Executive Committee

Thursday, July 12, 2018
3:45-4:45p
CPCA Classrooms

Scott McFarland, Chair

Agenda

ORDER OF BUSINESS	RELEVANT ATTACHMENTS	REPORTING	ACTION A = Approval D = Discussion I = Information
I. Call to Order		Scott McFarland, Chair	A
II. Approval of Agenda		Scott McFarland, Chair	A
III. Approval of Minutes	• Minutes from April 26, 2018 • Minutes from June 12, 2018, joint call	Scott McFarland, Chair	A
IV. CEO Report		Carmela Castellano-Garcia	I/D
V. Association Health Plan Update	• *Memo:* Association Health Plan Strategy	Carmela Castellano-Garcia	I/D/A
VI. Epic Update	• PowerPoint slide deck (previously shared on 6/12 call and 7/3 Board call)	Carmela Castellano-Garcia	I/D
VII. Closed Session (CEO Assessment)	• *Handouts will be provided as needed.*	Scott McFarland, Chair	I/D/A
VIII. Adjourn		Scott McFarland, Chair	A

EXECUTIVE COMMITTEE MEETING

April 26, 2018

Meeting Minutes

Members Present : Scott McFarland (Chair), Doreen Bradshaw, Naomi Fuchs, Jane Garcia, Britta Guerrero, Kerry Hydash, Danielle Myers, and Richard Veloz

Members Absent: Jane Garcia, Kevin Mattson, David Vliet

Guests: Ben Flores, Paulo Soares, Deb Farmer, Cathy Frey, Gary Rotto, Marty Lynch, Chirstine NOguera, Louise McCarthy, and Isabel Becerra

Staff: Carmela Castellano-Garcia, Robert Beaudry, Heather Barclay

1. Call to Order

Board Chair Scott McFarland called the meeting to order at 3:45p.

2. Approval of Agenda

Motion

A motion was made and seconded to approve the agenda as presented. (Fuchs/Myers). **The motion carried.**

3. Approval of Minutes

Motion

A motion was made and seconded to approve the January 2018 minutes as presented. (Hydash/Bradshaw). **The motion carried.**

4. CEO report

Carmela provided a report on three (3) main items. The thanked the members, and staff, for great participation at this year's Day at the Capitol event. She also discussed the addition and impact of Vice President of Organizational Development, Buddy Orange. He'll be assisting in a variety of organizational projects including clarifying pathways for staff advancements, cross departmental initiatives to prioritize key areas/tasks; including personal CEO leadership development.

The third item is a "temperature check" around the future of the Clinic Leadership Institute (CLI) program, and the future of health center leadership development. This has been a priority topic for the last several years – the importance of advancing diverse leadership candidates. Encouraging and developing future leaders also fits within the organizations' workforce goal. She mentioned that in addition to running HealthManagement+, perhaps CLI is something CPCA could take on since the program is currently slated to sunset in the future (the exact timing is TBD). The question for CPCA is

what is our role in developing future health center leaders and what more can we be doing in that arena? Members are generally supportive of CPCA taking on CLI but would like to see a more concrete proposal. Questions include would CLI sell their curriculum, would we model their program, start from scratch, etc. There was also discussion about their faculty and coaches. It was questioned whether Buddy could do some training for members on professional development plans. CHC sucesssion planning and CLI are the key topics to consider, and health center training would come later as we figure out the best way to leverage Buddy's skills. Members discussed other leadership programs (UCSF, Managing to Leading; NACHC's Match program, Sierra Health Foundation's program for minority health leaders), and also the option for doing regional programs to help contain costs. It was noted that while there are programs for emerging leaders and development for c-suite leaders, there is still a lack of development programs for grooming future CEOs. Member Christine Noguera offered to assist Carmela with related CLI outreach if need be.

5. Association Health Plans

Carmela introduced this topic and noted that a few months ago, Herrmann Spetzler brought this idea to her with the goal of getting better pricing on health benefits for HC employees, and the idea has also emerged in the past there has been more interest lately. Staff is recommending an RFP process under the guidance of a Board workgroup, and that the RFP would be sent to NonStop Wellness (a current CPCA partner), Essential Health Access, and any other vendors at the request of the workgroup. It was noted the value for the membership is the value of lower costs through group purchasing. While there is an optics downside with regard to the ACA, the upside is the group purchase savings. A feasibility study would also be conducted, but there is value in reducing members' operational costs and the biggest benefit to members is competitive pricing. While no official vetting has occurred with the membership, staff has already received interest in the idea. It was noted we'd have to reach a certain milestone for an association health plan to be worthwhile. Members agreed to explore the idea in further detail under the guidance of a Board workgroup, keeping optics in mind during the exploration process.

6. Conference Awardees 2018

Carmela noted the proposed 2018 Conference Awardees. We propose to honor Herrmann Spetzler as a Hero (posthumously). To date, Robin Affrime is the only retiring CEO (Clinic Legacy) we're aware of. We'll do something special for Herrmann and if anyone learns of any additional retiring CEOs, please let us know.

7. EPIC Partnership Update

Robert Beaudry and Andy Principe led this item, noting there was an Executive Committee call held recently to discuss Epic. The Committee requested to see: a financial risk analysis; the impact on CPCA budget; functionality of a New Market Tax Credit (NMTC). The pros/cons of a NMTC were discussed, and it was noted the presented business plan is inclusive of all costs. CPCA would be granted about $7.5M and our liability is $5.2M so there's a subsidy. CPCA can also capitalize some monies already spent on getting to this point, which would reimburse CPCA for work done to date. It was noted we have a Letter of Intent (to fund) from PCDC, and we expect one from NCB soon. PCDC can fund ahead of the NMTC being available, and banks can start lending before the NMTC is finalized.

A pro forma budget was reviewed, and it was noted that implementation costs are passed through one way or another. Assumptions and plans are based on eight (8) participants (those who have signed MOU to date). It was noted that while more than eight (8) health centers are interested, eight (8) have signed an MOU to date, and we anticipate more than eight (8) over the next seven (7) years. We can run additional numbers, but we reach our goals in either scenario. We'd essentially have a line of credit under the NMTC scenario. CPCA would be granted about $7.5M and our liability is $5.2M so there's a subsidy. Can capitalize some monies already spent on getting to this point, which would reimburse CPCA for work done to date. A NMTC does have a high closing cost. Net benefit to CPCA is $1.8M. Works out to be enough to build the CA specific configuration. Members inquire what the financial ratio asset/debt year-to-year is and staff will put that together. The Board will be asked to approve the contract and initiative, in order to move forward to secure the NMTC and would have final review of all documents first. The Board could approve the deal, but debt ration information would be brought back before the Board signs off on financing. Andy noted the plan would be to secure the loans against the signed contracts and lenders have accepted that.

Motion

> A motion was made and seconded to allow staff to proceed with developing definitive documents (contractual agreements, loan documents, health center contract and Epic contract) and bring those back for review, along with financial ratios and terms sheet via a joint Executive/Finance Committee call, and that group will make the final recommendation to the Board. (McFarland/Myers). **The motion carried.**

Carmela noted we will convene a special Board meeting after the joint Exec/Finance call.

8. Maintaining Unity

Carmela introduced this item, noting that we're working against each other in some regions of the state and how do we handle these issues when they arise; how do we stick together when we disagree. The key issue is: How do we work together to benefit the Association as a whole? An example of going down different paths legislatively was provided as background. It's not good optics for the Association and its members when there's not open communication when we have differences. Members agree there's been feedback at the Capitol that CHCs aren't united and that has some potentially serious implications for all of us. It was suggested to form a "Unity Workgroup" to explore these issues further – including looking at the "why" behind taking different paths, how to communicate when on different paths, and how to be supportive of staff when these challenges arise. Britta Guererro offered to lead a Board-level workgroup with Carmela, and the workgroup will include a member from the Central Valley/Central Coast area (Carmela will discuss with Reymundo Espinoza). If anyone else is interested in joining this Unity Workgroup, please let Carmela or Britta know.

9. Adjourn

The meeting was adjourned by Chair Scott McFarland at 4:40p.

Exec/Finance Joint Call re: EPIC

June 12, 2018

Minutes

Members : Cathy Frey, Nik Gupta, Paula Zandi, Naomi Fuchs, Ashley (??), Louise McCarthy, Marty Lynch, Kerry Hydash, Scott McFarland, Christine Noguera, and Danielle Myers

Staff: Carmela Castellano-Garcia, Robert Beaudry, David Anderson, Heather Barclay

Guest: Andy Principe, consultant

Robert Beaudry, VP and COO, and Andy Principe, Consultant, provided a brief introduction and today, attention will be focused on the PowerPoint slides, which includes an overview/outline for today's discussion. Background materials include: finance mitigation strategy; health center contract; and Epic contract (98% done). Please keep documents confidential, we already heard from Epic that the Business Plan was leaked, so please do not share these attachments.

Andy provided detail on the PowerPoint and reviewed the call's objectives. He noted that the Epic/CPCA offering includes the most robust suite of products Epic has to offer to date – portals, mobile apps, everything they offer is included. Health centers incur costs for implementation on top of the per encounter price, which includes the Epic-hosted product (the EHR, interfaces, hosting, support, maintenance, etc.)

There was discussion about the contract in regard to changes in cost based on users and of the 30 or so cost-related variables, one (1) is the number of active users. The LLC vehicle would be used to simplify the complicated pricing schema and will also be reviewed by legal. There is no per-user fee in the agreement, so that will be edited accordingly. Andy noted there are implementation costs separate from training-related costs, but that an ongoing training program will be created and access will be included in the per encounter cost. Andy noted that OSHPD reports will be part of the California-specific build and Epic is aware of that need. Interface details are included in the Epic contract, which will be passed through to the members.

If CPCA wanted to spin-off the business in the future, or raise capital by brining on investors, we could by selling part of the organization; however, Epic is NOT interested in CPCA selling the LLC to another party and we'd have to remain majority shareholder. The LLC Board would have flexibility in future governance and ownership (for example, if users wanted to buy-in, etc. they potentially could).

Andy noted the goal of the health center agreements is to create parity and support the license and "obligation to use" license, which gives the health center all rights to use/access the hosting platform including software maintenance. Any financial harm from a health center cancelling their relationship with CPCA will not trigger additional harm. There were some penalties created to theoretically recoup associated investments made on health centers' behalf, as it was necessary to create a financial protection for CPCA and the related penalties aren't outside the norm.

It was noted the Technical Advisory Group (TAG) has not specifically reviewed these documents, but Robert did note he worked closely with TAG Chair Wunna Mine from Golden Valley Health Center. He

noted the Epic contract needs to be finalized before the health center contract is finished, and in reply to CPCA becoming a vendor if this initiative passes, it would be similar to our role in Revenue Cycle Management (RCM). Some additional technical questions were briefly discussed including termination penalties and rights to data - members will send additional questions directly to Robert. While the TAG won't specifically review the documents, legal counsel has reviewed and more information will be disseminated before the July 3 Board call, and by then, the contracts will be finished.

Robert noted we've contacted two health centers who have previously signed direct agreements with Epic – Yakima Health Center and a health center and we discussed terms and conditions with them. Andy detailed the financial information noting the New Market Tax Credit (NMTC) is the way to go and availability could be the only issue and we expect this option to be available to us. Models were created on the high end. Regarding closing costs, that is something to discuss with PCDC as CPCA prefers not to risk its' own $400-500k. Members were expecting a new proposed budget including the Epic bottom lines, so staff will be sure to put that together in advance of the Board call. Sandy Birkman, Director of Finance & Operations, noted the CPCA building loan is through Feb. 2020 and refinance will be necessary and we could do that at the same time as it could be hard to get a loan if there's a second lien. The building loan was a 10-year loan and a balloon payment (approx. $3.5M) is due, this refinancing is the preferred option. Members requested a re-stated budget, including the anticipated bottom line, along with revenue and expenses for the project.

Regarding training, three (3) health centers are slated to implement the product at the same time, and a training curriculum will be developed accordingly to prepare those members to go "live" with standard configuration. The majority of those costs are included in the $1.7M for standard configuration. Local, on-site training would be paid by the health center, and a byproduct is the ability to create training resources that would be available at no additional cost to those members who join in the future. Ventures funds were mentioned – there is $10M available in unrestricted funds at the Board's discretion. There is also $8M outstanding from clinic loans. Sandy noted there is $20M in assets and $3.68 is in the building, and $1.8M are grant-restricted dollars – the balance is unrestricted. If members didn't pay back loans, they would be written off as bad debt. Members want to see everything combined in terms of financials with the global impact/bottom line.

To recap, Robert noted staff will get what has been requested so that a decision can be made on the July 3 Board call. He suggests that Nik, Kerry, Sandy and Andy should chat to make sure we have everything we need, and also noted that the underwriting process could still change final figures. Robert noted we can also explore additional mechanisms in terms of collateral to protect CPCA. He also noted CPCA is still in talks with potential funders such as Sutter and Centene and we may still get funds to reduce CPCA's upfront costs. Should members have additional questions, Robert would welcome further conversation offline.

California Primary Care Association

DISCUSSION

Date: July 2, 2018

To: Executive Committee

From: Val Sheehan, Director of Development & External Relations

Re: Association Health Plan Strategy

MEMORANDUM

Background

At the last CPCA Executive Committee meeting on April 26, 2018, the Executive Committee reviewed and discussed a memo outlining the potential opportunity to pursue an Association Health Plan (AHP) strategy. The AHP strategy is compelling because it has the potential to reduce health center operating costs by leveraging the collective buying power of CPCA members to group purchase health insurance at rates that are as good as, if not better than, what they are currently being offered. Offering robust health insurance plans is also an employee recruitment and retention strategy. At a time when workforce is on the forefront of many health center CEOs' minds, being able to offer affordable, yet robust health insurance plans can be key to recruiting and retaining high quality providers and staff.

After some discussion, the Executive Committee members agreed with staff's recommendation to form a brain trust to assist in the continued vetting of this strategy, including interviewing interested groups. Following the Board and committee meetings, CPCA staff organized a member brain trust that included:

- Victoria Abrams – Executive Vice President, Health Center Partners
- Robin Affrime – Chief Executive Officer, CommuniCare Health Centers
- Tracy Garmer – Executive VP and Chief Operations Officer, Health Center Partners
- Christine Noguera – Chief Executive Officer, Community Medical Centers
- Tim Rine – Executive Director, North Coast Clinics Network
- Mary Szecsey – Executive Director, West County Health Centers
- Henry Tuttle – Chief Executive Officer, Health Center Partners

Current Status

CPCA staff created activities and a timeline with a goal of potentially selecting a group to work with to develop an AHP. To begin the process, CPCA staff released an RFP on May 21, 2018 and shared the RFP with interested groups by using existing networks, but also by forming a new relationship with the California Association of Health Underwriters (CAHU). CPCA staff reached out to CAHU asking them to forward the RFP to their members. This strategy helped ensure that CPCA staff cast a wide net to capture the target audience.

CPCA received proposals from the following groups who were interested in partnering on some type of AHP strategy:

1. Decisely (a partner company with EPIC Insurance Brokers)
2. Essential Access Health
3. Keenan & Associates
4. Nonstop Insurance and Administrative Services
5. Shepler & Fear General Agency

A workgroup of CPCA staff reviewed and scored all proposals and presented the top 3 finalists to the brain trust for their approval. The top 3 finalists were: Essential Access Health, Keenan & Associates, and Nonstop Insurance and Administrative Services. Following a brain trust call on June 14, 2018, where brain trust members approved the staff's recommendation, all finalists were scheduled into interview slots. Interviews with the finalists were held during the last two weeks of June.

Next Steps

CPCA staff are now in the process of developing a side-by-side comparison of the offerings to inform a final discussion by the brain trust on Monday, July 9, 2018. It is the staff's expectation that a recommendation or series of recommendations will determined and will be presented at the Executive Committee meeting on July 12, 2018.

CPCA/Epic
Executive Committee Summary
June 2018

Objectives

- CPCA / Epic Contract Key Provisions
- CPCA / Health Center Contract Key Provisions
- Financing Summary and Recommendation
- CPCA Financial Summary
- Discussion and Questions

Recap: Negotiation Highlights

	October 2017	April 2018
10 year commitment	2M annual encounters	4M annual encounters[1]
Cost to Health Center	$6.00 / encounter	$4.50 / encounter[2]
Startup capital	$4.0-4.5M	$4.9-5.4M[3, 4]
7 year margin	$5.4M	$5.1-6.7M[5]

1. Based on the 8 signed MOUs totaling 3.6M annual encounters, and the possibility for patient growth and the implementation of additional health centers beyond year 4.
2. The need to capitalize the implementations to secure approximately $2.0M in additional funding via New Market Tax Credits could make this number higher for a limited period in return for drastically reduced implementation capital costs. Without NMTC, the fee may be raised as high as $5.00 / encounter for a period of 36-months for each Health Center, and then reduced to $4.50 / encounter.
3. Under this model, CPCA will receive approximately $7.1M in startup capital, of which approximately $2.2M is a subsidy and $4.9M is a 7 year loan with an interest-only introductory period.
4. Increases in startup capital needs are partly driven by large health centers implementing early in the process. These numbers are likely to change somewhat as the funding strategy provides considerable flexibility.
5. Contract negotiation with Epic have been completed and documents are ready for execution.

CPCA / Epic Key Contract Provisions

- This agreement secures what CPCA believes, based on market intelligence, to be the best possible inclusive price for the Epic suite of products.
- There is no capital outlay to acquire licenses as the “per encounter” price includes access to the license, hosting, support and maintenance.
- The suite of products included is the most comprehensive suite of tools available to participating Health Centers

Epic Included Components	
EpicCare EHR with the enhanced Behavioral Health and Dental modules	Interfaces
Resolute Billing and Cadence Scheduling	Patient Kiosk (software, not hardware)
CareEverywhere (external provider access)	HEDIS Quality Measures
MyChart Portal and Haiku Mobile Apps	Cosmos (data repository)
Cogito analytics and the Enhanced Analytics Package (HealthyPlanet)	Available FQHC templates, tools, and reports (UDS, Title X, Ryan White)

Hosting / Software Agreement Key Provisions

Hosting Agreement	Software Agreement
CPCA maintains direct relationship to Epic as hosting vendor	CPCA maintains direct relationship to Epic as software vendor
Eliminates upfront capital fees for health centers	Eliminates upfront capital fees for health centers
Fee increases are capped over life of contract	Fee increases are capped over life of contract
Eliminates need for CPCA or Health Center staff to maintain server hardware	Linkage to hosting agreement regarding role of Epic
Epic staff accountable for application performance	Provision to require implementation of features when required by law, with commitment to spread cost across California customers
Suitable liability and insurance for data breaches	Transferable to an entity owned at least 50% by CPCA
Provides access to security audits	Requires continuity of staff through initial implementation, permits CPCA to work with third-party implementers (provided they sign agreement)

CPCA / Health Center Agreement Key Provisions

- Allows for CHC to access the Epic hosted platform, and includes access to all software, hosting, support, and maintenance.
- Provides a balanced agreement between CPCA and participating members.
- Provides parity between Epic/CPCA contract and CPCA/CHC contract in key areas such as indemnification, insurance requirements, etc.
- CHCs may cancel without cause, but penalty limits potential of financial harm to CPCA.
- Establishes data use and security policies.
- Defines expected service levels.
- Clarifies fee schedule and additional billing scenarios.

Financing Summary and Recommendations

	Option A	Option B	Option C	
	Line of Credit	**Conventional Loan**	**NMTC Loan**	**NMTC Subsidy**
Loan Amount	$5.0M	$5.4M	$5.1M	$7.5M
Interest Rate	LIBOR + 3% (currently ~5.03%)	5.35-5.75%	5.35-5.75%	Market rates
Loan Type	Non-revolving line of credit	Conventional Loan	Leverage loan for NMTC	Interest only
Term	7 years	7 years	7 years	7 years, no prepayment
Repayment Term	Interest only first 32 months Amortizing 52 remaining months	Interest only first 18 months Amortizing on 15 year total term month 19 and beyond	Interest only first 18 months Amortizing on 15 year total term month 19 and beyond	Interest only full 7 years
Fees	0.75%	1.00%	Closing costs and other fees of approximately $800k, paid out of loan/subsidy.	
Conditions	Debt service reserve - $1.0M Shareholder in bank - 1% of bank loan	Performance reviews Full recourse to CPCA	Performance reviews Full recourse to CPCA	
Collateral	Lien on New LLC assets Pledge of Ventures receivables	2nd lien position on CPCA property Pledge of Ventures receivables	2nd lien position on CPCA property Pledge of Ventures receivables	
Monthly Payments*	Months 1-18 - $22,083 Months 33-84 - $109,829	Months 1-18 - $26,282 Months 19-84 - $97,136	Months 1-18 - $24,241 Months 19-84 - $89,592	
* Assumes loan balance paid at end of 7 year period regardless of allowable amortization schedule.				

Option C offers the best results for CPCA: considerably greater capital at a lower total cost. In this scenario, CPCA would be compensated for up to $300k of pre-development costs, and would also be able to acquire a Learning Management System that would be instrumental in Epic program success. The LMS could also be leveraged beyond the Epic project to create new ways of leveraging CPCA training and technical assistance content.

Should New Market Tax Credits not be available, Option B is viable and preferred over Option A.

All estimates are based on highest end of interest rate range, and thus all numbers are subject to change at time of loan closing.

California Primary Care Association

CPCA Financial Status

Financial Year End 3-31-18

	March 31, 2017				March 31, 2018			
	CPCA	Ventures	Advocates	Combined	CPCA	Ventures	Advocates	Combined
Statement of Financial Position								
ASSETS:								
Current Assets								
Cash & Equivalents	$ 3,090,327	$ 4,168,171	$ 1,063	$ 7,259,561	$ 2,285,298	$ 2,327,588	$ 134,852	$ 4,747,738
Grants Receivable	$ 510,692			$ 510,692	$ 461,156		$ -	$ 461,156
Dues and Accounts Receivable	$ 324,242			$ 324,242	$ 785,085		$ -	$ 785,085
Current Portion of Loan Receivable		$ 2,278,200		$ 2,278,200		$ 2,351,527		$ 2,351,527
Prepaid Expenses/Undeposited Funds	$ 186,649		$ 846	$ 187,495	$ 104,660		$ 24,777	$ 129,437
Due from (to) affiliate	$ 99,241	$ (128,849)	$ 29,608	$ -	$ 433,744	$ (314,757)	$ (118,987)	$ -
Noncurrent Assets								
Certificates of Deposit	$ 806,713			$ 806,713	$ 873,715		$ -	$ 873,715
Loan Receivable, Net		$ 4,099,373		$ 4,099,373		$ 6,141,716	$ -	$ 6,141,716
Property and Equipment, Net	$ 4,871,647			$ 4,871,647	$ 4,627,660		$ -	$ 4,627,660
TOTAL ASSETS	**$ 9,889,511**	**$ 10,416,895**	**$ 31,517**	**$ 20,337,923**	**$ 9,571,318**	**$ 10,506,074**	**$ 40,642**	**$ 20,118,034**
LIABILITIES & NET ASSETS								
Current Liabilities								
Accounts Payable	$ 215,905			$ 215,905	$ 397,337	$ -	$ 3,138	$ 400,475
Accrued Expenses	$ 275,029			$ 275,029	$ 294,233	$ -	$ -	$ 294,233
Deferred Revenue	$ 427,794			$ 427,794	$ 187,945	$ -	$ -	$ 187,945
Current Portion of Loan Payable	$ 131,925	$ 44,954		$ 176,879	$ 128,235	$ -	$ -	$ 128,235
Loan Payable (net)	$ 3,635,667			$ 3,635,667	$ 3,688,370	$ -	$ -	$ 3,688,370
								$ -
TOTAL LIABILITIES	**$ 4,686,320**	**$ 44,954**		**$ 4,731,274**	**$ 4,696,120**	**$ -**	**$ 3,138**	$ 4,699,258
								$ -
TOTAL NET ASSETS	**$ 5,203,191**	**$ 10,371,941**	**$ 31,517**	**$ 15,606,649**	**$ 4,875,198**	**$ 10,506,074**	**$ 37,504**	**$ 15,418,776**
Unrestricted	$ 3,062,255	$ 10,371,941	$ 31,517	$ 13,465,713	$ 3,039,458	$ 10,506,074	$ 37,504	$ 13,583,036
Temporarily Restricted	$ 2,140,936			$ 2,140,936	$ 1,835,740	0	0	$ 1,835,740
Cash on Hand - how many days organization could operate with no further cash				*257 days*				*172 days*
Current Ratio - compares current assets to current liabilities to show ability to meet short-term financial obligations				*9.64*				*7.99*
Debt Ratio - indicates the percentage of assets that are provided via debt				*0.24*				*0.24*
						with epic financing		*0.49*
Profit and Loss								
Total Income	$ 9,693,951	$ 200,582	$ 703,017	$ 10,597,550	$ 10,756,339	$ 189,254	$ 911,183	$ 11,856,776
Total Expenses	$ 10,128,130	$ 151,986	$ 703,017	$ 10,983,133	$ 10,950,598	$ 55,142	$ 905,195	$ 11,910,935
Net Income	**$ (434,179)**	**$ 48,596**	**$ -**	**$ (385,583)**	**$ (194,259)**	**$ 134,112**	**$ 5,988**	**$ (54,159)**

California Primary Care Association

Discussion and Questions