center SJCC is seeking recognition as a patient-centered medical home. With the move to an enterprise health information infrastructure that bridges information across the ambulatory and acute care continuum, new staffing models supporting team-based care and population health, and more sophisticated capabilities around data analytics, SJCC is poised for success with its PCMH work. Key areas of focus in the PCMH effort include improvements in access and continuity, patient engagement, quality measurement and management, and patient experience.

Organizational Capacity

Discuss the major changes in the organization's capacity over the past year that have impacted or may impact the progress of the designated project, including changes in:

- **Staffing, including key vacancies;**
- **Operations;**
- **Systems, including financial, clinical, and/or practice management systems; and**
- **Financial status, including the most current audit findings, as applicable.**

The Hazelton Location requires absorbing a Public Health service into the FQHC and integrate into Primary Care. It also is close in proximity to some large Homeless encampments and services which adds another dimension to service needs Recently, SJCC implemented a new Health Information System (Cerner) that provides electronic patient, administrative and financial data efficiently and will allow information to be obtained with analyses of processes, outcomes and clinical activities. Some of the programs such as reminder calls and referral programs were not part of the original install and so staff have had to create temporary workarounds. In the next months some programs such as reminder calls and referral programs will be implemented to further optimize the automated medical record. Through the expansion of hours of availability more access is available to patients and accounts for some of the continued growth. SJCC's Executive Director retired December 2017. The SJCC Board hired an ED in April who subsequently resigned. Subsequently, the Interim CEO has been offered and has now started. The Interim Chief Financial Officer (CFO) for SJCC began a year and a half ago. A civil service position is now being finalized with the County

system for a permanent Finance Director. This person will be hired about the beginning of the 2019 year. The CMO has many years of experience in Medicine and in Medical leadership in an FQHC and is well known and respected among the physician community.

Program Narrative Update - Telehealth

Telehealth

Describe your use of telehealth to provide comprehensive primary health care services and engage in professional education, as applicable.

Note: Telehealth is defined as the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

San Joaquin County Clinics has been utilizing telehealth to support patient care by utilizing resources around our community. We currently utilize Direct Derm to store and forward referrals to Board Certified Dermatologist. We also provide same day access for teleretinoscopy (EyePACS) service that is reviewed by a doctor at UC Berkley and assigned a diagnosis within 24 hours. More use of telehealth is in the horizon for this organization. We are in the beginning stages of rolling out e-consult in the coming months for our specialty clinics and expect to see that transition over to primary care in the near future.

Program Narrative Update - Patient Capacity

Patient Capacity

Referencing the % Change 2015-2017 Trend, % Change 2016-2017, and % Progress Toward Goal columns:

- Discuss the trends in unduplicated patients served and report progress in reaching the projected number of patients to be served in the identified categories. In the Patient Capacity Narrative column, explain key factors driving changes in patient numbers and any negative trends or limited progress toward the projected patient goals.

Notes:

- **2015-2017 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report.**
- **Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and explanations in the Patient Capacity Narrative section.**

Designation Period: 7/1/2014 - 12/31/2020

Unduplicated Patients	2015 Patient Number ⓘ	2016 Patient Number ⓘ	2017 Patient Number ⓘ	% Change 2015-2017 Trend ⓘ	% Change 2016-2017 Trend ⓘ	% Progress Toward Goal ⓘ	Projected Number of Patients	Patient Capacity Narrative (for Current Designation Period)

Notes:

- 2015-2017 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report.
- Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and explanations in the Patient Capacity Narrative section.

Designation Period: 7/1/2014 - 12/31/2020

Unduplicated Patients	2015 Patient Number (i)	2016 Patient Number (i)	2017 Patient Number (i)	% Change 2015-2017 Trend (i)	% Change 2016-2017 Trend (i)	% Progress Toward Goal (i)	Projected Number of Patients	Patient Capacity Narrative (for Current Designation Period)
Total Unduplicated Patients	29144	28895	31224	7.14%	8.06%	N/A	N/A	SJCC has seen an increase since 2014 with 25,862 patients to 28,895 in 2016 and 31,224 in 2017. SJCC continues to expand within the financial ability to do so. In 2017, SJCC added two clinic sites – one on Hazelton Street in Stockton and one in Manteca. These added sites will have expanded provider/staff and should further grow the capacity for clients. There is demand beyond the current patient load which is exhibited in pressure for appointments and patients are known to be showing up in the Hospital Emergency Department for Ambulatory care. San Joaquin County has a population of 745,424 of which 41.3% are below 200% of federal Poverty level and 16.1% uninsured. 30.9% of the population is on Medi-Cal. There are approximately 20,000 of SJCC's managed care plan members yet to schedule at least annually. SJCC is working to see that population. SJCC has expanded hours in two clinics to 65 hours per week including Saturday hours. So this makes more convenient times available to the working families. With additional providers capacity is expanding. SJCC expects to continue to grow to give more people access.

Notes:

- 2015-2017 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report.
- Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and explanations in the Patient Capacity Narrative section.

Designation Period: 7/1/2014 - 12/31/2020

Special Populations	2015 Patient Number (i)	2016 Patient Number (i)	2017 Patient Number (i)	% Change 2015-2017 Trend (i)	% Change 2016-2017 Trend (i)	% Progress Toward Goal (i)	Projected Number of Patients	Patient Capacity Narrative (for Current Designation Period)

Notes:

- **2015-2017 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report.**
- **Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and explanations in the Patient Capacity Narrative section.**

Designation Period: 7/1/2014 - 12/31/2020

Special Populations	2015 Patient Number ⓘ	2016 Patient Number ⓘ	2017 Patient Number ⓘ	% Change 2015-2017 Trend ⓘ	% Change 2016-2017 Trend ⓘ	% Progress Toward Goal ⓘ	Projected Number of Patients	Patient Capacity Narrative (for Current Designation Period)
Total Migratory and Seasonal Agricultural Worker Patients	731	697	915	25.17%	31.28%	Data not available	Data not available	San Joaquin County has 3% of the land in agriculture. So it is not a significant employer of Migrant and/or seasonal Agricultural Workers. Immediately to the south are seven counties which constitute the largest farming valley in California and employ significant numbers of such workers. SJCC saw 915 migratory or seasonal agricultural workers as reported in the 2017 UDS report.

Notes:

- 2015-2017 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report.
- Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and explanations in the Patient Capacity Narrative section.

Designation Period: 7/1/2014 - 12/31/2020

Special Populations	2015 Patient Number (i)	2016 Patient Number (i)	2017 Patient Number (i)	% Change 2015-2017 Trend (i)	% Change 2016-2017 Trend (i)	% Progress Toward Goal (i)	Projected Number of Patients	Patient Capacity Narrative (for Current Designation Period)
Total People Experiencing Homelessness Patients	434	359	433	-0.23%	20.61%	Data not available	Data not available	The 2016 Community Health Needs Assessment reported 2,641 homeless in San Joaquin County. In the past year, SJCC served 433 patients who self-identified as Homeless. There may be other patients who have not made any statement which would indicate they are homeless. Homelessness has become a much more visible problem to the community. There are calls in the community to "solve" the homelessness problem. The San Joaquin County Board of Supervisors have adopted strategic priorities on homelessness to provide guidance and foster collaboration and coordination between the County, Cities and other stakeholders engaged in activities that serve the homeless population or those facing homelessness. San Joaquin County was awarded funding under the Section 1115 Medi-Cal waiver for the Whole Person Care (WPC) pilot program. This pilot program is an opportunity to innovatively create and test a care management infrastructure geared toward serving high-risk and high-utilizers of care. The WPC pilot has established target populations, one of which are adult Medi-Cal beneficiaries who are homeless or at risk of homelessness upon discharge of a facility. SJCC has committed to partnering with this WPC pilot program as the health center that will support primary care needs for these beneficiaries. 58.3% of renters are paying more than 30% of their income on rent. There are over 20 known shelters in San Joaquin serving the Homeless including the Mary Graham Children's Shelter operated by San Joaquin County and served by Clinical staff of SJCC. The unemployment rate in 2018 is 8.9%

Notes:

- 2015-2017 Patient Number data are pre-populated from Tables 3a and 4 in the UDS Report.
- Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and explanations in the Patient Capacity Narrative section.

Designation Period: 7/1/2014 - 12/31/2020

Special Populations	2015 Patient Number ⓘ	2016 Patient Number ⓘ	2017 Patient Number ⓘ	% Change 2015-2017 Trend ⓘ	% Change 2016-2017 Trend ⓘ	% Progress Toward Goal ⓘ	Projected Number of Patients	Patient Capacity Narrative (for Current Designation Period)
Total Public Housing Resident Patients	557	0	0	-100.00%	Data not available	Data not available	Data not available	San Joaquin County's supply of public housing is very limited. Furthermore, SJCC does not operate a site located in or immediately accessible to a public housing site - which is the reason for reporting "0" in 2016 and 2017. SJCC does not intend to establish a site located in or immediately accesible to a public housing site during the current designation period.

Notes:

- 2015-2017 Patient Number data are pre-populated from Table 5 in the UDS Report.
- Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section.

Designation Period: 7/1/2014 - 12/31/2020

Patients and Visits by Service Type	2015 Patient Number ⓘ	2016 Patient Number ⓘ	2017 Patient Number ⓘ	% Change 2015-2017 Trend ⓘ	% Change 2016-2017 Trend ⓘ	% Progress Toward Goal ⓘ	Projected Number of Patients	Patient Capacity Narrative (for Current Project Period)

Notes:

- **2015-2017 Patient Number data are pre-populated from Table 5 in the UDS Report.**
- **Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section.**

Designation Period: 7/1/2014 - 12/31/2020

Patients and Visits by Service Type	2015 Patient Number ⓘ	2016 Patient Number ⓘ	2017 Patient Number ⓘ	% Change 2015-2017 Trend ⓘ	% Change 2016-2017 Trend ⓘ	% Progress Toward Goal ⓘ	Projected Number of Patients	Patient Capacity Narrative (for Current Project Period)
Total Medical Services Patients	29144	28869	31224	7.14%	8.08%	98.05%	31846	SJCC has seen an increase since 2014 with 25,862 patients to 28,895 in 2016 and 31,224 in 2017. SJCC continues to expand within the financial ability to do so. In 2017, SJCC added two clinic sites – one on Hazelton Street in Stockton and one in Manteca. These added sites will have expanded provider/staff and should further grow the capacity for clients. There is demand beyond the current patient load which is exhibited in pressure for appointments and patients are known to be showing up in the Hospital Emergency Department for Ambulatory care. UDS Mapper shows that the FQHC's serving San Joaquin County are reaching 38% of the target population, so there is much more access still needed. Within the financial constraints of SJCC, SJCC will continue to grow services to reach more of those needed services. San Joaquin County has a population of 745,424 of which 41.3% are below 200% of federal Poverty level and 16.1% uninsured. 30.9% of the population is on Medi-Cal. There are approximately 20,000 of SJCC's managed care plan members yet to schedule at least annually.
Total Dental Services Patients	0	0	0	Data not available	Data not available	Data not available	0	SJCC is doing preventive dental varnishes. SJCC participates in a First 5 Dental program for referring patients for services and listed providers seeing patients at reduced fees.

Notes:

- 2015-2017 Patient Number data are pre-populated from Table 5 in the UDS Report.
- Patient projections cannot be edited during the AC submission. If pre-populated patient projections are not accurate, provide adjusted projections and an explanation in the Patient Capacity Narrative section.

Designation Period: 7/1/2014 - 12/31/2020

Patients and Visits by Service Type	2015 Patient Number (i)	2016 Patient Number (i)	2017 Patient Number (i)	% Change 2015-2017 Trend (i)	% Change 2016-2017 Trend (i)	% Progress Toward Goal (i)	Projected Number of Patients	Patient Capacity Narrative (for Current Project Period)
Total Mental Health Services Patients	0	337	410	Data not available	21.66%	Data not available	0	SJCC will continue to grown the number of patients accessing mental health services. The psychiatrist is providing consult services primarily to primary care physicians ofter around psychotropic medications and intervention strategies. They also see a small group of patients for therapy. Therapeutic counseling will be increased as the availability of therapists increases. The LCSW's are doing therapy counseling sessions. These are expected to exceed the numbers of patients from the previous years since there are now two LCSW's full time and more planned for the future.
Total Substance Use Disorder Services Patients	0	0	0	Data not available	Data not available	Data not available	0	Substance Abuse counselors have recently joined SJCC and are beginning to assess and intervene with patients on substance use and abuse. This begins with one person but is also expected to increase in the future.
Total Enabling Services Patients	7696	1132	578	-92.49%	-48.94%	7.29%	7929	Enabling services have been consistently provided over the past three years. However, the reporting of them in UDS has varied with the changes of leadership. The services are been recorded and tracked and the process and procedures for reporting will return to the expected levels of over 7,000.

Program Narrative Update - Clinical/Financial Performance Measures

Clinical/Financial Performance Measures

Referencing the % Change 2015-2017 Trend, % Change 2016-2017 Trend, and % Progress Toward Goal columns, discuss the trends for:

- Each of the measures aligned with HRSA and BPHC clinical priorities:
  - Diabetes: Hemoglobin A1c Poor Control
  - Screening for Clinical Depression and Follow-Up Plan
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
  - Body Mass Index (BMI) Screening and Follow-Up
- The measures within each of the remaining sections for which you have experienced a negative trend. If you have no negative trends within one or more of these sections (e.g., Preventive Health Screenings and Services), state this in the Measure Narrative field for the relevant section(s).

In the Clinical/Financial Performance Measures Narrative column, describe the following as it relates to the data:

a. An explanation of negative trends;
b. Key contributing and restricting factors affecting progress toward goals; and
c. Plans for improving progress and/or overcoming barriers to ensure goal achievement.

Notes:

- See PAL 2017-02 for details about the two performance measures that were updated in 2017.
- 2015 – 2017 Measure fields will prepopulate from UDS, if available.
- (*) Due to the fact that Cervical Cancer and IVD goals were set and reported in UDS based on different measure definitions, data will not display for some fields.
- (**) If you have no negative trends within one or more of these sections (e.g., Preventive Health Screenings and Services), state this in the Measure Narrative field for the relevant section(s).>
- Performance measure goals cannot be edited during the AC submission. If pre-populated performance measure goals are not accurate, provide an adjusted goal and explanation in the appropriate Measure Narrative section (e.g., goal for the low birth weight measure has increased based on improved patient tracking via a new EHR).

Measures Aligned with HRSA and BPHC Clinical and Financial Priorities

Clinical Measures

Performance Measure	2015 Measures	2016 Measures	2017 Measures	% Change 2015-2017 Trend	% Change 2016-2017 Trend	% Progress toward Goal	Measure Goals	Measure Narrative
Diabetes: Hemoglobin A1c Poor Control	Data not available	Numerator: 811.2857 Denominator : 3786.0000 Calculated Value: 21.4300	Numerator: 1032.0000 Denominator : 3440.0000 Calculated Value: 30.0000	Data not available	39.99%	94.01%	31.91%	Diabetes control between 2016-2017 we are Trending upward and increased compliance by 39.99%. We are nearly meeting our goal at 94.01% compliance. An ever changing population makes it increasingly difficult to perform patient outreach in order to assist in managing their diseases. Our Population Health Management department will aid in managing the incoming member assignments in the upcoming year. The ability to have one patient record across multiple care settings will help produce comprehensive reports to capture and analyze data to more efficiently provide patient care. We will develop real time reports to identify the diabetic patient population who have poor hemoglobin A1c control and utilize the resources available at the organization to help them better control their hemoglobin A1c.
Screening for Clinical Depression and Follow-Up Plan	Data not available	Numerator: 10590.0000 Denominator : 19325.0000 Calculated Value: 54.8000	Numerator: 14206.0000 Denominator : 20103.0000 Calculated Value: 70.6700	Data not available	28.96%	89.61%	78.86%	For our depression measure the 2015-2017 measure period saw a slight decrease of -3.01%. Between 2016-2017 we increased compliance by 28.90%. Since rebounding in 2017 we are progressing at 89.61% towards our goal. Varying workflows and treatment options across each of the clinics had caused our performance to slip, the workflow issues had since been resolved. We will be improving our progress in the upcoming year by reinforcing best practices and developing reports to see where there are lapse in care for patients.

Performance Measure	2015 Measures	2016 Measures	2017 Measures	% Change 2015-2017 Trend	% Change 2016-2017 Trend	% Progress toward Goal	Measure Goals	Measure Narrative
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Numerator: 53.0000 Denominator: 70.0000 Calculated Value: 75.7100	Numerator: 4900.0000 Denominator: 6056.0000 Calculated Value: 80.9100	Numerator: 4908.0000 Denominator: 6726.0000 Calculated Value: 72.9700	-3.62%	-9.81%	133.40%	54.70%	Child Weight Assessment and Counseling performance slipped by -3.62% between 2015-2017 and also in 2016-2017 by -9.81% From our 2017 measure outcomes we are still currently above our measure goal of 54.70% Our new Hazelton clinic, formerly Public Health clinic, was absorbed by this FQHC and have had struggles converting from offering limited primary care to advance primary care. We will provide additional trainings and emphasize the advance care required for our patients.We will continue to monitor quality and make necessary interventions to improve our outcomes and maintain our compliance above our goal.
Body Mass Index (BMI) Screening and Follow-Up	Data not available	Numerator: 10107.0000 Denominator: 16664.0000 Calculated Value: 60.6500	Numerator: 10945.0000 Denominator: 17855.0000 Calculated Value: 61.3000	Data not available	1.07%	114.37%	53.60%	We increased our BMI Screening and Follow-up compliance by 12.91% between 2015-2017 and also increased between 2016-2017 by 1.07%. From our 2017 measure outcomes we are still currently above our measure goal of 53.60% Since converting to an electric health recording in the outpatient space the EHR's has allowed us to easily capture the result of BMI scores and provider documentation of follow up plans if required. We will continue to work internally to develop best practices and stress the importance of these screenings for our patients.

Perinatal Health

Performance Measure	2015 Measures	2016 Measures	2017 Measures	% Change 2015-2017 Trend	% Change 2016-2017 Trend	% Progress toward Goal	Measure Goals
Early Entry into Prenatal Care	Numerator: 510.0000 Denominator: 909.0000 Calculated Value: 56.1100	Numerator: 625.0000 Denominator: 1092.0000 Calculated Value: 57.2300	Numerator: 680.0000 Denominator: 1106.0000 Calculated Value: 61.4800	9.57%	7.43%	78.92%	77.90%
Low Birth Weight	Numerator: 66.0000 Denominator: 653.0000 Calculated Value: 8.5800	Numerator: 82.0000 Denominator: 782.0000 Calculated Value: 10.4900	Numerator: 63.0000 Denominator: 740.0000 Calculated Value: 8.5100	-0.82%	-18.88%	109.10%	7.80%

Measure Narrative

Our patients that received prenatal care in the first trimester has increased between 2015-2017 by 9.57% and again by 7.43% between 2016-2017 and our progress is now 78.92% towards our goal. We have also reduced the number of low birth weight deliveries during the 2017 measurement period and increased our progress towards our goal to 91.66%. We have improved in these two areas since last year and expect to continue to increase

compliance during the upcoming year. Increased access to OB/GYN providers by adding providers has allowed more patients to schedule appointments and begin prenatal care sooner. Ongoing recruitment and adding an additional OB/GYN clinic in Manteca will provide additional access for patients. As new managed Medi-Cal population changes it makes it increasingly difficult to perform patient outreach in order to offer preventative health screenings and services. We plan to utilize our resources in our Population Health Management department in the current measurement period to better manage the incoming member assignments.

Preventive Health Screenings and Services

Performance Measure	2015 Measures	2016 Measures	2017 Measures	% Change 2015-2017 Trend	% Change 2016-2017 Trend	% Progress toward Goal	Measure Goals
Dental Sealants for Children between 6 – 9 Years	Data not available	Data not available	Numerator: 0.0000 Denominator: 0.0000 Calculated Value: 0.0000	Data not available	Data not available	Data not available	0.00%
Tobacco Use: Screening and Cessation Intervention	Data not available	Numerator: 13726.0000 Denominator: 15087.0000 Calculated Value: 90.9900	Numerator: 18180.0000 Denominator: 20801.0000 Calculated Value: 87.4000	Data not available	-3.95%	111.15%	78.63%
Colorectal Cancer Screening	Data not available	Numerator: 30.0000 Denominator: 70.0000 Calculated Value: 42.8600	Numerator: 2585.0000 Denominator: 7641.0000 Calculated Value: 33.8300	Data not available	-21.07%	56.52%	59.85%
Cervical Cancer Screening *	Data not available	Data not available	Numerator: 38.0000 Denominator: 70.0000 Calculated Value: 54.2900	Data not available	Data not available	99.93%	54.33%
Childhood Immunization Status (CIS)	Data not available	Numerator: 42.0000 Denominator: 70.0000 Calculated Value: 60.0000	Numerator: 31.0000 Denominator: 70.0000 Calculated Value: 44.2900	Data not available	-26.18%	60.08%	73.72%

Measure Narrative

We have experienced a decrease in Tobacco Screening compliance by -4.41% and in 2016-2017 we saw another decrease of -3.95%. Although compliance has been decreasing we are still above our measure goal of 78.63%. There was a decrease of Colorectal Cancer Screenings of -28.24% between 2015 – 2017 and another decrease of -21.07% between 2016-2017. Progress towards our goal is 56.52%. Our new clinic, Hazelton, has drastically reduced our overall performance on the Tobacco Screening and Colorectal Cancer Screening measures. There is a need for additional education on provider expectations, training on proper documentation and best practices for patient encounters. We will work closely with the clinic manager at the Hazelton clinic to increase these measure outcomes. Cervical Cancer Screening decreased between 2015-2017 by -15.55% and increased our compliance by 2.67% between 2016-2017.Our current progress is 99.93% towards our goal. Adding an additional OB/GYN clinic in Manteca will provide additional access for patients who are referred to OB/GYN providers for their Cervical Cancer Screenings. We have been working with our health plan partners to incentivize patients to come in to get their screening done. Childhood Immunization saw a significant drop of -46.55% between 2015-2017 and continued to decrease by -26.18% for 2016-2017. We are sitting at 60.08% towards our goal of 73.72%. Immunization continues to be a difficult measure to satisfy since the addition of more immunization and decreasing the age from 3 to 2. Parents are hesitant to have the influenza vaccine administered to their children. Rotavirus vaccine also proves to be difficult to achieve patient compliance. We will continue to provide education to parents about the vaccine and continue to ask at every encounter. We are also exploring possibility of having nurses available near waiting areas to administer flu vaccines while patients wait for their appointments.

Chronic Disease Management

Performance Measure	2015 Measures	2016 Measures	2017 Measures	% Change 2015-2017 Trend	% Change 2016-2017 Trend	% Progress toward Goal	Measure Goals

Performance Measure	2015 Measures	2016 Measures	2017 Measures	% Change 2015-2017 Trend	% Change 2016-2017 Trend	% Progress toward Goal	Measure Goals
Use of Appropriate Medications for Asthma	Data not available	Numerator: 144.0000 Denominator: 159.0000 Calculated Value: 90.5700	Numerator: 185.0000 Denominator: 197.0000 Calculated Value: 93.9100	Data not available	3.69%	191.34%	49.08%
Coronary Artery Disease (CAD): Lipid Therapy	Numerator: 64.0000 Denominator: 70.0000 Calculated Value: 91.4300	Numerator: 444.0000 Denominator: 513.0000 Calculated Value: 86.5500	Numerator: 308.0000 Denominator: 363.0000 Calculated Value: 84.8500	-7.20%	-1.96%	109.08%	77.79%
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet *	Data not available	Data not available	Numerator: 596.0000 Denominator: 694.0000 Calculated Value: 85.8800	Data not available	Data not available	110.10%	78.00%
Controlling High Blood Pressure	Data not available	Numerator: 3208.0000 Denominator: 6316.0000 Calculated Value: 50.7900	Numerator: 3209.0000 Denominator: 5426.0000 Calculated Value: 59.1400	Data not available	16.44%	93.25%	63.42%
HIV Linkage to Care	Numerator: 12.0000 Denominator: 13.0000 Calculated Value: 92.3100	Numerator: 8.0000 Denominator: 11.0000 Calculated Value: 72.7300	Numerator: 7.0000 Denominator: 11.0000 Calculated Value: 63.6400	-31.06%	-12.50%	85.19%	74.70%

Measure Narrative

Asthma compliance dropped by -5.36% between 2015 – 2017. We increased compliance between 2016 – 2017 by 3.69% and exceeded our goal of 49.08%. ICD-10 codes have helped identify patients with specific severity of asthma that meet the criteria. Unspecified asthma diagnosis has caused issues by increasing our denominator and affect our outcomes. We will work with providers to ensure they are specifying the type of asthma when entering a diagnosis and reviewing problem list of past unspecified asthma diagnosis. The CAD measure between 2015 – 2017 decreased in compliance by -7.20% and between 2016-2017 another decrease of -1.96%. We are still over our measure goal of 77.79%. IVD has also decreased in compliance by -7.52% between 2015-2017 and again by -.87% between 2016-2017. We remain above our goal of 78.00% for IVD. Health coaches have been placed in clinics to educate patients and provide them with tools and resources to successfully manage their diseases. The introduction of the Hazelton clinic has decreased our compliance on these measures and we will provide additional training to help better manage these chronic diseases. Controlling High Blood Pressure between 2015-2017 saw an increase in compliance by 25.46% and between 2016-2017 increased again by 16.44%. We are now 93.25% toward our goal. Recent implementation of an enterprise electronic health record is one example of the organizations progression. Having one patient record across multiple care settings helps produce comprehensive reports to capture and analyze data more efficiently to provide better patient care. We saw a significant decline in HIV Linkage to Care between 2015-2017 of -31.06% and between 2016-2017 another decrease of -12.50%. Currently 85.19% towards our goal. Documentation of follow up appointments and no shows for newly diagnosed HIV positive patients is an issue. We will utilize our resources to actively reach out to these patients to ensure they are receiving the care they need.

Financial Measures

Performance Measure	2015 Measures	2016 Measures	2017 Measures	% Change 2015-2017 Trend	% Change 2016-2017 Trend	% Progress toward Goal	Measure Goals
Total Cost Per Patient (Costs)	Numerator: 14156697.0000 Denominator: 29144.0000 Calculated Value: 485.7500	Numerator: 14474996.0000 Denominator: 28895.0000 Calculated Value: 500.9516	Numerator: 19950757.0000 Denominator: 31224.0000 Calculated Value: 638.9558	31.54%	27.55%	88.09%	725.33 : 1 Ratio
Medical Cost Per Medical Visit (Costs)	Numerator: 13250560.0000 Denominator: 91768.0000 Calculated Value: 144.3919	Numerator: 13397030.0000 Denominator: 88064.0000 Calculated Value: 152.1283	Numerator: 18392731.0000 Denominator: 95415.0000 Calculated Value: 192.7656	33.50%	26.71%	82.44%	233.83 : 1 Ratio

Measure Narrative

SJCC saw an increase in medical cost per medical visit, from $144.39 in 2015 up to $152.13 in 2016; cost per visit continued to rise to $192.77 in 2017 and is projected at $269.98 for the designation period. SJCC continues to expand sites and services, with medical visits projected to increase by 29.0%, to 123,055 in 2019 from the 95,41 reported in 2017. A major contributing factor is the projected increased volume of medical visits due to expanded hours at several sites, continued ramp up of operations at the two sites added in 2017 and increased provider staffing. While the increased visits mitigate the impact of rising costs to a degree, the moderating effect is more than offset by limiting factors resulting in a rising cost per visit. SJCC is projecting increased cost per visit due to re-structuring provider compensation to aid in recruitment and retention, inflationary pressures on supplies and services, increases in salaries and benefits resulting from collective bargaining agreements, and additional staff to support the new Cerner HIS and PCMH initiatives. Total cost per patient increased from $485.75 in 2015 to $500.95 in 2016, with $638.96 reported in 2017 and $890.93 projected for the designation period. Total patients are projected to increase by 19.4%, from 31,224 in 2017 to 37,290 in the designation period. The same contributing and restricting factors mentioned for medical cost per visit apply to total cost per patient.

Additional Measures

Performance Measure	2015 Measures	2016 Measures	2017 Measures	% Change 2015-2017 Trend	% Change 2016-2017 Trend	% Progress toward Goal	Measure Goals	Is This Performance Measure Applicable?
(Oral Health) Percentage of children referred for oral health care at well-child office visits.	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	33.20%	(•) Yes ( ) No

Measure Narrative

Oral Health – Dental referrals increased compliance between 2015-2017 by 18.96% and between 2016-2017 increased by 5.12%. We have been above our target measure goal for the last 3 measure years. Access to dental care for the Medi-cal patient population is still an issue. Staff and providers continue to provide patients list of known community dental resources so they may receive care.

Close Window

Budget Narrative

The total budget amount required to implement the FQHC LAL delivery plan for year three of the designation period is $33,222,816. The budget is aligned and consistent with the proposed delivery plan. At the end of the third year of the designation period, SJCC estimates an increase of 29.0% in utilization to 123,055 medical visits from the 95,415 medical visits reported for Calendar Year 2017 UDS. UDS 2017 reported unduplicated medical patients are 31,224 and are projected to be 37,290 at the end of the 2019 LAL re-certification period, a 19.4% increase.

The majority of program income, 75.8%, comes from Medi-Cal Managed Care, 11.2% from Medicare and 12.1% from Medi-Cal. Other payers comprise less than 1% of net patient revenue. Total patient service revenue is projected at $17.4 million.

Other revenues include local government funding from the County of San Joaquin of $15.8 million.

Total Direct Charges are projected at $25,036,033 for the third year of the designation period. Roughly 75% of direct expense is comprised of salaries and benefits: $10.8 million, or 58%, for medical providers; $6.3 million, or 34%, for clinical support staff; and $1.7 million, or 8%, for other staff.

Of the remaining 25% of direct charges, significant items are purchased services of $3.7 million for transportation, translation services and support from the San Joaquin County Health Care Services Agency, $1.0 million for pharmaceuticals and other medical supplies, and $0.3 million for the legacy eCW EHR and practice management system.

Indirect charges are budgeted at $8.2 million, or 32.7% of direct charges, roughly consistent with the second year of the designation period, based on the SJGH Medicare cost report.

Expenses increased significantly in the current projection due to additional providers to accommodate the expansion of services at several sites, continued ramp up of services at the two new sites added in 2017 (Hazelton and Manteca), ongoing inflationary pressures on supplies and purchased services, increases in salaries and benefits resulting from collective bargaining agreements and additional staff to support the new Cerner Health Information System and PCMH program initiatives.

San Joaquin Community Clinics
Financial Statement Comments
July 31, 2018

Summary

The Total visits for the month of July were 8,993. July's Billable visits of 8,551 were less than budgeted visits of 8,613 by 62 or .7%.

Gross Patient Revenue of $1.0 million was less than budget by $743,000 or 41.6%. Net Patient Revenue of $1.9 million was greater than budget by $672,000 or 55.9%. As part of validating the new Cerner system, we are reviewing the processing of charges and claims to confirm that charges are captured timely and claims properly generated.

- Research is still ongoing regarding the review of resource providers to determine if billable or non-billable.
- Gross Patient Revenue is impacted by several issues, primarily:
    - Encounters that have not been completed by the provider and are missing charges.
    - Charges are unposted in PWPM due to coding backlog.
- Charges and contractual allowances were not flowing correctly from PWPM to the PeopleSoft general ledger accounts.

As reports and data become available from the Cerner system, we continue to identify and address revenue cycle issues related to system setup and clinical operations. Given the issues noted above, Gross Patient Revenue and Contractual Adjustments will be over or understated for the next several months as charging and mapping issues are addressed; in the meantime, net revenue has been booked based on the previous methodology using historical net revenues per visit by clinic by payor.

Capitation Revenue of $519,000 was greater than budget by $107,000 or 25.9%, presumably due to retroactive adjustments by the health plan. We are in the process of confirming the nature and amount of the adjustment with HPSJ.

Total Expenses of $2.3 million were less than budget by $484,000 (17.4%). The resulting Net Loss of $428,000 was less than Budgeted Net Loss by $1,155,000. Total cost per billable visit was $269.29 in July versus budget of $323.52.

SJGH went live on the Cerner and PeopleSoft systems on 3/5/18 and July is the fourth complete month of activity for both systems. Implementation issues continued to impact the monthly close process; however, Finance is getting caught up. August and September financials will be ready at the November meeting, with the reporting becoming current with the December meeting. Work flows and reports continue to be reviewed and refined as staff become familiar with the new systems.

Explanations of major variances are explained below.

Revenue

As mentioned above, Gross Patient Revenue was less than budget by $743,000 or 41.6%. The following gross revenue figures were posted in July; however, they were impacted by the issues noted above and will be corrected in future months as system issues are resolved.

Gross Patient Revenue per visit was $122.13, which was less than budget by 41.1%. Managed Care Medi-Cal was $700,000, or 57.1%, less than budget; Medicare was $235,000, or 100.5%, less than budget; Medi-Cal Fee-For-Service was $187,000, or 74.6%, less than budget; Self Pay was $141,000, or 285.9%, greater than budget; and Commercial was $239,000, or 915.9%, greater than budget. Net Patient Revenue of $1.9 million was greater than budget by $672,000, primarily due to positive Contractual Adjustments of $311,000 million for the month versus a budgeted write-off of $997,000. Deductions from revenue were favorable to budget by $1.4 million (131.2%).

Capitation revenue of $519,000 was greater than budget by $107,000 (25.9%) as noted above.

Expenses

Salaries & Benefits of $1.2 million were less than budget by $352,000 (22.9%). Salaries of $695,000 were better than budget by $371,000 or 34.8%. This favorable variance is due to favorable variances for Physician salaries of $289,000, Mid-level Providers of $35,000, and Non-Providers of $46,000. The Physician salaries positive variance is due to twelve provider vacancies.

Benefits of $487,000 were unfavorable to budget by $19,000 or 4.1%, predominantly due to unfavorable variances in Pension & Retirement ($17,000) and Vacation, Holiday, Sick Leave ($32,000). These were offset by favorable variances in FICA ($7,000) and Group Health ($23,000). Benefits as a percentage of salaries is 70.0%, higher than budget of 43.8%.

Professional Fees/Registry of $101,000 were greater than budget by $9,000 (9.8%) primarily due to MD Comp-Individual ($8,000). MD Comp-Individual is unfavorable in Primary Medicine ($2,000) and Healthy Beginnings French Camp ($6,000).

Supplies of $66,000 were less than budget by $28,000 (30.0%). Favorable variances in Pharmaceuticals ($17,000), Other Medical Supplies ($7,000), Minor Medical Instruments ($5,000), Other Minor Equipment ($2,000), and Other Non-Medical Supplies ($4,000). These were offset by unfavorable variances in Oxygen & Other Medical Gases ($5,000) and Food ($2,000).

Purchased Services of $330,000 were less than budget by $13,000 (3.7%). This is predominantly due favorable variances for Temporary Staffing in the following clinics – Family Medicine ($14,000), Family Practice-Calif. St. ($7,000), and Primary Medicine ($10,000). These were offset by unfavorable variances for Temporary Staffing in the following clinics – FQ Admin ($2,000), Healthy Beginnings-Calif. St. ($7,000) and Healthy Beginnings-+French Camp ($7,000)

Depreciation of $22,000 was greater than budget by $9,000 (68.9%), predominantly in SJCC-Manteca ($8,000) due to the new Lease Agreement for SJCC-Manteca Leasehold Improvements, not in budget due to the timing of the lease approval by the County. Not budgeted in FY 2018-19.

Other Expense of $49,000 was greater than budget by $11,000 (27.7%). Predominantly due to unfavorable variances for Rent/Lease Buildings ($8,000) and Telephone ($3,000). Rent/Lease Buildings was unfavorable due to 2 invoices being vouchered in July. Telephone was unfavorable in following clinics – Children's Health ($800), Healthy Beginnings Calif St ($800), Healthy Beginnings French Camp ($400), and SJCC-Manteca ($800).

San Joaquin Community Clinics
Financial Statement Comments
July 31, 2018

Accounts Receivable

July's Gross Accounts Receivables (AR) of $4.1 million was $796,000 less than June and $1.3 million more than May. Average days of revenue in AR is at 84.0, which is down from 87.1 in June and up from 56.7 in May. As discussed last month, the increase in AR is due to held Medi-Cal claims for all clinics through June and continued to impact July AR balances.

Cash collections (excluding capitation) were $263,000 in July, which represents a slight increase from June collections of $251,000. Cash collections averaged $804,000 per month in FY 2018. Cash collections were impacted by the held claims discussed above as well as cash posting delays in the new system. Cash collections should return to normal levels as the held claims are released and collected. Cash collections increased to $2.1M in August and $526,000 in September.

San Joaquin Community Clinics
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
8,993	8,613	380	4.4%	Total Visits	8,993	8,613	380	4.4%
8,551	8,613	(62)	-0.7%	Billable Visits	8,551	8,613	(62)	-0.7%
24.8	138.0	113.3	82.1%	Total FTEs	24.8	138.0	113.3	82.1%
				Patient Revenue				
$ (1,259)	$ 234,196	$ (235,455)	-100.5%	Medicare	$ (1,259)	$ 234,196	$ (235,455)	-100.5%
$ 63,741	$ 250,792	(187,051)	-74.6%	Medi-Cal Fee-for-Service	$ 63,741	$ 250,792	(187,051)	-74.6%
$ 526,650	$ 1,226,726	(700,076)	-57.1%	Medi-Cal Managed Care	$ 526,650	$ 1,226,726	(700,076)	-57.1%
$ 264,800	$ 26,066	238,734	915.9%	Insurance	$ 264,800	$ 26,066	238,734	915.9%
$ 190,395	$ 49,333	141,062	285.9%	Self Pay	$ 190,395	$ 49,333	141,062	285.9%
$ -	$ 127	(127)	-100.0%	Indigent	$ -	$ 127	(127)	-100.0%
1,044,327	**1,787,240**	**(742,913)**	-41.6%	**Gross Patient Revenue**	**1,044,327**	**1,787,240**	**(742,913)**	-41.6%
310,962	(996,737)	1,307,699	131.2%	Contractual Adjustments	310,962	(996,737)	1,307,699	-131.2%
519,095	412,172	106,923	25.9%	Capitation Rev	519,095	412,172	106,923	25.9%
1,874,384	**1,202,675**	**671,709**	55.9%	**Net Patient Revenue**	**1,874,384**	**1,202,675**	**671,709**	55.9%
0	0	0		Other Revenue	0	0	0	100.0%
1,874,384	**1,202,675**	**671,709**	55.9%	**Total Revenue**	**1,874,384**	**1,202,675**	**671,709**	55.9%
				Operating Expense				
695,249	1,066,239	370,990	34.8%	Salaries	695,249	1,066,239	370,990	34.8%
486,773	467,525	(19,248)	-4.1%	Benefits	486,773	467,525	(19,248)	-4.1%
1,182,022	**1,533,764**	**351,742**	22.9%	**Total Salaries & Benefits**	**1,182,022**	**1,533,764**	**351,742**	22.9%
101,349	92,283	(9,066)	-9.8%	Professional Fees/Registry	101,349	92,283	(9,066)	-9.8%
65,889	94,192	28,303	30.0%	Supplies	65,889	94,192	28,303	30.0%
330,335	342,973	12,638	3.7%	Purchased Services	330,335	342,973	12,638	3.7%
21,645	12,818	(8,827)	-68.9%	Depreciation	21,645	12,818	(8,827)	-68.9%
49,257	38,576	(10,681)	-27.7%	Other Expense	49,257	38,576	(10,681)	-27.7%
1,750,497	**2,114,606**	**364,109**	17.2%	**Total Direct Expense**	**1,750,497**	**2,114,606**	**364,109**	17.2%
552,240	671,881	119,640	17.8%	Overhead Allocation	552,240	671,881	119,640	17.8%
2,302,737	**2,786,487**	**483,749**	17.4%	**Total Expenses**	**2,302,737**	**2,786,487**	**483,749**	17.4%
(428,353)	**(1,583,812)**	**1,155,458**	73.0%	**Net Income (Loss)**	**(428,353)**	**(1,583,812)**	**1,155,458**	-73.0%
				Key Ratios				
$ 122.13	$ 207.50	$ (85.38)	-41.1%	Gross Pt Revenue/Billable Visit	$ 122.13	$ 207.50	$ (85.38)	-41.1%
$ 219.20	$ 139.63	$ 79.57	57.0%	Total Revenue/Billable Visit (excl Oth Rev)	$ 219.20	$ 139.63	$ 79.57	57.0%
$ 204.71	$ 245.51	$ 40.80	16.6%	Direct Costs/Billable Visit	$ 204.71	$ 245.51	$ 40.80	16.6%
$ 64.58	$ 78.01	$ 13.43	17.2%	Indirect Costs/Billable Visit	$ 64.58	$ 78.01	$ 13.43	17.2%
$ 269.29	$ 323.52	$ 54.23	16.8%	Total Medical Cost/Billable Visit	$ 269.29	$ 323.52	$ 54.23	16.8%
$ (50.09)	$ (183.89)	$ 133.79	-72.8%	Net Income(Loss)/Billable Visit	$ (50.09)	$ (183.89)	$ (133.79)	72.8%
$ 673.24	$ 808.80	$ 135.57	16.8%	Total Cost/Patient (1)	$ 673.24	$ 808.80	$ 135.57	16.8%
179.5%	67.3%	112.2%	166.7%	Net Pt Rev as % of Gross Rev	179.5%	67.3%	112.2%	166.7%
70.0%	43.8%	-26.2%	-59.7%	Benefits as a % of Salaries	70.0%	43.8%	-26.2%	-59.7%
31.5%	31.8%	0.2%	0.7%	Overhead % of Direct Exp	31.5%	31.8%	0.2%	0.7%
$ 4,149				Gross Patient AR (in 000s)				
$ (1,109)				Less Reserves (in 000s)				
$ 3,039				Net AR (in 000s)				
$ 2,149				Wrap AR (in 000s)				
84.0				Gross AR Days				
$ 782				Cash Receipts (in 000s)				
				Payer Mix				
-0.1%	13.1%	-13.2%	-100.9%	Medicare	-0.1%	13.1%	-13.2%	-100.9%
6.1%	14.0%	-7.9%	-56.5%	Medi-Cal	6.1%	14.0%	-7.9%	-56.5%
50.4%	68.6%	-18.2%	-26.5%	Medi-Cal Managed Care	50.4%	68.6%	-18.2%	-26.5%
25.4%	1.5%	23.9%	1638.6%	Insurance	25.4%	1.5%	23.9%	1638.6%
18.2%	2.9%	15.4%	537.4%	Self Pay / Indigent	18.2%	2.8%	15.5%	558.8%
100.0%	100.1%	-0.1%	-0.1%		100.0%	100.0%	0.0%	0.0%

Children's Health Services
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
1,792	1,420	372	26.2%	**Total Visits**	1,792	1,420	372	26.2%
1,620	1,362	258	18.9%	**Billable Visits**	1,620	1,362	258	18.9%
4.6	18.9	14.3	75.4%	**Total FTEs**	4.6	18.9	14.3	75.4%
				Patient Revenue				
0	0	0		Medicare	0	0	0	
21,087	50,476	(29,389)	-58.2%	Medi-Cal Fee-for-Service	21,087	50,476	(29,389)	-58.2%
108,906	315,530	(206,624)	-65.5%	Medi-Cal Managed Care	108,906	315,530	(206,624)	-65.5%
91,594	1,769	89,825	5077.7%	Insurance	91,594	1,769	89,825	5077.7%
36,330	1,128	35,202	3120.8%	Self Pay	36,330	1,128	35,202	3120.8%
0	0	0		Indigent	0	0	0	
257,916	**368,903**	**(110,987)**	-30.1%	**Gross Patient Revenue**	**257,916**	**368,903**	**(110,987)**	-30.1%
38,342	(206,016)	244,358	118.6%	Contractual Adjustments	38,342	(206,016)	244,358	-118.6%
114,505	79,212	35,293	44.6%	Capitation Rev	114,505	79,212	35,293	44.6%
410,763	**242,099**	**168,664**	69.7%	**Net Patient Revenue**	**410,763**	**242,099**	**168,664**	69.7%
0	0	0		Other Revenue	0	0	0	
410,763	**242,099**	**168,664**	69.7%	**Total Revenue**	**410,763**	**242,099**	**168,664**	69.7%
				Operating Expense				
114,103	154,128	40,025	26.0%	Salaries	114,103	154,128	40,025	26.0%
75,817	55,391	(20,426)	-36.9%	Benefits	75,817	55,391	(20,426)	-36.9%
189,920	**209,519**	**19,599**	9.4%	**Total Salaries & Benefits**	**189,920**	**209,519**	**19,599**	9.4%
0	0	0		Professional Fees/Registry	0	0	0	
8,650	7,037	(1,613)	-22.9%	Supplies	8,650	7,037	(1,613)	-22.9%
6,150	6,250	100	1.6%	Purchased Services	6,150	6,250	100	1.6%
674	661	(13)	-2.0%	Depreciation	674	661	(13)	-2.0%
5,796	5,335	(461)	-8.6%	Other Expense	5,796	5,335	(461)	-8.6%
211,189	**228,802**	**17,613**	7.7%	**Total Direct Expense**	**211,189**	**228,802**	**17,613**	7.7%
82,014	78,946	(3,068)	-3.9%	Allocation of Direct Admin Exp	82,014	#DIV/0!	#DIV/0!	
63,800	69,121	5,321	7.7%	Overhead Allocation	63,800	69,121	5,321	7.7%
357,003	**376,869**	**19,866**	5.3%	**Total Expenses**	**357,003**	**#DIV/0!**	**#DIV/0!**	
53,760	**(134,770)**	**188,530**	139.9%	**Net Income (Loss)**	**53,760**	**#DIV/0!**	**#DIV/0!**	
				Key Ratios				
$ 159.21	$ 270.85	$ (111.65)	-41.2%	Gross Pt Revenue/Billable Visit	$ 159.21	$ 270.85	$ (111.65)	-41.2%
$ 253.56	$ 177.75	$ 75.80	42.6%	Total Revenue/Billable Visit (excl Oth Rev)	$ 253.56	$ 177.75	$ 75.80	42.6%
$ 130.36	$ 167.99	$ 37.63	22.4%	Direct Costs/Billable Visit	$ 130.36	$ 167.99	$ 37.63	22.4%
$ 90.01	$ 108.71	$ 18.70	17.2%	Indirect Costs/Billable Visit	$ 90.01	#DIV/0!	#DIV/0!	
$ 220.37	$ 276.70	$ 56.33	20.4%	Total Medical Cost/Billable Visit	$ 220.37	#DIV/0!	#DIV/0!	
$ 33.19	$ (98.95)	$ 132.14	-133.5%	Net Income(Loss)/Billable Visit	$ 33.19	#DIV/0!	#DIV/0!	
66.4%	35.9%	-30.5%	-84.9%	Benefits as a % of Salaries	66.4%	35.9%	-30.5%	-84.9%
30.2%	30.2%	0.0%	0.0%	Overhead % of Direct Exp	30.2%	30.2%	0.0%	0.0%
$ 818				Gross Patient AR (in 000s)				
$ (166)				Less Reserves (in 000s)				
$ 653				Net AR (in 000s)				
$ 424				Wrap AR (in 000s)				
94.6				Gross AR Days				
$ 157				Cash Receipts (in 000s)				
				Payer Mix				
0.0%	0.0%	0.0%		Medicare	0.0%	0.0%	0.0%	
8.2%	13.7%	-5.5%	-40.2%	Medi-Cal	8.2%	13.7%	-5.5%	-40.2%
42.2%	85.5%	-43.3%	-50.6%	Medi-Cal Managed Care	42.2%	85.5%	-43.3%	-50.6%
35.5%	0.5%	35.0%	7305.8%	Insurance	35.5%	0.5%	35.0%	7305.8%
14.1%	0.3%	13.8%	4506.7%	Self Pay / Indigent	14.1%	0.3%	13.8%	4506.7%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Family Medicine Clinic
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
1,755	1,423	332	23.3%	**Total Visits**	1,755	1,423	332	23.3%
1,712	1,423	289	20.3%	**Billable Visits**	1,712	1,390	322	23.2%
2.1	17.4	15.2	87.7%	**Total FTEs**	2.1	17.4	15.2	87.7%
				Patient Revenue				
616	44,977	(44,361)	-98.6%	Medicare	616	44,977	(44,361)	-98.6%
5,131	26,476	(21,345)	-80.6%	Medi-Cal Fee-for-Service	5,131	26,476	(21,345)	-80.6%
73,406	170,106	(96,700)	-56.8%	Medi-Cal Managed Care	73,406	170,106	(96,700)	-56.8%
26,416	3,803	22,613	594.6%	Insurance	26,416	3,803	22,613	594.6%
24,379	13,987	10,392	74.3%	Self Pay	24,379	13,987	10,392	74.3%
0	127	(127)	-100.0%	Indigent	0	127	(127)	-100.0%
129,947	**259,476**	**(129,529)**	-49.9%	**Gross Patient Revenue**	**129,947**	**259,476**	**(129,529)**	-49.9%
95,884	(151,394)	247,278	163.3%	Contractual Adjustments	95,884	(151,394)	247,278	-163.3%
94,581	71,184	23,397	32.9%	Capitation Rev	94,581	71,184	23,397	32.9%
320,411	**179,266**	**141,145**	78.7%	**Net Patient Revenue**	**320,411**	**179,266**	**141,145**	78.7%
0	0	0		Other Revenue	0	0	0	
320,411	**179,266**	**141,145**	78.7%	**Total Revenue**	**320,411**	**179,266**	**141,145**	78.7%
				Operating Expense				
74,558	106,904	32,346	30.3%	Salaries	74,558	106,904	32,346	30.3%
56,297	51,304	(4,993)	-9.7%	Benefits	56,297	51,304	(4,993)	-9.7%
130,855	**158,208**	**27,353**	17.3%	**Total Salaries & Benefits**	**130,855**	**158,208**	**27,353**	17.3%
170	0	(170)		Professional Fees/registry	170	0	(170)	
25,915	30,628	4,713	15.4%	Supplies	25,915	30,628	4,713	15.4%
2,103	15,806	13,703	86.7%	Purchased Services	2,103	15,806	13,703	86.7%
4,171	3,922	(249)	-6.3%	Depreciation	4,171	3,922	(249)	-6.3%
2,144	2,561	417	16.3%	Other Expense	2,144	2,561	417	16.3%
165,358	**211,125**	**45,767**	21.7%	**Total Direct Expense**	**165,358**	**211,125**	**45,767**	21.7%
41,322	55,528	14,207	25.6%	Allocation of Direct Admin Exp	41,322	#DIV/0!	#DIV/0!	
73,965	94,436	20,471	21.7%	Overhead Allocation	73,965	94,436	20,471	21.7%
280,645	**361,090**	**80,445**	22.3%	**Total Expenses**	**280,645**	**#DIV/0!**	**#DIV/0!**	
39,767	**(181,824)**	**221,590**	121.9%	**Net Income (Loss)**	**39,767**	**#DIV/0!**	**#DIV/0!**	
				Key Ratios				
$ 75.90	$ 182.34	$ (106.44)	-58.4%	Gross Pt Revenue/Billable Visit	$ 75.90	$ 186.67	$ (110.77)	-59.3%
$ 187.16	$ 125.98	$ 61.18	48.6%	Total Revenue/Billable Visit (excl Oth Rev)	$ 187.16	$ 128.97	$ 58.19	45.1%
$ 96.59	$ 148.37	$ 51.78	34.9%	Direct Costs/Billable Visit	$ 96.59	$ 151.89	$ 55.30	36.4%
$ 67.34	$ 105.39	$ 38.05	36.1%	Indirect Costs/Billable Visit	$ 67.34	#DIV/0!	#DIV/0!	
$ 163.93	$ 253.75	$ 89.82	35.4%	Total Medical Cost/Billable Visit	$ 163.93	#DIV/0!	#DIV/0!	
$ 23.23	$ (127.77)	$ 151.00	-118.2%	Net Income(Loss)/Billable Visit	$ 23.23	#DIV/0!	#DIV/0!	
75.5%	48.0%	-27.5%	-57.3%	Benefits as a % of Salaries	75.5%	48.0%	-27.5%	-57.3%
44.7%	44.7%	0.0%	0.0%	Overhead % of Direct Exp	44.7%	44.7%	0.0%	0.0%
$ 660				Gross Patient AR (in 000s)				
$ (193)				Less Reserves (in 000s)				
$ 467				Net AR (in 000s)				
$ 342				Wrap AR (in 000s)				
75.2				Gross AR Days				
$ 124				Cash Receipts (in 000s)				
				Payer Mix				
0.5%	17.3%	-16.9%	-97.3%	Medicare	0.5%	17.3%	-16.9%	-97.3%
3.9%	10.2%	-6.3%	-61.3%	Medi-Cal	3.9%	10.2%	-6.3%	-61.3%
56.5%	65.6%	-9.1%	-13.8%	Medi-Cal Managed Care	56.5%	65.6%	-9.1%	-13.8%
20.3%	1.5%	18.9%	1287.0%	Insurance	20.3%	1.5%	18.9%	1287.0%
18.8%	5.4%	13.3%	244.9%	Self Pay / Indigent	18.8%	5.4%	13.3%	244.9%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Family Practice Clinic
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
366	500	(134)	-26.8%	**Total Visits**	366	500	(134)	-26.8%
353	500	(147)	-29.4%	**Billable Visits**	353	500	(147)	-29.4%
1.4	12.9	11.5	89.0%	**Total FTEs**	1.4	12.9	11.5	89.0%
				Patient Revenue				
0	41,716	(41,716)	-100.0%	Medicare	0	41,716	(41,716)	-100.0%
3,757	5,656	(1,899)	-33.6%	Medi-Cal Fee-for-Service	3,757	5,656	(1,899)	-33.6%
35,716	100,639	(64,923)	-64.5%	Medi-Cal Managed Care	35,716	100,639	(64,923)	-64.5%
14,092	879	13,213	1503.2%	Insurance	14,092	879	13,213	1503.2%
4,669	4,599	70	1.5%	Self Pay	4,669	4,599	70	1.5%
0	0	0	#DIV/0!	Indigent	0	0	0	#DIV/0!
58,235	**153,489**	**(95,254)**	-62.1%	**Gross Patient Revenue**	**58,235**	**153,489**	**(95,254)**	-62.1%
11,757	(90,045)	101,802	113.1%	Contractual Adjustments	11,757	(90,045)	101,802	-113.1%
22,202	36,463	(14,261)	-39.1%	Capitation Rev	22,202	36,463	(14,261)	-39.1%
92,193	**99,907**	**(7,714)**	-7.7%	**Net Patient Revenue**	**92,193**	**99,907**	**(7,714)**	-7.7%
0	0	0		Other Revenue	0	0	0	
92,193	**99,907**	**(7,714)**	-7.7%	**Total Revenue**	**92,193**	**99,907**	**(7,714)**	-7.7%
				Operating Expense				
38,539	69,241	30,702	44.3%	Salaries	38,539	69,241	30,702	44.3%
55,090	36,452	(18,638)	-51.1%	Benefits	55,090	36,452	(18,638)	-51.1%
93,629	**105,693**	**12,064**	11.4%	**Total Salaries & Benefits**	**93,629**	**105,693**	**12,064**	11.4%
581	0	(581)		Professional Fees/Registry	581	0	(581)	
4,458	4,628	170	3.7%	Supplies	4,458	4,628	170	3.7%
605	7,392	6,787	91.8%	Purchased Services	605	7,392	6,787	91.8%
235	226	(9)	-3.8%	Depreciation	235	226	(9)	-3.8%
3,520	3,623	103	2.8%	Other Expense	3,520	3,623	103	2.8%
103,027	**121,562**	**18,535**	15.2%	**Total Direct Expense**	**103,027**	**121,562**	**18,535**	15.2%
18,518	32,847	14,329	43.6%	Allocation of Direct Admin Exp	18,518	30,342	11,824	39.0%
47,290	55,797	8,507	15.2%	Overhead Allocation	47,290	55,797	8,507	15.2%
168,835	**210,206**	**41,371**	19.7%	**Total Expenses**	**168,835**	**207,701**	**38,866**	18.7%
(76,642)	**(110,299)**	**33,657**	30.5%	**Net Income (Loss)**	**(76,642)**	**(107,794)**	**31,152**	-28.9%
				Key Ratios				
$ 164.97	$ 306.98	$ (142.01)	-46.3%	Gross Pt Revenue/Billable Visit	$ 164.97	$ 306.98	$ (142.01)	-46.3%
$ 261.17	$ 199.81	$ 61.36	30.7%	Total Revenue/Billable Visit (excl Oth Rev)	$ 261.17	$ 199.81	$ 61.36	30.7%
$ 291.86	$ 243.12	$ (48.74)	-20.0%	Direct Costs/Billable Visit	$ 291.86	$ 243.12	$ (48.74)	-20.0%
$ 186.42	$ 177.29	$ (9.14)	-5.2%	Indirect Costs/Billable Visit	$ 186.42	$ 172.28	$ (14.15)	-8.2%
$ 478.29	$ 420.41	$ (57.87)	-13.8%	Total Medical Cost/Billable Visit	$ 478.29	$ 415.40	$ (62.88)	-15.1%
$ (217.12)	$ (220.60)	$ 3.48	-1.6%	Net Income(Loss)/Billable Visit	$ (217.12)	$ (215.59)	$ (1.53)	0.7%
142.9%	52.6%	-90.3%	-171.5%	Benefits as a % of Salaries	142.9%	52.6%	-90.3%	-171.5%
45.9%	45.9%	0.0%	0.0%	Overhead % of Direct Exp	45.9%	45.9%	0.0%	0.0%
$ 267				Gross Patient AR (in 000s)				
$ (97)				Less Reserves (in 000s)				
$ 170				Net AR (in 000s)				
$ 138				Wrap AR (in 000s)				
89.1				Gross AR Days				
$ 28				Cash Receipts (in 000s)				
				Payer Mix				
0.0%	27.2%	-27.2%	-100.0%	Medicare	0.0%	27.2%	-27.2%	-100.0%
6.5%	3.7%	2.8%	75.1%	Medi-Cal	6.5%	3.7%	2.8%	75.1%
61.3%	65.6%	-4.2%	-6.5%	Medi-Cal Managed Care	61.3%	65.6%	-4.2%	-6.5%
24.2%	0.6%	23.6%	4125.5%	Insurance	24.2%	0.6%	23.6%	4125.5%
8.0%	3.0%	5.0%	167.6%	Self Pay / Indigent	8.0%	3.0%	5.0%	167.6%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Primary Medicine Clinic
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
2,647	2,497	150	6.0%	**Total Visits**	2,647	2,497	150	6.0%
2,597	2,497	100	4.0%	**Billable Visits**	2,597	2,497	100	4.0%
8.6	34.9	26.3	75.4%	**Total FTEs**	8.6	34.9	26.3	75.4%
				Patient Revenue				
466	120,315	(119,849)	-99.6%	Medicare	466	120,315	(119,849)	-99.6%
12,036	15,654	(3,618)	-23.1%	Medi-Cal Fee-for-Service	12,036	15,654	(3,618)	-23.1%
135,357	263,593	(128,236)	-48.6%	Medi-Cal Managed Care	135,357	263,593	(128,236)	-48.6%
47,288	5,392	41,896	777.0%	Insurance	47,288	5,392	41,896	777.0%
52,726	9,303	43,423	466.8%	Self Pay	52,726	9,303	43,423	466.8%
0	0	0	#DIV/0!	Indigent	0	0	0	#DIV/0!
247,873	**414,257**	**(166,384)**	-40.2%	**Gross Patient Revenue**	**247,873**	**414,257**	**(166,384)**	-40.2%
50,194	(259,066)	309,260	119.4%	Contractual Adjustments	50,194	(259,066)	309,260	-119.4%
153,216	122,682	30,534	24.9%	Capitation Rev	153,216	122,682	30,534	24.9%
451,282	**277,873**	**173,409**	62.4%	**Net Patient Revenue**	**451,282**	**277,873**	**173,409**	62.4%
0	0	0		Other Revenue	0	0	0	
451,282	**277,873**	**173,409**	62.4%	**Total Revenue**	**451,282**	**277,873**	**173,409**	62.4%
				Operating Expense				
201,093	321,235	120,142	37.4%	Salaries	201,093	321,235	120,142	37.4%
100,789	121,356	20,567	16.9%	Benefits	100,789	121,356	20,567	16.9%
301,882	**442,591**	**140,709**	31.8%	**Total Salaries & Benefits**	**301,882**	**442,591**	**140,709**	31.8%
7,650	5,417	(2,233)	-41.2%	Professional Fees/Registry	7,650	5,417	(2,233)	-41.2%
3,214	9,725	6,511	67.0%	Supplies	3,214	9,725	6,511	67.0%
0	10,585	10,585	100.0%	Purchased Services	0	10,585	10,585	100.0%
315	302	(13)	-4.3%	Depreciation	315	302	(13)	-4.3%
411	794	383	48.2%	Other Expense	411	794	383	48.2%
313,472	**469,414**	**155,942**	33.2%	**Total Direct Expense**	**313,472**	**469,414**	**155,942**	33.2%
78,821	88,652	9,831	11.1%	Allocation of Direct Admin Exp	78,821	81,892	3,071	3.8%
107,019	160,258	53,239	33.2%	Overhead Allocation	107,019	160,258	53,239	33.2%
499,312	**718,324**	**219,012**	30.5%	**Total Expenses**	**499,312**	**711,564**	**212,252**	29.8%
(48,029)	**(440,451)**	**392,421**	89.1%	**Net Income (Loss)**	**(48,029)**	**(433,691)**	**385,662**	-88.9%
				Key Ratios				
$ 95.45	$ 165.90	$ (70.46)	-42.5%	Gross Pt Revenue/Billable Visit	$ 95.45	$ 165.90	$ (70.46)	-42.5%
$ 173.77	$ 111.28	$ 62.49	56.2%	Total Revenue/Billable Visit (excl Oth Rev)	$ 173.77	$ 111.28	$ 62.49	56.2%
$ 120.71	$ 187.99	$ 67.29	35.8%	Direct Costs/Billable Visit	$ 120.71	$ 187.99	$ 67.29	35.8%
$ 71.56	$ 99.68	$ 28.12	28.2%	Indirect Costs/Billable Visit	$ 71.56	$ 96.98	$ 25.42	26.2%
$ 192.26	$ 287.67	$ 95.41	33.2%	Total Medical Cost/Billable Visit	$ 192.26	$ 284.97	$ 92.70	32.5%
$ (18.49)	$ (176.39)	$ 157.90	-89.5%	Net Income(Loss)/Billable Visit	$ (18.49)	$ (173.68)	$ 155.19	-89.4%
50.1%	37.8%	-12.3%	-32.7%	Benefits as a % of Salaries	50.1%	37.8%	-12.3%	-32.7%
34.1%	34.1%	0.0%	0.0%	Overhead % of Direct Exp	34.1%	34.1%	0.0%	0.0%
$ 1,077				Gross Patient AR (in 000s)				
$ (361)				Less Reserves (in 000s)				
$ 716				Net AR (in 000s)				
$ 558				Wrap AR (in 000s)				
96.9				Gross AR Days				
$ 212				Cash Receipts (in 000s)				
				Payer Mix				
0.2%	29.0%	-28.9%	-99.4%	Medicare	0.2%	29.0%	-28.9%	-99.4%
4.9%	3.8%	1.1%	28.5%	Medi-Cal	4.9%	3.8%	1.1%	28.5%
54.6%	63.6%	-9.0%	-14.2%	Medi-Cal Managed Care	54.6%	63.6%	-9.0%	-14.2%
19.1%	1.3%	17.8%	1365.7%	Insurance	19.1%	1.3%	17.8%	1365.7%
21.3%	2.2%	19.0%	847.2%	Self Pay / Indigent	21.3%	2.2%	19.0%	847.2%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Healthy Beginnings - California St.
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
775	752	23	3.1%	**Total Visits**	775	752	23	3.1%
775	752	23	3.1%	**Billable Visits**	775	752	23	3.1%
2.4	12.6	10.2	81.1%	**Total FTEs**	2.4	12.6	10.2	81.1%
				Patient Revenue				
0	4,385	(4,385)	-100.0%	Medicare	0	4,385	(4,385)	-100.0%
5,642	55,029	(49,387)	-89.7%	Medi-Cal Fee-for-Service	5,642	55,029	(49,387)	-89.7%
66,571	112,167	(45,597)	-40.7%	Medi-Cal Managed Care	66,571	112,167	(45,597)	-40.7%
31,470	1,609	29,861	1855.9%	Insurance	31,470	1,609	29,861	1855.9%
34,493	1,757	32,736	1863.2%	Self Pay	34,493	1,757	32,736	1863.2%
0	0	0		Indigent	0	0	0	
138,176	**174,947**	**(36,771)**	-21.0%	**Gross Patient Revenue**	**138,176**	**174,947**	**(36,771)**	-21.0%
(1,894)	(78,728)	76,834	97.6%	Contractual Adjustments	(1,894)	(78,728)	76,834	-97.6%
41,476	33,839	7,637	22.6%	Capitation Rev	41,476	33,839	7,637	22.6%
177,757	**130,058**	**47,699**	36.7%	**Net Patient Revenue**	**177,757**	**130,058**	**47,699**	36.7%
0	0	0		Other Revenue	0	0	0	
177,757	**130,058**	**47,699**	36.7%	**Total Revenue**	**177,757**	**130,058**	**47,699**	36.7%
				Operating Expense				
73,134	81,757	8,623	10.5%	Salaries	73,134	81,757	8,623	10.5%
42,345	42,070	(275)	-0.7%	Benefits	42,345	42,070	(275)	-0.7%
115,479	**123,827**	**8,348**	6.7%	**Total Salaries & Benefits**	**115,479**	**123,827**	**8,348**	6.7%
0	0	0		Professional Fees/Registry	0	0	0	
13,774	8,623	(5,151)	-59.7%	Supplies	13,774	8,623	(5,151)	-59.7%
23,548	16,543	(7,005)	-42.3%	Purchased Services	23,548	16,543	(7,005)	-42.3%
1,305	1,280	(25)	-1.9%	Depreciation	1,305	1,280	(25)	-1.9%
6,772	4,092	(2,680)	-65.5%	Other Expense	6,772	4,092	(2,680)	-65.5%
160,879	**154,365**	**(6,514)**	-4.2%	**Total Direct Expense**	**160,879**	**154,365**	**(6,514)**	-4.2%
43,938	37,439	(6,499)	-17.4%	Allocation of Direct Admin Exp	43,938	34,584	(9,354)	-27.0%
67,167	64,447	(2,720)	-4.2%	Overhead Allocation	67,167	64,447	(2,720)	-4.2%
271,984	**256,251**	**(15,732)**	-6.1%	**Total Expenses**	**271,984**	**253,396**	**(18,588)**	-7.3%
(94,226)	**(126,193)**	**31,967**	25.3%	**Net Income (Loss)**	**(94,226)**	**(123,338)**	**29,112**	-23.6%
				Key Ratios				
$ 178.29	$ 232.64	$ (54.35)	-23.4%	Gross Pt Revenue/Billable Visit	$ 178.29	$ 232.64	$ (54.35)	-23.4%
$ 229.36	$ 172.95	$ 56.41	32.6%	Total Revenue/Billable Visit (excl Oth Rev)	$ 229.36	$ 172.95	$ 56.41	32.6%
$ 207.59	$ 205.27	$ (2.31)	-1.1%	Direct Costs/Billable Visit	$ 207.59	$ 205.27	$ (2.31)	-1.1%
$ 143.36	$ 135.49	$ (7.87)	-5.8%	Indirect Costs/Billable Visit	$ 143.36	$ 131.69	$ (11.67)	-8.9%
$ 350.95	$ 340.76	$ (10.19)	-3.0%	Total Medical Cost/Billable Visit	$ 350.95	$ 336.96	$ (13.98)	-4.2%
$ (121.58)	$ (167.81)	$ 46.23	-27.5%	Net Income(Loss)/Billable Visit	$ (121.58)	$ (164.01)	$ 42.43	-25.9%
57.9%	51.5%	-6.4%	-12.5%	Benefits as a % of Salaries	57.9%	51.5%	-6.4%	-12.5%
41.8%	41.8%	0.0%	0.0%	Overhead % of Direct Exp	41.8%	41.7%	0.0%	0.0%
$ 420				Gross Patient AR (in 000s)				
$ (95)				Less Reserves (in 000s)				
$ 325				Net AR (in 000s)				
$ 218				Wrap AR (in 000s)				
68.3				Gross AR Days				
$ 56				Cash Receipts (in 000s)				
				Payer Mix				
0.0%	2.5%	-2.5%	-100.0%	Medicare	0.0%	2.5%	-2.5%	-100.0%
4.1%	31.5%	-27.4%	-87.0%	Medi-Cal	4.1%	31.5%	-27.4%	-87.0%
48.2%	64.1%	-15.9%	-24.9%	Medi-Cal Managed Care	48.2%	64.1%	-15.9%	-24.9%
22.8%	0.9%	21.9%	2376.4%	Insurance	22.8%	0.9%	21.9%	2376.4%
25.0%	1.0%	24.0%	2385.6%	Self Pay / Indigent	25.0%	1.0%	24.0%	2385.6%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Healthy Beginnings - French Camp
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
753	664	89	13.4%	**Total Visits**	753	664	89	13.4%
753	664	89	13.4%	**Billable Visits**	753	664	89	13.4%
2.3	12.5	10.2	81.8%	**Total FTEs**	2.3	12.5	10.2	81.8%
				Patient Revenue				
0	4,163	(4,163)	-100.0%	Medicare	0	4,163	(4,163)	-100.0%
7,852	31,108	(23,256)	-74.8%	Medi-Cal Fee-for-Service	7,852	31,108	(23,256)	-74.8%
70,434	84,649	(14,215)	-16.8%	Medi-Cal Managed Care	70,434	84,649	(14,215)	-16.8%
21,600	2,867	18,733	653.4%	Insurance	21,600	2,867	18,733	653.4%
16,122	1,911	14,211	743.6%	Self Pay	16,122	1,911	14,211	743.6%
0	0	0		Indigent	0	0	0	
116,008	**124,698**	**(8,690)**	-7.0%	**Gross Patient Revenue**	**116,008**	**124,698**	**(8,690)**	-7.0%
61,573	(7,434)	69,007	-928.3%	Contractual Adjustments	61,573	(7,434)	69,007	-928.3%
41,720	32,086	9,634	30.0%	Capitation Rev	41,720	32,086	9,634	30.0%
219,300	**149,350**	**69,950**	46.8%	**Net Patient Revenue**	**219,300**	**149,350**	**69,950**	46.8%
0	0	0		Other Revenue	0	0	0	
219,300	**149,350**	**69,950**	46.8%	**Total Revenue**	**219,300**	**149,350**	**69,950**	46.8%
				Operating Expense				
68,981	109,277	40,296	36.9%	Salaries	68,981	109,277	40,296	36.9%
50,526	38,672	(11,854)	-30.7%	Benefits	50,526	38,672	(11,854)	-30.7%
119,507	**147,949**	**28,442**	19.2%	**Total Salaries & Benefits**	**119,507**	**147,949**	**28,442**	19.2%
9,615	3,533	(6,082)	-172.1%	Professional Fees/Registry	9,615	3,533	(6,082)	-172.1%
2,787	12,008	9,221	76.8%	Supplies	2,787	12,008	9,221	76.8%
23,548	16,551	(6,997)	-42.3%	Purchased Services	23,548	16,551	(6,997)	-42.3%
2,761	2,701	(60)	-2.2%	Depreciation	2,761	2,701	(60)	-2.2%
2,932	870	(2,062)	-237.0%	Other Expense	2,932	870	(2,062)	-237.0%
161,150	**183,612**	**22,462**	12.2%	**Total Direct Expense**	**161,150**	**183,612**	**22,462**	12.2%
36,889	26,686	(10,203)	-38.2%	Allocation of Direct Admin Exp	36,889	24,651	(12,238)	-49.6%
67,280	76,658	9,378	12.2%	Overhead Allocation	67,280	76,658	9,378	12.2%
265,319	**286,956**	**21,637**	7.5%	**Total Expenses**	**265,319**	**284,921**	**19,602**	6.9%
(46,019)	**(137,606)**	**91,587**	66.6%	**Net Income (Loss)**	**(46,019)**	**(135,571)**	**89,552**	-66.1%
				Key Ratios				
$ 154.06	$ 187.80	$ (33.74)	-18.0%	Gross Pt Revenue/Billable Visit	$ 154.06	$ 187.80	$ (33.74)	-18.0%
$ 291.23	$ 224.92	$ 66.31	29.5%	Total Revenue/Billable Visit (excl Oth Rev)	$ 291.23	$ 224.92	$ 66.31	29.5%
$ 214.01	$ 276.52	$ 62.51	22.6%	Direct Costs/Billable Visit	$ 214.01	$ 276.52	$ 62.51	22.6%
$ 138.34	$ 155.64	$ 17.30	11.1%	Indirect Costs/Billable Visit	$ 138.34	$ 152.57	$ 14.24	9.3%
$ 352.35	$ 432.16	$ 79.81	18.5%	Total Medical Cost/Billable Visit	$ 352.35	$ 429.10	$ 76.75	17.9%
$ (61.11)	$ (207.24)	$ 146.12	-70.5%	Net Income(Loss)/Billable Visit	$ (61.11)	$ (204.17)	$ 143.06	-70.1%
73.2%	35.4%	-37.9%	-107.0%	Benefits as a % of Salaries	73.2%	35.4%	-37.9%	-107.0%
41.8%	41.8%	0.0%	0.0%	Overhead % of Direct Exp	41.8%	41.7%	0.0%	0.0%
$ 366				Gross Patient AR (in 000s)				
$ (82)				Less Reserves (in 000s)				
$ 285				Net AR (in 000s)				
$ 190				Wrap AR (in 000s)				
47.5				Gross AR Days				
$ 149				Cash Receipts (in 000s)				
				Payer Mix				
0.0%	3.3%	-3.3%	-100.0%	Medicare	0.0%	3.3%	-3.3%	-100.0%
6.8%	24.9%	-18.2%	-72.9%	Medi-Cal	6.8%	24.9%	-18.2%	-72.9%
60.7%	67.9%	-7.2%	-10.6%	Medi-Cal Managed Care	60.7%	67.9%	-7.2%	-10.6%
18.6%	2.3%	16.3%	709.8%	Insurance	18.6%	2.3%	16.3%	709.8%
13.9%	1.5%	12.4%	806.8%	Self Pay / Indigent	13.9%	1.5%	12.4%	806.8%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

SJCC Hazelton Clinic
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
333	563	(230)	-40.9%	**Total Visits**	333	563	(230)	-40.9%
192	563	(371)	-65.9%	**Billable**	192	563	(371)	-65.9%
0.9	6.0	5.1	85.7%	**Total FTEs**	0.9	6.0	5.1	85.7%
				Patient Revenue				
(2,341)	5,865	(8,206)	-139.9%	Medicare	(2,341)	5,865	(8,206)	-139.9%
3,885	38,552	(34,667)	-89.9%	Medi-Cal Fee-for-Service	3,885	38,552	(34,667)	-89.9%
7,676	56,153	(48,477)	-86.3%	Medi-Cal Managed Care	7,676	56,153	(48,477)	-86.3%
12,763	6,949	5,814	83.7%	Insurance	12,763	6,949	5,814	83.7%
5,282	7,121	(1,839)	-25.8%	Self Pay	5,282	7,121	(1,839)	-25.8%
0	0	0		Indigent	0	0	0	#DIV/0!
27,265	**114,640**	**(87,375)**	-76.2%	**Patient Revenue**	**27,265**	**114,640**	**(87,375)**	-76.2%
4,780	(79,303)	84,083	-106.0%	Contractual Adjustments	4,780	(79,303)	84,083	-106.0%
13,175	18,353	(5,178)	-28.2%	Physician Capitation	13,175	18,353	(5,178)	-28.2%
45,220	**53,690**	**(8,470)**	-15.8%	**Net Patient Revenue**	**45,220**	**53,690**	**(8,470)**	-15.8%
0	0	0		Other Revenue	0	0	0	
45,220	**53,690**	**(8,470)**	-15.8%	**Total Revenue**	**45,220**	**53,690**	**(8,470)**	-15.8%
				Operating Expense				
4,279	39,503	35,224	89.2%	Salaries	4,279	39,503	35,224	89.2%
3,659	14,797	11,138	75.3%	Benefits	3,659	14,797	11,138	75.3%
7,938	**54,300**	**46,362**	85.4%	**Total Salaries & Benefits**	**7,938**	**54,300**	**46,362**	85.4%
0	0	0		Professional Fees/Registry	0	0	0	
3,066	12,388	9,322	75.2%	Supplies	3,066	12,388	9,322	75.2%
122,797	123,307	510	0.4%	Purchased Services	122,797	123,307	510	0.4%
0	0	0		Depreciation	0	0	0	
136	260	124	47.7%	Other Expense	136	260	124	47.7%
133,937	**190,255**	**56,318**	29.6%	**Total Direct Expense**	**133,937**	**190,255**	**56,318**	29.6%
8,670	24,533	15,863	64.7%	Allocation of Direct Admin Exp	8,670	22,662	13,992	61.7%
57,044	81,030	23,986	29.6%	Overhead Allocation	57,044	81,030	23,986	29.6%
199,651	**295,818**	**96,167**	32.5%	**Total Expenses**	**199,651**	**293,947**	**94,296**	32.1%
(154,431)	**(242,128)**	**87,697**	36.2%	**Net Income (Loss)**	**(154,431)**	**(240,257)**	**85,826**	-35.7%
				Key Ratios				
$ 142.01	$ 203.62	$ (61.62)	-30.3%	Gross Pt Revenue/Billable Visit	$ 142.01	$ 203.62	$ (61.62)	-30.3%
$ 235.52	$ 95.36	$ 140.16	147.0%	Total Revenue/Billable Visit (excl Oth Rev)	$ 235.52	$ 95.36	$ 140.16	147.0%
$ 697.59	$ 337.93	$ (359.66)	-106.4%	Direct Costs/Billable Visit	$ 697.59	$ 337.93	$ (359.66)	-106.4%
$ 342.26	$ 187.50	$ (154.76)	-82.5%	Indirect Costs/Billable Visit	$ 342.26	$ 184.18	$ (158.08)	-85.8%
$ 1,039.85	$ 525.43	$ (514.42)	-97.9%	Total Medical Cost/Billable Visit	$ 1,039.85	$ 522.11	$ (517.74)	-99.2%
$ (804.33)	$ (430.07)	$ (374.26)	87.0%	Net Income(Loss)/Billable Visit	$ (804.33)	$ (426.74)	$ (377.58)	88.5%
85.5%	37.5%	-48.1%	-128.3%	Benefits as a % of Salaries	85.5%	37.5%	-48.1%	-128.3%
42.6%	42.6%	0.0%	0.0%	Overhead % of Direct Exp	42.6%	42.6%	0.0%	0.0%
$ 218				Gross Patient AR (in 000s)				
$ (49)				Less Reserves (in 000s)				
$ 168				Net AR (in 000s)				
$ 113				Wrap AR (in 000s)				
116.4				Gross AR Days				
$ 15				Cash Receipts (in 000s)				
				Payer Mix				
-8.6%	5.1%	-13.7%	-267.8%	Medicare	-8.6%	5.1%	-13.7%	-267.8%
14.2%	33.6%	-19.4%	-57.6%	Medi-Cal	14.2%	33.6%	-19.4%	-57.6%
28.2%	49.0%	-20.8%	-42.5%	Medi-Cal Managed Care	28.2%	49.0%	-20.8%	-42.5%
46.8%	6.1%	40.7%	672.2%	Insurance	46.8%	6.1%	40.7%	672.2%
19.4%	6.2%	13.2%	211.9%	Self Pay / Indigent	19.4%	6.2%	13.2%	211.9%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

SJCC Manteca Clinic
Income Statement
July 31, 2018

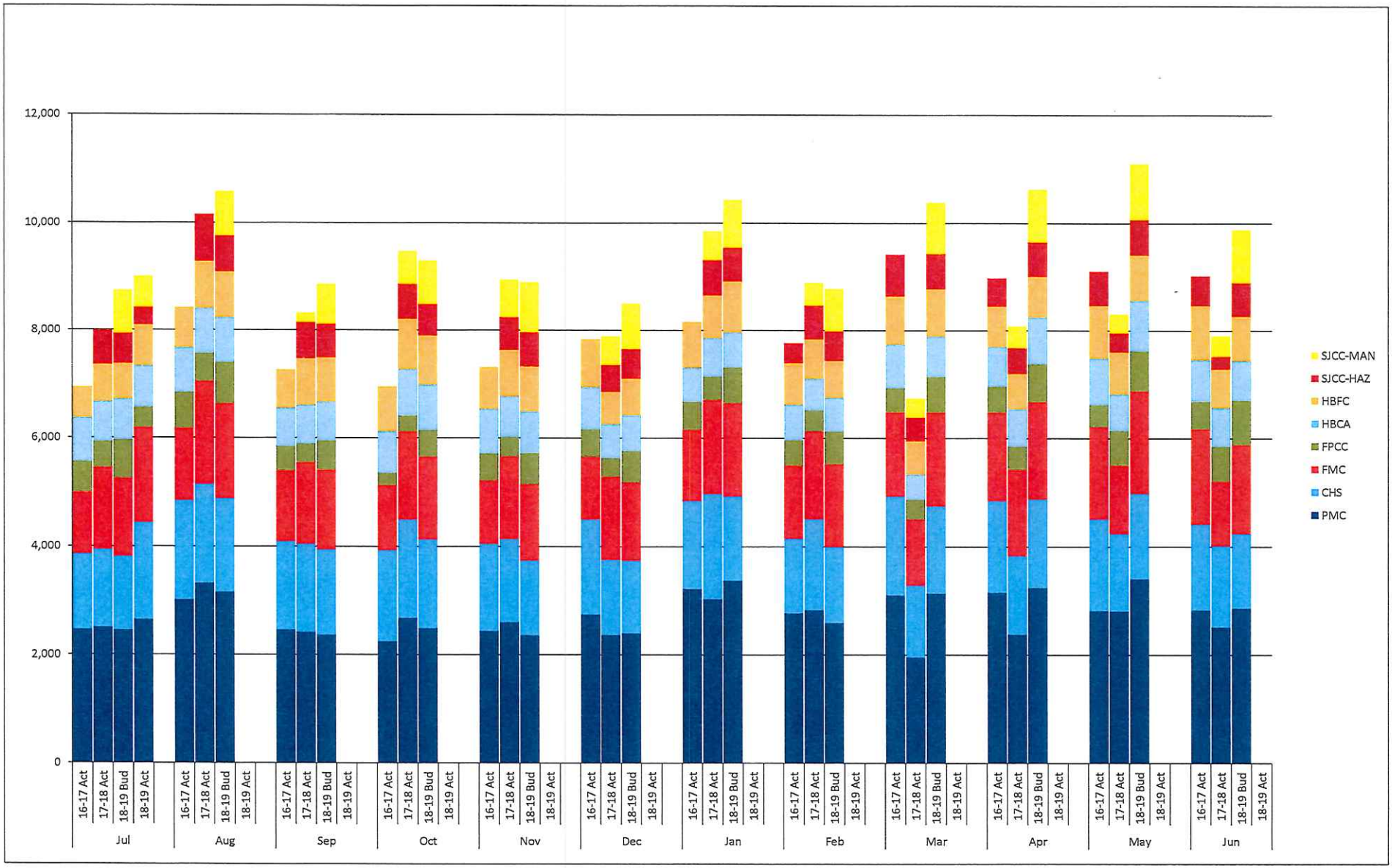
Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
572	794	(222)	-28.0%	**Total Visits**	572	794	(222)	-28.0%
549	794	(245)	-30.9%	**Billable Visits**	549	794	(245)	-30.9%
2.5	14.0	11.5	82.2%	**Total FTEs**	2.5	14.0	11.5	82.2%
				Patient Revenue				
0	12,775	(12,775)	-100.0%	Medicare	0	12,775	(12,775)	-100.0%
4,350	27,841	(23,491)	-84.4%	Medi-Cal Fee-for-Service	4,350	27,841	(23,491)	-84.4%
28,585	123,889	(95,304)	-76.9%	Medi-Cal Managed Care	28,585	123,889	(95,304)	-76.9%
19,578	2,798	16,780	599.7%	Insurance	19,578	2,798	16,780	599.7%
16,394	9,527	6,867	72.1%	Self Pay	16,394	9,527	6,867	72.1%
0	0	0		Indigent	0	0	0	#DIV/0!
68,907	**176,830**	**(107,923)**	-61.0%	**Patient Revenue**	**68,907**	**176,830**	**(107,923)**	-61.0%
50,327	(124,751)	175,078	140.3%	Contractual Adjustments	50,327	(124,751)	175,078	-140.3%
38,223	18,353	19,870	108.3%	Physician Capitation	38,223	18,353	19,870	108.3%
157,457	**70,432**	**87,025**	123.6%	**Net Patient Revenue**	**157,457**	**70,432**	**87,025**	123.6%
0	0	0		Other Revenue	0	0	0	
157,457	**70,432**	**87,025**	123.6%	**Total Revenue**	**157,457**	**70,432**	**87,025**	123.6%
				Operating Expense				
76,019	112,999	36,980	32.7%	Salaries	76,019	112,999	36,980	32.7%
57,903	37,983	(19,920)	-52.4%	Benefits	57,903	37,983	(19,920)	-52.4%
133,922	**150,982**	**17,060**	11.3%	**Total Salaries & Benefits**	**133,922**	**150,982**	**17,060**	11.3%
0	0	0		Professional Fees/Registry	0	0	0	
2,493	8,710	6,217	71.4%	Supplies	2,493	8,710	6,217	71.4%
4,982	2,441	(2,541)	-104.1%	Purchased Services	4,982	2,441	(2,541)	-104.1%
8,790	469	(8,321)	-1774.3%	Depreciation	8,790	469	(8,321)	-1774.3%
19,214	10,396	(8,818)	-84.8%	Other Expense	19,214	10,396	(8,818)	-84.8%
169,402	**172,998**	**3,596**	2.1%	**Total Direct Expense**	**169,402**	**172,998**	**3,596**	2.1%
21,912	37,842	15,930	42.1%	Allocation of Direct Admin Exp	21,912	34,956	13,044	37.3%
68,676	70,133	1,458	2.1%	Overhead Allocation	68,676	70,133	1,457	2.1%
259,989	**280,973**	**20,984**	7.5%	**Total Expenses**	**259,989**	**278,087**	**18,098**	6.5%
(102,533)	**(210,541)**	**108,009**	51.3%	**Net Income (Loss)**	**(102,533)**	**(207,655)**	**105,122**	-50.6%
				Key Ratios				
$ 125.51	$ 222.71	$ (97.19)	-43.6%	Gross Pt Revenue/Billable Visit	$ 125.51	$ 222.71	$ (97.19)	-43.6%
$ 286.81	$ 88.71	$ 198.10	223.3%	Total Revenue/Billable Visit (excl Oth Rev)	$ 286.81	$ 88.71	$ 198.10	223.3%
$ 308.56	$ 217.88	$ (90.68)	-41.6%	Direct Costs/Billable Visit	$ 308.56	$ 217.88	$ (90.68)	-41.6%
$ 165.00	$ 135.99	$ (29.01)	-21.3%	Indirect Costs/Billable Visit	$ 165.00	$ 132.35	$ (32.65)	-24.7%
$ 473.57	$ 353.87	$ (119.70)	-33.8%	Total Medical Cost/Billable Visit	$ 473.57	$ 350.24	$ (123.33)	-35.2%
$ (186.76)	$ (265.17)	$ 78.40	-29.6%	Net Income(Loss)/Billable Visit	$ (186.76)	$ (261.53)	$ 74.77	-28.6%
76.2%	33.6%	-42.6%	-126.6%	Benefits as a % of Salaries	76.2%	33.6%	-42.6%	-126.6%
40.5%	40.5%	0.0%	0.0%	Overhead % of Direct Exp	40.5%	40.5%	0.0%	0.0%
$ 322				Gross Patient AR (in 000s)				
$ (71)				Less Reserves (in 000s)				
$ 251				Net AR (in 000s)				
$ 167				Wrap AR (in 000s)				
172.1				Gross AR Days				
$ 42				Cash Receipts (in 000s)				
				Payer Mix				
0.0%	7.2%	-7.2%	-100.0%	Medicare	0.0%	7.2%	-7.2%	-100.0%
6.3%	15.7%	-9.4%	-59.9%	Medi-Cal	6.3%	15.7%	-9.4%	-59.9%
41.5%	70.1%	-28.6%	-40.8%	Medi-Cal Managed Care	41.5%	70.1%	-28.6%	-40.8%
28.4%	1.6%	26.8%	1695.6%	Insurance	28.4%	1.6%	26.8%	1695.6%
23.8%	5.4%	18.4%	341.6%	Self Pay / Indigent	23.8%	5.4%	18.4%	341.6%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

FQ Administration
Income Statement
July 31, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
0.0	9.0	9.0	100.0%	Total FTEs	0.0	9.0	9	100.0%
0	**0**	**0**		**Total Patient Revenue**	**0**	**0**	**0**	
0	0	0		(Deductions) from Revenue	0	0	0	
0	0	0		Other Allowances	0	0	0	
0	0	0		**Net Revenue**	0	0	0	
0	0	0		Other Revenue	0	0	0	
0	0	0		**Total Revenue**	0	0	0	
				Operating Expense				
44,542	71,195	26,653	37.4%	Salaries	44,542	71,195	26,653	37.4%
44,348	69,500	25,152	36.2%	Benefits	44,348	69,500	25,152	36.2%
88,890	**140,695**	**51,805**	36.8%	**Total Salaries & Benefits**	**88,890**	**140,695**	**51,805**	36.8%
83,333	83,333	0	0.0%	Professional Fees/Registry	83,333	54,167	(29,166)	-53.8%
1,532	445	(1,087)	-244.2%	Supplies	1,532	445	(1,087)	-244.2%
146,601	144,098	(2,503)	-1.7%	Purchased Services	146,601	144,098	(2,503)	-1.7%
3,395	3,257	(138)	-4.2%	Depreciation	3,395	3,257	(138)	-4.2%
8,333	10,645	2,312	21.7%	Other Expense	8,333	10,645	2,312	21.7%
332,083	**382,473**	**50,390**	13.2%	**Total Direct Expense**	**332,083**	**353,307**	**21,224**	6.0%
0	0	0		Overhead Allocation	0	0	0	
332,083	**382,473**	**50,390**	13.2%	**Total Expenses**	**332,083**	**353,307**	**21,224**	6.0%
(332,083)	**(382,473)**	**50,390**	-13.2%	**Net Income (Loss)**	**(332,083)**	**(353,307)**	**21,224**	-6.0%

FQHC Visits

July 2018

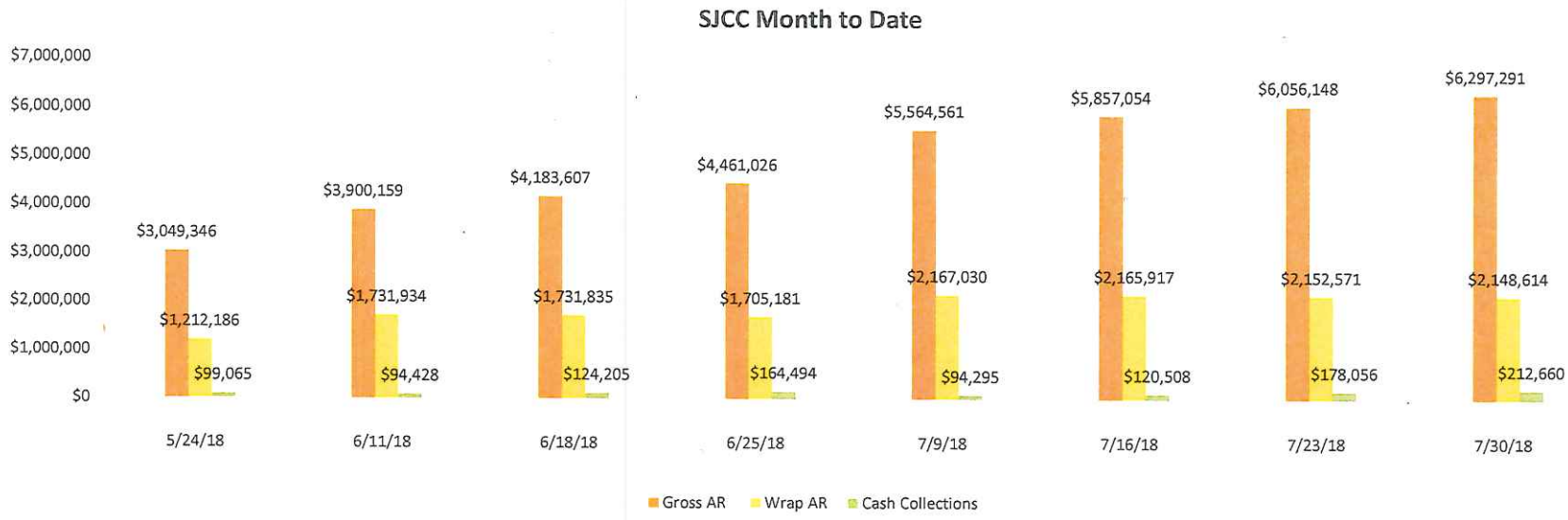


FQHC Visits

July 2018

	Clinic	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total Year
16-17 Act	CHS	1,383	1,827	1,631	1,686	1,605	1,752	1,618	1,380	1,815	1,693	1,691	1,584	**19,665**
	FMC	1,143	1,333	1,308	1,199	1,170	1,160	1,312	1,348	1,552	1,630	1,707	1,763	**16,625**
	FPCC	562	669	451	228	503	503	523	471	456	489	405	508	**5,768**
	PMC	2,470	3,015	2,458	2,241	2,438	2,747	3,224	2,771	3,112	3,156	2,822	2,834	**33,288**
	HBCA	813	821	702	766	823	783	632	651	813	733	865	778	**9,180**
	HBFC	572	753	721	836	785	893	853	782	888	751	977	997	**9,808**
	SJCC-Haz	-	-	-	-	-	-	-	364	780	523	631	553	**2,851**
	Total	**6,943**	**8,418**	**7,271**	**6,956**	**7,324**	**7,838**	**8,162**	**7,767**	**9,416**	**8,975**	**9,098**	**9,017**	**97,185**
17-18 Act	CHS	1,432	1,818	1,622	1,814	1,538	1,381	1,940	1,676	1,329	1,454	1,425	1,502	**18,931**
	FMC	1,516	1,910	1,513	1,627	1,526	1,536	1,738	1,624	1,220	1,580	1,271	1,197	**18,258**
	FPCC	479	518	337	292	360	345	438	388	362	425	638	642	**5,224**
	PMC	2,506	3,325	2,418	2,680	2,600	2,368	3,032	2,832	1,957	2,362	2,812	2,510	**31,402**
	HBCA	731	828	716	866	749	625	708	586	468	693	677	716	**8,363**
	HBFC	695	874	866	933	859	604	791	730	617	652	778	727	**9,126**
	SJCC-Haz	630	885	674	643	614	502	661	631	438	476	362	235	**6,751**
	SJCC-Man	-	-	179	612	696	531	540	420	352	401	348	378	**4,457**
	Total	**7,989**	**10,158**	**8,325**	**9,467**	**8,942**	**7,892**	**9,848**	**8,887**	**6,743**	**8,043**	**8,311**	**7,907**	**102,512**
18-19 Bud	CHS	1,362	1,726	1,572	1,643	1,370	1,337	1,557	1,404	1,608	1,634	1,577	1,368	**18,156**
	FMC	1,441	1,750	1,474	1,528	1,413	1,445	1,721	1,529	1,732	1,797	1,896	1,647	**19,373**
	FPCC	707	773	537	492	573	580	667	602	668	712	745	824	**7,880**
	PMC	2,452	3,157	2,367	2,483	2,366	2,400	3,374	2,591	3,139	3,245	3,408	2,871	**33,852**
	HBCA	752	826	713	841	767	665	645	627	745	866	935	744	**9,125**
	HBFC	664	844	829	909	841	676	943	688	876	749	839	811	**9,668**
	SJCC-Haz	558	677	622	586	630	547	638	547	657	649	668	627	**7,406**
	SJCC-Man	794	831	738	813	932	850	890	784	965	982	1,036	995	**10,610**
	Total	**8,730**	**10,585**	**8,851**	**9,295**	**8,891**	**8,499**	**10,435**	**8,772**	**10,390**	**10,634**	**11,103**	**9,887**	**116,070**
18-19 Act	CHS	1,792												**1,792**
	FMC	1,755												**1,755**
	FPCC	366												**366**
	PMC	2,647												**2,647**
	HBCA	775												**775**
	HBFC	753												**753**
	SJCC-Haz	333												**333**
	SJCC-Man	572												**572**
	Total	**8,993**	-	-	-	-	-	-	-	-	-	-	-	**8,993**

KEY PERFORMANCE INDICATORS SJCC Totals	5/24/18	6/11/18	6/18/18	6/25/18	7/9/18	7/16/18	7/23/18	7/30/18
SJCC Business Office								
Cash Collections	$99,065	$94,428	$124,205	$164,494	$94,295	$120,508	$178,056	$212,660
Open Receipt Batches	$96,515	$298,215	$298,215	$299,210	$389,842	$812,172	$1,147,308	$1,147,417
Unposted ERA's	$526,847	$1,169,285	$1,058,994	$1,253,906	$2,224,612	$2,374,868	$2,640,572	$2,223,876
Gross AR	$3,049,346	$3,900,159	$4,183,607	$4,461,026	$5,564,561	$5,857,054	$6,056,148	$6,297,291
Gross AR Days (90 day average)	61.9	79.2	84.9	90.6	113.0	118.9	122.9	127.8
Average Daily Revenue (90 day average)	$49,259	$49,259	$49,259	$49,259	$49,259	$49,259	$49,259	$49,259
Wrap AR	$1,212,186	$1,731,934	$1,731,835	$1,705,181	$2,167,030	$2,165,917	$2,152,571	$2,148,614
AR over 90 Days	$508,496	$528,668	$614,768	$807,263	$1,148,669	$1,339,579	$1,671,284	$1,954,592
% of AR over 90 Days	17%	14%	15%	18%	21%	23%	28%	31%
AR over 120 Days	$423,572	$433,455	$394,691	$410,143	$416,756	$404,073	$391,655	$391,103
% of AR over 120 Days	$0	$0	9%	9%	7%	7%	6%	6%
AR over 180 Days	$205,173	$188,934	$142,476	$140,472	$165,347	$178,452	$165,515	$159,602
% of AR over 180 Days	7%	5%	3%	3%	3%	3%	3%	3%
AR over 365 Days	$76,140	$94,324	$98,684	$108,336	$122,384	$131,001	$141,430	$152,457
% of AR over 365 Days	2%	2%	2%	2%	2%	2%	2%	2%
Patient Credit Balance Total (EOM)	$44,854	$37,445	$56,395	$56,614	$775,202	$976,286	$1,321,257	$1,605,506
Total Not Coded	$96,515	$55,163	$28,437	$28,724	$46,250	$55,931	$70,663	$58,484
Total Claims Produced Today	$56,182	$20,517	$34,286	$19,628	$12,455	$22,688	$13,961	$13,628
Total Number of claims for month	7224	1869	16318	18862	2334	4945	7444	11223
Total Number of clean claims for month	7028	1722	15852	18182	2273	4827	7247	10994
Total number of error claims for month	196	28	466	680	61	118	197	229
Clean Claims from ClaimRemedi/Trizetto	97%	92%	97%	96%	97%	98%	97%	98%


SJCC Month to Date
$7,000,000
$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0
$3,049,346
$1,212,186
$99,065
$3,900,159
$1,731,934
$94,428
$4,183,607
$1,731,835
$124,205
$4,461,026
$1,705,181
$164,494
$5,564,561
$2,167,030
$94,295
$5,857,054
$2,165,917
$120,508
$6,056,148
$2,152,571
$178,056
$6,297,291
$2,148,614
$212,660
5/24/18
6/11/18
6/18/18
6/25/18
7/9/18
7/16/18
7/23/18
7/30/18
Gross AR
Wrap AR
Cash Collections

SAN JOAQUIN COUNTY CLINICS
SUMMARY OF CHARGE AND PAYMENT FLOWS

DRAFT 10 30 2018