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

Quality Strategy

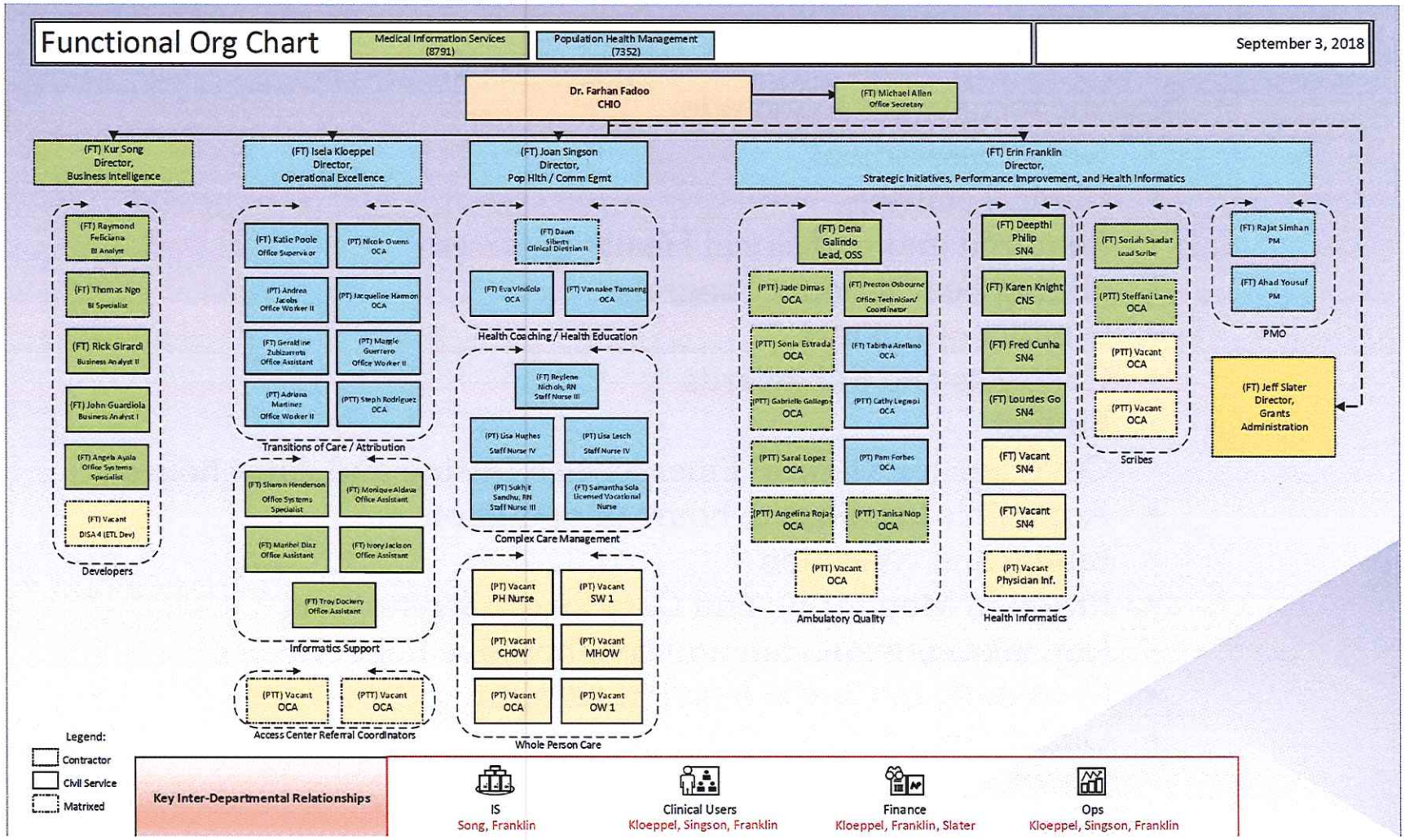
September 25, 2018

SAN JOAQUIN GENERAL HOSPITAL

Overview

- Restructuring of the team
- HRSA activities
- Quality Improvement /Quality Assurance Plan
- Next steps

Team Restructuring



HRSA (Health Resources & Services Administration) activities

- Redesignation Application (annual renewal) – Oct.3
- OSV (Onsite visit) – November 6
  - Specific focus areas to include:
    - Needs assessment
    - Clinical staffing
    - Required and additional Health Services
    - Sliding Fee Discount Program
    - Conflict of Interest
    - Contracts and Subawards
    - Budget
    - Coverage for Medical Emergencies During and After hours
    - Accessible locations & hours of operation
    - Billing and collection
    - Program Monitoring and Data Reporting systems
    - Key management staff and collaborative relationships
    - Continuity of Care & hospital admitting
    - Quality Improvement/Assurance
    - Board Authority
    - Board Composition

Quality Improvement/Assurance

The reorganization yielded an Ambulatory Quality team within the new department structure.

The team has completed the following:

—Thorough review of the QI/QA Policy

—Added a Quality sub committee

—Refined processes and procedures

Next Steps

1. Approve Quality Improvement/Assurance Policy
2. Regain visibility.

   The Cerner implementation has resulted in a certain degree of lost visibility for the team. Plans for new modules/solutions to be added to the Cerner platform along with ***HealtheIntent*** are among a few of our strategic plans to regain visibility and ensure that quality is at the forefront of our mission.

UDS Health Center Performance Comparison Report

BHCMIS ID: 09E01121 - SAN JOAQUIN, COUNTY OF, Stockton, CA
Program: Look-alike

Date Requested: 08/31/2018 02:17 PM EST
Date of Last Report Refreshed: 05/18/2018

UDS Health Center Performance Comparison Report - 2017

Health Center - Universal

	Health Center	Healthy People 2020 Goals[4]	Averages							Health Center Adjusted Quartile[5]
			CA	National	Urban	Size	Sites[1]	Special population Agricultural Workers[2]	Special population Homeless[3]	
						20,000-49,999	11-15	Below 25%	Below 25%	
			n = 197	n = 1429	n = 810	n = 313	n = 150	n = 1392	n = 1337	
QUALITY OF CARE INDICATORS/HEALTH OUTCOMES*										
Early Entry into Prenatal Care										
Access to Prenatal Care (first prenatal visit in 1st trimester)	61.48%	77.90%	77.91%	73.98%	73.29%	73.31%	73.94%	73.54%	73.99%	-
Low Birth Weight (live births < 2500 grams)	8.51%	7.80%	6.62%	8.00%	8.14%	8.29%	7.65%	8.12%	7.99%	-
Preventive Health Screenings and Services										
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	72.97%	-	66.80%	65.84%	67.86%	65.89%	63.92%	65.38%	65.86%	-
Body Mass Index (BMI) Screening and Follow-Up Plan*	61.30%	-	64.85%	63.45%	63.01%	65.44%	64.41%	63.14%	63.56%	-
Tobacco Use Screening and Cessation Intervention*	87.40%	-	88.51%	87.28%	87.51%	87.49%	87.11%	87.11%	87.37%	-
Colorectal Cancer Screening*	33.83%	70.50%	44.98%	42.15%	42.05%	42.64%	41.22%	41.96%	42.49%	-
Screening for Depression and Follow-Up Plan*	70.67%	-	63.76%	66.00%	66.63%	64.52%	67.76%	65.62%	66.19%	-
Cervical Cancer Screening*	54.29%	93.00%	59.23%	55.61%	57.35%	56.01%	55.86%	55.43%	55.90%	-
Childhood Immunization Status*	44.29%	80.00%	43.01%	40.40%	41.98%	38.24%	40.16%	40.11%	40.37%	-
Dental Sealants for Children between 6-9 Years	-	28.10%	54.38%	50.68%	51.00%	46.94%	49.25%	50.08%	50.55%	-

'-' - Data cannot be calculated.

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[2]Special Population Agricultural Workers category is based on whether or not Agricultural Workers/Seasonal Agricultural Worker patients account for >=25% or <25% of total Health Center patient population.

[3]Special Population Homeless category is based on whether or not Homeless patients account for >=25% or <25% of total Health Center patient population.

[4]Refer to http://www.healthypeople.gov/2020/default.aspx for more information. A dash indicates that the clinical measure does not exactly align with any existing Healthy People 2020 goal.

[5]Health Center adjusted quartile results from a statistical model adjusting for special populations, uninsured and minority patients, and EHR use. Clinical performance for each measure is ranked from Quartile 1, highest 25% of reporting health centers, to Quartile 4, lowest 25% of reporting health centers.

*Effective with calendar year 2016 reporting, clinical quality measures (CQMs) were changed to align with the Centers for Medicare and Medicaid Services' electronic specified clinical quality measures (eCQMs) and therefore caution should be used for trends between 2015 and 2017 UDS CQMs. Health centers are encouraged to review the year over year differences before using for comparisons. Annual UDS Manuals that outline clinical measurement requirements can be found here: https://bphc.hrsa.gov/datareporting/reporting/.

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QUALITY OF CARE INDICATORS/HEALTH OUTCOMES*										
Chronic Disease Management										
Use of Appropriate Medications for Asthma*	93.91%	-	86.61%	86.40%	86.98%	87.64%	85.33%	86.37%	86.50%	-
Coronary Artery Disease (CAD): Lipid Therapy	84.85%	-	78.62%	80.52%	80.71%	81.98%	79.92%	80.35%	80.59%	-
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	85.88%	-	78.97%	79.09%	79.59%	80.06%	80.62%	79.00%	79.07%	-
HIV Linkage to Care	63.64%	-	90.51%	84.27%	85.48%	80.78%	79.64%	84.26%	84.46%	-
Controlling High Blood Pressure (Hypertensive Patients with Blood Pressure < 140/90)*	59.14%	61.20%	64.62%	62.74%	62.05%	62.16%	62.29%	62.67%	62.83%	-
Diabetes: Hemoglobin A1c Poor Control (Diabetic Patients with HbA1c > 9%) or No Test During Year*	30.00%	16.20%	34.01%	33.01%	33.35%	32.66%	32.50%	32.94%	32.91%	-

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		Averages									
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					20,000-49,999	11-15	Below 25%	Below 25%			
		n = 197	n = 1429	n = 810	n = 313	n = 150	n = 1392	n = 1337	25th	Median	75th
COSTS											
Cost Per Patient											
Total Cost per Total Patient	$638.96	$1,108.21	$941.73	$978.52	$891.05	$903.38	$942.85	$929.21	$670.89	$848.43	$1,118.67
Medical Cost per Medical Patient	$589.06	$744.28	$603.17	$616.86	$576.23	$581.70	$601.77	$597.51	$476.53	$585.59	$730.76
Dental Cost per Dental Patient	-	$576.19	$511.38	$496.98	$481.22	$466.13	$508.56	$509.96	$392.17	$510.38	$687.18
Mental Health Cost per Mental Health Patient	$531.01	$1,083.46	$829.51	$839.43	$850.60	$747.38	$835.26	$821.83	$408.96	$716.35	$1,155.99
Substance Abuse Cost per Substance Abuse Patient	-	$1,147.90	$1,162.25	$1,223.24	$1,126.68	$1,506.05	$1,169.50	$1,121.89	$423.76	$997.89	$2,016.29
Vision Cost per Vision Patient	-	$222.11	$222.59	$214.15	$223.02	$206.13	$219.63	$222.46	$111.76	$187.40	$285.42
Enabling Services Cost per Enabling Patient	$1,023.48	$685.42	$747.54	$812.65	$643.13	$657.77	$773.27	$748.90	$397.76	$971.77	$2,378.19

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		Averages							National Percentiles		
	Health Center	CA	National	Urban	Size	Sites[1]	Special population Agricultural Workers[2]	Special population Homeless[3]			
					20,000-49,999	11-15	Below 25%	Below 25%			
		n = 197	n = 1429	n = 810	n = 313	n = 150	n = 1392	n = 1337	25th	Median	75th
COSTS											
Cost Per Visit											
Total Cost per Total Visit	$189.63	$241.54	$232.44	$237.84	$222.44	$223.27	$233.58	$231.59	$188.99	$227.66	$277.94
Medical Cost per Medical Visit	$192.77	$210.18	$192.82	$198.27	$186.43	$183.79	$192.83	$190.92	$162.09	$192.77	$238.39
Dental Cost per Dental Visit	-	$194.03	$199.92	$194.82	$189.30	$186.78	$200.23	$199.41	$169.50	$212.90	$271.26
Mental Health Cost per Mental Health Visit	$244.35	$222.96	$171.47	$172.94	$169.65	$160.52	$171.24	$171.28	$124.85	$171.95	$243.48
Substance Abuse Cost per Substance Abuse Visit	-	$147.52	$159.94	$158.20	$151.99	$166.63	$159.36	$161.20	$94.38	$171.75	$316.95
Vision Cost per Vision Visit	-	$172.02	$167.60	$161.24	$166.01	$150.20	$164.38	$167.75	$94.09	$153.60	$224.60
Enabling Services Cost per Enabling Visit	$1,023.48	$270.42	$301.82	$311.89	$252.18	$311.33	$311.89	$308.84	$184.14	$418.71	$959.16

'-' - Data cannot be calculated.

[1]Sites are defined as Active Sites (includes only Permanent) as of 12/31/2017. This count excludes Admin only and To-be Verified types of sites.

[2]Special Population Agricultural Workers category is based on whether or not Agricultural Workers/Seasonal Agricultural Worker patients account for >=25% or <25% of total Health Center patient population.

[3]Special Population Homeless category is based on whether or not Homeless patients account for >=25% or <25% of total Health Center patient population.

Close Window

San Joaquin Community Clinics
Financial Statement Comments
Pre-audit June 30, 2018

Summary

The Total visits for the month of June were 7,907. June's Billable visits of 7,703 were less than budgeted visits of 8,889 by 1,186 or 13.3%. Year-to-date billable visits are less than budget by 5,041 or 5.0%. At the time the budget was prepared, the scheduled date to go live on the new Cerner system was 7/10/17. The new Cerner system went live on 3/5/2018. Provider productivity continued in June at a lower level than projected due to user training, as reflected in the negative variance in visits noted above.

Gross Patient Revenue of $1.5 million was less than budget by $85,000 or 5.2%. Net Patient Revenue of $11,000 was less than budget by $1.5 million or 99.3%. This was due primarily to an adjustment to reserve for potentially non-billable visits. 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. During the course of this review, we identified several resource providers that have been billed for in the past that may not be billable, depending on what services are provided during the course of a visit. The research continues; however, an estimated reserve of $1.3 million was entered in June for dates of service from 7/1/14 to current, pending the final determination of these resource providers as billable or non-billable. This adjustment, along with the shortfall in billable visits, accounted for the $1.5 million negative variance in June net revenue. A full accounting of the number of visits and net revenues impacted will be provided once the analysis is complete.

As reports and data become available from the Cerner system, we are able to identify revenue cycle issues related to system setup and clinical operations. We noted that there is a lag in the processing of charges and are in the process of identifying the impact and any necessary adjusting journal entries for year-end accruals of charges and adjustments. Net revenue should not be affected as we have accrued the net revenue based on visit volume and average payment rates by payor.

Capitation Revenue of $415,000 was less than budget by $101,000 or 19.6%, primarily due to a negative retroactive adjustment of $64,000. Capitation revenue is generally consistent from month to month; however, the budgeted capitation revenue was allocated based on monthly visit volume, which will create greater variances to budget from month to month. Year-to-date capitation revenue is 4.4% below budget.

Total Expenses of $1.7 million were less than budget by $669,000 (28.1%). The resulting Net Loss of $1.7 million was greater than Budgeted Net Loss by $870,000. While total cost per billable visit was lower in June at $222.42 versus budget of $267.95, year-to-date total cost per billable visit of $281.78 is only 0.3% less than budget of $282.71.

SJGH went live on the Cerner and PeopleSoft systems on 3/5/18 and June is the third complete month of activity for both systems. Implementation issues continued to impact the monthly close process. Work flows and reports are in the process of being reviewed and refined as staff become familiar with the new systems. Adjustments will be made in future months to ensure accurate financial reports for fiscal year end.

Explanations of major variances are explained below.

Revenue

As mentioned above, Gross Patient Revenue was less than budget by $85,000 or 5.2%. Gross Patient Revenue per visit was $198.75, which was greater than budget by 9.3%. Managed Care Medi-Cal was $8,000, or 0.7%, greater

than budget; Medicare was $87,000, or 36.1%, less than budget; Medi-Cal Fee-For-Service was $10,000, or 5.1%, less than budget; Self Pay was $9,000, or 26.2%, greater than budget; and Commercial was $3,000, or 20.5%, less than budget. Net Patient Revenue of $11,000 was less than budget by $1.5 million, primarily due to Contractual Adjustments of $1.9 million for the month, offset by $415,000 of Capitation Revenue. Deductions from revenue were unfavorable to budget by $1.4 million (231.8%).

Capitation revenue of $415,000 was less than budget by $101,000 (19.6%) as noted above.

Expenses

Salaries & Benefits of $1.2 million were less than budget by $186,000 (13.9%). Salaries of $717,000 were better than budget by $210,000 or 22.7%. This favorable variance is due to favorable Physician salaries of $252,000 offset by unfavorable variances for Mid-level Providers of $30,000 and Non-Providers of $12,000. The Physician salaries positive variance was due to eleven provider vacancies, in which one of these vacancies are currently being filled by a Locum. The Locum is working in Healthy Beginnings-French Camp.

Benefits of $433,000 were unfavorable to budget by $25,000 or 6.1%, predominantly due to unfavorable variances in Pension & Retirement ($20,000) and Vacation, Holiday, Sick Leave ($21,000). These were offset by favorable variances in FICA ($4,000) and Group Health ($11,000). Benefits as a percentage of salaries is 60.3%, higher than budget of 44.0% and above year-to-date actual of 54.6%.

Professional Fees/Registry of $4,000 were less than budget by $75,000 (94.3%) primarily due to MD Comp-Locums ($51,000) and Medical Consult ant & Mgmt ($25,000). MD Comp-Locums favorable variance is primarily due to no expenses in Children's Health ($5,000), Family Practice ($5,000), Primary Medicine ($10,000), and Healthy Beginnings-California St ($5,000). Also, an accrual correction in SJCC-Manteca ($20,000). Medical Consultant & Mgmt is favorable due to expense being shared with FQ-Admin and ACS Admin. It was budgeted all in FQ-Admin. These were offset by a slight over budget in MD Comp – Individual ($2,000).

Supplies of $164,000 were greater than budget by $63,000 (62.0%). This is predominantly due to physical inventory write off across all clinics ($85,000) offset by favorable variances in Other Medical Supplies ($8,000), Office & Admin Supplies ($5,000), Minor Medical Equipment ($6,000), and Other Minor Equipment ($2,000).

Purchased Services of negative $92,000 were less than budget by $307,000 (142.6%). This is predominantly due to correction of FY 2018 accruals ($366,000). Following expenses were over accrued in FY2018 – El Concilio ($82,000) and SST for Psychiatrist /LCSW ($284,000). Psychiatrist/LCSW were budgeted in FQ Clinics and are not being charged to clinics. This correction is offset by an unfavorable variance in Repairs & Maint for eClinical Works ($65,000). When the current budget was developed, it was anticipated that eClinical Works costs would terminate in December; therefore, there is no budget for January through June for the monthly support costs. Due to the delay in converting to the Cerner System, additional expenses will be incurred to keep eClinical Works on line through March 2019. This expense has been included in the FY2018-2019 budget. Repairs & Maint : Buildings is favorable across all Clinics ($5,000).

Depreciation of $22,000 was greater than budget by $11,000 (96.7%), predominantly in SJCC-Manteca ($9,000) 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. This expense has been included in the FY2018-19 budget.

Other Expense of $8,000 was less than budget by $10,000 (56.3%). Predominantly due to favorable variances in Non-Medical Equipment Rent Expense ($1,000), Electricity ($2,000), License & Taxes ($1,000), Telephone ($1,000), Outside Training ($2,000), Travel ($2,000) and Dues/Subscriptions ($1,000).

Accounts Receivable

June's Gross Accounts Receivables (AR) of $4.9 million was $2.0 million more than May and $2.4 million more than April. Average days of revenue in AR is at 82.7, which is up from 56.7 in May and up from 53.0 in April. As discussed last month, the increase in AR due to held Medi-Cal claims for all clinics continued in June and have impacted June AR balances.

Cash collections (excluding capitation) were $251,000 in June, which represents an increase from May collections of $149,000 and a decrease from the FY 2018 average year-to-date of $804,000. Cash collections averaged $843,000 per month in FY 2017. 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. This process will take several months to complete.

San Joaquin Community Clinics
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
7,907	8,889	(982)	-11.0%	Total Visits	102,512	101,344	1,168	1.2%
7,703	8,889	(1,186)	-13.3%	Billable Visits	96,303	101,344	(5,041)	-5.0%
22.0	132.1	110.0	83.3%	Total FTEs	111.6	132.1	20.4	15.5%
				Patient Revenue				
$ 154,375	$ 241,741	$ (87,367)	-36.1%	Medicare	$ 2,208,828	$ 2,571,986	$ (363,158)	-14.1%
$ 186,963	$ 196,980	(10,016)	-5.1%	Medi-Cal Fee-for-Service	2,398,612	$ 2,391,232	7,379	0.3%
$ 1,130,606	$ 1,122,983	7,622	0.7%	Medi-Cal Managed Care	13,470,752	$ 12,991,711	479,040	3.7%
$ 13,444	$ 16,919	(3,475)	-20.5%	Insurance	237,995	$ 191,371	46,624	24.4%
$ 45,506	$ 36,049	9,457	26.2%	Self Pay	447,706	$ 412,860	34,846	8.4%
$ 44	$ 1,052	(1,008)	-95.8%	Indigent	1,580	$ 11,653	(10,073)	-86.4%
1,530,937	**1,615,724**	**(84,787)**	-5.2%	**Gross Patient Revenue**	**18,765,472**	**18,570,813**	**194,659**	1.0%
(1,935,455)	(583,359)	(1,352,096)	-231.8%	Contractual Adjustments	(12,134,771)	(7,042,187)	(5,092,584)	72.3%
415,236	516,637	(101,401)	-19.6%	Capitation Rev	5,657,849	5,920,190	(262,341)	-4.4%
10,719	**1,549,002**	**(1,538,283)**	-99.3%	**Net Patient Revenue**	**12,288,550**	**17,448,816**	**(5,160,266)**	-29.6%
0	0	0		Other Revenue	0	0	0	100.0%
10,719	**1,549,002**	**(1,538,283)**	-99.3%	**Total Revenue**	**12,288,550**	**17,448,816**	**(5,160,266)**	-29.6%
				Operating Expense				
717,521	927,916	210,395	22.7%	Salaries	8,635,100	10,750,351	2,115,251	19.7%
432,951	408,144	(24,807)	-6.1%	Benefits	4,712,444	5,061,648	349,204	6.9%
1,150,473	**1,336,060**	**185,587**	13.9%	**Total Salaries & Benefits**	**13,347,544**	**15,811,999**	**2,464,455**	15.6%
4,468	79,034	74,566	94.3%	Professional Fees/Registry	1,833,532	948,400	(885,132)	-93.3%
163,667	101,020	(62,647)	-62.0%	Supplies	1,482,286	1,170,590	(311,696)	-26.6%
(91,667)	215,137	306,804	142.6%	Purchased Services	3,036,094	3,098,849	62,755	2.0%
21,645	11,004	(10,641)	-96.7%	Depreciation	278,799	139,967	(138,832)	-99.2%
7,816	17,873	10,057	56.3%	Other Expense	364,951	216,276	(148,675)	-68.7%
1,256,402	**1,760,128**	**503,726**	28.6%	**Total Direct Expense**	**20,343,206**	**21,386,081**	**1,042,875**	4.9%
456,845	621,708	164,863	26.5%	Overhead Allocation	6,792,884	7,264,513	471,629	6.5%
1,713,247	**2,381,836**	**668,589**	28.1%	**Total Expenses**	**27,136,090**	**28,650,594**	**1,514,504**	5.3%
(1,702,529)	**(832,834)**	**(869,695)**	-104.4%	**Net Income (Loss)**	**(14,847,540)**	**(11,201,778)**	**(3,645,762)**	32.5%
				Key Ratios				
$ 198.75	$ 181.77	$ 16.98	9.3%	Gross Pt Revenue/Billable Visit	$ 194.86	$ 183.24	$ 11.61	6.3%
$ 1.39	$ 174.26	$ (172.87)	-99.2%	Total Revenue/Billable Visit (excl Oth Rev)	$ 127.60	$ 172.17	$ (44.57)	-25.9%
$ 163.11	$ 198.01	$ 34.90	17.6%	Direct Costs/Billable Visit	$ 211.24	$ 211.02	$ (0.22)	-0.1%
$ 59.31	$ 69.94	$ 10.63	15.2%	Indirect Costs/Billable Visit	$ 70.54	$ 71.68	$ 1.14	1.6%
$ 222.42	$ 267.95	$ 45.53	17.0%	Total Medical Cost/Billable Visit	$ 281.78	$ 282.71	$ 0.93	0.3%
$ (221.03)	$ (93.69)	$ (127.33)	135.9%	Net Income(Loss)/Billable Visit	$ (154.18)	$ (110.53)	$ 43.64	-39.5%
$ 556.05	$ 669.88	$ 113.84	17.0%	Total Cost/Patient (1)	$ 704.45	$ 706.76	$ 2.32	0.3%
0.7%	95.9%	-95.2%	-99.3%	Net Pt Rev as % of Gross Rev	65.5%	94.0%	-28.5%	-30.3%
60.3%	44.0%	-16.4%	-37.2%	Benefits as a % of Salaries	54.6%	47.1%	-7.5%	-15.9%
36.4%	35.3%	-1.0%	-2.9%	Overhead % of Direct Exp	33.4%	34.0%	0.6%	1.7%
$ 4,944				Gross Patient AR (in 000s)				
$ (1,313)				Less Reserves (in 000s)				
$ 3,631				Net AR (in 000s)				
$ 409				Wrap AR (in 000s)				
87.1				Gross AR Days				
$ 666				Cash Receipts (in 000s)				
				Payer Mix				
10.1%	15.0%	-4.9%	-32.6%	Medicare	11.8%	13.8%	-2.1%	-15.0%
12.2%	12.2%	0.0%	0.2%	Medi-Cal	12.8%	12.9%	-0.1%	-0.7%
73.9%	69.5%	4.3%	6.3%	Medi-Cal Managed Care	71.8%	70.0%	1.8%	2.6%
0.9%	1.0%	-0.2%	-16.1%	Insurance	1.3%	1.0%	0.2%	23.1%
3.0%	2.3%	0.6%	27.5%	Self Pay / Indigent	2.4%	2.3%	0.1%	4.7%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Children's Health Services
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
1,502	1,434	68	4.7%	Total Visits	18,931	18,936	(5)	0.0%
1,399	1,434	(35)	-2.4%	Billable Visits	17,245	18,936	(1,691)	-8.9%
3.7	21.0	17.3	82.5%	Total FTEs	18.6	21.0	2.4	11.4%
				Patient Revenue				
0	0	0		Medicare	0	0	0	
8,553	59,852	(51,300)	-85.7%	Medi-Cal Fee-for-Service	509,804	790,457	(280,653)	-35.5%
84,864	286,637	(201,773)	-70.4%	Medi-Cal Managed Care	3,654,449	3,785,557	(131,108)	-3.5%
(501)	1,809	(2,310)	-127.7%	Insurance	16,941	23,896	(6,955)	-29.1%
3,183	372	2,810	754.7%	Self Pay	24,568	4,917	19,651	399.7%
0	0	0		Indigent	0	0	0	
96,098	**348,671**	**(252,573)**	-72.4%	**Gross Patient Revenue**	**4,205,763**	**4,604,827**	**(399,064)**	-8.7%
(167,738)	(189,070)	21,332	11.3%	Contractual Adjustments	(2,876,345)	(2,497,004)	(379,341)	15.2%
85,342	98,024	(12,682)	-12.9%	Capitation Rev	1,062,582	1,294,582	(232,000)	-17.9%
13,703	**257,625**	**(243,922)**	-94.7%	**Net Patient Revenue**	**2,392,000**	**3,402,405**	**(1,010,405)**	-29.7%
0	0	0		Other Revenue	0	0	0	
13,703	**257,625**	**(243,922)**	-94.7%	**Total Revenue**	**2,392,000**	**3,402,405**	**(1,010,405)**	-29.7%
				Operating Expense				
133,575	118,847	(14,728)	-12.4%	Salaries	1,433,161	1,595,036	161,875	10.1%
69,761	63,083	(6,678)	-10.6%	Benefits	783,266	824,813	41,547	5.0%
203,335	**181,930**	**(21,405)**	-11.8%	**Total Salaries & Benefits**	**2,216,427**	**2,419,849**	**203,422**	8.4%
(5,141)	5,000	10,141	202.8%	Professional Fees/Registry	8,721	60,000	51,279	85.5%
4,795	7,825	3,030	38.7%	Supplies	91,319	94,718	3,399	3.6%
(18,187)	6,451	24,638	381.9%	Purchased Services	20,641	78,040	57,399	73.6%
674	760	86	11.3%	Depreciation	7,985	9,120	1,135	12.4%
1,326	2,569	1,243	48.4%	Other Expense	37,650	31,169	(6,481)	-20.8%
186,803	**204,535**	**17,732**	8.7%	**Total Direct Expense**	**2,382,743**	**2,692,896**	**310,153**	11.5%
4,698	35,728	31,030	86.9%	Allocation of Direct Admin Exp	635,293	654,909	19,616	3.0%
56,433	61,790	5,357	8.7%	Overhead Allocation	717,002	813,524	96,522	11.9%
247,934	**302,053**	**54,119**	17.9%	**Total Expenses**	**3,735,038**	**4,161,329**	**426,292**	10.2%
(234,232)	**(44,428)**	**(189,803)**	-427.2%	**Net Income (Loss)**	**(1,343,038)**	**(758,924)**	**(584,113)**	77.0%
				Key Ratios				
$ 68.69	$ 243.15	$ (174.46)	-71.8%	Gross Pt Revenue/Billable Visit	$ 243.89	$ 243.18	$ 0.71	0.3%
$ 9.79	$ 179.65	$ (169.86)	-94.5%	Total Revenue/Billable Visit (excl Oth Rev)	$ 138.71	$ 179.68	$ (40.97)	-22.8%
$ 133.52	$ 142.63	$ 9.12	6.4%	Direct Costs/Billable Visit	$ 138.17	$ 142.21	$ 4.04	2.8%
$ 43.69	$ 68.00	$ 24.31	35.7%	Indirect Costs/Billable Visit	$ 78.42	$ 77.55	$ (0.87)	-1.1%
$ 177.21	$ 210.64	$ 33.43	15.9%	Total Medical Cost/Billable Visit	$ 216.59	$ 219.76	$ 3.17	1.4%
$ (167.42)	$ (30.98)	$ (136.43)	440.4%	Net Income(Loss)/Billable Visit	$ (77.88)	$ (40.08)	$ (37.80)	94.3%
52.2%	53.1%	0.9%	1.6%	Benefits as a % of Salaries	54.7%	51.7%	-2.9%	-5.7%
30.2%	30.2%	0.0%	0.0%	Overhead % of Direct Exp	30.1%	30.2%	0.1%	0.4%
$ 896				Gross Patient AR (in 000s)				
$ (181)				Less Reserves (in 000s)				
$ 715				Net AR (in 000s)				
$ 80				Wrap AR (in 000s)				
88.5				Gross AR Days				
$ 126				Cash Receipts (in 000s)				
				Payer Mix				
0.0%	0.0%	0.0%		Medicare	0.0%	0.0%	0.0%	
8.9%	17.2%	-8.3%	-48.2%	Medi-Cal	12.1%	17.2%	-5.0%	-29.4%
88.3%	82.2%	6.1%	7.4%	Medi-Cal Managed Care	86.9%	82.2%	4.7%	5.7%
-0.5%	0.5%	-1.0%	-200.4%	Insurance	0.4%	0.5%	-0.1%	-22.4%
3.3%	0.1%	3.2%	3001.2%	Self Pay / Indigent	0.6%	0.1%	0.5%	447.1%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Family Medicine Clinic
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
1,197	1,193	4	0.3%	Total Visits	18,258	14,584	3,674	25.2%
1,180	1,193	(13)	-1.1%	Billable Visits	17,641	14,584	3,057	21.0%
1.7	19.8	18.1	91.2%	Total FTEs	13.9	19.8	5.9	29.7%
				Patient Revenue				
55,619	33,839	21,780	64.4%	Medicare	513,497	413,606	99,891	24.2%
25,142	18,481	6,661	36.0%	Medi-Cal Fee-for-Service	316,554	225,893	90,661	40.1%
252,913	132,285	120,628	91.2%	Medi-Cal Managed Care	2,227,841	1,616,902	610,939	37.8%
2,549	3,158	(609)	-19.3%	Insurance	38,148	38,603	(455)	-1.2%
18,655	16,650	2,004	12.0%	Self Pay	167,565	203,517	(35,952)	-17.7%
0	242	(242)	-100.0%	Indigent	1,305	2,952	(1,647)	-55.8%
354,878	**204,655**	**150,223**	73.4%	**Gross Patient Revenue**	**3,264,910**	**2,501,474**	**763,436**	30.5%
(357,778)	(109,415)	(248,363)	-227.0%	Contractual Adjustments	(2,314,026)	(1,337,371)	(976,655)	73.0%
63,989	64,142	(153)	-0.2%	Capitation Rev	1,012,171	784,000	228,171	29.1%
61,088	**159,382**	**(98,294)**	-61.7%	**Net Patient Revenue**	**1,963,055**	**1,948,103**	**14,952**	0.8%
0	0	0		Other Revenue	0	0	0	
61,088	**159,382**	**(98,294)**	-61.7%	**Total Revenue**	**1,963,055**	**1,948,103**	**14,952**	0.8%
				Operating Expense				
100,400	99,703	(697)	-0.7%	Salaries	1,048,859	1,317,507	268,648	20.4%
43,475	40,222	(3,253)	-8.1%	Benefits	542,933	592,921	49,988	8.4%
143,875	**139,925**	**(3,950)**	-2.8%	**Total Salaries & Benefits**	**1,591,792**	**1,910,428**	**318,636**	16.7%
0	0	0		Professional Fees/registry	1,929	0	(1,929)	
62,891	34,760	(28,131)	-80.9%	Supplies	436,540	394,570	(41,970)	-10.6%
(32,032)	5,288	37,320	705.7%	Purchased Services	(10,758)	63,280	74,038	117.0%
4,171	3,245	(926)	-28.5%	Depreciation	48,680	46,302	(2,378)	-5.1%
2,306	2,781	475	17.1%	Other Expense	29,224	33,837	4,613	13.6%
181,211	**185,999**	**4,788**	2.6%	**Total Direct Expense**	**2,097,408**	**2,448,417**	**351,009**	14.3%
17,350	20,971	3,621	17.3%	Allocation of Direct Admin Exp	493,175	352,358	(140,816)	-40.0%
81,056	83,197	2,142	2.6%	Overhead Allocation	936,603	1,095,177	158,574	14.5%
279,617	**290,167**	**10,551**	3.6%	**Total Expenses**	**3,527,185**	**3,895,952**	**368,767**	9.5%
(218,528)	**(130,785)**	**(87,743)**	-67.1%	**Net Income (Loss)**	**(1,564,130)**	**(1,947,849)**	**383,719**	-19.7%
				Key Ratios				
$ 300.83	$ 171.55	$ 129.28	75.4%	Gross Pt Revenue/Billable Visit	$ 185.08	$ 171.52	$ 13.56	7.9%
$ 51.78	$ 133.60	$ (81.81)	-61.2%	Total Revenue/Billable Visit (excl Oth Rev)	$ 111.28	$ 133.58	$ (22.30)	-16.7%
$ 153.61	$ 155.91	$ 2.30	1.5%	Direct Costs/Billable Visit	$ 118.90	$ 167.88	$ 48.99	29.2%
$ 83.42	$ 87.32	$ 3.90	4.5%	Indirect Costs/Billable Visit	$ 81.05	$ 99.25	$ 18.20	18.3%
$ 237.03	$ 243.22	$ 6.19	2.5%	Total Medical Cost/Billable Visit	$ 199.95	$ 267.14	$ 67.19	25.2%
$ (185.25)	$ (109.63)	$ (75.62)	69.0%	Net Income(Loss)/Billable Visit	$ (88.67)	$ (133.56)	$ 44.89	-33.6%
43.3%	40.3%	-3.0%	-7.3%	Benefits as a % of Salaries	51.8%	45.0%	-6.8%	-15.0%
44.7%	44.7%	0.0%	0.0%	Overhead % of Direct Exp	44.7%	44.7%	0.1%	0.2%
$ 782				Gross Patient AR (in 000s)				
$ (228)				Less Reserves (in 000s)				
$ 553				Net AR (in 000s)				
$ 89				Wrap AR (in 000s)				
72.9				Gross AR Days				
$ 144				Cash Receipts (in 000s)				
				Payer Mix				
15.7%	16.5%	-0.9%	-5.2%	Medicare	15.7%	16.5%	-0.8%	-4.9%
7.1%	9.0%	-1.9%	-21.5%	Medi-Cal	9.7%	9.0%	0.7%	7.4%
71.3%	64.6%	6.6%	10.3%	Medi-Cal Managed Care	68.2%	64.6%	3.6%	5.6%
0.7%	1.5%	-0.8%	-53.5%	Insurance	1.2%	1.5%	-0.4%	-24.3%
5.3%	8.3%	-3.0%	-36.3%	Self Pay / Indigent	5.2%	8.3%	-3.1%	-37.3%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Family Practice Clinic
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
642	845	(203)	-24.0%	Total Visits	5,224	6,438	(1,214)	-18.9%
605	845	(240)	-28.4%	Billable Visits	4,924	6,438	(1,514)	-23.5%
2.4	10.0	7.6	76.1%	Total FTEs	8.0	10.0	2.0	19.6%
				Patient Revenue				
18,053	43,925	(25,873)	-58.9%	Medicare	221,142	334,784	(113,642)	-33.9%
3,480	4,093	(613)	-15.0%	Medi-Cal Fee-for-Service	35,477	31,197	4,280	13.7%
89,199	100,610	(11,412)	-11.3%	Medi-Cal Managed Care	631,313	766,817	(135,504)	-17.7%
1,938	1,470	468	31.8%	Insurance	10,214	11,201	(987)	-8.8%
6,938	2,553	4,385	171.8%	Self Pay	32,926	19,457	13,469	69.2%
0	112	(112)	-100.0%	Indigent	0	856	(856)	-100.0%
119,608	**152,764**	**(33,156)**	-21.7%	**Gross Patient Revenue**	**931,072**	**1,164,312**	**(233,240)**	-20.0%
133,591	(21,442)	155,033	723.0%	Contractual Adjustments	(348,166)	(163,419)	(184,747)	113.1%
31,667	46,271	(14,604)	-31.6%	Capitation Rev	287,644	352,662	(65,018)	-18.4%
284,867	**177,593**	**107,273**	60.4%	**Net Patient Revenue**	**870,551**	**1,353,555**	**(483,005)**	-35.7%
0	0	0		Other Revenue	0	0	0	
284,867	**177,593**	**107,273**	60.4%	**Total Revenue**	**870,551**	**1,353,555**	**(483,005)**	-35.7%
				Operating Expense				
56,813	69,685	12,872	18.5%	Salaries	672,846	558,012	(114,834)	-20.6%
38,770	30,286	(8,484)	-28.0%	Benefits	444,858	303,949	(140,909)	-46.4%
95,583	**99,971**	**4,388**	4.4%	**Total Salaries & Benefits**	**1,117,703**	**861,961**	**(255,742)**	-29.7%
(1,799)	5,000	6,799	136.0%	Professional Fees/Registry	52,841	60,000	7,159	11.9%
2,140	5,431	3,291	60.6%	Supplies	35,105	59,778	24,673	41.3%
(166,124)	6,128	172,252	2810.9%	Purchased Services	(35,040)	73,500	108,540	147.7%
235	346	111	32.2%	Depreciation	3,677	4,157	480	11.5%
907	706	(201)	-28.5%	Other Expense	30,844	8,500	(22,344)	-262.9%
(69,058)	**117,582**	**186,640**	158.7%	**Total Direct Expense**	**1,205,130**	**1,067,896**	**(137,234)**	-12.9%
5,848	15,654	9,806	62.6%	Allocation of Direct Admin Exp	140,641	159,332	18,690	11.7%
(31,698)	53,970	85,668	158.7%	Overhead Allocation	544,825	490,972	(53,852)	-11.0%
(94,908)	**187,206**	**282,114**	150.7%	**Total Expenses**	**1,890,596**	**1,718,200**	**(172,396)**	-10.0%
379,774	**(9,613)**	**389,387**	4050.8%	**Net Income (Loss)**	**(1,020,045)**	**(364,644)**	**(655,401)**	179.7%
				Key Ratios				
$ 197.59	$ 180.79	$ 16.80	9.3%	Gross Pt Revenue/Billable Visit	$ 189.09	$ 180.85	$ 8.24	4.6%
$ 470.59	$ 210.17	$ 260.42	123.9%	Total Revenue/Billable Visit (excl Oth Rev)	$ 176.80	$ 210.24	$ (33.45)	-15.9%
$ (114.08)	$ 139.15	$ 253.23	182.0%	Direct Costs/Billable Visit	$ 244.75	$ 165.87	$ (78.87)	-47.6%
$ (42.70)	$ 82.40	$ 125.10	151.8%	Indirect Costs/Billable Visit	$ 139.21	$ 101.01	$ (38.20)	-37.8%
$ (156.79)	$ 221.55	$ 378.33	170.8%	Total Medical Cost/Billable Visit	$ 383.96	$ 266.88	$ (117.08)	-43.9%
$ 627.38	$ (11.38)	$ 638.76	-5615.0%	Net Income(Loss)/Billable Visit	$ (207.16)	$ (56.64)	$ (150.52)	265.8%
68.2%	43.5%	-24.8%	-57.0%	Benefits as a % of Salaries	66.1%	54.5%	-11.6%	-21.4%
45.9%	45.9%	0.0%	0.0%	Overhead % of Direct Exp	45.2%	46.0%	0.8%	1.7%
$ 280				Gross Patient AR (in 000s)				
$ (102)				Less Reserves (in 000s)				
$ 178				Net AR (in 000s)				
$ 8				Wrap AR (in 000s)				
90.1				Gross AR Days				
$ 38				Cash Receipts (in 000s)				
				Payer Mix				
15.1%	28.8%	-13.7%	-47.5%	Medicare	23.8%	28.8%	-5.0%	-17.4%
2.9%	2.7%	0.2%	8.6%	Medi-Cal	3.8%	2.7%	1.1%	42.2%
74.6%	65.9%	8.7%	13.2%	Medi-Cal Managed Care	67.8%	65.9%	1.9%	3.0%
1.6%	1.0%	0.7%	68.4%	Insurance	1.1%	1.0%	0.1%	14.0%
5.8%	1.7%	4.1%	232.5%	Self Pay / Indigent	3.5%	1.7%	1.8%	102.7%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Primary Medicine Clinic
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
2,510	2,850	(340)	-11.9%	Total Visits	31,402	32,610	(1,208)	-3.7%
2,510	2,850	(340)	-11.9%	Billable Visits	30,506	32,610	(2,104)	-6.5%
7.9	31.3	23.4	74.6%	Total FTEs	31.5	31.3	(0.2)	-0.8%
				Patient Revenue				
60,607	115,037	(54,430)	-47.3%	Medicare	1,266,067	1,316,186	(50,119)	-3.8%
7,218	19,178	(11,960)	-62.4%	Medi-Cal Fee-for-Service	164,459	219,426	(54,967)	-25.1%
204,309	280,297	(75,989)	-27.1%	Medi-Cal Managed Care	3,129,292	3,207,003	(77,711)	-2.4%
(1,769)	5,158	(6,927)	-134.3%	Insurance	44,374	59,014	(14,640)	-24.8%
5,153	12,428	(7,275)	-58.5%	Self Pay	111,850	142,198	(30,348)	-21.3%
44	589	(545)	-92.6%	Indigent	275	6,743	(6,468)	-95.9%
275,563	**432,688**	**(157,125)**	-36.3%	**Gross Patient Revenue**	**4,716,318**	**4,950,570**	**(234,252)**	-4.7%
(202,926)	(205,688)	2,762	1.3%	Contractual Adjustments	(3,176,253)	(2,353,359)	(822,894)	35.0%
130,156	153,560	(23,404)	-15.2%	Capitation Rev	1,723,209	1,756,949	(33,740)	-1.9%
202,793	**380,560**	**(177,767)**	-46.7%	**Net Patient Revenue**	**3,263,275**	**4,354,160**	**(1,090,886)**	-25.1%
0	0	0		Other Revenue	0	0	0	
202,793	**380,560**	**(177,767)**	-46.7%	**Total Revenue**	**3,263,275**	**4,354,160**	**(1,090,886)**	-25.1%
				Operating Expense				
201,007	276,324	75,317	27.3%	Salaries	2,386,022	3,480,730	1,094,708	31.5%
87,686	104,633	16,947	16.2%	Benefits	1,130,082	1,273,792	143,710	11.3%
288,693	**380,957**	**92,264**	24.2%	**Total Salaries & Benefits**	**3,516,104**	**4,754,522**	**1,238,418**	26.0%
7,335	10,000	2,665	26.7%	Professional Fees/Registry	326,154	120,000	(206,154)	-171.8%
17,470	10,894	(6,576)	-60.4%	Supplies	143,606	123,250	(20,356)	-16.5%
(76,462)	4,117	80,579	1957.2%	Purchased Services	(8,983)	49,500	58,483	118.1%
315	301	(14)	-4.6%	Depreciation	3,675	3,621	(54)	-1.5%
660	1,452	792	54.6%	Other Expense	11,740	17,592	5,852	33.3%
238,010	**407,721**	**169,711**	41.6%	**Total Direct Expense**	**3,992,295**	**5,068,485**	**1,076,190**	21.2%
13,472	44,337	30,865	69.6%	Allocation of Direct Admin Exp	712,414	683,885	(28,529)	-4.2%
81,257	139,196	57,939	41.6%	Overhead Allocation	1,351,112	1,730,381	379,269	21.9%
332,738	**591,254**	**258,516**	43.7%	**Total Expenses**	**6,055,821**	**7,482,751**	**1,426,930**	19.1%
(129,945)	**(210,694)**	**80,749**	38.3%	**Net Income (Loss)**	**(2,792,547)**	**(3,128,591)**	**336,044**	-10.7%
				Key Ratios				
$ 109.78	$ 151.82	$ (42.04)	-27.7%	Gross Pt Revenue/Billable Visit	$ 154.60	$ 151.81	$ 2.79	1.8%
$ 80.79	$ 133.53	$ (52.74)	-39.5%	Total Revenue/Billable Visit (excl Oth Rev)	$ 106.97	$ 133.52	$ (26.55)	-19.9%
$ 94.82	$ 143.06	$ 48.24	33.7%	Direct Costs/Billable Visit	$ 130.87	$ 155.43	$ 24.56	15.8%
$ 37.74	$ 64.40	$ 26.66	41.4%	Indirect Costs/Billable Visit	$ 67.64	$ 74.03	$ 6.39	8.6%
$ 132.56	$ 207.46	$ 74.90	36.1%	Total Medical Cost/Billable Visit	$ 198.51	$ 229.46	$ 30.95	13.5%
$ (51.77)	$ (73.93)	$ 22.16	-30.0%	Net Income(Loss)/Billable Visit	$ (91.54)	$ (95.94)	$ 4.40	-4.6%
43.6%	37.9%	-5.8%	-15.2%	Benefits as a % of Salaries	47.4%	36.6%	-10.8%	-29.4%
34.1%	34.1%	0.0%	0.0%	Overhead % of Direct Exp	33.8%	34.1%	0.3%	0.9%
$ 1,231				Gross Patient AR (in 000s)				
$ (413)				Less Reserves (in 000s)				
$ 818				Net AR (in 000s)				
$ 41				Wrap AR (in 000s)				
93.6				Gross AR Days				
$ 191				Cash Receipts (in 000s)				
				Payer Mix				
22.0%	26.6%	-4.6%	-17.3%	Medicare	26.8%	26.6%	0.3%	1.0%
2.6%	4.4%	-1.8%	-40.9%	Medi-Cal	3.5%	4.4%	-0.9%	-21.3%
74.1%	64.8%	9.4%	14.5%	Medi-Cal Managed Care	66.4%	64.8%	1.6%	2.4%
-0.6%	1.2%	-1.8%	-153.8%	Insurance	0.9%	1.2%	-0.3%	-21.1%
1.9%	3.0%	-1.1%	-37.3%	Self Pay / Indigent	2.4%	3.0%	-0.6%	-21.0%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Healthy Beginnings - California St.
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
716	748	(32)	-4.3%	Total Visits	8,363	8,962	(599)	-6.7%
746	748	(2)	-0.3%	Billable Visits	8,470	8,962	(492)	-5.5%
2.1	14.0	11.9	84.8%	Total FTEs	12.6	14.0	1.4	10.3%
				Patient Revenue				
3,194	1,409	1,785	126.7%	Medicare	42,984	16,873	26,111	154.8%
55,344	51,566	3,778	7.3%	Medi-Cal Fee-for-Service	562,147	617,560	(55,413)	-9.0%
147,908	101,260	46,648	46.1%	Medi-Cal Managed Care	1,294,432	1,212,693	81,739	6.7%
1,548	1,031	517	50.2%	Insurance	14,383	12,347	2,036	16.5%
2,589	633	1,956	308.9%	Self Pay	16,456	7,581	8,875	117.1%
0	0	0		Indigent	0	0	0	
210,582	**155,899**	**54,683**	35.1%	**Gross Patient Revenue**	**1,930,402**	**1,867,054**	**63,348**	3.4%
(697,876)	(66,897)	(630,979)	-943.2%	Contractual Adjustments	(1,526,695)	(801,157)	(725,538)	90.6%
36,025	44,035	(8,010)	-18.2%	Capitation Rev	456,961	527,368	(70,407)	-13.4%
(451,268)	**133,037**	**(584,305)**	-439.2%	**Net Patient Revenue**	**860,669**	**1,593,265**	**(732,596)**	-46.0%
0	0	0		Other Revenue	0	0	0	
(451,268)	**133,037**	**(584,305)**	-439.2%	**Total Revenue**	**860,669**	**1,593,265**	**(732,596)**	-46.0%
				Operating Expense				
81,036	155,853	74,817	48.0%	Salaries	941,853	1,175,082	233,229	19.8%
49,236	49,411	175	0.4%	Benefits	535,145	439,753	(95,392)	-21.7%
130,272	**205,264**	**74,992**	36.5%	**Total Salaries & Benefits**	**1,476,998**	**1,614,835**	**137,837**	8.5%
0	5,000	5,000	100.0%	Professional Fees/Registry	0	60,000	60,000	100.0%
13,569	8,597	(4,972)	-57.8%	Supplies	93,444	99,482	6,038	6.1%
(30,347)	16,183	46,530	287.5%	Purchased Services	105,617	194,718	89,101	45.8%
1,305	394	(911)	-231.2%	Depreciation	10,190	5,277	(4,913)	-93.1%
562	1,408	846	60.1%	Other Expense	30,646	17,089	(13,557)	-79.3%
115,360	**236,846**	**121,486**	51.3%	**Total Direct Expense**	**1,716,894**	**1,991,401**	**274,507**	13.8%
10,295	15,975	5,680	35.6%	Allocation of Direct Admin Exp	291,593	266,320	(25,273)	-9.5%
48,163	98,883	50,720	51.3%	Overhead Allocation	715,390	831,410	116,020	14.0%
173,819	**351,704**	**177,885**	50.6%	**Total Expenses**	**2,723,878**	**3,089,131**	**365,253**	11.8%
(625,087)	**(218,667)**	**(406,420)**	-185.9%	**Net Income (Loss)**	**(1,863,209)**	**(1,495,866)**	**(367,343)**	24.6%
				Key Ratios				
$ 282.31	$ 208.42	$ 73.89	35.5%	Gross Pt Revenue/Billable Visit	$ 227.92	$ 208.33	$ 19.59	9.4%
$ (604.98)	$ 177.86	$ (782.84)	-440.2%	Total Revenue/Billable Visit (excl Oth Rev)	$ 101.62	$ 177.78	$ (76.16)	-42.8%
$ 154.66	$ 316.64	$ 161.98	51.2%	Direct Costs/Billable Visit	$ 202.71	$ 222.20	$ 19.50	8.8%
$ 78.37	$ 153.55	$ 75.18	49.0%	Indirect Costs/Billable Visit	$ 118.89	$ 122.49	$ 3.60	2.9%
$ 233.03	$ 470.19	$ 237.17	50.4%	Total Medical Cost/Billable Visit	$ 321.60	$ 344.69	$ 23.09	6.7%
$ (838.01)	$ (292.34)	$ (545.67)	186.7%	Net Income(Loss)/Billable Visit	$ (219.98)	$ (166.91)	$ (53.07)	31.8%
60.8%	31.7%	-29.1%	-91.6%	Benefits as a % of Salaries	56.8%	37.4%	-19.4%	-51.8%
41.8%	41.8%	0.0%	0.0%	Overhead % of Direct Exp	41.7%	41.8%	0.1%	0.2%
$ 450				Gross Patient AR (in 000s)				
$ (102)				Less Reserves (in 000s)				
$ 348				Net AR (in 000s)				
$ 14				Wrap AR (In 000s)				
70.7				Gross AR Days				
$ 53				Cash Receipts (in 000s)				
				Payer Mix				
1.5%	0.9%	0.6%	67.8%	Medicare	2.2%	0.9%	1.3%	146.4%
26.3%	33.1%	-6.8%	-20.5%	Medi-Cal	29.1%	33.1%	-4.0%	-12.0%
70.2%	65.0%	5.3%	8.1%	Medi-Cal Managed Care	67.1%	65.0%	2.1%	3.2%
0.7%	0.7%	0.1%	11.2%	Insurance	0.7%	0.7%	0.1%	12.7%
1.2%	0.4%	0.8%	202.7%	Self Pay / Indigent	0.9%	0.4%	0.4%	109.9%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

Healthy Beginnings - French Camp
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
727	694	33	4.8%	Total Visits	9,126	8,620	506	5.9%
757	694	63	9.1%	Billable Visits	9,242	8,620	622	7.2%
2.0	13.8	11.7	85.4%	Total FTEs	12.4	13.8	1.3	9.5%
				Patient Revenue				
13,832	4,012	9,820	244.8%	Medicare	70,484	49,825	20,659	41.5%
73,155	30,382	42,774	140.8%	Medi-Cal Fee-for-Service	414,348	377,305	37,043	9.8%
295,556	80,649	214,907	266.5%	Medi-Cal Managed Care	1,357,869	1,001,566	356,303	35.6%
7,148	1,613	5,535	343.1%	Insurance	55,972	20,034	35,938	179.4%
4,459	420	4,039	961.7%	Self Pay	22,856	5,215	17,640	338.3%
0	0	0		Indigent	0	0	0	
394,150	**117,076**	**277,074**	236.7%	**Gross Patient Revenue**	**1,921,528**	**1,453,946**	**467,582**	32.2%
(286,757)	1,575	(288,332)	-18306.8%	Contractual Adjustments	(717,273)	19,565	(736,838)	-3766.1%
37,551	42,058	(4,507)	-10.7%	Capitation Rev	500,841	522,308	(21,467)	-4.1%
144,943	**160,709**	**(15,765)**	-9.8%	**Net Patient Revenue**	**1,705,096**	**1,995,819**	**(290,723)**	-14.6%
0	0	0		Other Revenue	0	0	0	
144,943	**160,709**	**(15,765)**	-9.8%	**Total Revenue**	**1,705,096**	**1,995,819**	**(290,723)**	-14.6%
				Operating Expense				
72,056	81,724	9,668	11.8%	Salaries	837,503	1,100,648	263,145	23.9%
42,613	41,204	(1,409)	-3.4%	Benefits	493,240	538,305	45,065	8.4%
114,670	**122,928**	**8,258**	6.7%	**Total Salaries & Benefits**	**1,330,743**	**1,638,953**	**308,210**	18.8%
3,300	8,534	5,234	61.3%	Professional Fees/Registry	331,546	102,400	(229,146)	-223.8%
23,723	13,869	(9,854)	-71.0%	Supplies	139,936	161,063	21,127	13.1%
(38,681)	16,195	54,876	338.8%	Purchased Services	77,288	194,718	117,430	60.3%
2,760	2,701	(59)	-2.2%	Depreciation	32,648	32,406	(242)	-0.7%
688	1,098	410	37.4%	Other Expense	9,155	13,291	4,136	31.1%
106,460	**165,325**	**58,865**	35.6%	**Total Direct Expense**	**1,921,317**	**2,142,831**	**221,514**	10.3%
19,270	11,997	(7,273)	-60.6%	Allocation of Direct Admin Exp	290,253	207,519	(82,734)	-39.9%
44,447	69,023	24,576	35.6%	Overhead Allocation	796,157	894,632	98,475	11.0%
170,176	**246,345**	**76,169**	30.9%	**Total Expenses**	**3,007,726**	**3,244,981**	**237,255**	7.3%
(25,233)	**(85,636)**	**60,404**	70.5%	**Net Income (Loss)**	**(1,302,631)**	**(1,249,163)**	**(53,468)**	4.3%
				Key Ratios				
$ 520.38	$ 168.70	$ 351.68	208.5%	Gross Pt Revenue/Billable Visit	$ 207.91	$ 168.67	$ 39.24	23.3%
$ 191.36	$ 231.57	$ (40.21)	-17.4%	Total Revenue/Billable Visit (excl Oth Rev)	$ 184.49	$ 231.53	$ (47.04)	-20.3%
$ 140.55	$ 238.22	$ 97.67	41.0%	Direct Costs/Billable Visit	$ 207.89	$ 248.59	$ 40.70	16.4%
$ 84.12	$ 116.74	$ 32.62	27.9%	Indirect Costs/Billable Visit	$ 117.55	$ 127.86	$ 10.31	8.1%
$ 224.68	$ 354.96	$ 130.29	36.7%	Total Medical Cost/Billable Visit	$ 325.44	$ 376.45	$ 51.01	13.6%
$ (33.31)	$ (123.40)	$ 90.08	-73.0%	Net Income(Loss)/Billable Visit	$ (140.95)	$ (144.91)	$ 3.97	-2.7%
59.1%	50.4%	-8.7%	-17.3%	Benefits as a % of Salaries	58.9%	48.9%	-10.0%	-20.4%
41.8%	41.8%	0.0%	0.0%	Overhead % of Direct Exp	41.4%	41.8%	0.3%	0.7%
$ 501				Gross Patient AR (in 000s)				
$ (112)				Less Reserves (in 000s)				
$ 389				Net AR (in 000s)				
$ 2				Wrap AR (in 000s)				
61.8				Gross AR Days				
$ 67				Cash Receipts (in 000s)				
				Payer Mix				
3.5%	3.4%	0.1%	2.4%	Medicare	3.7%	3.4%	0.2%	7.0%
18.6%	26.0%	-7.4%	-28.5%	Medi-Cal	21.6%	26.0%	-4.4%	-16.9%
75.0%	68.9%	6.1%	8.9%	Medi-Cal Managed Care	70.7%	68.9%	1.8%	2.6%
1.8%	1.4%	0.4%	31.6%	Insurance	2.9%	1.4%	1.5%	111.4%
1.1%	0.4%	0.8%	215.4%	Self Pay / Indigent	1.2%	0.4%	0.8%	231.6%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

SJCC Hazelton Clinic
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
235	600	(365)	-60.8%	Total Visits	6,751	6,246	505	8.1%
148	600	(452)	-75.3%	Billable	4,059	6,246	(2,187)	-35.0%
0.8	5.0	4.2	83.2%	Total FTEs	3.1	5.0	1.9	38.8%
				Patient Revenue				
2,969	30,873	(27,905)	-90.4%	Medicare	49,673	321,524	(271,851)	-84.6%
20,821	2,877	17,945	623.8%	Medi-Cal Fee-for-Service	290,239	29,960	260,279	868.8%
41,482	70,715	(29,232)	-41.3%	Medi-Cal Managed Care	451,411	736,445	(285,034)	-38.7%
2,451	1,033	1,418	137.3%	Insurance	48,777	10,759	38,018	353.4%
5,265	1,794	3,471	193.4%	Self Pay	50,909	18,687	32,223	172.4%
0	79	(79)	-100.0%	Indigent	0	822	(822)	-100.0%
72,989	**107,371**	**(34,382)**	-32.0%	**Patient Revenue**	**891,009**	**1,118,197**	**(227,188)**	-20.3%
(376,780)	19,343	(396,123)	-2047.9%	Contractual Adjustments	(776,118)	201,441	(977,559)	-485.3%
7,481	36,668	(29,186)	-79.6%	Physician Capitation	360,380	381,867	(21,487)	-5.6%
(296,310)	**163,382**	**(459,692)**	-281.4%	**Net Patient Revenue**	**475,271**	**1,701,505**	**(1,226,234)**	-72.1%
0	0	0		Other Revenue	0	0	0	
(296,310)	**163,382**	**(459,692)**	-281.4%	**Total Revenue**	**475,271**	**1,701,505**	**(1,226,234)**	-72.1%
				Operating Expense				
4,970	21,303	16,333	76.7%	Salaries	58,131	256,890	198,759	77.4%
2,050	16,003	13,953	87.2%	Benefits	28,268	199,283	171,015	85.8%
7,020	**37,306**	**30,286**	81.2%	**Total Salaries & Benefits**	**86,398**	**456,173**	**369,775**	81.1%
0	0	0		Professional Fees/Registry	279,880	0	(279,880)	
3,354	11,917	8,563	71.9%	Supplies	34,097	144,925	110,828	76.5%
272,391	119,592	(152,799)	-127.8%	Purchased Services	1,571,405	1,451,405	(120,000)	-8.3%
0	0	0		Depreciation	0	0	0	
0	3,463	3,463	100.0%	Other Expense	938	42,098	41,160	97.8%
282,764	**172,278**	**(110,486)**	-64.1%	**Total Direct Expense**	**1,972,720**	**2,094,601**	**121,881**	5.8%
3,568	11,002	7,434	67.6%	Allocation of Direct Admin Exp	134,590	155,136	20,547	13.2%
120,429	73,373	(47,056)	-64.1%	Overhead Allocation	831,206	892,091	60,884	6.8%
406,762	**256,653**	**(150,108)**	-58.5%	**Total Expenses**	**2,938,515**	**3,141,828**	**203,313**	6.5%
(703,072)	**(93,272)**	**(609,800)**	-653.8%	**Net Income (Loss)**	**(2,463,245)**	**(1,440,323)**	**(1,022,921)**	71.0%
				Key Ratios				
$ 492.31	$ 178.95	$ 313.35	175.1%	Gross Pt Revenue/Billable Visit	$ 219.50	$ 179.03	$ 40.47	22.6%
$ (1,998.59)	$ 272.30	$ (2,270.90)	-834.0%	Total Revenue/Billable Visit (excl Oth Rev)	$ 117.08	$ 272.42	$ (155.33)	-57.0%
$ 1,907.23	$ 287.13	$ (1,620.10)	-564.2%	Direct Costs/Billable Visit	$ 485.98	$ 335.35	$ (150.63)	-44.9%
$ 836.36	$ 140.63	$ (695.73)	-494.7%	Indirect Costs/Billable Visit	$ 237.92	$ 167.66	$ (70.26)	-41.9%
$ 2,743.58	$ 427.76	$ (2,315.83)	-541.4%	Total Medical Cost/Billable Visit	$ 723.90	$ 503.01	$ (220.89)	-43.9%
$ (4,742.18)	$ (155.45)	$ (4,586.72)	2950.5%	Net Income(Loss)/Billable Visit	$ (606.82)	$ (230.60)	$ (376.22)	163.1%
41.3%	75.1%	33.9%	45.1%	Benefits as a % of Salaries	48.6%	77.6%	28.9%	37.3%
42.6%	42.6%	0.0%	0.0%	Overhead % of Direct Exp	42.1%	42.6%	0.5%	1.1%
$ 463				Gross Patient AR (in 000s)				
$ (105)				Less Reserves (in 000s)				
$ 358				Net AR (in 000s)				
$ 148				Wrap AR (in 000s)				
175.5				Gross AR Days				
$ 10				Cash Receipts (in 000s)				
				Payer Mix				
4.1%	28.8%	-24.7%	-85.9%	Medicare	5.6%	28.8%	-23.2%	-80.6%
28.5%	2.7%	25.8%	964.7%	Medi-Cal	32.6%	2.7%	29.9%	1115.8%
56.8%	65.9%	-9.0%	-13.7%	Medi-Cal Managed Care	50.7%	65.9%	-15.2%	-23.1%
3.4%	1.0%	2.4%	249.1%	Insurance	5.5%	1.0%	4.5%	469.0%
7.2%	1.7%	5.5%	313.5%	Self Pay / Indigent	5.7%	1.7%	4.0%	227.5%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

SJCC Manteca Clinic
Income Statement
June 30, 2018

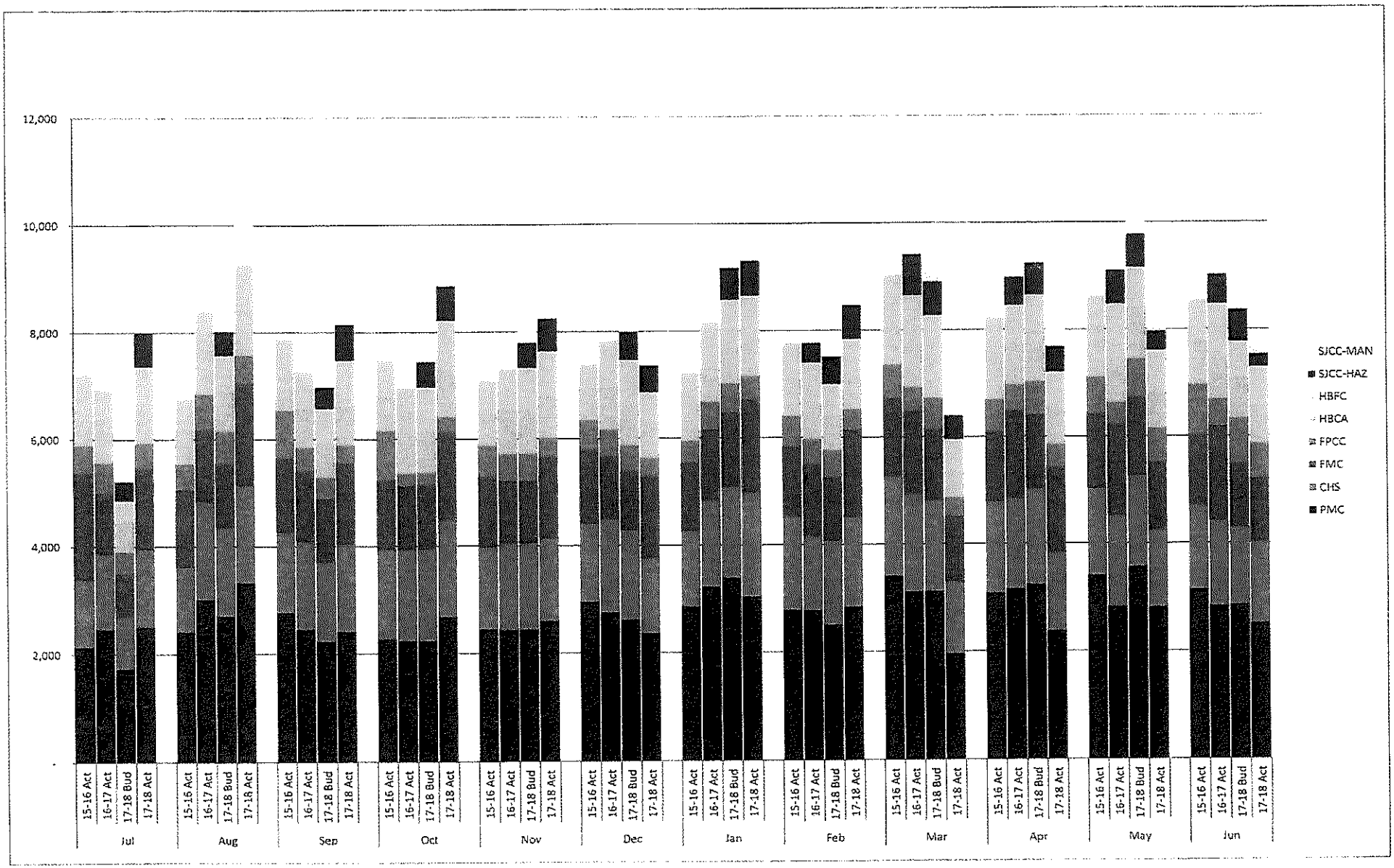
Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
378	525	(147)	-28.0%	Total Visits	4,457	4,948	(491)	-9.9%
357	525	(168)	-32.0%	Billable Visits	4,216	4,948	(732)	-14.8%
1.3	11.0	9.7	88.0%	Total FTEs	7.1	11.0	3.9	35.6%
				Patient Revenue				
101	12,646	(12,545)	-99.2%	Medicare	44,980	119,187	(74,207)	-62.3%
(6,751)	10,549	(17,300)	-164.0%	Medi-Cal Fee-for-Service	105,582	99,434	6,149	6.2%
14,376	70,530	(56,154)	-79.6%	Medi-Cal Managed Care	724,145	664,729	59,416	8.9%
79	1,646	(1,567)	-95.2%	Insurance	9,186	15,514	(6,329)	-40.8%
(736)	1,199	(1,934)	-161.4%	Self Pay	20,575	11,287	9,288	82.3%
0	30	(30)	-100.0%	Indigent	0	280	(280)	-100.0%
7,070	**96,600**	**(89,530)**	**-92.7%**	**Patient Revenue**	**904,468**	**910,432**	**(5,964)**	**-0.7%**
20,809	(11,765)	32,574	276.9%	Contractual Adjustments	(399,894)	(110,883)	(289,011)	260.6%
23,024	31,879	(8,855)	-27.8%	Physician Capitation	254,060	300,453	(46,392)	-15.4%
50,903	**116,714**	**(65,811)**	**-56.4%**	**Net Patient Revenue**	**758,635**	**1,100,002**	**(341,367)**	**-31.0%**
0	0	0		Other Revenue	0	0	0	
50,903	**116,714**	**(65,811)**	**-56.4%**	**Total Revenue**	**758,635**	**1,100,002**	**(341,367)**	**-31.0%**
				Operating Expense				
57,187	56,780	(407)	-0.7%	Salaries	702,499	686,208	(16,291)	-2.4%
57,573	36,650	(20,923)	-57.1%	Benefits	469,788	457,215	(12,573)	-2.7%
114,760	**93,430**	**(21,330)**	**-22.8%**	**Total Salaries & Benefits**	**1,172,287**	**1,143,423**	**(28,864)**	**-2.5%**
(19,696)	0	19,696		Professional Fees/Registry	126,206	0	(126,206)	
34,784	7,410	(27,374)	-369.4%	Supplies	493,879	89,000	(404,879)	-454.9%
0	1,668	1,668	100.0%	Purchased Services	109,608	20,000	(89,608)	-448.0%
8,790	0	(8,790)		Depreciation	131,710	0	(131,710)	
1,367	1,771	404	22.8%	Other Expense	186,428	21,200	(165,228)	-779.4%
140,006	**104,279**	**(35,727)**	**-34.3%**	**Total Direct Expense**	**2,220,118**	**1,273,623**	**(946,495)**	**-74.3%**
346	9,899	9,553	96.5%	Allocation of Direct Admin Exp	136,623	126,472	(10,151)	-8.0%
56,758	42,275	(14,484)	-34.3%	Overhead Allocation	900,590	516,327	(384,263)	-74.4%
197,110	**156,452**	**(40,657)**	**-26.0%**	**Total Expenses**	**3,257,331**	**1,916,422**	**(1,340,910)**	**-70.0%**
(146,206)	**(39,738)**	**(106,468)**	**-267.9%**	**Net Income (Loss)**	**(2,498,696)**	**(816,420)**	**(1,682,276)**	**206.1%**
				Key Ratios				
$ 19.80	$ 184.00	$ (164.20)	-89.2%	Gross Pt Revenue/Billable Visit	$ 214.54	$ 184.00	$ 30.54	16.6%
$ 142.59	$ 222.31	$ (79.73)	-35.9%	Total Revenue/Billable Visit (excl Oth Rev)	$ 179.95	$ 222.31	$ (42.36)	-19.1%
$ 392.17	$ 198.63	$ (193.54)	-97.4%	Direct Costs/Billable Visit	$ 526.61	$ 257.40	$ (269.21)	-104.6%
$ 159.95	$ 99.38	$ (60.58)	-61.0%	Indirect Costs/Billable Visit	$ 246.03	$ 129.91	$ (116.12)	-89.4%
$ 552.12	$ 298.00	$ (254.12)	-85.3%	Total Medical Cost/Billable Visit	$ 772.64	$ 387.31	$ (385.33)	-99.5%
$ (409.54)	$ (75.69)	$ (333.85)	441.1%	Net Income(Loss)/Billable Visit	$ (592.69)	$ (165.00)	$ (427.69)	259.2%
100.7%	64.5%	-36.1%	-56.0%	Benefits as a % of Salaries	66.9%	66.6%	-0.2%	-0.4%
40.5%	40.5%	0.0%	0.0%	Overhead % of Direct Exp	40.6%	40.5%	0.0%	-0.1%
$ 343				Gross Patient AR (in 000s)				
$ (76)				Less Reserves (in 000s)				
$ 268				Net AR (in 000s)				
$ 26				Wrap AR (in 000s)				
130.3				Gross AR Days				
$ 38				Cash Receipts (in 000s)				
				Payer Mix				
1.4%	13.1%	-11.7%	-89.1%	Medicare	5.0%	13.1%	-8.1%	-62.0%
-95.5%	10.9%	-106.4%	-974.4%	Medi-Cal	11.7%	10.9%	0.8%	6.9%
203.3%	73.0%	130.3%	178.5%	Medi-Cal Managed Care	80.1%	73.0%	7.1%	9.7%
1.1%	1.7%	-0.6%	-34.8%	Insurance	1.0%	1.7%	-0.7%	-40.4%
-10.4%	1.3%	-11.7%	-918.2%	Self Pay / Indigent	2.3%	1.3%	1.0%	79.0%
100.0%	100.0%	0.0%	0.0%		100.0%	100.0%	0.0%	0.0%

FQ Administration
Income Statement
June 30, 2018

Current Month					Year to Date			
Actual	Budget	Variance	% Var		Actual	Budget	Variance	% Var
0.0	6.2	6.2	100.0%	Total FTEs	4.4	6.2	2	29.7%
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				
10,478	47,697	37,219	78.0%	Salaries	554,227	580,238	26,011	4.5%
41,788	26,652	(15,136)	-56.8%	Benefits	284,865	431,617	146,752	34.0%
52,265	**74,349**	**22,084**	29.7%	**Total Salaries & Benefits**	**839,092**	**1,011,855**	**172,763**	17.1%
20,469	45,500	25,031	55.0%	Professional Fees/Registry	706,255	546,000	(160,255)	-29.4%
941	317	(624)	-196.9%	Supplies	14,358	3,804	(10,554)	-277.5%
(2,224)	39,515	41,739	105.6%	Purchased Services	1,206,315	973,688	(232,627)	-23.9%
3,395	3,257	(138)	-4.2%	Depreciation	40,235	39,084	(1,151)	-2.9%
0	2,625	2,625	100.0%	Other Expense	28,325	31,500	3,175	10.1%
74,846	**165,563**	**90,717**	54.8%	**Total Direct Expense**	**2,834,581**	**2,605,931**	**(228,650)**	-8.8%
0	0	0		Overhead Allocation	0	0	0	
74,846	**165,563**	**90,717**	54.8%	**Total Expenses**	**2,834,581**	**2,605,931**	**(228,650)**	-8.8%
(74,846)	**(165,563)**	**90,717**	-54.8%	**Net Income (Loss)**	**(2,834,581)**	**(2,605,931)**	**(228,650)**	8.8%

FQHC Visits

June 2018

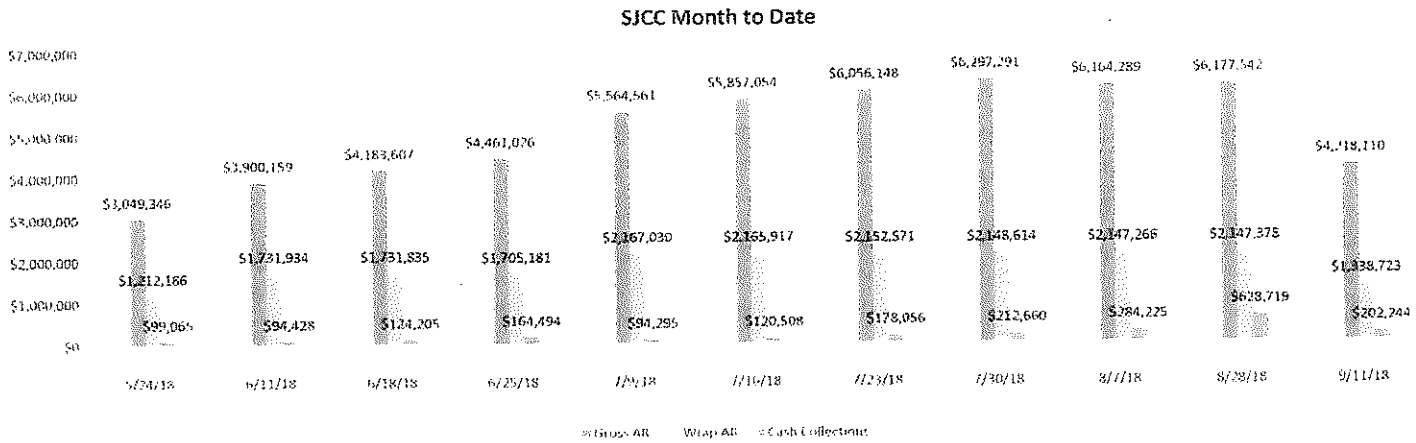


FQHC Visits

June 2018

	Clinic	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total Year
15-16 Act	CHS	1,248	1,198	1,496	1,644	1,513	1,458	1,405	1,735	1,861	1,700	1,626	1,569	**18,453**
	FMC	1,979	1,444	1,381	1,304	1,317	1,380	1,282	1,314	1,456	1,311	1,390	1,321	**16,879**
	FPCC	528	479	891	932	598	560	411	569	633	594	684	931	**7,810**
	PMC	2,132	2,421	2,768	2,276	2,454	2,947	2,852	2,780	3,401	3,083	3,399	3,136	**33,649**
	HBCA	691	645	662	603	580	570	660	701	808	884	933	825	**8,562**
	HBFC	646	577	675	736	630	481	624	671	877	657	597	775	**7,946**
	Total	**7,224**	**6,764**	**7,873**	**7,495**	**7,092**	**7,396**	**7,234**	**7,770**	**9,036**	**8,229**	**8,629**	**8,557**	**93,299**
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 Bud	CHS	968	1,645	1,475	1,686	1,605	1,669	1,700	1,562	1,703	1,786	1,703	1,434	**18,936**
	FMC	800	1,199	1,183	1,212	1,159	1,104	1,382	1,183	1,332	1,377	1,460	1,193	**14,584**
	FPCC	393	599	404	229	509	479	548	512	579	624	717	845	**6,438**
	PMC	1,729	2,706	2,227	2,239	2,445	2,616	3,385	2,502	3,113	3,237	3,561	2,850	**32,610**
	HBCA	569	739	635	766	823	746	663	631	737	928	977	748	**8,962**
	HBFC	400	680	649	838	786	850	896	604	803	690	730	694	**8,620**
	SJCC-Haz	360	447	399	476	465	529	600	514	628	600	628	600	**6,246**
	SJCC-Man	300	368	323	378	361	400	420	378	484	483	528	525	**4,948**
	Total	**5,519**	**8,383**	**7,295**	**7,824**	**8,153**	**8,393**	**9,594**	**7,886**	**9,379**	**9,725**	**10,304**	**8,889**	**101,344**
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**

KEY PERFORMANCE INDICATORS SJCC Totals	5/24/18	5/11/18	6/18/18	6/25/18	7/9/18	7/16/18	7/23/18	7/30/18	8/7/18	8/28/18	9/11/18
SJCC Business Office											
Cash Collections	$99,065	$94,428	$124,205	$164,494	$94,295	$120,508	$178,056	$212,660	$284,225	$628,719	$202,244
Open Receipt Batches	$96,515	$298,215	$298,215	$299,210	$389,842	$812,172	$1,147,308	$1,147,417	$2,102,824	$2,465,189	$1,959,266
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	$1,388,795	$199,066	$1,006,341
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	$6,164,289	$6,177,542	$4,218,110
Gross AR Days (90 day average)	61.9	79.2	84.9	90.6	113.0	118.9	122.9	127.8	125.1	125.4	85.6
Average Daily Revenue (90 day average)	$49,259	$49,259	$49,259	$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	$2,147,266	$2,147,378	$1,338,723
AR over 90 Days	$508,496	$528,668	$614,768	$807,263	$1,148,669	$1,339,579	$1,671,284	$1,954,592	$2,114,022	$2,638,337	$2,256,359
% of AR over 90 Days	17%	14%	15%	18%	21%	23%	28%	31%	34%	43%	53%
AR over 120 Days	$423,572	$433,455	$394,691	$410,143	$416,756	$404,073	$391,655	$391,103	$386,115	$395,283	$398,995
% of AR over 120 Days	$0	$0	9%	9%	7%	7%	6%	6%	6%	98%	9%
AR over 180 Days	$205,173	$188,934	$142,476	$140,472	$165,347	$178,452	$165,515	$159,602	$158,535	$180,157	$195,522
% of AR over 180 Days	7%	5%	3%	3%	3%	3%	3%	3%	3%	45%	5%
AR over 365 Days	$76,140	$94,324	$98,684	$108,336	$122,384	$131,001	$141,430	$152,457	$162,943	$189,051	$205,684
% of AR over 365 Days	2%	2%	2%	2%	2%	2%	2%	2%	3%	47%	5%
Patient Credit Balance Total (EOM)	$44,854	$37,445	$56,395	$56,614	$775,202	$976,286	$1,321,257	$1,605,506	$1,772,815	$2,354,160	$1,995,290
Total Not Coded	$96,515	$55,163	$28,437	$28,724	$46,250	$55,931	$70,663	$58,484	$4,040,846	$5,427,513	$5,492,767
Total Claims Produced Today	$56,182	$20,517	$34,286	$19,628	$12,455	$22,688	$13,961	$13,628	$98,252	$89,291	$65,075
Total Number of claims for month	7,224	1,869	16,318	18,862	2,334	4,945	7,444	11,223	2,016	10,132	4,593
Total Number of clean claims for month	7,028	1,722	15,852	18,182	2,273	4,827	7,247	10,994	1,996	9,850	4,403
Total number of error claims for month	196	28	466	680	61	118	197	229	20	282	190
Clean Claims from ClaimRemedi/Trizetto	97%	92%	97%	96%	97%	98%	97%	98%	99%	97%	96%


SJCC Month to Date
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7/9/18
7/16/18
7/23/18
7/30/18
8/7/18
8/28/18
9/11/18
Gross AR
Wrap AR
Cash Collection

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Trump Administration's New Regulation Could Cripple Health Care Providers' Ability to Serve their Communities

OAKLAND, CA, September 24, 2018 - The California Association of Public Hospitals and Health Systems (CAPH) is deeply concerned about the regulation released over the weekend by the Trump Administration that would make it harder for immigrants who access public services to become lawful permanent residents.

"This regulation is a misguided departure from current policy that could severely weaken public health care system providers' ability to care for their patients. It could force families and communities to live in fear and avoid accessing needed health care services," said CAPH President and CEO Erica Murray.

The proposed regulation issued by the Department of Homeland Security would expand the definition of public charge, a term that can be used to deny an immigrant from gaining legal permanent status because they would be deemed likely to use essential public services. Under the proposed regulation, "public charge" would be expanded to include a broad list of public services, including Medicaid (called Medi-Cal in California), housing subsidies, food vouchers, and help for low-income seniors to afford prescription drugs. Public charge previously only considered cash assistance and government-funded institutionalized long-term care.

The proposed policy change has not yet been posted to the Federal Register. Once it is, the public will have 60 days to comment. The Administration cannot enforce the policy until at least 60 days after the final rule is published.

CAPH represents California's 21 public health care systems that disproportionately serve low-income patients and communities. Together, these systems are the core of the state's health care safety net, delivering care to all who need it, regardless of ability to pay or circumstance. Though just 6% of all health care systems in the state, California's public health care systems serve more than 2.85 million patients a year, provide 11.5 million outpatients visits annually, and operate more than half of the state's top-level trauma and burn centers. California's public health care systems operate in 15 counties where more than 80% of Californians live. They provide 35% of all hospital care to Medi-Cal beneficiaries and 40% of hospital care to the remaining uninsured in the communities they serve.

Low-income families rely on public health care systems across California for preventive, primary, specialty, and surgical care. Although public health care system providers are trying to assure patients of their safety when they arrive for services, many are avoiding care out of fear of the potential consequences for their immigration status. An expanded public charge definition will only exacerbate this unfortunate and unhealthy situation.

"Our health care systems are focused on keeping patients healthy and well, providing an array of needed services to improve their well-being," said Murray. "The proposed changes would hurt providers' ability to care for patients and create safe spaces for them to maintain good health."

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