Exhibit F

Community Health Centers of Arkansas, Inc.

FEDERALLY QUALIFIED HEALTH CENTERS

The Facts

- Community Health Centers (CHCs, also known as Federally Qualified Health Centers or FQHCs) receive federal grants to provide primary and preventive care in medically underserved areas or to medically underserved populations.

- Health centers are **required** by law to use their federal grants to provide a specific set of primary and preventive care services to their patients.

- Congress created a **fair Medicaid payment methodology (Prospective Payment System or PPS), a bundled payment for health centers,** to ensure that health centers did not need to use their federal grant dollars to subsidize their Medicaid payments.

- Health centers' costs per encounter, compared to the average revenue received per privately insured patient is **$0.59 on the $1.00**

- Health centers are required to see everyone, regardless of their ability to pay. They cannot turn away any patient for any reason.

- Health centers are **"financially frail,"** many operate on just 3 months reserves but some cannot even attain that goal.

- Health centers cannot **cost shift** due to such minimal operating margins.

- Reductions in payment to the health centers will result in health centers closing **locations in the most rural, underserved, vulnerable communities** and **laying off physicians, nurses, dentists, and other staff**...which will **negatively impact the economy** of those already struggling rural underserved and economically deprived communities.

- Health centers are required to meet **19 HRSA/BPHC Requirements** as part of their federal grant which include, but are not limited to: mandatory FQHC services, staffing, operations, sliding fees, governance structure, contracts, budgets, audits, reporting, scope of project, business, financial, and clinical quality of care standards and requirements...all of which take funding.

- Any revenues generated above costs, **MUST be reinvested** into providing health center services.

July 2013 revised

FQHC Prospective Payment System:
History & Why it is Essential to Health Centers

Health Centers' Medicaid Prospective Payment System is an example of true delivery-system reform. It is essentially a capitated rate that covers a set of bundled "FQHC services," under which providers have no incentive to increase utilization of tests or procedures, as they do not bill in a traditional fee-for-service methodology. The PPS serves to provide greater predictability of revenues to health centers, thereby incentivizing them to keep costs down and better manage risk and patients' chronic conditions, as they simply will not be reimbursed for any additional services that must be provided for patients whose health is poorly managed.

Heath centers are legally obligated to provide care to anyone who walks in the door, regardless of ability to pay. This fundamental mission should not be compromised by placing health centers at risk because of too-low reimbursement rates for the nearly 39 percent of health center patients who are covered by Medicaid. The original intent of Congress' creation of the FQHC PPS was to ensure that health centers were not forced to subsidize care for Medicaid-insured individuals with their Section 330 grant funding from HRSA. Instead, there was a recognition that health centers could not fulfill their mission to serve everyone regardless of ability to pay if the government was shortchanging them on reimbursement for covered beneficiaries.

The current PPS was created by Congress to ensure that Medicaid covers *most* of the reasonable costs associated with furnishing covered FQHC services to its beneficiaries. Each health center's PPS rate is developed on an individual basis by state and Federal regulatory agencies, and takes into account that health centers' average costs per patient, but only reimburses for what the state and federal governments deem a reasonable, or adequate portion of such costs. On average, health centers are reimbursed for approximately 80 percent of their costs incurred for treating Medicaid beneficiaries. In addition, all revenues received by health centers are reinvested in care for health center patients—meaning that there are no profits per se.

Lastly, FQHC services are focused on primary care and prevention, thereby reducing unnecessary and more expensive care in other settings such as emergency departments. It is a cost-effective use of Medicaid funds, as health centers treat 14 percent of all Medicaid beneficiaries with only 1 percent of Medicaid spending, while at the same time also saving the health care system $24 billion annually in reduced emergency, hospital, and specialty care costs.

Community Health Centers of Arkansas, Inc.

Community Health Center Data

Data Point	All HCs
Total Patients	164560
Total Encounters	589976
Patient Demographics	
# Uninsured Patients	65970
• Uninsured % of CHC Patients	40%
• % of State Uninsured seen by CHC	13%
# Medicaid Patients	46238
• Medicaid % of CHC Patients	28%
# Medicare Patients	20218
• Medicare % of CHC Patients	12%
Private Insured	31923
• Private Insured % of CHC Patient	19%
*0-138%	142,694
*138-400%	21,125
*400% +	739
Patient Ages: 0-19	47,859
Patient Ages: 20-64	100,307
Costs	
Cost Per Patient Year	$574.28
Cost Per Encounter	$160.18
Cost Per Medical Patient	$498.09
Cost Per Medical Encounter	$157.70
Revenues	
Medicaid Dollars Collected	$22,984,754
Medicare Dollars Collected	$8,798,803
Total Private Dollars Collected	$6,297,425
Self-Pay Collected	$10,777,600
**Total Collected	$48,862,511
HRSA/BPHC Grant Funds	$30,953,748
Uncompensated Care	
Self-Pay Sliding Discounts	$19,775,405
Self-Pay Bad Debt Write Off	$3,048,730

*Estimate ** Inclusive of Self-Pay and All insurance

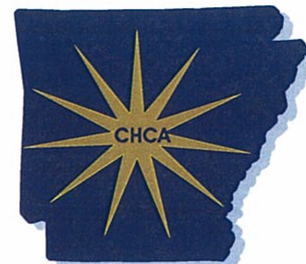
Source: 2012 Arkansas CHCs' Preliminary HRSA/BPHC Uniform Data System (UDS)

July 2013

Community Health Center Locations In Arkansas

Green Forest
Rogers 2
Siloam Springs
3
Springdale
Fayetteville
Huntsville
Yellville
Marshall
Deer
Pocahontas
Corning
Walnut Ridge
Batesville
Swifton
2
Jonesboro
Lake City
Bytheville
Trumann
Lepanto
Fairfield Bay
Heber Springs
Newport
Mountainburg
Mulberry
Clinton
Bald Knob
Cherry Valley
Parkin
2
Augusta
Searcy
Wynne
Ft. Smith 2
Barling
Ratcliff
Kensett
McCrory
West Memphis 2
Conway
Cabot
2
Des Arc
Cotton Plant
Madison
Hughes
Brinkley
CHCA
Marianna
Little Rock (Homeless)
Carlisle
Hazen
Acorn
Mena
Mt. Ida
College Station
England
Clarendon
Lake View
Redfield
Altheimer
Pine Bluff
DeQueen
Amity
Rison
Hope
Bearden
Monticello
Hampton
Dermott
Portland
Lewisville
Strong
Eudora
Wilmot

- ARcare
- Boston Mountain Rural Health Center, Inc.
- CABUN Rural Health Services, Inc.
- Community Clinic at St. Francis House, Inc.
- Corning Area Healthcare, Inc.
- East Arkansas Family Health Center, Inc.
- Healthy Connections, Inc.
- Jefferson Comprehensive Care System, Inc.
- Lee County Cooperative Clinic, Inc.
- Mainline Health Systems, Inc.
- Mid-Delta Health Systems, Inc.
- River Valley Primary Care Services, Inc.



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Community Health Centers of Arkansas, Inc.
Revenues compared to Costs-Estimated Losses

Estimated Losses with (1902(a)(15) Wavier)	
ARcare	($250-$800K)
Boston Mount	($930-1.8mil)
CABUN	($570-700K)
Community Clinic	($500k-1.5mil)
Corning	($1.3-1.8mil)
East Arkansas	($850-1.1mil)
HCI	($250-1.4mil)
Jefferson	($1.0-1.2mil)
Lee County	($700-800k)
Mainline	($850-1mil)
Mid-Delta	($350-430k)
River Valley	($1.1mil)
Statewide	($8,650,00 – $13,630,000)

(X*Y)/2= Z; (C*Z)= A; (60*Z)= R ; (36.30*Z)=R2; (R-A) = L (Low Range); (R2-A) = L (High Range)

X= Number of Uninsured Patients 19-64 below 150% FPL
Y= Average number of visits per patient per year
C= Cost per patient visit from the CHC's Cost Report
Z= Number of patient visits assuming, 50% take up rate
A= Average Total Cost of Private Option patients
R= Revenue @ NovaSys Rate for 90213
R2= Revenue @ Private Practice Medicaid Rate for 90213
L= Loss
$60 NovaSys Rate for 99213 ; $36.30 Private Practice Medicaid rate 99213

Estimates are based off of the 2012 HRSA/BPHC UDS data

Revised 1:37 PM 7/19/2013 with CHCs Identified