



April 18, 2012

Monroe County Grants Administration Office  
Lisa Tennyson/Office of Management & Budget  
1100 Simonton Street, 2<sup>nd</sup> Floor, Room 2-213  
Key West, FL 33040

RE: 2013-Human Services Advisory Board Application

Dear Ms. Tennyson,

Enclosed please find one original and seven copies of our grant application and request for funding in the amount of \$200,000.00 from the Human Services Advisory Board fiscal year 2013 funding period.

On behalf of our patients and the communities that we serve, we are forever grateful and appreciate all the support the Advisory Board and the Monroe County Commission has provided to the Clinic in years past.

Sincerely,

Jill Miranda Baker

President, Board of Directors

305.853.1788



**MONROE COUNTY  
HUMAN SERVICES ADVISORY BOARD  
Application for Funding  
Fiscal Year 2013  
October 1, 2012 – September 30, 2013**

Agency Name	The Good Health Clinic
Physical Address	91555 Overseas Highway
Mailing Address	Same
City, State, Zip	Tavernier, FL 33070
Phone	305.853.1788
Fax	305.853.1789
Email	Goodhealthclinic@comcast.net
Who should we contact with questions about this application?	Kim Sovia-Crandon, Executive Director

Amount received for prior fiscal year ending 09/30/11	\$40,000
Amount received for current fiscal year ending 09/30/12	\$40,000
Amount requested for upcoming fiscal year ending 09/30/13	\$200,000



## CERTIFICATION

To the best of our knowledge and belief, the information contained in this application and attachments is true and correct. Monroe County is hereby authorized to verify all information contained herein, and we understand that any inaccuracies, omissions, or any other information found to be false may result in rejection of this application. This certifies that this request for funding is consistent with our organization's Articles of Incorporation and Bylaws and has been approved by a majority of the Board of Directors.

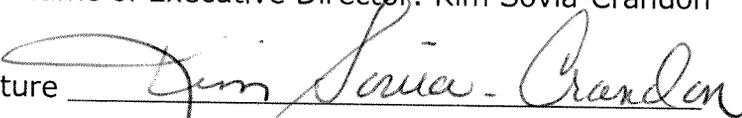
We affirm that the Agency will use Monroe County funds for the purposes as submitted in this Application for Funding. Any change will require written approval from the Monroe County Board of County Commissioners.

We understand that the agency must substantially meet the eligibility criteria to be considered for Monroe County funding and that any applicable attachments not included disqualify the agency's application.

We understand that all funding received through this opportunity must be spent for the benefit of Monroe County.

We further understand that meeting the Eligibility Criteria in no way ensures that the agency will be recommended for funding by the Human Services Advisory Board. These recommendations are determined by service needs of the community, availability of funds, etc. HSAB funding recommendations must be approved by the Monroe County Board of County Commissioners.

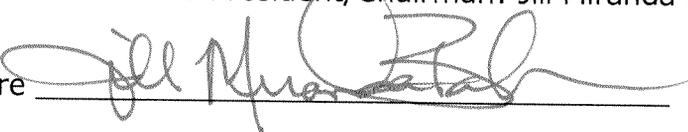
Typed Name of Executive Director: Kim Sovia-Crandon

Signature 

Title: Executive Director

Date: 4.18.12

Typed Name of Board President/Chairman: Jill Miranda Baker

Signature 

Title: Board President

Date: 4.18.12



Detailed instructions for each question appear in the separate instruction document.

1. Insert your agency's board-approved mission statement below.

*The mission of the Good Health Clinic is to provide FREE medical care to uninsured and indigent residents of the Upper Keys of Monroe County, Florida.*

2. List the services your agency provides.

*We provide free primary, secondary, tertiary, ancillary and specialty and sub-specialty healthcare services in its entirety to qualified residents residing in the Upper Keys. We provide free preventive healthcare choices, quality of life preventative healthcare programs and medications, to include all necessary surgical procedures. Patients have access to well over sixty three (63) physicians, specialty physicians and technicians' associated with our healthcare program services.*

3. What specific services will be funded by this request?

*Funding is needed for clinical operational expenses for direct and in-direct client/patient program services such as; medical personnel, medical support personnel, medical supplies, patient support personnel, community outreach services, quality of life educational services/programs and administrative facility operational expenses.*

4. Funding category:

If you have been previously funded by HSAB, do you request to have the HSAB consider changing your funding category? Please circle yes or no: Yes **No**

If yes, please circle the new category for which you would like to be considered:  
Medical                  Core Services                  Quality of Life

If you have not been previously funded, please circle the funding category that you believe best matches your services:    Medical                  Core Services                  Quality of Life

5. Will County HSAB funds be used as match for a grant? **NO**
6. If you answered "yes" to Question #5, please specify the following for each grant:
  - a. grant award title, granting agency, and purpose:
  - b. grant amount:
  - c. match percentage requirement and amount:
  - d. expected award date:

7. If your organization was funded with HSAB funds last year, please briefly and specifically explain:

- a. how the funds were spent:

*Funds off set a portion of the Clinics medical personnel and patient support services expenses, as well as quality of life health programs associated with the GHC's free patient program and operational facility expenditures.*

- b. how they were used to leverage additional funding:

*We were able to increase the number of client/patients reached through our community outreach program both in the public and private sector. The expansion of the program not only*



*brought more clients into the Clinic, it enabled us to increase donations from the business community and through other family foundations by 50%.*

8. Do you plan to allocate any part of this HSAB grant, if awarded, as a sub-grant to another organization? *If yes, please list the recipient(s), the purpose(s), and amount(s). Please make sure these are included on Attachment D, under "Grants to Other Organizations."* **NO**
9. Does your organization allocate sub-grants to other organizations using other sources (non County) of funding? *If yes, please list the recipient(s), the purpose(s), and amount(s). Please make sure these are included on Attachment E, under "Grants to Other Organizations."* **NO**
10. Will you or have you applied for other sources of County funding? *If yes, please list source(s) and amount(s). Also be sure to reflect this information on Attachment F.* **YES**

SAFF funds, amount requested: \$10,000. Recommended for BOCC approval: \$6,300

11. What needs or problems in this community does your agency address?

*We address all of the medical and healthcare needs of the homeless, indigent and uninsured, low income residents that have resided in the Upper Keys for a minimum of 6 months FREE of charge to the client. This also includes preventative and quality of life health care needs at no cost to the client. We address the needs of the working class residents by keeping them from postponing or forgoing important early intervention and screenings for prevalent conditions such as; diabetes, cancer, asthma, and heart disease, as well as other ailments associated with living in a tropical environment. The combination of a higher percentage of residents who are both low-income and uninsured in our region is very problematic and must be addressed for the welfare of our community.*

12. What statistical data support the needs listed in Question #11?

- The 2010 US Census report (attached) indicates 9.5% of clients residing in Key Largo live below poverty level, the percentage in Islamorada is listed as 13.4%, and these percentages do not include unincorporated areas of the Upper Keys.
- Monroe County Health Status Summary Report (attached). Supporting medical journal articles posted on line in RE to the need for preventative medicine as well as diabetes care and outcomes, disparities across rural America.
- The Florida Department of Health 2010 "Prevention Pays" health statistics and assessment (attached). Their report states that healthcare related costs have skyrocketed "The US spends a disproportionate share of its gross domestic product (GDP) on health care expenditures relative to other industrialized countries. Healthcare spending ballooned to over 16.7% of the nation's gross domestic product by 2007. By 2015, health expenditures are expected to surpass \$4 trillion nationwide. Since 1988, only 3% (\$9.1 billion) of those expenditures have been spent on public health."
- Statistical data through the GHC RxAssist patient program also shows a tremendous increase of clinic services for new and renewed patients residing in Monroe County over the past few years. *(Year end and YTD statistical report included)*

13. What are the causes (not the symptoms) of these problems?

*Addressing the healthcare needs of Monroe County uninsured, homeless and low income residents is multi faceted and exacerbated by a few of the following issues:*



- No other FREE healthcare facilities in Monroe County other than the GHC.
- The climate of politics at the State and Federal level over the years concerning healthcare.
- The fiscal cutbacks in social service programs as well as in Medicare and Medicaid.
- The ever changing instability of the economic forecast.
- The back log (years), for veterans to qualify for disability and medical treatments.
- Low wages, lack of jobs, high cost of living and minimal low income housing units.
- Cost of private health insurance, elimination of pre-existing health exclusions.
- Restricted medical benefits for people working in the Florida Keys.

14. Describe your target population as specifically as possible.

- Residents that live at or below 200% of the Federal poverty guidelines.
- Residents that have resided in the Upper Keys for a minimum of six (6) months.
- Clients between 18-65 years of age. Half our clients are in the 45-64 age group.
- All ethnic origins, all genders, all religious beliefs.
- Residents who are totally uninsured and have no access to healthcare benefits.

15. How are clients referred to your agency?

*Word of mouth, all media outlets to include the internet, the GHC's Community Outreach program, referrals from Monroe County Health Department, State of Florida Health Department, Pastoral Services, Mariners hospitals, Baptist Health South Florida facilities, private physicians and our network of community service groups/organizations such as AHEC, Rural Health Network, Guidance Care Center, MARC, Hospice and others.*

16. What steps are taken to be sure that prospective clients are eligible and that the neediest clients are given priority?

*We have specific guidelines and a strict application process, established by the FL Department of Health, as well as through Baptist Health South Florida's Pastoral Services Division. The formula requires screening with the GHC Patient Administrative Support personnel to insure clients meet the eligibility requirements for free healthcare. All of our clients are the neediest in the communities that we serve and 100% of them are approved for quality healthcare.*

17. Describe any networking arrangements that are in place with other agencies.

*The GHC is tightly linked with a strong collaboration with Mariners Hospital and Baptist Health South Florida, including all their subsidiary hospitals and outpatient services. These solid arrangements have resulted in efficient and low-cost service delivery with unparalleled continuity of preventative and quality of life healthcare, giving our clients access to over hundreds of physicians and specialists, in every medical field imaginable. Last year, to date, medical services extended to clients exceeded \$20,000,000.00, our volunteer physicians provide in-kind services/treatments to clients in excess of a \$1,000,000.00.*

*Our "volunteer" partners/network include the Florida Keys Radiology and pathology services, Baptist Cardio Vascular Institute of Miami, the Breast Center of Homestead, Homestead Diagnostic Center, Women's Wellness Center in Miami, Hematology/Oncology Center of Miami, as well as the Florida Department of Health, University of Miami School of Medicine, Department of Family Medicine and the Open Door Health Clinic.*

*The GHC also spends an invaluable amount of time through our Client/Patient assist program to connect our clients with pharmaceutical industry-sponsored "compassionate need" assistance program enabling the GHC to provide free medications and quality of life health related products to insure our clients maintain their wellness program. To date the GHC has dispensed well over \$800,000 in medication costs.*



*We are also work closely, and network with, all the Monroe County non-profit organizations and agencies, such as, but not limited to; Monroe County Department of Health, AHEC, Center for Independent Living, Florida Keys Healthy Start Coalition, WomanKind, Inc., Rural Health Network, Hospice of the Florida Keys, Guidance Care Center, Florida Keys Outreach Coalition, United Way, American Red Cross, American Cancer Society just to name a few.*

18. List all sites and hours of operation. Please note which of these sites will be using HSAB funding.

*The GHC is located at: 91555 Overseas Highway, Tavernier. Currently the Clinic is open Monday through Thursday between the hours of 9:00 a.m. and 3:00 p.m. It is the hope/desire of the board and Clinic management to increase the hours of operation to five (5) days a week and one (1) Saturday a month, once appropriate long term funding is in place.*

19. What financial challenges do you expect in the next two years, and how do you plan to respond to them?

*As long as the economic and political climate continues to remain unstable and as long as the issues outlined in question # 13 remain a constant in the Florida Keys, we anticipate a larger number of uninsured residents seeking out and qualifying for our services. As healthcare costs rise, as outlined in our supporting documentation, our cost of services will continue to rise.*

*As long as medical and health care costs continue to spiral out of control with no government intervention in site, we anticipate cost of services to rise. This will be a constant struggle for all free healthcare facilities throughout the United States. However, we are constantly putting the GHC in the forefront of the public through our newly established community outreach program. Through those efforts we will continue to nurture benefactors such as our donors, corporate and business community leaders and private family foundations. We continually explore other grant avenues both at the local, State and Federal levels, as well as private and public grant foundations/programs found throughout the Country that the GHC's mission and service programs would fit with their requirements.*

20. What organizational challenges do you expect in the next two years, and how do you plan to respond to them?

*Our challenges include the established of a strong retention and compensation plan that will enable to the GHC to continue to attract and maintain qualified medical physicians and medical support staff, as well as the retention of a qualified executive administrator to oversee the financial and administrative elements associated with a non-profit, to include grant writing and grant administration. The GHC is currently at a growing stage where services need to be expanded to meet the needs of our clients.*

*We are responding in a proactive way by retaining the services of an outside consultant proficient in the Free Health Care Clinic industry. The agency will be doing organization and operational assessment (S.W.O.T. analysis), as well as review of the Clinic's patient care and programs to determine what the future direction of the GHC will be to insure we are adequate and properly meeting the needs of the community and the industry.*

21. How are clients represented in the operation of your agency?



*Client/Patient advocacy is crucial to insure the GHC is meeting the demands and needs of the clients we serve. The makeup of the board of directors includes representation from a patient/client. We have also incorporated the need for a bi-lingual patient advocate in house to insure there is no miscommunication with our Hispanic client base. The GHC Medical Director, along with a few of our attending physicians act as patient advocates to insure that clients have full understanding of the policies and procedures of services rendered.*

22. Is your agency monitored by an outside entity? If so, by whom and how often?

*The GHC is monitored by the Florida Department of Health on an annual basis. The board of directors, professional personnel and medical staff are monitored by Baptist Health South Florida's division of Pastoral Care on a quarterly basis. We maintain the services of an outside CPA firm that does audits on an annual basis. The GHC has also entered into a consulting services agreement with Free Clinic Solutions and will provide an internal assessment of the GHC's organizational and operation program, an external community health needs assessment and an internal governance assessment.*

23. Over 2500 hours of program services were contributed by a minimum of 40 volunteers in the last year. Over **\$6,552,703.00** in **hospital services**, over **\$161,204** worth of **medications** provided, over **\$481,000.00** in **physician fees** were provided **FREE** to qualified patients of the GHC in **2011**.

24. Will any services funded by the County be performed under subcontract by another agency? If so, what services, and who will perform them? **NO**

25. What measurable outcomes do you plan to accomplish in the next funding year?

*Establishment of an external community health needs assessment to determine types of client service/programs that can be enhanced. Increase the number of client visits by at least 20%, adjust the hours of operation by an additional 5 to 8 hours a week. Improve and increase our exposure within the community through a more defined community outreach program, thus reaching out to more low income, uninsured residents that may not have the capability to come into the clinic due to transportation issues.*

26. How will you measure these outcomes?

*The GHC maintains a very detailed statistical reporting system via our RxAssist program, enabling us to track the number and type of prescription given, types of surgical procedures, client visits, as well as types of volunteer provider services given, hours, and productivity. This enables us to monitor, on a quarterly basis, projected versus actual outcomes for the year.*

27. Provide information about units of service below.

Service	Unit (hour, session, day, etc.)	Cost per unit (current year)
New Patient Admin. Eval.	Session	\$250 free to client
Renew Patient Admin.	Session	\$250 free to client
New Patient Physician Consult/Physical	Session	\$500 fee to client



Client/Patient Sick Visits	Session	\$250 free to client
Client/Patient Annuals	Session	\$400 free to client
Client/Patient F/U Visit	Session	\$250 free to client
Blood Pressure Check	Session	\$75 free to client
Client/Patient Minor Procedure	Session	\$800 free to client
Pre-Op visit	Session	\$400 free to client
F/U to ER Visit	Session	\$250 free to client
Gynecological Colpo	Session	\$500 free to client
Gynecological Cryo	Session	\$700 free to client
Gynecological Colp Biopsy	Session	\$800 free to client
Derm Consult/Eval	Session	\$500 free to client
Derm Biopsy	Session	\$500 free to client
Derm Follow-up	Session	\$250 free to client
Medication Standard	Session	\$275 to \$400 free to client
Meds Patient Assist Application	Session	\$100 free to client
Medication Specialized	Session	\$401 to \$29,000 free to client
Medical Records Release	Session	Between \$25 to \$75
Patient Copy of Records	Session	\$20

27. In 300 words or less, address any topics not covered above (*optional*).

**Required Attachments**

*Required attachments were distributed to you as a separate document. Be sure to include these with your application. Please note: the required attachments A through F are only available in Microsoft Excel format. We require that you use this format, since it will automatically expand rows, generate totals and percentages, and align figures for easier reading. Please label each attachment with your organization name and attachment letter.*



## ATTACHMENT CHECKLIST

<b>LABEL AND ATTACH THE FOLLOWING IN THE ORDER SHOWN, AFTER THIS PAGE IF NOT APPLICABLE, PLEASE SO INDICATE AND EXPLAIN</b>	<b>ATTACHED?</b>		<b>COMMENTS You must explain any "NO" answers</b>
	<b>YES</b>	<b>NO</b>	
A-1. Current Board Information Form	x		
B. Agency Compensation Detail	x		
C. Profile of Clients, Client Numbers and Services (Performance Report)	x		
D. County HSAB Funding Budget	x		
E. Agency Expenses	x		
F. Agency Revenue	x		
G. Copy of Audited Financial Statement from most recent fiscal year (2010) if organization's expenses are \$150,000 or greater.	x		
H. Copy of filed IRS Form 990 from most recent fiscal year (2010)	x		
I. Copy of current fee schedule		x	All services are free
J. Copy of IRS Letter of Determination indicating 501 C 3 status & Copy of GUIDESTAR printout	x		
K. Copy of Current Monroe County and City Occupational Licenses	x		
L. Copy of Florida Dept. of Children And Families License or Certification		x	N/A to services that we provide
M. Copy of any other Federal or State Licenses	x		
N. Copy of Florida Dept. of Health Licenses/Permits	x		
O. Copy of front page of Agency's EEO Policy/Plan	x		
P. Copy of Summary Report of most current Evaluation/Monitoring *	x		
Q. Data showing need for your program (See Question 12)	x		
R. Other (specify) TWO PAGE LIMIT		x	Pertinent info in application

\* must include summary of deficiencies and suggested corrective action; may include your responses and actions taken.







# GHC Executive Board Meeting

March 30, 2012 at Tasters Grille

**Call to order:** meeting began at 1200 hours presided by President Jill Miranda Baker. Executive Directors present: Claudia Stober. Brett Ekblom, out of town but conferred with President prior to departure. Others present: Kim Sovia-Crandon, Dr. Sandy Yankow.

## **Business discussed:**

### Free Clinic Solutions:

Discussion held pertaining to proposal from Free Clinic Solutions. Contract agreement as presented, fee of \$4,800 plus expenses, was approved. Motion made/approved to proceed forward. Board/staff to work on hotel/food to be provided as in-kind donation to minimize Mark Cruise's out of pocket expenses.

### New Board Director:

Motion made/approved to accept Cheryl Meads to fill vacant board seat. A three year term beginning April 18, 2012.

### Donor Appreciation Dinner:

It was decided to postpone the donor appreciation dinner to be hosted by the Pareira's until the fall.

**Adjournment:** Meeting concluded at 1300 hours.



## January 18, 2012, the Good Health Clinic Board of Directors Minutes

**Annual Meeting:** Due to 2011 scheduling conflicts during the holiday season the board of directors were unable to meet for the annual meeting that was to have been held during the last quarter of the fiscal year. Let it be known that the January 18, 2012 board meeting will be conducted and considered as the Clinic's 2011 year end Annual Meeting as outlined in the by-laws.

**Annual Meeting call to order:** The meeting was called to order at 1810 hrs by Miranda Baker, sitting in for Vice President Eckblom.

**Directors Present:** Jill Miranda Baker, Dan Cole, Bob Foley, Claudia Stober, David DeHaas, Shawn Tolley.  
**Directors Absent:** Brett Eckblom. **Others Present:** Dr. Sandy Yankow, Medical Director, Kim Sovia-Crandon, Executive Director

**Approval of November minutes:** Motion made by Foley, seconded by Stober to approve minutes as presented. MMC.

**Board resignations:** Miranda Baker presented the board with the resignations of both Shelley Miklas and Nancy Hershoff. The board voiced their reluctance and sadness in accepting their resignation. There was discussion about possibly having them be on one of the standing committees, should they desire at some point in the future. Yankow made mention of possibly serving on an Advisory Committee. Miranda Baker went over the four current standing committees as outlined in the Clinic by-laws. She recommended that we need to have these committee's working first before the board creates more. It was made mentioned that the by-laws do not state that there cannot be "volunteers" from the community to serve on any one of the committees.

Both Miranda Baker and Stober commented that during the special called Executive Meeting on Tuesday, January 18, that Hershoff said she would still head up and be involved with the Swim-A-Thon. Foley asked that either an elegant thank you letter or plaque signed by the board be presented to both directors for all of their hard work and time put in during their tenure. Miranda Baker said she will look into that and get back with the board. Motion made by Stober to accept resignations, seconded by Tolley. **MMC with DeHaas opposing.**

**Board Restructuring:** Miranda Baker addressed the board and explained the need for restructuring. She presented the same statement given to the Executive Committee, eloquently stating that the Clinic has a dysfunctional board. The key responsibilities of a board are 1) providing guidance, 2) setting policy and 3) fundraising. It is not the role of the board to micro manage the operation of the Clinic, nor get involved in human resource issues or medical issues.

Foley concurred with Miranda Baker concerning the dysfunctionality of the board, however praised the work done by the previous executive members. He highly recommended expanding the board and insuring there was a diverse group. Discussion ensued. Tolley mentioned the need for an Administrator for the Clinic and to utilize the bookkeeper in a more expanded role. He firmly believes in the power of numbers and the need to expand the board and bring people to the table that can get involved financially.

Directors proposed a number of names for consideration, however, it was clearly stated that before we bring new community leaders (CPA, attorney, financial planner, consumer, etc.) to the table to serve on the board that the current board needs to get their act together first. All agreed, with the possibility of approaching one potential candidate, Barbara Neal. Both Foley and Sovia-Crandon were asked to approach her.

Miranda Baker did extensive research concerning a plan of action as to where the board needs to be. She made mention the need to redefine the mission statement, develop both a long term and short term strategic vision, as well as a S.W.O.T. (strengths, weaknesses, opportunities, threats) analysis. She reached out to the Florida Association of Free Clinics for guidance and spoke with CEO, Marisel Losa, concerning the current situation. Recommendation was made to reach out to Mark Cruise with Free Clinic Solutions, a consulting, coaching, training and management facilitator. Miranda Baker did contact and speak with Cruise, a copy of the companies brochure was given to each director in their board package.



**Board Commitment:** Before delving into the possibility and cost of hiring a professional facilitator, Miranda Baker wanted a firm commitment by the current sitting board of seven (7) to insure they would be willing to commit to participate in the changes and the developmental growth of the Clinic. All directors present, to include absent V. President, Ekblom, agreed and went on record to serve and commit. With full board approval, Miranda Baker will move forward and have a more in depth conversation with Free Clinic Solutions concerning the possibility, availability and cost of facilitating a strategic planning session and would report back to the board. She feels this outreach will be a huge advantage for all involved.

**Acceptance of Interim Officers:** With the board now down to seven, motion was made to accept Jill Miranda Baker as President, Brett Ekblom as Vice. President and Claudia Stober as Secretary/Treasurer. Prior to the motion, it was made clear that the elected positions of the Executive Committee would be for a period of six (6) months to get the board and the Clinic through the transition, with re-evaluation done in six (6) months. Motion made by Tolley, seconded by DeHaas. **MMC**

**Approval of 2012 Budget:** The finance committee presented a copy of the revised draft budget for review and approval. Discussion ensued concerning the area involving contracted professionals. Yankow went on record stating that he was not pleased with the reduction of hours and should the Clinic bring in a physician assistant or a nurse practitioner, they would have to work under his license, to reduce his hours just so someone could work under his license was not going to happen. Sovia-Crandon also had concerns with the budget cuts in certain administrative areas as well.

Tolley, with other members in agreement, reiterated that the budget was a guideline and not set in stone and mentioned that budgets can be revisited on a monthly basis and could be adjusted to meet the needs and requirements of the clinic. Tolley made motion for submitting the budget as a guide, seconded by DeHaas, with clear specifics for any proposed changes for review on a monthly basis. **MMC with Cole opposing the budget as presented.**

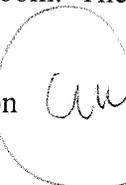
**By-Law Changes:** Motion made by DeHaas, seconded by Folley to accepted the two by-law changes as outlined below. **MMC**

- A) The executive committee at their discretion, and on a case by case basis, can extend an expiring directors term to exceed six (6) years if they feel it is in the best interest of the Clinic.
- B) The board has the authority to add an additional director at large to the executive committee with a position title to be determined by the executive committee.

**Executive Directors and Medical Directors Reports:** The President of the Board requested that each director please take time out to read the Executive Director and Medical Directors year end reports that were presented to the board in their board package. Included was the Executive Directors year-end profit and loss comparison from 2004 to 2011 showing, after taking a net loss over the past two years in excess of \$62,000.00 the clinic, for the first time in its history, had a net profit of over \$55,000.00. Copies of the Executive Directors administrative and financial year end reports, as well as the Medical Directors year end reports that were presented to the board are attached to the minutes (total 4 pages 2 sided each).

The meeting adjourned at 7:15 p.m., with the next full board meeting scheduled for 5:30 pm on Wednesday **February 15**, to be held at Mariners Hospital Executive board meeting room. There was no executive board meeting scheduled at this time.

Respectfully submitted to the best of my knowledge: Kim Sovia-Crandon



Good Health Clinic  
Attachment A 2 (continued)







**ATTACHMENT C - PROFILE OF CLIENTS, CLIENT NUMBERS AND SERVICES (Performance Report)  
2012  
Good Health Clinic**

List Services Here	Target Population	Age	# of Persons in Target Population	Area	Days/Hours	Total Number of Clients Served during most recent completed fiscal year	3/31/2012
Free Primary HealthCare	Homeless, indigent, uninsured residents living at or below 200% of Federal poverty level.	18-65	4,500 +	Upper Keys	M-Thur 9a-3p	2,300	817
Free Prescriptions/Meds	same	18-65	same	Upper Keys	M-F 9a-4p	2011 Value \$161,204.00	2012 Value \$38,700.00
No. of Free Prescriptions	Same	18-65	same	Upper Keys	M-Thur 9a-3p	1,200	350
Free Surgical Operations	same	18-65	same	Upper Keys	M-F 9a-4p	48	13
Free access to surgical pathology physicians	same	18-65	same	Upper Keys	M-F 9a-4p	1,185	646
Free hospital services	same	18-65	same	Upper Keys	M-F 9a-4p	2011 Value \$6,552,703.00	2012 Value \$1,465,377.00
Free Optomology Services/Surgery	same	18-65	same	Upper Keys	M-F 9a-4p	32	5
Free Nerology Services	same	18-65	same	Upper Keys	M-F 9a-4p	8	8
Free ENT Services	same	18-65	same	Upper Keys	M-F 9a-4p	24	3
Free Orthopedic treatment/surgery	same	18-65	same	Upper Keys	M-F 9a-4p	49	15
Free Internal Medicine	same	18-65	same	Upper Keys	M-F 9a-4p	43	1
F. Dermatology Treatment	same	18-65	same	Upper Keys	Thur 9a-1p	243	37
F. Podiatry Treatment/surgery	same	18-65	same	Upper Keys	M-F 9a-4p	21	17
F. Cardio/Pulmonary	same	18-65	same	Upper Keys	M-F 9a-4p	5	7
Free Gastro. Treatment/Surgery	same	18-65	same	Upper Keys	M-F 9a-4p	56	3
Mental Health	same	18-65	same	Upper Keys	M-F 9a-4p	16	0
Free Oncology Services	same	18-65	same	Upper Keys	M-F 9a-4p	12	2
<b>Total</b>						<b>4,733</b>	<b>2,165</b>
<b>Unduplicated Clients for Entire Agency</b>							
<i>(See instructions - this is not a total of the numbers above)</i>							

**ADDITIONAL INFORMATION REQUIRED:**

Please indicate the number of clients served who are Monroe County residents: 2,300 ++

**Please list or describe achieved measurable outcomes for your target populations:**

Our RxAssist program tracks all patient data and services provided through the Clinic enabling us to provide a variety of measurable statistical outcomes, as well as patient demographics. We also track all medication/prescriptions that are dispensed. Quarterly reports are required by the Florida Department of Health, Mariners Hospital and Baptist Health South Florida. We are also required to provide matrix outcomes for any grants received from Health Foundation of South Florida.



## ATTACHMENT D - COUNTY HSAB FUNDING BUDGET

2012  
Good Health Clinic

Show the proposed budget detail for the County HSAB funds requested.  
The total must match with the total funding requested.

	Proposed Expense Budget for Upcoming Year Ending:	
	1/31/2012	
Expenditures	Total	%
Salaries - Program	185,000	0.925
Payroll Taxes - Program	0	0
Employee Benefits - Program	0	0
Salaries - Administrative	0	0
Payroll Taxes - Administrative	0	0
Employee Benefits - Administrative	0	0
<b>Subtotal Personnel</b>	<b>185,000</b>	<b>92.5%</b>
Postage	800	0.4%
Office Supplies	2,000	1.0%
Professional Fees	2,500	1.3%
Rent	5,000	2.5%
Phone & Utilities	0	0
Repair and Maint.	0	0
Travel/Educational Programing	0	0
Miscellaneous	0	0
Grants to Other Organizations	0	0
<i>List others below</i>	0	0
Medical Supplies	2,500	1.3%
Media Relations	0	0
Printing & Reproduction Program Services	2,200	1.1%
		0
		0
		0
		0
		0
		0
		0
		0
		0
		0
<b>Total Expenses</b>	<b>200,000</b>	<b>100.0%</b>



## ATTACHMENT E - AGENCY EXPENSES

2012

Complete this worksheet for the entire agency.  
Please round all amounts to the nearest dollar.

Good Health Clinic

	Proposed Expense Budget for Upcoming Year Ending:		Projected Expenses for Current Year Ending:	
	12/31/2012		12/31/2011	
Expenditures	Total	%	Total	%
Salaries - Program	235,000	64%	160,000	60%
Payroll Taxes - Program	11,600	0	5,000	0
Employee Benefits - Program	0	0	4,200	0
Salaries - Administrative	40,000	0	20,400	0
Payroll Taxes - Administrative	0	0	0	0
Employee Benefits - Administrative	0	0	0	0
<b>Subtotal Personnel</b>	<b>286,600</b>	<b>78%</b>	<b>189,600</b>	<b>71%</b>
Postage	1,300	0%	803	0%
Office Supplies	4,500	1%	6,200	2%
Office/Medical Equipment	2,000	1%	1,000	0%
Medical Supplies	2,500	1%	2,100	1%
Professional Fees	4,000	1%	3,650	1%
Rent	11,000	3%	10,500	4%
Utilities	5,000	1%	3,900	1%
Telecommunications	1,200	0%	0	0
Repair and Maint.	3,500	1%	300	0%
Travel	1,500	0%	300	0%
Education/Conference	2,500	1%	100	0%
Grants to Other Organizations	0	0	0	0
<i>List others below</i>		0		0
Fund Raising Expenses	3,500	1%	12,324	5%
Community Outreach/Prog. Services	9,800	3%	1,900	1%
Consulting Fee	7,000	2%	23,665	9%
Corp Fee/Dues & Subscriptions	2,500	1%	1,522	1%
Janitorial/Bio Waste Services	2,400	1%	2,300	1%
Ins/Corp & Medical Licenses/Permits	5,000	1%	3,400	1%
Marketing/Public Relations	2,500	1%	500	0%
RxAssist Medical Records	2,000	1%	1,500	1%
Web/IT Support	5,800	2%	1,500	1%
		0		0
<b>Total Expenses</b>	<b>366,100</b>	<b>100%</b>	<b>267,064</b>	<b>100%</b>
<b>Revenue Over/(Under) Expenses</b>	<b>61,200</b>		<b>35,816</b>	



## ATTACHMENT F - AGENCY REVENUE

2012

Complete this worksheet for the entire agency.  
Please round all amounts to the nearest dollar.  
In-Kind will not be included in percentages or total.

Good Health Clinic

	Proposed Revenue Budget for Upcoming Year Ending:			Projected Revenue for Current Year Ending:		
	12/31/2012			12/31/2011		
	Cash	In-Kind	%-age of Total	Cash	In-Kind	%-age of Total
<b>Revenue Sources</b>						
Monroe County	200,000		47%	40,000		13%
Children and Fam			0%			0%
M.C. Sheriff's Dept.			0%			0%
City of Key West			0%			0%
City of Marathon			0%			0%
Village of Islamorada			0%			0%
City of Layton			0%			0%
City of Key Colony Beach			0%			0%
Client fees			0%			0%
Donations	20,000		5%	25,619		8%
Sheriff Shared Asset	6,300	(waiting appro	1%			0%
United Way			0%			0%
<i>List all others below</i>			0%			0%
BHSF Grant	175,000	6,000,000	41%	125,000	6,553,000	41%
Health Foundation Grant	15,000		4%	15,000		5%
J. Mahoney Foundation			0%	15,000		5%
Fund Raising Events	11,000	5,000	3%	82,261	10,000	27%
			0%			0%
			0%			0%
			0%			0%
			0%			0%
			<b>100%</b>			<b>100%</b>
<b>Total Revenue</b>	<b>427,300</b>	<b>6,005,000</b>		<b>302,880</b>	<b>6,563,000</b>	



THE GOOD HEALTH CLINIC, INC.

Financial Statements and  
Schedule of Financial Assistance with  
Independent Auditors' Report Thereon

For the Years Ended  
December 31, 2010 and 2009

**SMITH, BUZZI & ASSOCIATES, LLC.**  
**CERTIFIED PUBLIC ACCOUNTANTS**  
2103 CORAL WAY, SUITE 305  
MIAMI, FLORIDA 33145  
TEL. (305) 285-2300  
FAX (305) 285-2309

JULIO M. BUZZI, C.P.A.  
JOSE E. SMITH, C.P.A.

MEMBERS:  
AMERICAN INSTITUTE OF  
CERTIFIED PUBLIC ACCOUNTANTS  
FLORIDA INSTITUTE OF  
CERTIFIED PUBLIC ACCOUNTANTS

**INDEPENDENT AUDITORS' REPORT**

To the Board of Directors  
The Good Health Clinic, Inc.:

We have audited the accompanying statements of financial position of The Good Health Clinic, Inc. (a non-profit organization), as of December 31, 2010 and 2009 and the related statements of activities, cash flows and functional expenses for the years then ended. These financial statements are the responsibility of The Good Health Clinic, Inc.'s management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America, Government Auditing Standards, issued by the Comptroller General of the United States and the provisions of Office of Management and Budget Circular A-133, "Audits of States, Local Governments and Non-Profit Organizations". Those standards and OMB Circular A-133 require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of The Good Health Clinic, Inc., as of December 31, 2010 and 2009 and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

*Smith, Burgin & Associates, LLC.*

April 27, 2011

THE GOOD HEALTH CLINIC, INC.  
 Statements of Financial Position  
 December 31, 2010 and 2009

	<u>2010</u>	<u>2009</u>
<b>CURRENT ASSETS</b>		
Cash and Equivalents	\$ 41,678	83,224
Grants and Contributions		
Receivable - Current	16,587	8,124
Prepaid Insurance	1,606	1,138
Prepaid Rent and Other		
Current Assets	<u>2,026</u>	<u>2,920</u>
Total Current Assets	<u>61,897</u>	<u>95,406</u>
 <b>PROPERTY AND EQUIPMENT</b>		
Medical Equipment	24,594	24,594
Office Equipment	<u>12,759</u>	<u>12,759</u>
Total Property and Equipment	37,353	37,353
Accumulated Depreciation - Equipment	<u>(36,885)</u>	<u>(36,729)</u>
Net Property and Equipment	<u>468</u>	<u>624</u>
	<u>62,365</u>	<u>96,030</u>
 <b>CURRENT LIABILITIES</b>		
Accounts Payable and Accrued Expenses	2,505	3,418
Due to Sub-Lessee	-	1,000
Deferred Revenue	<u>-</u>	<u>1,500</u>
Total Current Liabilities	<u>2,505</u>	<u>5,918</u>
 <b>COMMITMENTS AND CONTINGENCIES</b>		
 <b>NET ASSETS</b>		
Unrestricted Net Assets	<u>59,860</u>	<u>90,112</u>
Total Net Assets	<u>59,860</u>	<u>90,112</u>
	<u>\$ 62,365</u>	<u>96,030</u>

See accompanying notes to financial statements

THE GOOD HEALTH CLINIC, INC.

Statements of Activities

For the Year Ended December 31, 2010  
 (With Summarized Comparative Totals for the Year Ended December 31, 2009)

	Unrestricted		
	Operations	Property and Equipment	
	Total 2010		Total 2009
<b>SUPPORT AND REVENUES:</b>			
Support:			
Contributions	\$ 17,911	-	19,118
Grant	155,182	-	139,979
Funds Released from Restriction	-	-	-
Total support	<u>173,093</u>	-	<u>159,097</u>
Revenues:			
Interest and Other Income	<u>4,999</u>	-	<u>936</u>
Total revenues	<u>4,999</u>	-	<u>936</u>
Total Support and Revenues	<u>178,092</u>	-	<u>160,033</u>
Expenses:			
Program services	189,205	-	139,679
Management and administration	<u>18,983</u>	<u>156</u>	<u>45,396</u>
Total expenses	<u>208,188</u>	<u>156</u>	<u>185,075</u>
CHANGE IN NET ASSETS	(30,096)	(156)	(25,042)
Net assets, beginning of year	<u>89,488</u>	<u>624</u>	<u>115,154</u>
Net assets, end of year	<u>\$ 59,392</u>	<u>468</u>	<u>\$ 90,112</u>

See accompanying notes to financial statements.

THE GOOD HEALTH CLINIC, INC.

Statements of Cash Flows

For the Years Ended December 31, 2010 and 2009

	<u>2010</u>	<u>2009</u>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	\$ (30,252)	(25,042)
Adjustments to reconcile changes in net assets to net cash flows from operating activities:		
Depreciation expense	156	156
Changes in operating assets and Liabilities:		
Grants and contributions receivable	(8,463)	(2,260)
Prepaid expenses	426	(677)
Accounts payable	(913)	(4,022)
Due to sub-lessee	(1,000)	1,000
Deferred revenue	<u>(1,500)</u>	<u>(2,179)</u>
Net cash flows used by operating activities	<u>(41,546)</u>	<u>(33,024)</u>
 CASH FLOWS FROM INVESTING ACTIVITIES	 <u>-</u>	 <u>(780)</u>
 CASH FLOWS FROM FINANCING ACTIVITIES	 <u>-</u>	 <u>-</u>
 NET CHANGE IN CASH AND EQUIVALENTS	 (41,546)	 (33,804)
 CASH AND EQUIVALENTS, BEGINNING OF YEAR	 <u>83,224</u>	 <u>117,028</u>
 CASH AND EQUIVALENTS, END OF YEAR	 <u>\$ 41,678</u>	 <u>83,224</u>

See accompanying notes to financial statements

THE GOOD HEALTH CLINIC, INC.

Statements of Functional Expenses

For the Year Ended December 31, 2010  
 (With Summarized Comparative Totals for the Year Ended December 31, 2009)

	Program Services	Management and General	Program Development/ Fund Raising	Total 2010	Total 2009
Salaries and Benefits	\$ 54,956	2,483	810	58,249	52,165
Professional Fee - Physician/Management	94,159	5,110	4,088	103,357	89,548
Occupancy	9,555	525	420	10,500	11,250
Utilities	3,523	189	76	3,788	5,026
Clinic - Supplies and Cleaning	2,131	112	-	2,243	570
Insurance	-	2,189	-	2,189	2,210
Advertising	4,306	-	-	4,306	3,990
Office Supplies	4,532	246	148	4,926	3,527
Dues and Subscriptions	1,655	-	-	1,655	783
Software and Software Subscriptions	1,034	70	45	1,149	781
Office Costs	6,475	529	212	7,216	3,421
Repairs and Maintenance	371	93	-	464	309
Licenses and Permits	827	-	-	827	819
Accounting and Bookkeeping	5,681	1,495	299	7,475	10,676
Total Expenses	\$ 189,205	13,041	6,098	208,344	185,075

See accompanying notes to financial statements.

THE GOOD HEALTH CLINIC, INC.

Notes to Financial Statements

December 31, 2010 and 2009

**(1) Summary of Significant Accounting Policies**

**(a) Organization**

The Good Health Clinic, Inc. (the "Organization") was incorporated in the State of Florida in September of 2003 and is a tax exempt organization under Section 501(c)(3) of the Internal Revenue Code. The Organization has one location in Monroe County, Florida. The mission of the Organization is to provide primary, secondary and tertiary medical care to the uninsured indigent residents of the Upper Florida Keys. The Organization participates in the state of Florida Volunteer Health care Provider Program ("VHCPP"). The VHCPP, a result of the "Access to Health Care Act" (section 766.1115, Florida Statutes) which was signed into law in 1992, provides licensed healthcare professionals sovereign immunity protection for uncompensated services rendered to eligible clients.

**(b) Basis of Accounting**

The financial statements of the Organization have been prepared on the accrual basis of accounting reflecting all significant receivables, payables and other liabilities and conform to accounting principles generally accepted in the United States of America as applicable to not-for-profit organizations.

**(c) Basis of Presentation**

Financial statement presentation follows the requirement of the Financial Accounting Standards Board in its Statement of Financial Accounting Standards ("SFAS") No. 117, "Financial Statements of Not-for-Profit Organizations". Under SFAS No. 117, the Organization is required to report information regarding its financial position and activities according to three classes of net assets; unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. The Organization adopted SFAS No. 117 for the year ended December 31, 2007. There were no permanently restricted assets as of December 31, 2010 and 2009.

THE GOOD HEALTH CLINIC, INC.  
Notes to Financial Statements  
December 31, 2010 and 2009

(1) Summary of Significant Accounting Policies - (Cont.)

(c) Basis of Presentation - (Cont.)

The present classes of net assets are reported as follows:

- Unrestricted Net Assets - Net assets that are not subject to donor-imposed restrictions.
- Temporarily Restricted Net Assets - Net assets subject to donor-imposed stipulations that may or will be met either by actions of the Organization/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statements of activities as net assets released from restrictions.

	<u>2010</u>	<u>2009</u>
<u>Temporarily Restricted</u> <u>Net Assets:</u>		
Baptist Health South Florida	\$ -	\$ -

THE GOOD HEALTH CLINIC, INC.

Notes to Financial Statements

December 31, 2010 and 2009

(1) Summary of Significant Accounting Policies - (Cont.)

(d) Uses of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

(e) Cash and Cash Equivalents

The Organization maintains its cash deposits at a bank. Cash deposits at the bank as of December 31, 2010 and 2009 are within the federal insurance limits. All cash deposits are in interest bearing investments held by banks with an initial maturity of three months or less to be cash equivalents. Cash and cash equivalents does not include cash received with donor-imposed restrictions that limit their use to long-term purposes. Cash and cash equivalents also does not include cash held by investment managers and designated for investment.

(f) Accounts Receivable

Accounts receivable are stated at the amount management expects to collect from balances outstanding at December 31, 2010 and 2009 from contributions and grants. Management has concluded that realization of losses on balances outstanding at December 31, 2010 and 2009, if any, will be immaterial.

(g) Revenue Recognition

Grants and contributions received are recorded at fair value as increases in unrestricted, temporarily or permanently restricted net assets, depending on the existence and/or nature of any donor restrictions.

All grant and donor-restricted contributions are reported as increases in temporarily or permanently restricted net assets, depending on the restriction. When a restriction expires, (that is, when a stipulated time restriction ends or purpose restriction is accomplished), temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions.

THE GOOD HEALTH CLINIC, INC.  
Notes to Financial Statements  
December 31, 2010 and 2009

(1) Summary of Significant Accounting Policies - (Cont.)

(h) Donations

Donations are reflected as contributions in the accompanying statements at their estimated values at the date of receipt. The Organization records contributions if they meet the criteria for recognition under SFAS No. 116, "Accounting for Contributions Received and Contributions Made".

(i) Income Taxes

The Organization was organized as a non-profit organization and has received exemption under the provisions of Section 501(c)(3) of the Internal Revenue Code.

(j) Functional Expenses

The costs of providing various programs and other activities have been summarized on a functional basis in the statements of activities and in the statements of functional expenses. Accordingly, certain costs have been estimated and allocated among the programs and supporting services benefited.

(2) Summary of Funding

The following summarizes the Organizations funding for the years ending December 31, 2010 and 2009, respectively:

<u>Grants</u>	<u>2010</u>	<u>2009</u>
Baptist Health South Florida	\$106,250	\$100,000
Monroe County Florida	48,932	34,084
Other	-	5,895
<u>Contributions</u>		
Other	<u>17,911</u>	<u>19,118</u>
	<u>\$173,093</u>	<u>159,097</u>

THE GOOD HEALTH CLINIC, INC.  
Notes to Financial Statements  
December 31, 2010 and 2009

**(3) Grants and Other Accounts Receivable**

Grants and other accounts receivable are composed of the following amounts due:

	<u>2010</u>	<u>2009</u>
<u>Grant Receivable</u>		
Baptist Health South Florida	\$ -	-
Monroe County, Florida	16,587	5,831
Other	-	1,043
<u>Other Account Receivable</u>		
Florida Keys Area Health Education Center - rent on sublease	-	1,250
	<u>\$ 16,587</u>	<u>8,124</u>

**(4) Property and Equipment/Prior Period Adjustment**

SFAS No. 157, Fair Value Measurements, provides that contributions of property and equipment should be recognized at fair value at the date of contribution. SFAS No. 93, Recognition of Depreciation by Not-For-Profit Organizations, requires all not-for-profit organizations to recognize depreciation for all property and equipment except land used as a building site and similar assets. The Organization recorded donated property based upon the fair value as reported in the Organizations tax returns.

Depreciation for 2010 amounted to \$156.

THE GOOD HEALTH CLINIC, INC.

Notes to Financial Statements

December 31, 2010 and 2009

(5) Deferred Revenue

The Organization records income received in advance as a refundable advance (deferred revenue) until it is earned. The refundable advance consisted of the following:

	<u>2010</u>	<u>2009</u>
Florida Keys Area Health Education Center	-	1,500

(6) Insurance

The Organization has elected not to carry insurance covering its assets or business papers. No employee fidelity insurance is carried. As referred to above in Note 1, nature of the organization and summary of significant accounting policies, the Organization participates in the State of Florida Volunteer Health Care Provider Program ("VHCPP"). The VHCPP, a result of the "Access to Health Care Act" (section 766.1115, Florida Statutes) provides licensed healthcare professionals sovereign immunity protection for uncompensated services rendered to eligible clients.

(7) Commitments

The Organization is the lessee of office space in Tavernier, Florida under a non-cancelable operating lease. Rental expense paid to the lessor, exclusive of reimbursement for utilities, was \$10,500 and \$11,250 for the years ended December 31, 2010 and 2009, respectively. Future minimum annual rental payment under this lease for 2010 is \$12,000.

(8) Economic Dependency

The Organization does not charge any fees for its services rendered. For the years ended December 31, 2010 and 2009 the Organization received all its funding from contributions and grants. For 2010 and 2009, changes in net assets amounted to (\$30,252) and (\$25,042), respectively and cash flows decreased respectively by \$41,546 and \$33,804. As a result, the Organization is looking at different ways to provide the same services while increasing funding, including grant proposals. Increased revenue sources and controlled costs are essential to the Organization remaining a viable concern.



Form **990**  
 Department of the Treasury  
 Internal Revenue Service

**Return of Organization Exempt From Income Tax**  
 Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)  
 The organization may have to use a copy of this return to satisfy state reporting requirements.

OMB No. 1545-0047  
**2010**  
 Open to Public Inspection

**A** For the 2010 calendar year, or tax year beginning \_\_\_\_\_, and ending \_\_\_\_\_

**B** Check if applicable:  
 Address change  
 Name change  
 Initial return  
 Terminated  
 Amended return  
 Application pending

**C** Name of organization: **GOOD HEALTH CLINIC, INC.**  
 Doing Business As \_\_\_\_\_  
 Number and street (or P.O. box if mail is not delivered to street address) Room/suite: **91555 OVERSEAS HIGHWAY**  
 City or town, state or country, and ZIP + 4: **TAVERNIER FL 33070**

**D** Employer identification number: **04-3745805**

**E** Telephone number: \_\_\_\_\_

**F** Name and address of principal officer: \_\_\_\_\_

**G** Gross receipts\$ **178,092**

**H(a)** Is this a group return for affiliates?  Yes  No  
**H(b)** Are all affiliates included?  Yes  No  
 If "No," attach a list. (see instructions)

**I** Tax-exempt status:  501(c)(3)  501(c) ( ) (insert no.)  4947(a)(1) or  527

**J** Website: **N/A**

**K** Form of organization:  Corporation  Trust  Association  Other

**L** Year of formation: **2003** **M** State of legal domicile: **FL**

**H(c)** Group exemption number: \_\_\_\_\_

**Part I Summary**

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: <b>PROVIDE FREE PRIMARY HEALTH CARE, DIAGNOSTIC AND EDUCATIONAL SERVICES TO INDIGENT AND UNISURED INDIVIDUALS RESIDING IN THE UPPER FLORIDA KEYS AREA.</b>		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	
	4	Number of independent voting members of the governing body (Part VI, line 1b)	
	5	Total number of individuals employed in calendar year 2010 (Part V, line 2a)	
	6	Total number of volunteers (estimate if necessary)	
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	
7b	Net unrelated business taxable income from Form 990-T, line 34		
Revenue	8	Prior Year	Current Year
	9	159,097	173,093
	10	363	4,540
	11	573	459
	12	160,033	178,092
Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	
	14	Benefits paid to or for members (Part IX, column (A), line 4)	
	15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	
	16a	Professional fundraising fees (Part IX, column (A), line 11e)	
	16b	Total fundraising expenses (Part IX, column (D), line 25) <b>6,098</b>	
Net Assets or Fund Balances	17	132,910	150,095
	18	185,075	208,344
	19	-25,042	-30,252
	20	Beginning of Current Year	End of Year
	21	96,030	62,365
22	5,918	2,505	
22	90,112	59,860	

**Part II Signature Block**

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete. Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge.

**Sign Here**

Signature of officer: \_\_\_\_\_ Date: \_\_\_\_\_  
 Type or print name and title: \_\_\_\_\_

**Paid Preparer Use Only**

Print/Type preparer's name: **JULIO BUZZI** Preparer's signature: \_\_\_\_\_ Date: **08/16/11** Check  if self-employed  if PTIN **P00853282**  
 Firm's name: **Smith, Buzzi & Associates, LLC** Firm's EIN: **80-0631935**  
 Firm's address: **2103 Coral Way Suite 305 Miami, FL 33145** Phone no. **305-285-2300**

May the IRS discuss this return with the preparer shown above? (see instructions)  Yes  No

For Paperwork Reduction Act Notice, see the separate instructions. DAA

G+H - Good Health Clinic Audit  
 2 sided, page 8 of 19

**Part III Statement of Program Service Accomplishments**

Check if Schedule O contains a response to any question in this Part III

1 Briefly describe the organization's mission:

**PROVIDE FREE PRIMARY HEALTH CARE, DIAGNOSTIC AND EDUCATIONAL SERVICES TO INDIGENT AND UNISURED INDIVIDUALS RESIDING IN THE UPPER FLORIDA KEYS AREA.**

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?  Yes  No

If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services?  Yes  No

If "Yes," describe these changes on Schedule O.

4 Describe the exempt purpose achievements for each of the organization's three largest program services by expenses. Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported.

4a (Code: ) (Expenses \$ **189,205** including grants of\$ ) (Revenue \$ **19,139** )

**PROVIDE FREE PRIMARY HEALTH CARE, DIAGNOSTIC AND EDUCATIONAL SERVICES TO INDIVIDUALS RESIDING IN THE UPPER FLORIDA KEYS AREA AND TO EDUCATE INDIVIDUALS ABOUT HEALTHY LIVING ALTERNATIVES**

4b (Code: ) (Expenses \$ including grants of\$ ) (Revenue \$ )

4c (Code: ) (Expenses \$ including grants of\$ ) (Revenue \$ )

4d Other program services. (Describe in Schedule O.)

(Expenses \$ including grants of\$ ) (Revenue \$ )

4e Total program service expenses **▶ 189,205**

**Part IV Checklist of Required Schedules**

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2 Is the organization required to complete Schedule B, Schedule of Contributors? (see instructions)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	<input type="checkbox"/>	<input type="checkbox"/>
4 <b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6 Did the organization maintain any donor advised funds or any similar funds or accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9 Did the organization report an amount in Part X, line 21; serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10 Did the organization, directly or through a related organization, hold assets in term, permanent, or quasi-endowments? If "Yes," complete Schedule D, Part V	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable.		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14a Did the organization maintain an office, employees, or agents outside of the United States?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, and program service activities outside the United States? If "Yes," complete Schedule F, Parts I and IV	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the United States? If "Yes," complete Schedule F, Parts II and IV	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the United States? If "Yes," complete Schedule F, Parts III and IV	<input type="checkbox"/>	<input checked="" type="checkbox"/>
17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	<input type="checkbox"/>	<input checked="" type="checkbox"/>
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	<input type="checkbox"/>	<input checked="" type="checkbox"/>
20a Did the organization operate one or more hospitals? If "Yes," complete Schedule H	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b If "Yes" to line 20a, did the organization attach its audited financial statements to this return? <b>Note.</b> Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Part IV Checklist of Required Schedules (continued)**

	Yes	No
21 Did the organization report more than \$5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II		<b>X</b>
22 Did the organization report more than \$5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III		<b>X</b>
23 Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J		<b>X</b>
24a Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25		<b>X</b>
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
c Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
25a <b>Section 501(c)(3) and 501(c)(4) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I		<b>X</b>
b Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I		<b>X</b>
26 Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? If "Yes," complete Schedule L, Part II		<b>X</b>
27 Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? If "Yes," complete Schedule L, Part III		<b>X</b>
28 Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):		
a A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV		<b>X</b>
b A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV		<b>X</b>
c An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV		<b>X</b>
29 Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M		<b>X</b>
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M		<b>X</b>
31 Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I		<b>X</b>
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II		<b>X</b>
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I		<b>X</b>
34 Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1		<b>X</b>
35 Is any related organization a controlled entity within the meaning of section 512(b)(13)?		<b>X</b>
a Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2		
	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
36 <b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2		<b>X</b>
37 Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI		<b>X</b>
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O	<b>X</b>	

**Part V Statements Regarding Other IRS Filings and Tax Compliance**

Check if Schedule O contains a response to any question in this Part V

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable		
1b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		<input checked="" type="checkbox"/>
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file. (see instructions)		
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		<input checked="" type="checkbox"/>
b	If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		<input checked="" type="checkbox"/>
b	If "Yes," enter the name of the foreign country: <b>▶</b> See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		<input checked="" type="checkbox"/>
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		<input checked="" type="checkbox"/>
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible?		<input checked="" type="checkbox"/>
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		<input checked="" type="checkbox"/>
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		<input checked="" type="checkbox"/>
d	If "Yes," indicate the number of Forms 8282 filed during the year		
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		<input checked="" type="checkbox"/>
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		<input checked="" type="checkbox"/>
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		<input checked="" type="checkbox"/>
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		<input checked="" type="checkbox"/>
8	<b>Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.</b> Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		
9	<b>Sponsoring organizations maintaining donor advised funds.</b>		
a	Did the organization make any taxable distributions under section 4966?		
b	Did the organization make a distribution to a donor, donor advisor, or related person?		
10	<b>Section 501(c)(7) organizations.</b> Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12		
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities		
11	<b>Section 501(c)(12) organizations.</b> Enter:		
a	Gross income from members or shareholders		
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)		
12a	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year		
13	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
a	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O.		
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans		
c	Enter the amount of reserves on hand		
14a	Did the organization receive any payments for indoor tanning services during the tax year?		<input checked="" type="checkbox"/>
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O		

**Part VI Governance, Management, and Disclosure** For each "Yes" response to lines 2 through 7b below, and for a "No" response to line 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

Check if Schedule O contains a response to any question in this Part VI

**Section A. Governing Body and Management**

	1a	1b	Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year				
b Enter the number of voting members included in line 1a, above, who are independent				
2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?				<b>X</b>
3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?				<b>X</b>
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?				<b>X</b>
5 Did the organization become aware during the year of a significant diversion of the organization's assets?				<b>X</b>
6 Does the organization have members or stockholders?				<b>X</b>
7a Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?				<b>X</b>
b Are any decisions of the governing body subject to approval by members, stockholders, or other persons?				<b>X</b>
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a The governing body?			<b>X</b>	
b Each committee with authority to act on behalf of the governing body?			<b>X</b>	
9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O				<b>X</b>

**Section B. Policies** (This Section B requests information about policies not required by the Internal Revenue Code.)

	Yes	No
10a Does the organization have local chapters, branches, or affiliates?		<b>X</b>
b If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?		
11a Has the organization provided a copy of this Form 990 to all members of its governing body before filing the form?	<b>X</b>	
b Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
12a Does the organization have a written conflict of interest policy? If "No," go to line 13	<b>X</b>	
b Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	<b>X</b>	
c Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done	<b>X</b>	
13 Does the organization have a written whistleblower policy?		<b>X</b>
14 Does the organization have a written document retention and destruction policy?		<b>X</b>
15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
a The organization's CEO, Executive Director, or top management official	<b>X</b>	
b Other officers or key employees of the organization	<b>X</b>	
If "Yes" to line 15a or 15b, describe the process in Schedule O. (See instructions.)		
16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?		<b>X</b>
b If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?		

**Section C. Disclosure**

- 17 List the states with which a copy of this Form 990 is required to be filed **FL**
- 18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you make these available. Check all that apply.  
 Own website  Another's website  Upon request
- 19 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public.
- 20 State the name, physical address, and telephone number of the person who possesses the books and records of the organization: **KIM SOVIA CRANDON 305-853-1788 91555 OVERSEAS HIGHWAY**

**TAVERNIER**

**FL 33070**

**Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

Check if Schedule O contains a response to any question in this Part VII

**Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees**

**1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
  - List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
  - List the organization's five **current** highest compensated employees (other than an officer, director, trustee, or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
  - List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
  - List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.
- List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

Check this box if neither the organization nor any related organizations compensated any current officer, director, or trustee.

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) <b>SANFORD YANKOW MD</b> MEDICAL DIRECTOR	40.00						0	0	0	
(2) <b>SHAWN TOLLEY</b> TREASURER	1.00	X					0	0	0	
(3) <b>BRETT EKBLUM</b> VICE PRESIDENT	1.00	X		X			0	0	0	
(4) <b>ROBERT FOLLEY</b> PRESIDENT	1.00	X					0	0	0	
(5) <b>NANCY HERSHOFF</b> SECRETARY	1.00	X		X			0	0	0	
(6) <b>BRENDA PIERCE</b> BOARD MEMBER	1.00	X		X			0	0	0	
(7) <b>PATRICIA SINERVO</b> PRESIDENT	1.00	X		X			0	0	0	
(8) <b>DAVID DEHAAS</b> BOARD MEMBER	1.00	X					0	0	0	
(9) <b>CLAUDIA STOBER</b> TREASURER	1.00	X		X			0	0	0	
(10) <b>SHELLEY MIKLAS</b> DIRECTOR	1.00	X					0	0	0	
(11) <b>DAN COLE</b> DIRECTOR	1.00	X					0	0	0	
(12) <b>JILL MIRANDER-BAKER</b> DIRECTOR	1.00	X					0	0	0	
(13)										
(14)										
(15)										
(16)										

**Part VII Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)**

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(17) .....										
(18) .....										
(19) .....										
(20) .....										
(21) .....										
(22) .....										
(23) .....										
(24) .....										
(25) .....										
(26) .....										
(27) .....										
(28) .....										
<b>1b Sub-total</b> .....										
<b>c Total from continuation sheets to Part VII, Section A</b> .....										
<b>d Total (add lines 1b and 1c)</b> .....										

**2** Total number of individuals (including but not limited to those listed above) who received more than \$100,000 in reportable compensation from the organization **0**

	Yes	No
<b>3</b> Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? If "Yes," complete Schedule J for such individual .....		<b>X</b>
<b>4</b> For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? If "Yes," complete Schedule J for such individual .....		<b>X</b>
<b>5</b> Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? If "Yes," complete Schedule J for such person .....		<b>X</b>

**Section B. Independent Contractors**

**1** Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization.

(A) Name and business address	(B) Description of services	(C) Compensation
SANFORD YANKOW MD TAVERNIER FL 33070	9155 OVERSEAS HIGHWAY MEDICAL SERVICE	102,207

**2** Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 in compensation from the organization **1**

**Part VIII Statement of Revenue**

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512, 513, or 514	
<b>Contributions, gifts, grants and other similar amounts</b>	<b>1a</b> Federated campaigns	<b>1a</b>					
	<b>b</b> Membership dues	<b>1b</b>					
	<b>c</b> Fundraising events	<b>1c</b>					
	<b>d</b> Related organizations	<b>1d</b>					
	<b>e</b> Government grants (contributions)	<b>1e</b>	48,932				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	124,161				
	<b>g</b> Noncash contributions included in lines 1a-1f: \$						
<b>h Total.</b> Add lines 1a-1f			173,093				
<b>Program Service Revenue</b>	<b>2a</b> OTHER	Busn. Code	4,540	4,540			
	<b>b</b>						
	<b>c</b>						
	<b>d</b>						
	<b>e</b>						
	<b>f</b> All other program service revenue						
	<b>g Total.</b> Add lines 2a-2f			4,540			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts)		459	459			
	<b>4</b> Income from investment of tax-exempt bond proceeds						
	<b>5</b> Royalties						
	<b>6a</b> Gross Rents	(i) Real	(ii) Personal				
	<b>b</b> Less: rental exps.						
	<b>c</b> Rental inc. or (loss)						
	<b>d</b> Net rental income or (loss)						
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
	<b>b</b> Less: cost or other basis & sales exps.						
	<b>c</b> Gain or (loss)						
	<b>d</b> Net gain or (loss)						
	<b>8a</b> Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	<b>a</b>					
		<b>b</b> Less: direct expenses	<b>b</b>				
<b>c</b> Net income or (loss) from fundraising events							
<b>9a</b> Gross income from gaming activities. See Part IV, line 19	<b>a</b>						
	<b>b</b> Less: direct expenses	<b>b</b>					
	<b>c</b> Net income or (loss) from gaming activities						
<b>10a</b> Gross sales of inventory, less returns and allowances	<b>a</b>						
	<b>b</b> Less: cost of goods sold	<b>b</b>					
	<b>c</b> Net income or (loss) from sales of inventory						
<b>Miscellaneous Revenue</b>		<b>Busn. Code</b>					
<b>11a</b>							
<b>b</b>							
<b>c</b>							
<b>d</b> All other revenue							
<b>e Total.</b> Add lines 11a-11d							
<b>12 Total revenue.</b> See instructions.			178,092	4,999	0	0	

**Part IX Statement of Functional Expenses**

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.  
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to governments and organizations in the U.S. See Part IV, line 21				
2 Grants and other assistance to individuals in the U.S. See Part IV, line 22				
3 Grants and other assistance to governments, organizations, and individuals outside the U.S. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	58,249	54,956	2,483	810
8 Pension plan contributions (include section 401(k) and section 403(b) employer contributions)				
9 Other employee benefits				
10 Payroll taxes				
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 7				
f Investment management fees				
g Other				
12 Advertising and promotion				
13 Office expenses	7,216	6,475	529	212
14 Information technology				
15 Royalties				
16 Occupancy	10,500	9,555	525	420
17 Travel				
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization				
23 Insurance				
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24f. If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O.)				
a PROFESSIONAL FEES - PHYSICIAN	103,357	94,159	5,110	4,088
b ACCOUNTING AND BOOKEEPING	7,475	5,681	1,495	299
c OFFICE SUPPLIES	4,926	4,532	246	148
d PROMOTION	4,306	4,306		
e UTILITIES	3,788	3,523	189	76
f All other expenses	8,527	6,018	2,464	45
25 Total functional expenses. Add lines 1 through 24f	208,344	189,205	13,041	6,098
26 Joint costs. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720). Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

**Part X Balance Sheet**

		(A) Beginning of year		(B) End of year
<b>Assets</b>	1 Cash—non-interest bearing	83,224	1	41,678
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net	8,124	3	16,587
	4 Accounts receivable, net		4	
	5 Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6 Receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions)		6	
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use		8	
	9 Prepaid expenses and deferred charges	4,058	9	3,632
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 37,353		
	b Less: accumulated depreciation	10b 36,885	624	10c 468
	11 Investments—publicly traded securities		11	
	12 Investments—other securities. See Part IV, line 11		12	
	13 Investments—program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11		15	
16 <b>Total assets.</b> Add lines 1 through 15 (must equal line 34)		96,030	16	62,365
<b>Liabilities</b>	17 Accounts payable and accrued expenses	3,418	17	
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities. Complete Part X of Schedule D	2,500	25	2,505
	26 <b>Total liabilities.</b> Add lines 17 through 25	5,918	26	2,505
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117, check here <input type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>			
	27 Unrestricted net assets		27	
	28 Temporarily restricted net assets		28	
	29 Permanently restricted net assets		29	
	<b>Organizations that do not follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 30 through 34.</b>			
	30 Capital stock or trust principal, or current funds	90,112	30	59,860
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 <b>Total net assets or fund balances</b>	90,112	33	59,860
	34 <b>Total liabilities and net assets/fund balances</b>	96,030	34	62,365

Form 990 (2010)

**Part XI Reconciliation of Net Assets**

Check if Schedule O contains a response to any question in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	178,092
2	Total expenses (must equal Part IX, column (A), line 25)	2	208,344
3	Revenue less expenses. Subtract line 2 from line 1	3	-30,252
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	90,112
5	Other changes in net assets or fund balances (explain in Schedule O)	5	
6	Net assets or fund balances at end of year. Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	59,860

**Part XII Financial Statements and Reporting**

Check if Schedule O contains a response to any question in this Part XII

		Yes	No
1	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		X
2b	Were the organization's financial statements audited by an independent accountant?		X
2c	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O.		
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		
3b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.		

**SCHEDULE A**  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No. 1545-0047

**2010**

Open to Public Inspection

Name of the organization

**GOOD HEALTH CLINIC, INC.**

Employer identification number

**04-3745805**

**Part I Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is: (For lines 1 through 11, check only one box.)

- 1  A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i)**.
- 2  A school described in **section 170(b)(1)(A)(ii)**. (Attach Schedule E.)
- 3  A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii)**.
- 4  A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii)**. Enter the hospital's name, city, and state: .....
- 5  An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv)**. (Complete Part II.)
- 6  A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v)**.
- 7  An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 8  A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)
- 9  An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2)**. (Complete Part III.)
- 10  An organization organized and operated exclusively to test for public safety. See **section 509(a)(4)**.
- 11  An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2). See **section 509(a)(3)**. Check the box that describes the type of supporting organization and complete lines 11e through 11h.
  - a  Type I    b  Type II    c  Type III—Functionally integrated    d  Type III—Other
- e  By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2).
- f  If the organization received a written determination from the IRS that it is a Type I, Type II, or Type III supporting organization, check this box
- g Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?
  - (i) A person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the supported organization?
  - (ii) A family member of a person described in (i) above?
  - (iii) A 35% controlled entity of a person described in (i) or (ii) above?

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		

h Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1–9 above or IRC section (see instructions))	(iv) Is the organization in col. (i) listed in your governing document?		(v) Did you notify the organization in col. (i) of your support?		(vi) Is the organization in col. (i) organized in the U.S.?		(vii) Amount of support
			Yes	No	Yes	No	Yes	No	
(A)									
(B)									
(C)									
(D)									
(E)									
<b>Total</b>									

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule A (Form 990 or 990-EZ) 2010

**Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**  
 (Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 <b>Total.</b> Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 <b>Public support.</b> Subtract line 5 from line 4						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
11 <b>Total support.</b> Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	

13 **First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here**

**Section C. Computation of Public Support Percentage**

14 Public support percentage for 2010 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2009 Schedule A, Part II, line 14	15	%
16a <b>33 1/3% support test—2010.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <input type="checkbox"/>		
b <b>33 1/3% support test—2009.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <input type="checkbox"/>		
17a <b>10%-facts-and-circumstances test—2010.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization <input type="checkbox"/>		
b <b>10%-facts-and-circumstances test—2009.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part IV how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization <input type="checkbox"/>		
18 <b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions <input type="checkbox"/>		

**Part III Support Schedule for Organizations Described in Section 509(a)(2)**

(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 <b>Total.</b> Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 <b>Public support</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ▶	(a) 2006	(b) 2007	(c) 2008	(d) 2009	(e) 2010	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 <b>Total support.</b> (Add lines 9, 10c, 11, and 12.)						
14 <b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> <input type="checkbox"/>						

**Section C. Computation of Public Support Percentage**

15 Public support percentage for 2010 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	%
16 Public support percentage from 2009 Schedule A, Part III, line 15	<b>16</b>	%

**Section D. Computation of Investment Income Percentage**

17 Investment income percentage for 2010 (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	%
18 Investment income percentage from 2009 Schedule A, Part III, line 17	<b>18</b>	%

- 19a **33 1/3% support tests—2010.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization
- b **33 1/3% support tests—2009.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization
- 20 **Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions

**Part IV Supplemental Information.** Complete this part to provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

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**Schedule B**  
 (Form 990, 990-EZ,  
 or 990-PF)  
 Department of the Treasury  
 Internal Revenue Service

**Schedule of Contributors**

OMB No. 1545-0047

▶ Attach to Form 990, 990-EZ, or 990-PF.

**2010**

<b>Name of the organization</b> <b>GOOD HEALTH CLINIC, INC.</b>	<b>Employer identification number</b> <b>04-3745805</b>
--	--

Organization type (check one):

- |                    |   |
|--------------------|---|
| <b>Filers of:</b>  | <b>Section:</b>   |
| Form 990 or 990-EZ | <input checked="" type="checkbox"/> 501(c)( <b>3</b> ) (enter number) organization                        |
|                    | <input type="checkbox"/> 4947(a)(1) nonexempt charitable trust <b>not</b> treated as a private foundation |
|                    | <input type="checkbox"/> 527 political organization   |
| Form 990-PF        | <input type="checkbox"/> 501(c)(3) exempt private foundation  |
|                    | <input type="checkbox"/> 4947(a)(1) nonexempt charitable trust treated as a private foundation            |
|                    | <input type="checkbox"/> 501(c)(3) taxable private foundation   |

Check if your organization is covered by the **General Rule** or a **Special Rule**.

**Note.** Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

**General Rule**

- For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II.

**Special Rules**

- For a section 501(c)(3) organization filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), and received from any one contributor, during the year, a contribution of the greater of (1) \$5,000 or (2) 2% of the amount on (i) Form 990, Part VIII, line 1h or (ii) Form 990-EZ, line 1. Complete Parts I and II.
- For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, aggregate contributions of more than \$1,000 for use exclusively for religious, charitable, scientific, literary, or educational purposes, or the prevention of cruelty to children or animals. Complete Parts I, II, and III.
- For a section 501(c)(7), (8), or (10) organization filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions for use exclusively for religious, charitable, etc., purposes, but these contributions did not aggregate to more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an exclusively religious, charitable, etc., purpose. Do not complete any of the parts unless the **General Rule** applies to this organization because it received nonexclusively religious, charitable, etc., contributions of \$5,000 or more during the year ..... ▶ \$ .....

**Caution.** An organization that is not covered by the General Rule and/or the Special Rules does not file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2 of its Form 990, or check the box on line H of its Form 990-EZ, or on line 2 of its Form 990-PF, to certify that it does not meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization <b>GOOD HEALTH CLINIC, INC.</b>	Employer identification number <b>04-3745805</b>
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**Part I Contributors (see instructions)**

(a) No.	(b) Name, address, and ZIP + 4	(c) Aggregate contributions	(d) Type of contribution
1	<b>ROBERT GINTEL</b> ..... .....	\$ 5,000	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
2	<b>OTHER CONTRIBUTIONS LESS THAN \$5,000</b> ..... .....	\$ 12,911	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
3	<b>BAPTIST HEALTH SOUTH FLORIDA</b> ..... .....	\$ 106,250	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	..... ..... .....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	..... ..... .....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)
	..... ..... .....	\$ .....	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II if there is a noncash contribution.)

SCHEDULE D (Form 990)

Department of the Treasury Internal Revenue Service

Supplemental Financial Statements

Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.

Attach to Form 990. See separate instructions.

OMB No. 1545-0047

2010

Open to Public Inspection

Name of the organization

Employer identification number

GOOD HEALTH CLINIC, INC.

04-3745805

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 1 Total number at end of year, 2 Aggregate contributions to (during year), 3 Aggregate grants from (during year), 4 Aggregate value at end of year, 5 Did the organization inform all donors... Yes No, 6 Did the organization inform all grantees... Yes No.

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution..., 3 Number of conservation easements modified..., 4 Number of states where property subject to conservation easement is located, 5 Does the organization have a written policy..., 6 Staff and volunteer hours devoted to monitoring..., 7 Amount of expenses incurred in monitoring..., 8 Does each conservation easement reported on line 2(d) above satisfy the requirements..., 9 In Part XIV, describe how the organization reports conservation easements...

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

Table with 2 columns: \$, \$, \$, \$, \$, \$. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIV, the text of the footnote to its financial statements that describes these items. b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenues included in Form 990, Part VIII, line 1 (ii) Assets included in Form 990, Part X 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenues included in Form 990, Part VIII, line 1 b Assets included in Form 990, Part X

**Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)**

3 Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):

- a  Public exhibition
- b  Scholarly research
- c  Preservation for future generations
- d  Loan or exchange programs
- e  Other .....

4 Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIV.

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?  Yes  No

**Part IV Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.**

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?  Yes  No

b If "Yes," explain the arrangement in Part XIV and complete the following table:

- c Beginning balance .....
- d Additions during the year .....
- e Distributions during the year .....
- f Ending balance .....

	Amount
1c	
1d	
1e	
1f	

2a Did the organization include an amount on Form 990, Part X, line 21?  Yes  No

b If "Yes," explain the arrangement in Part XIV.

**Part V Endowment Funds. Complete if organization answered "Yes" to Form 990, Part IV, line 10.**

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance .....					
b Contributions .....					
c Net investment earnings, gains, and losses .....					
d Grants or scholarships .....					
e Other expenditures for facilities and programs .....					
f Administrative expenses .....					
g End of year balance .....					

2 Provide the estimated percentage of the year end balance held as:

- a Board designated or quasi-endowment ▶ ..... %
- b Permanent endowment ▶ ..... %
- c Term endowment ▶ ..... %

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

- (i) unrelated organizations .....
- (ii) related organizations .....

	Yes	No
3a(i)		
3a(ii)		
3b		

b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R? .....

4 Describe in Part XIV the intended uses of the organization's endowment funds.

**Part VI Land, Buildings, and Equipment. See Form 990, Part X, line 10.**

Description of investment	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land .....				
b Buildings .....				
c Leasehold improvements .....				
d Equipment .....	37,353		36,885	468
e Other .....				
<b>Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).)</b> ▶				<b>468</b>

**Part VII Investments—Other Securities.** See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1) Financial derivatives		
(2) Closely-held equity interests		
(3) Other		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(I)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.)		

**Part VIII Investments—Program Related.** See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation: Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 13.)		

**Part IX Other Assets.** See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.)	

**Part X Other Liabilities.** See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Amount
(1) Federal income taxes	
(2) DEFERRED REVENUE	1,500
(3) DUE TO SUB-LESSEE	1,005
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.)	<b>2,505</b>

2. FIN 48 (ASC 740) Footnote. In Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740).

**Part XI Reconciliation of Change in Net Assets from Form 990 to Audited Financial Statements**

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	178,092
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	208,344
3	Excess or (deficit) for the year. Subtract line 2 from line 1	3	-30,252
4	Net unrealized gains (losses) on investments	4	
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV.)	8	
9	Total adjustments (net). Add lines 4 through 8	9	
10	Excess or (deficit) for the year per audited financial statements. Combine lines 3 and 9	10	-30,252

**Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return**

1	Total revenue, gains, and other support per audited financial statements	1	178,092
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
a	Net unrealized gains on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIV.)	2d	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	178,092
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIV.)	4b	
c	Add lines 4a and 4b	4c	
5	Total revenue. Add lines 3 and 4c. (This must equal Form 990, Part I, line 12.)	5	178,092

**Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return**

1	Total expenses and losses per audited financial statements	1	208,344
2	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIV.)	2d	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	208,344
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIV.)	4b	
c	Add lines 4a and 4b	4c	
5	Total expenses. Add lines 3 and 4c. (This must equal Form 990, Part I, line 18.)	5	208,344

**Part XIV Supplemental Information**

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9; Part III, lines 1a and 4; Part IV, lines 1b and 2b; Part V, line 4; Part X, line 2; Part XI, line 8; Part XII, lines 2d and 4b; and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

SCHEDULE O  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Name of the organization

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on  
Form 990 or 990-EZ or to provide any additional information.  
▶ Attach to Form 990 or 990-EZ.

OMB No. 1545-0047

2010

Open to Public  
Inspection

GOOD HEALTH CLINIC, INC.

Employer identification number  
04-3745805

Form 990, Part VI, Line 11b - Organization's Process to Review Form 990  
TREASURER, WHO IS A PRACTICING CPA, PERFORMS INITIAL REVIEW OF TAX RETURN  
AND THEN PROVIDES RETURN TO THE BOARD OF DIRECTORS FOR THEIR REVIEW AND  
ACCEPTANCE.

Form 990, Part VI, Line 12c - Enforcement of Conflicts Policy  
REVIEWED ANNUALLY OR WHENEVER NEW BOARD MEMBER JOINS OR SIGNIFICANT SOURCE  
OF FUNDING IS PROCURED.

Form 990, Part VI, Line 15a - Compensation Process for Top Official  
DETERMINED BY BOARD OF DIRECTORS

Form 990, Part VI, Line 15b - Compensation Process for Officers  
APPROVED BU BOARD OF DIRECTORS

Form 990, Part VI, Line 19 - Governing Documents Disclosure Explanation  
TAX RETURNS ARE AVAILABLE ON GUIDESTAR.COM AND ALL OTHER DOCUMENTS ARE MADE  
AVAILABLE UPON REQUEST.



**Federal Statements**

Form 990, Part IX, Line 24f - All Other Expenses

Description	Total Expenses	Program Service	Management & General	Fund Raising
CLINIC SUPPLIES	\$ 2,243	2,131	112	
INSURANCE	2,189		2,189	
DUES AND SUBSCRIPTIONS	1,655	1,655		
SOFTWARE AND SOFTWARE SUB	1,149	1,034	70	45
LICENSES AND PERMITS	827	827		
REPAIRS	464	371	93	
Total	\$ 8,527	\$ 6,018	\$ 2,464	\$ 45



INTERNAL REVENUE SERVICE  
P. O. BOX 2508  
CINCINNATI, OH 45201

DEPARTMENT OF THE TREASURY

Date: SEP 17 2003

GOOD HEALTH CLINIC, INC.  
C/O SANFORD L. YANKOW, M.D.  
91555 OVERSEAS HWY, SUITE 2  
TAVERNIER, FL 33070

Employer Identification Number:  
04-3745805  
DLN:  
17053122014023  
Contact Person:  
JOHN M WHITE ID# 52118  
Contact Telephone Number:  
(877) 829-5500  
Accounting Period Ending:  
December 31  
Form 990 Required:  
Yes  
Addendum Applies:  
Yes

Dear Applicant:

Based on information supplied, and assuming your operations will be as stated in your application for recognition of exemption, we have determined you are exempt from federal income tax under section 501(a) of the Internal Revenue Code as an organization described in section 501(c)(3).

We have further determined that you are not a private foundation within the meaning of section 509(a) of the Code, because you are an organization described in sections 509(a)(1) and 170(b)(1)(A)(iii).

If your sources of support, or your purposes, character, or method of operation change, please let us know so we can consider the effect of the change on your exempt status and foundation status. In the case of an amendment to your organizational document or bylaws, please send us a copy of the amended document or bylaws. Also, you should inform us of all changes in your name or address.

As of January 1, 1984, you are liable for taxes under the Federal Insurance Contributions Act (social security taxes) on remuneration of \$100 or more you pay to each of your employees during a calendar year. You are not liable for the tax imposed under the Federal Unemployment Tax Act (FUTA).

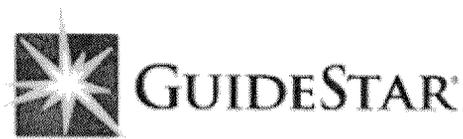
Since you are not a private foundation, you are not subject to the excise taxes under Chapter 42 of the Code. However, if you are involved in an excess benefit transaction, that transaction might be subject to the excise taxes of section 4958. Additionally, you are not automatically exempt from other federal excise taxes. If you have any questions about excise, employment, or other federal taxes, please contact your key district office.

Grantors and contributors may rely on this determination unless the Internal Revenue Service publishes notice to the contrary. However, if you lose your section 509(a)(1) status, a grantor or contributor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act, or the substantial or material change on the

Letter 947 (DO/CG)

J - Good Health Clinic  
501 C 3 Status





Category: Health Care Facilities and Programs

# GOOD HEALTH CLINIC INC

[Donate Now](#)

Tavernier, FL

## GUIDESTAR QUICK VIEW *Everything you need to know...*

[Print Report](#)

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[Tweet](#) 0

### GOOD HEALTH CLINIC INC

Physical Address: **Tavernier, FL 33070**

EIN: **04-3745805**



**GuideStar Seal**

Organization does not have a GuideStar Exchange Seal



**Registered with IRS**

Legitimacy information is available



**Financial Data**

Annual Revenue and Expense data reported



**Forms 990**

2010, 2009, and 2008 Forms 990 filed with the IRS



**Mission Objectives**

Mission Statement is available



**Impact Statement**

Impact Statement is *not* available



No Personal Reviews available

### Legitimacy Information

- This organization is registered with the IRS.

[Summary](#)

[Financial](#)

[Forms 990 & Docs](#)

[People](#)

[Program & Help](#)

[News](#)

J - Good Health Clinic  
GuideStar Printout pg 1 of 3



- This organization is required to file an IRS Form 990 or 990-EZ.

Institutional funders should note that an organization's inclusion on GuideStar.org does not satisfy IRS Rev. Proc. 2011-33 for identifying supporting organizations.

*Learn more about GuideStar Charity: Check, the only pre-grant due diligence tool that is 100% compliant with IRS Rev. Proc 2011-33.*

## Forms 990 from IRS

Login or register to view Forms 990 for 2010, 2009, and 2008.

[Subscribe Now](#)

## Annual Revenue & Expenses

Fiscal Year Starting: **Jan 01, 2008**  
 Fiscal Year Ending: **Dec 31, 2008**

### Revenue

**Total Revenue**                      **\$190,424**

### Expenses

**Total Expenses**                      **\$163,018**

*Is this information up-to-date?  
 Claim your report and update your  
 GuideStar Exchange profile today!*

[Subscribe Now](#)

Report Powered By:  


## Basic Organization Information

GOOD HEALTH CLINIC INC

**Physical Address:** Tavernier, FL 33070  
**EIN:** 04-3745805  
**NTEE Category:** E Health—General & Rehabilitative  
 E30 (Health Treatment Facilities  
 (Primarily Outpatient))  
**Year Founded:** 2003  
**Ruling Year:** 2003

Login or register to see this organization's full address, contact information, and more!

## Mission Statement

A FREE CLINIC PROVING SECONDARY AND TERTIARY HEALTHCARE TO THE INDIGENT AND UNINSURED RESIDENTS OF THE UPPER KEYS OF FLORIDA.

## Expert Reviews

There are no Expert Reviews for this organization. Learn more about [TakeAction@GuideStar](mailto:TakeAction@GuideStar).

## Impact Statement

This organization has not provided an impact statement.

## Personal Reviews

There are no reviews for this organization.

[Write a Review](#)                      Powered by 

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GUIDESTAR  
Nonprofit Report

Generated on April 16, 2012, at 4:32 PM EDT

GOOD HEALTH CLINIC INC

Also Known As:  
91555 Overseas Hwy , % Sanford L Yankow Md  
Tavernier, FL 33070

*Institutional funders should note that an organization's inclusion on guidestar.org does not satisfy IRS Rev. Proc. 2011-33 for verifying charitable status and identifying supporting organizations.*

Contact Information

GOOD HEALTH CLINIC INC

Also Known As:

Physical Address: Tavernier, FL 33070

[Register for free](#) to see this organization's full address, telephone number, Web site, and more!

At A Glance

Formerly Known As:

Category (NTEE): E Health—General & Rehabilitative /E30 (Health Treatment Facilities (Primarily Outpatient))

Mission Statement

A FREE CLINIC PROVING SECONDARY AND TERTIARY HEALTHCARE TO THE INDIGENT AND UNINSURED RESIDENTS OF THE UPPER KEYS OF FLORIDA.

Impact Statement

This organization has not provided an impact statement.

Background Statement

Financial Data

[FAQs on Financial Data](#) | [Digitizing IRS Form 990 Data](#)

[Login or register](#) to view this information.

Revenue and Expenses

[Login or register](#) to view this information.

Balance Sheet

Subscribe to [GuideStar Premium](#) to view this information, if available.

Forms 990 Received from the IRS 

[Login or register](#) to view this information.

Forms 990 Provided by the Nonprofit

[Login or register](#) to view this information.

Financial Statements

Subscribe to [GuideStar Premium](#) to view this information, if available.

Annual Reports

[Login or register](#) to view this information.

Formation Documents 

Subscribe to [GuideStar Premium](#) to view this information, if available.

Program:

Budoet: --



**2011 / 2012  
MONROE COUNTY BUSINESS TAX RECEIPT  
EXPIRES SEPTEMBER 30, 2012**

RECEIPT# 47162-88349

Business Name: GOOD HEALTH CLINIC INC

Owner Name: YANKOW SANFORD L PRES  
Mailing Address: 91555 OVERSEAS HWY  
Ste 2  
TAVERNIER, FL 33070

Business Location: 91555 OVERSEAS HWY STE 2  
TAVERNIER, FL 33070  
Business Phone: 305-853-1788  
Business Type: MEDICAL OFFICES (CLINIC OFFICE)

**Rooms                      Seats                      Employees                      Machines                      Stalls**

5

STATE LICENSE: ME 17585

For Vending Business Only

Number of Machines:

Vending Type:

Tax Amount	Transfer Fee	Sub-Total	Penalty	Prior Years	Collection Cost	Total Paid
0.00	0.00	0.00	0.00	0.00	0.00	0.00

Paid 302-11-00000264 12/15/2011 0.00

**THIS RECEIPT MUST BE POSTED CONSPICUOUSLY IN YOUR PLACE OF BUSINESS**

THIS BECOMES A TAX RECEIPT  
WHEN VALIDATED

**Danise D. Henriquez, CFC, Tax Collector**  
**PO Box 1129, Key West, FL 33041**

THIS IS ONLY A TAX.  
YOU MUST MEET ALL  
COUNTY AND/OR  
MUNICIPALITY PLANNING  
AND ZONING REQUIREMENTS.

**K - Good Health Clinic  
Monroe County License**





**FLORIDA DEPARTMENT OF AGRICULTURE & CONSUMER SERVICES**  
**COMMISSIONER ADAM H. PUTNAM**

October 25, 2011

Refer To: CH16323

GOOD HEALTH CLINIC, INC.  
ATTN: KIM SOVIA  
91555 OVERSEAS HWY STE 2  
TAVERNIER, FL 33070-2505

RE: GOOD HEALTH CLINIC, INC.  
REGISTRATION#: CH16323  
EXPIRATION DATE: October 16, 2012

Dear Sir or Madam:

The above-named organization/sponsor has complied with the registration requirements of Chapter 496, Florida Statutes, the Solicitation of Contributions Act. A COPY OF THIS LETTER SHOULD BE RETAINED FOR YOUR RECORDS.

Every charitable organization or sponsor which is required to register under s. 496.405 must conspicuously display the registration number issued by the Department and in capital letters the following statement on every printed solicitation, written confirmation, receipt, or reminder of a contribution:

"A COPY OF THE OFFICIAL REGISTRATION AND FINANCIAL INFORMATION MAY BE OBTAINED FROM THE DIVISION OF CONSUMER SERVICES BY CALLING TOLL-FREE (800-435-7352) WITHIN THE STATE. REGISTRATION DOES NOT IMPLY ENDORSEMENT, APPROVAL, OR RECOMMENDATION BY THE STATE."

The Solicitation of Contributions Act requires an annual renewal statement to be filed on or before the date of expiration of the previous registration. The Department will send a renewal package approximately 60 days prior to the date of expiration as shown above.

Thank you for your cooperation. If we may be of further assistance, please contact the Solicitation of Contributions section.

Sincerely,

**Fred Hartsfield**

Fred Hartsfield  
Regulatory Specialist I I  
850-410-3784  
Fax: 850-410-3804  
E-mail: fred.hartsfield@freshfromflorida.com

**M - Good Health Clinic**  
**FL Dept of AG & Consumer Services**



**Good Health Clinic**

---

**From:** <donotreply@sunbiz.org>  
**To:** <goodhealthclinic@comcast.net>  
**Sent:** Thursday, January 05, 2012 4:13 PM  
**Subject:** Sunbiz.org Payment Receipt

Thank you for submitting your payment to **Florida Department of State, Division of Corporations**. This email will serve as confirmation that your payment was received by our office. Your filing will be posted on our website <http://www.sunbiz.org/> within 1-3 business days.

The transaction information is listed below:

**Receipt Number:** 3558237403  
**Transaction Date/Time:** 1/5/2012 3:13:28 PM  
**Card Number:** XXXX XXXX XXXX 1599  
**Card Type:** MasterCard  
**Approval Code:** 624553  
**Payment Amount:** \$61.25  
**Document Number:** N03000001902

*debit Card*



M - Good Health Clinic  
FL Dpt of State, Div of Corporations



CERTIFICATE #: 2508

EXEMPTION #: HCC2339

# State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION  
DIVISION OF HEALTH QUALITY ASSURANCE

## HEALTH CARE CLINIC Certificate of Exemption

This is to confirm GOOD HEALTH CLINIC, INC has affirmed an exempt status according to Section 400.9905(3), Florida Statutes. This Certificate of Exemption is issued by the Agency for Health Care Administration to the holder identified below:

GOOD HEALTH CLINIC  
91555 OVERSEAS HWY  
STE 1  
TAVERNIER, FL 33070

File # 2570  
EFFECTIVE DATE: 03/01/2004

  
Deputy Secretary, Division of Health Quality Assurance

N - Good Health Clinic  
FL Agency for Health Care Admin.





STATE OF FLORIDA  
DEPARTMENT OF HEALTH  
Operating Permit

For: Biomedical Waste - Surgical Center/Walk-in Clinic

Issued To: Good Health Clinic, The  
91555 Overseas Hwy  
2  
Tavernier, FL 33070

Mailed To: The Good Health Clinic  
91555 Overseas Hwy  
Unit 2  
Tavernier, FL 33070

Audit Control: 44-BID-1801616  
Permit Number: 44-64-90249  
County: Monroe  
Issue Date: 09/30/2011  
Amount Paid: 125.00  
Date Paid: 09/13/2011  
Permit Expires On: 10/01/2012

*William C. Sudman*  
Issued By: Monroe County Health Department  
1100 Simonton St  
Ofc 242  
Key West, FL 33040

ORIGINAL - CUSTOMER

(Non-Transferable)

DISPLAY CERTIFICATE IN A CONSPICUOUS PLACE



STATE OF FLORIDA  
DEPARTMENT OF HEALTH  
Operating Permit

For: Biomedical Waste - Surgical Center/Walk-in Clinic

Issued To: Good Health Clinic, The  
91555 Overseas Hwy  
2  
Tavernier, FL 33070

Mailed To: The Good Health Clinic  
91555 Overseas Hwy  
Unit 2  
Tavernier, FL 33070

Audit Control: 44-BID-1801616  
Permit Number: 44-64-90249  
County: Monroe  
Issue Date: 09/30/2011  
Amount Paid: 125.00  
Date Paid: 09/13/2011  
Permit Expires On: 10/01/2012

*William C. Sudman*  
Issued By: Monroe County Health Department  
1100 Simonton St  
Ofc 242  
Key West, FL 33040

N - Good Health Clinic  
Dept. of Health Operating Permit



## **2.3 Probationary Period for New Employees**

GHC monitors and evaluates every new employee's performance for two months to determine whether further employment in a specific position or with GHC is appropriate. For this reason, as a newly hired employee or as a newly rehired employee, you are considered a probationary employee for the first two months of your employment.

This probationary period may be made longer if the Executive Director and Medical Director agree that more time is needed to permit you to reach an acceptable level of work performance. The probationary period is, in other words, an opportunity for you to demonstrate what you can do in the clinic and also for you to learn more about the clinic and the position so that you can decide whether or not to continue. If your performance on the job does not measure up to the clinic's expectations and/or standards, the employment relationship can be terminated by the clinic or by you without blame or stigma towards you and without advanced notice by the clinic.

When you have been working for GHC for almost two months, the Executive Director will conduct a performance evaluation, which may include: an assessment of the work you have been doing; and a review of your initial application/resume to GHC. All of this information is put together to make a decision whether or not you will become a non temporary employee and what sort of work assignments you will receive in the future.

The staff member understands that any employment at GHC is at-will and of indefinite duration, and that GHC may terminate employment at any time, with or without notice and with or without reason. No agreement to the contrary will be recognized.

---

## **3 EMPLOYMENT POLICIES**

### **3.1 Affirmative Action/Equal Opportunity Employment Policy**

In accordance with state and federal guidelines, the Good Health Clinic is an equal opportunity employer. It is our policy to hire the best-qualified applicant for the position, without regard to disability, race, color, ethnicity, religion, gender, sexual orientation, national origin, citizenship status, age, or veteran status.

### **3.2 EQUAL ACCESS**

GHC strives to be a model of equal access and reasonable accommodation for our patients and staff as well as the community at large. Toward this end we provide the following:

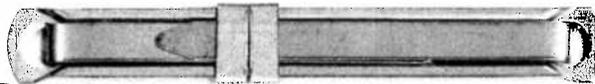
Physical Access: Our facilities, and all of our sponsored events, are accessible to people with all disabilities.

### **3.3 Job Descriptions**

GHC will maintain a written job description for all staff positions, both paid and volunteer. In the event new paid positions are created through expansion or reorganization, written job descriptions will be prepared and then approved by the Executive Director prior to filling the position.

Job descriptions are to be as detailed and explicit as possible. However, employees occasionally may be required to perform related duties not specified in the job description. In the event new major responsibilities or other significant changes occur, the job description will be rewritten to reflect these changes.





Rick Scott  
Governor

H. Frank Farmer, Jr., M.D., Ph.D.  
State Surgeon General

July 18, 2011

Ms. Norma Anderson  
Clinic Coordinator  
Good Health Clinic  
91555 Overseas Hwy  
Tavernier, Florida 33070

Dear Ms. Anderson:

Through this letter I would like to confirm the outcome of the quality assurance visit to the Good Health Clinic on July 15, 2011.

A review of 10 records was conducted to verify that the Eligibility and Patient Referral forms were part of the records, correctly completed and signed as required by the 766.1115 F.S.

As mentioned, all records were accurately prepared and included the above mentioned forms duly completed and signed by the patients and the DOH volunteer.

I would like to express my most sincere appreciation for your continue support and I look forward to continue working with you in years to come. If you have any question, do not hesitate to call me at (305) 336-1280.

Sincerely,

Maria Ortega  
Volunteer Coordinator  
Miami-Dade County Health Department

cc: Dr. Sanford Yankow  
Medical Director  
Good Health Clinic

Rene Ynestroza, MBA, MSMIS  
Sr. Public Health Services Manager



Miami-Dade County Health Department  
8175 NW 12 Street, #300, Miami, Florida 33126  
Tel: (305) 324-2400 Fax: (786) 336-1297  
Website: [www.dadehealth.org](http://www.dadehealth.org)



P - Good Health Clinic  
Dept. of Health Eval/Monitoring





#### Attachment Letter

Please find statistical support documentation that coincides with you response to questions # 11 and 12.

They are:

1. US Census Bureau Quick Facts for Key Largo (1 page)
2. US Census Bureau Quick Facts for Islamorada (1 page)
3. County Health Rankings for Monroe County (1 page)
4. Florida Charts for Monroe County Health Status Summary (5 pages)
5. 2010 Florida Department of Health Statistics & Assessment RE "Prevention Pays" (19 pages)
6. Medical Journal Report: "An Ounce of Prevention Costs, A Pound of Cure" (3 pages)
7. Medical Journal Report: "Diabetes Care & Outcomes: Disparities across Rural America." (4 pages)
8. RxAssist Statistical Report, YTD Comparison 2011-2012



## State &amp; County QuickFacts

**Key Largo CDP, Florida**

<b>People QuickFacts</b>	<b>Key Largo CDP</b>	<b>Florida</b>
Population, 2011 estimate	NA	19,057,542
Population, 2010	10,433	18,801,310
Population, percent change, 2000 to 2010	-12.2%	17.6%
Population, 2000	11,886	15,982,378
Persons under 5 years, percent, 2010	4.0%	5.7%
Persons under 18 years, percent, 2010	16.7%	21.3%
Persons 65 years and over, percent, 2010	18.0%	17.3%
Female persons, percent, 2010	48.1%	51.1%
White persons, percent, 2010 (a)	93.0%	75.0%
Black persons, percent, 2010 (a)	2.3%	16.0%
American Indian and Alaska Native persons, percent, 2010 (a)	0.5%	0.4%
Asian persons, percent, 2010 (a)	0.8%	2.4%
Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2010	1.8%	2.5%
Persons of Hispanic or Latino origin, percent, 2010 (b)	23.7%	22.5%
White persons not Hispanic, percent, 2010	71.3%	57.9%
Living in same house 1 year & over, 2006-2010	85.2%	83.1%
Foreign born persons, percent, 2006-2010	19.7%	19.2%
Language other than English spoken at home, pct age 5+, 2006-2010	26.4%	26.6%
High school graduates, percent of persons age 25+, 2006-2010	89.0%	85.3%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	25.4%	25.9%
Mean travel time to work (minutes), workers age 16+, 2006-2010	27.2	25.7
Housing units, 2010	8,459	8,989,580
Homeownership rate, 2006-2010	71.2%	69.7%
Housing units in multi-unit structures, percent, 2006-2010	15.3%	30.0%
Median value of owner-occupied housing units, 2006-2010	\$451,100	\$205,600
Households, 2006-2010	4,786	7,152,844
Persons per household, 2006-2010	2.41	2.53
Per capita money income in past 12 months (2010 dollars) 2006-2010	\$32,336	\$26,551
Median household income 2006-2010	\$50,582	\$47,661
→ Persons below poverty level, percent, 2006-2010	9.5%	13.8%
<b>Business QuickFacts</b>	<b>Key Largo CDP</b>	<b>Florida</b>
Total number of firms, 2007	2,187	2,009,589
Black-owned firms, percent, 2007	F	9.0%
American Indian- and Alaska Native-owned firms, percent, 2007	F	0.5%



## State &amp; County QuickFacts

**Islamoradaillage of Islands (village), Florida**

<b>People QuickFacts</b>	<b>Islamoradaillage of Islands</b>	<b>Florida</b>
Population, 2011 estimate	NA	19,057,542
Population, 2010	6,119	18,801,310
Population, percent change, 2000 to 2010	-10.6%	17.6%
Population, 2000	6,846	15,982,378
Persons under 5 years, percent, 2010	3.1%	5.7%
Persons under 18 years, percent, 2010	13.9%	21.3%
Persons 65 years and over, percent, 2010	22.0%	17.3%
Female persons, percent, 2010	48.2%	51.1%
White persons, percent, 2010 (a)	96.5%	75.0%
Black persons, percent, 2010 (a)	0.7%	16.0%
American Indian and Alaska Native persons, percent, 2010 (a)	0.4%	0.4%
Asian persons, percent, 2010 (a)	0.6%	2.4%
Native Hawaiian and Other Pacific Islander, percent, 2010 (a)	0.1%	0.1%
Persons reporting two or more races, percent, 2010	1.0%	2.5%
Persons of Hispanic or Latino origin, percent, 2010 (b)	9.6%	22.5%
White persons not Hispanic, percent, 2010	87.8%	57.9%
Living in same house 1 year & over, 2006-2010	92.2%	83.1%
Foreign born persons, percent, 2006-2010	10.6%	19.2%
Language other than English spoken at home, pct age 5+, 2006-2010	12.1%	26.6%
High school graduates, percent of persons age 25+, 2006-2010	95.5%	85.3%
Bachelor's degree or higher, pct of persons age 25+, 2006-2010	26.1%	25.9%
Mean travel time to work (minutes), workers age 16+, 2006-2010	21.4	25.7
Housing units, 2010	5,692	8,989,580
Homeownership rate, 2006-2010	77.7%	69.7%
Housing units in multi-unit structures, percent, 2006-2010	24.5%	30.0%
Median value of owner-occupied housing units, 2006-2010	\$649,900	\$205,600
Households, 2006-2010	2,674	7,152,844
Persons per household, 2006-2010	2.24	2.53
Per capita money income in past 12 months (2010 dollars) 2006-2010	\$46,140	\$26,551
Median household income 2006-2010	\$62,130	\$47,661
Persons below poverty level, percent, 2006-2010	13.4%	13.8%
<b>Business QuickFacts</b>	<b>Islamoradaillage of Islands</b>	<b>Florida</b>
Total number of firms, 2007	1,480	2,009,589
Black-owned firms, percent, 2007	F	9.0%



< Back to map (/app/florida/2012/rankings/outcomes/1)

	Monroe County	Error Margin	National Benchmark*	Florida	Trend	Rank (of 67)
<b>Health Outcomes</b>						<b>18</b>
<b>MORTALITY</b>						<b>32</b>
<u>Premature death</u> <small>(/app/florida/2012/measures/outcomes/1/map)</small>	8,662	7,814-9,510	5,466	7,781		
<b>MORBIDITY</b>						<b>9</b>
<u>Poor or fair health</u> <small>(/app/florida/2012/measures/outcomes/2/map)</small>	14%	9-22%	10%	15%		
<u>Poor physical health days</u> <small>(/app/florida/2012/measures/outcomes/36/map)</small>	3.6	2.7-4.5	2.6	3.5		
<u>Poor mental health days</u> <small>(/app/florida/2012/measures/outcomes/42/map)</small>	3.6	2.7-4.6	2.3	3.6		
<u>Low birthweight</u> <small>(/app/florida/2012/measures/outcomes/37/map)</small>	7.5%	6.8-8.2%	6.0%	8.6%		
<b>Health Factors</b>						<b>7</b>
<b>HEALTH BEHAVIORS</b>						<b>14</b>
<u>Adult smoking</u> <small>(/app/florida/2012/measures/factors/9/map)</small>	23%	17-30%	14%	19%		
<u>Adult obesity</u> <small>(/app/florida/2012/measures/factors/11/map)</small>	20%	17-23%	25%	26%		
<u>Physical inactivity</u> <small>(/app/florida/2012/measures/factors/70/map)</small>	19%	16-21%	21%	24%		
<u>Excessive drinking</u> <small>(/app/florida/2012/measures/factors/49/map)</small>	26%	21-31%	8%	16%		
<u>Motor vehicle crash death rate</u> <small>(/app/florida/2012/measures/factors/39/map)</small>	22	18-26	12	19		
<u>Sexually transmitted infections</u> <small>(/app/florida/2012/measures/factors/45/map)</small>	165		84	398		
<u>Teen birth rate</u> <small>(/app/florida/2012/measures/factors/14/map)</small>	29	26-32	22	44		
<b>CLINICAL CARE</b>						<b>42</b>
→ <u>Uninsured</u> <small>(/app/florida/2012/measures/factors/85/map)</small>	27%	25-29%	11%	25%		
<u>Primary care physicians</u> <small>(/app/florida/2012/measures/factors/4/map)</small>	1,145:1		631:1	983:1		
→ <u>Preventable hospital stays</u> <small>(/app/florida/2012/measures/factors/5/map)</small>	64	58-69	49	64		
→ <u>Diabetic screening</u> <small>(/app/florida/2012/measures/factors/77/map)</small>	77%	71-83%	89%	84%		
→ <u>Mammography screening</u> <small>(/app/florida/2012/measures/factors/59/map)</small>	61%	56-67%	74%	71%		
<b>SOCIAL &amp; ECONOMIC FACTORS</b>						<b>5</b>
<u>High school graduation</u> <small>(/app/florida/2012/measures/factors/21/map)</small>	85%			79%		
<u>Some college</u> <small>(/app/florida/2012/measures/factors/69/map)</small>	59%	55-64%	68%	58%		
<u>Unemployment</u> <small>(/app/florida/2012/measures/factors/23/map)</small>	7.4%		5.4%	11.5%		

Good Health Clinic  
County Health Rankings for Monroe

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## Monroe County, Florida

### County Health Status Summary

Indicator	Year(s)	Rate Type	County Quartile <sup>A</sup> 1=most favorable 4=least favorable	County Rate	State Rate	County Trend <sup>B</sup> (click to view)	Healthy People 2020 Goals <sup>C</sup>
<b>Actual Causes of Death*</b>							
<b>Physical Activity</b>							
Adults who meet moderate physical activity recommendations <sup>1</sup>	2007	Percent	1	42.7%	34.6%		
Adults who meet vigorous physical activity recommendations <sup>1</sup>	2007	Percent	1	34.0%	26.0%		
Adults who engage in no leisure-time physical activity <sup>1</sup>	2002	Percent	1	23.2%	26.4%		32.6%
<b>Overweight and Obesity</b>							
Adults who consume at least five servings of fruits and vegetables a day <sup>1</sup>	2007	Percent	3	24.2%	26.2%		
Adults who are overweight <sup>1</sup>	2010	Percent	2	36.9%	37.8%		
Adults who are obese <sup>1</sup>	2010	Percent	1	17.4%	27.2%		30.6%
<b>Tobacco Use</b>							
Adults who are current smokers <sup>1</sup>	2010	Percent	3	21.1%	17.1%		12%
<b>Socio-Demographics</b>							
Median income (in dollars) <sup>2</sup>	2006-10	Dollars	1	\$53,821	\$47,661		
Residents below 100% poverty <sup>2</sup>	2006-10	Percent	1	10.8%	13.8%		
Unemployment rate <sup>3</sup>	2010	Percent	1	7.4%	11.5%	Worse ↑	
Population that is linguistically isolated <sup>2</sup>	2006-10	Percent	4	5.2%	7.2%		
Population over 25 without high school diploma or equivalency <sup>2</sup>	2006-10	Percent	1	10.2%	14.7%		
<b>Health Status and Access to Care</b>							
Adults who rate their health status as "fair" or "poor" <sup>1</sup>	2010	Percent	1	13.3%	17.1%		
Adults with any type of health care insurance coverage <sup>1</sup>	2010	Percent	3	78.2%	83.0%		
Adults who could not see a dentist in the past year because of cost <sup>1</sup>	2007	Percent	1	16.9%	19.2%		
Adults who received a flu shot in the past year <sup>1</sup>	2010	Percent	2	37.9%	36.5%		
Total licensed family physicians <sup>4</sup>	2008-10	Per 100,000	1	21.4	22.9		
Total licensed dentists <sup>4</sup>	2008-10	Per 100,000	2	45.4	62.7		
Total hospital beds <sup>5</sup>	2008-10	Per 100,000	1	349.9	318.9		



 <b>Monroe County, Florida</b> <b>County Health Status Summary</b>							
Indicator	Year(s)	Rate Type	County Quartile <sup>A</sup> 1=most favorable 4=least favorable	County Rate	State Rate	County Trend <sup>B</sup> (click to view)	Healthy People 2020 Goals <sup>C</sup>
<b>Chronic Diseases</b>							
<b>Coronary Heart Disease</b>							
Coronary heart disease age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	1	79.2	104.5	Better ↓	100.8
Coronary heart disease age-adjusted hospitalization rate <sup>8</sup>	2008-10	Per 100,000	2	368.8	406.7	Better ↓	
<b>Stroke</b>							
Stroke age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	1	21.7	30.5	Better ↓	33.8
Stroke age-adjusted hospitalization rate <sup>8</sup>	2008-10	Per 100,000	1	166.2	265.5	Better ↓	
<b>Heart Failure</b>							
Heart failure age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	2	9.2	7.6	No Trend ↔	
Congestive heart failure age-adjusted hospitalization rate <sup>8</sup>	2008-10	Per 100,000	2	109.0	149.1	Better ↓	
Adults with diagnosed hypertension <sup>1</sup>	2010	Percent	1	33.1%	34.3%		
Adults who have diagnosed high blood cholesterol <sup>1</sup>	2010	Percent	2	36.5%	38.6%		13.5%
Adults who had their cholesterol checked in the past five years <sup>1</sup>	2007	Percent	2	73.4%	73.3%		
<b>Lung Cancer</b>							
Lung cancer age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	1	41.8	46.6	Better ↓	45.5
Lung cancer age-adjusted incidence rate <sup>9</sup>	2006-08	Per 100,000	1	63.3	65.9	No Trend ↔	
<b>Colorectal Cancer</b>							
Colorectal cancer age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	1	12.1	14.3	Better ↓	14.5
Colorectal cancer age-adjusted incidence rate <sup>9</sup>	2006-08	Per 100,000	1	35.7	42.0	Better ↓	
Adults 50 years of age and older who received a sigmoidoscopy or colonoscopy in the past five years <sup>1</sup>	2010	Percent	4	45.1%	56.4%		
Adults 50 years of age and older who received a blood stool test in the past year <sup>1</sup>	2010	Percent	4	9.5%	14.7%		
<b>Breast Cancer</b>							
Breast cancer age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	2	21.3	20.8	No Trend ↔	20.6
Breast cancer age-adj. incidence rate <sup>9</sup>	2006-08	Per 100,000	1	91.1	110.9	Better ↓	
Women 40 years of age and older who received a mammogram in the past year <sup>1</sup>	2010	Percent	3	51.9%	61.9%		



 <b>Monroe County, Florida</b> <b>County Health Status Summary</b>							
Indicator	Year(s)	Rate Type	County Quartile <sup>A</sup> 1=most favorable 4=least favorable	County Rate	State Rate	County Trend <sup>B</sup> (click to view)	Healthy People 2020 Goals <sup>C</sup>
<b>Chronic Diseases (continued)</b>							
<b>Prostate Cancer</b>							
Prostate cancer age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	2	17.1	17.5	No Trend ↔	21.2
Prostate cancer age-adjusted incidence rate <sup>9</sup>	2006-08	Per 100,000	1	72.1	130.8	Better ↓	
<b>Cervical Cancer</b>							
Cervical cancer age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	2	2.8	2.7	No Trend ↔	2.2
Cervical cancer age-adjusted incidence rate <sup>9</sup>	2006-08	Per 100,000	1	6.6	8.9	No Trend ↔	
Women 18 years of age and older who received a Pap test in the past year <sup>1</sup>	2010	Percent	4	50.7%	57.1%		93%
<b>Melanoma</b>							
Melanoma age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	4	4.5	2.8	No Trend ↔	2.4
Melanoma age-adjusted incidence rate <sup>9</sup>	2006-08	Per 100,000	3	20.5	17.6	No Trend ↔	
<b>Chronic Lower Respiratory Diseases</b>							
Chronic lower respiratory diseases (CLRD) age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	1	25.0	37.7	Better ↓	
CLRD age-adjusted hospitalization rate <sup>8</sup>	2008-10	Per 100,000	1	273.5	361.4	Better ↓	50.1
Adults who currently have asthma <sup>1</sup>	2010	Percent	1	5.7%	8.3%		
Asthma age-adjusted hospitalization rate <sup>8</sup>	2008-10	Per 100,000	1	539.9	755.1	No Trend ↔	
<b>Diabetes</b>							
Diabetes age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	1	11.6	19.6	Better ↓	65.8
Diabetes age-adjusted hospitalization rate <sup>8</sup>	2008-10	Per 100,000	1	1202.8	2198.0	No Trend ↔	
Amputation due to diabetes age-adjusted hospitalization rate <sup>8</sup>	2008-10	Per 100,000	1	11.2	24.7	Better ↓	
Adults with diagnosed diabetes <sup>1</sup>	2010	Percent	1	7.4%	10.4%		





## Monroe County, Florida County Health Status Summary

Indicator	Year(s)	Rate Type	County Quartile <sup>A</sup> 1=most favorable 4=least favorable	County Rate	State Rate	County Trend <sup>B</sup> (click to view)	Healthy People 2020 Goals <sup>C</sup>
<b>Communicable &amp; Infectious Diseases</b>							
Vaccine preventable diseases <sup>10</sup>	2008-10	Per 100,000	2	2.6	3.9	No Trend ↔	
HIV cases reported <sup>10</sup>	2008-10	Per 100,000	4	30.6	31.8		
AIDS cases reported <sup>10</sup>	2008-10	Per 100,000	4	44.6	22.3	No Trend ↔	
HIV/AIDS age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	4	10.9	6.5	No Trend ↔	3.7
TB cases reported <sup>10</sup>	2008-10	Per 100,000	4	6.1	4.6	No Trend ↔	1.0
Chlamydia cases reported <sup>10</sup>	2008-10	Per 100,000	1	165.1	387.0	Worse ↑	
Gonorrhea cases reported <sup>10</sup>	2008-10	Per 100,000	1	28.0	113.9	No Trend ↔	
Infectious syphilis cases reported <sup>10</sup>	2008-10	Per 100,000	4	4.8	5.8	No Trend ↔	
<b>Maternal, Infant &amp; Young Child Health</b>							
Early prenatal care (care began 1st trimester) <sup>7, 13</sup>	2008-10	Percent	1	84.0%	78.1%		77.9%
Low birth weight births (births < 2500 grams) <sup>7</sup>	2008-10	Percent	1	6.8%	8.7%	Worse ↑	
Premature births (births < 37 weeks gestation) <sup>7</sup>	2008-10	Percent	3	13.5%	13.9%	Worse ↑	11.4%
Multiple births <sup>7</sup>	2008-10	Percent	1	2.5%	3.2%	No Trend ↔	
Births to teens 15-19 <sup>7</sup>	2008-10	Rate per 1,000	1	22.0	37.0	Better ↓	
Repeat births to mothers 15-19 <sup>7</sup>	2008-10	Percent	2	16.5%	18.4%	No Trend ↔	
Infant death rate <sup>7</sup>	2008-10	Per 1,000 live births	1	5.2	6.9	No Trend ↔	6.0
Neonatal death rate <sup>7</sup>	2008-10	Per 1,000 live births	1	3.3	4.5	No Trend ↔	4.1
Postneonatal death rate <sup>7</sup>	2008-10	Per 1,000 live births	1	1.9	2.4	No Trend ↔	2.0
Fetal death ratio <sup>7</sup>	2008-10	Per 1,000 deliveries	4	8.5	7.2	No Trend ↔	5.6
Kindergarten children fully immunized <sup>11</sup>	2008-10	Percent	3	93.6%	90.8%	Better ↑	

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## Monroe County, Florida

### County Health Status Summary

Indicator	Year(s)	Rate Type	County Quartile <sup>A</sup> 1=most favorable 4=least favorable	County Rate	State Rate	County Trend <sup>B</sup> (click to view)	Healthy People 2020 Goals <sup>C</sup>
<b>Unintentional Injuries</b>							
Unintentional injuries age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	4	66.4	42.7	No Trend ↔↔↔	36.0
Motor vehicle crash age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	3	20.4	14.0	No Trend ↔↔↔	12.4
<b>Social and Physical Environment</b>							
Criminal homicide <sup>12</sup>	2008-10	Per 100,000	4	5.7	5.6	No Trend ↔↔↔	
Domestic violence offenses <sup>12</sup>	2008-10	Per 100,000	3	579.7	608.0	No Trend ↔↔↔	
Adults who currently have asthma <sup>1</sup>	2010	Percent	1	5.7%	8.3%		
Suicide age-adjusted death rate <sup>7</sup>	2008-10	Per 100,000	4	21.5	13.9	No Trend ↔↔↔	10.2

\*Actual causes of death are the major external (nongenetic) factors that contribute to death in the US, first identified by McGinnis and Foege in 1993. These three sets of behaviors each contribute to over 100,000 deaths annually in addition to their impact on morbidity, quality of life, and public health burden.

**Data Sources**

- <sup>1</sup>Florida Department of Health, Bureau of Epidemiology, Florida BRFSS survey
- <sup>2</sup>US Census Bureau
- <sup>3</sup>US Department of Labor, Bureau of Labor Statistics
- <sup>4</sup>Florida Department of Health, Division of Medical Quality Assurance
- <sup>5</sup>Florida Agency for Health Care Administration, Certificate of Need Office
- <sup>6</sup>Florida Department of Health, Office of Health Statistics and Assessment
- <sup>7</sup>Florida Department of Health, Office of Vital Statistics
- <sup>8</sup>Florida Agency for Health Care Administration (AHCA)
- <sup>9</sup>University of Miami (FL) Medical School, Florida Cancer Data System
- <sup>10</sup>Florida Department of Health, Division of Disease Control
- <sup>11</sup>Florida Department of Health, Bureau of Immunization
- <sup>12</sup>Florida Department of Law Enforcement

All Age-Adjusted rates are 3-year rates per 100,000 and are calculated using the 2000 Standard US Population. These rates also use July 1 Florida population estimates from the Florida Legislature, Office of Economic and Demographic Research.

[View ICD Codes for death, cancer, and hospitalization indicators](#)

**<sup>A</sup>County Quartiles**

<b>Most favorable situation</b> 1 (25% of counties)	<b>Average</b> 2 or 3 (50% of counties)	<b>Least favorable situation</b> 4 (25% of counties)
---	---	--

Quartiles in this report allow you to compare health data from one county to another in the state. Quartiles are calculated by ordering an indicator from most favorable to least favorable by county and dividing the list into 4 equal-size groups. In this report, a low quartile number (1) always represents more favorable health situations while fours (4) represent less favorable situations.

**<sup>B</sup>County Trends**

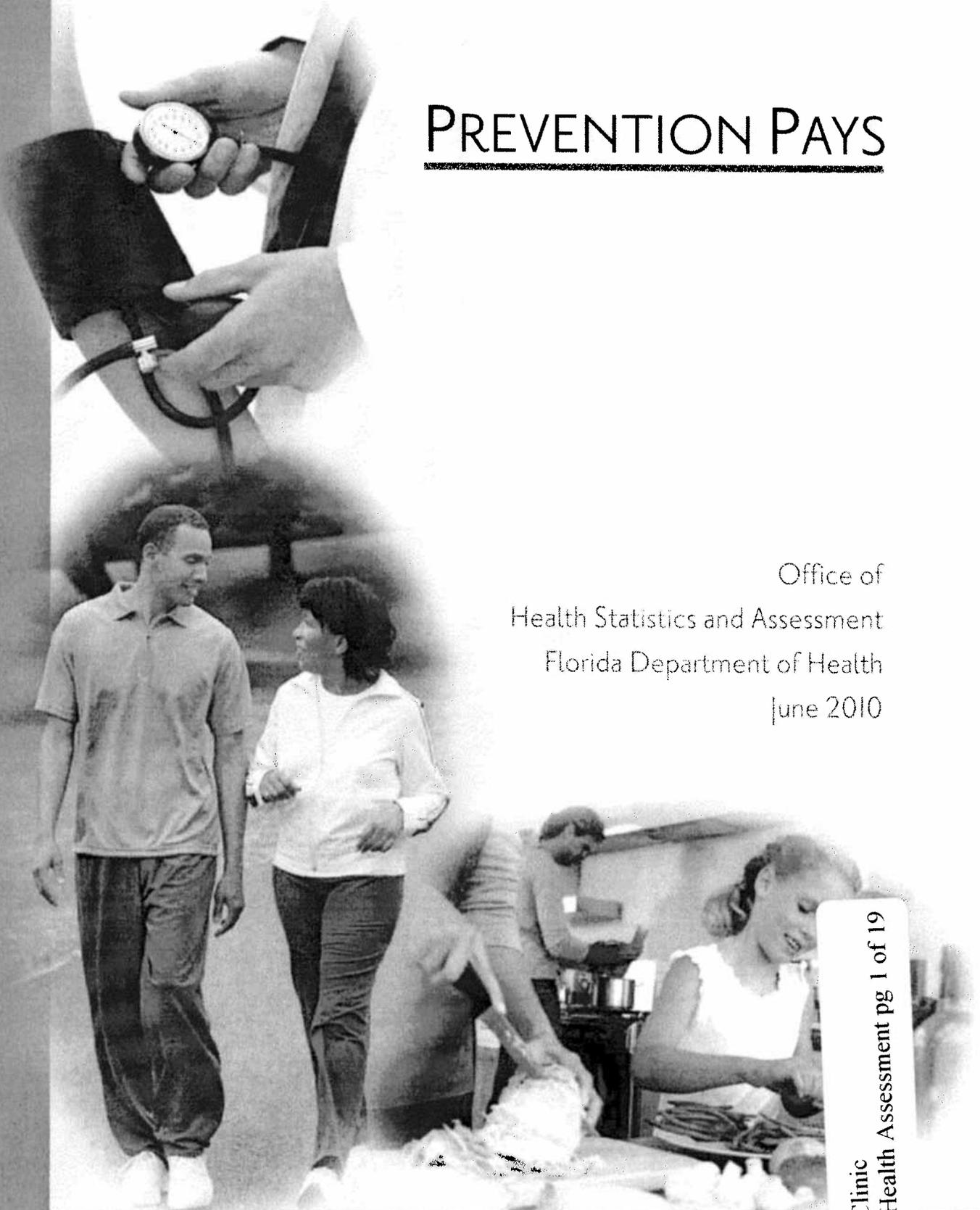
As with rates, there is also random variation in the trend lines of these rates, so that a line that slopes upward may not represent a statistically significant increase, particularly if it is based on small numbers. For that reason, we test statistically to determine whether or not we can be at least 95 percent confident that what appears to be an increase or decrease is real, not just the result of random fluctuation.

Trends only calculated for indicators with 12 or more years of data available.



# PREVENTION PAYS

Office of  
Health Statistics and Assessment  
Florida Department of Health  
June 2010



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2010 FI Dept Health Assessment pg 1 of 19

FLORIDA DEPARTMENT OF  
**HEALTH**



# ACKNOWLEDGMENTS

This report, Prevention Pays, represents the work of countless Florida public health professionals.

Important issues were identified by DOH Division Directors and Program Managers, and relevant citations from the literature were provided by content experts on their staffs.



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## EXECUTIVE SUMMARY

Today, Americans die prematurely from diseases linked largely to preventable causes. In general, they die after many years of unhealthy life, which further contributes to skyrocketing health care costs. Focusing our efforts and resources on prevention is essential to curbing these expenditures and to building healthy communities. In particular:

### **High-Risk Behaviors:**

The major causes of premature death and disability are related to high-risk behaviors, particularly tobacco use, over-eating, and inadequate physical activity. A reduction in these behaviors would not only reduce work and school absenteeism and increase the productivity of Floridians, but also would save millions of dollars in averted health care costs.

### **Injuries:**

Injuries are the leading cause of death among persons between ages 1 and 44 and overall the third leading direct cause of death after heart disease and cancer. Nearly 50 million injuries occur each year, placing a staggering burden on the U.S. health care system. State budgets share this burden through Medicaid, state employee health benefits, health care for the uninsured, child welfare services, and lost tax revenue for the injured and their caregivers.

### **Women's Health:**

In addition to the population-wide benefits to be realized by reducing chronic disease, there are additional long-term benefits related to improving the health of women of child-bearing age. Because healthy mothers have healthy babies, it is important to encourage women in this age group to have sound nutrition and regular physical exercise, to get regular mammograms and pap tests, to reduce sexually transmitted infections, and to reduce unplanned pregnancies.

### **Maternal and Infant Health:**

It is crucial that our babies get the best possible start in life. To reduce the high fiscal and social costs of poor birth and infant outcomes and inadequately diagnosed problems, mothers should get early regular prenatal care, including WIC (the federal supplemental nutrition program for women, infants and children); babies should be breastfed from the start and screened for metabolic problems; and, children found to have developmental delays should receive special services from birth through age three.

### **Adolescent and Adult Health:**

Adolescents put themselves at risk through a variety of behaviors, including those that lead to STDs and HIV. Adults put themselves at risk by lifestyle choices begun in adolescence and increase their risk when they do not take advantage of readily available screening for cancer, diabetes, hypertension and high cholesterol. The cost treating advanced cancers, heart attacks, strokes and complications of diabetes far outweighs the cost of prevention and early treatment.

### **Environmental Health:**

Providing safe food and water, breathing clean air and playing in clean recreational water are essential if we are to reduce illness-related costs and improve overall well-being.

During this time of economic uncertainty, there are unlikely to be budget increases to meet burgeoning health care needs. It is even more important now to use scarce health resources efficiently and effectively, by focusing our efforts on prevention.



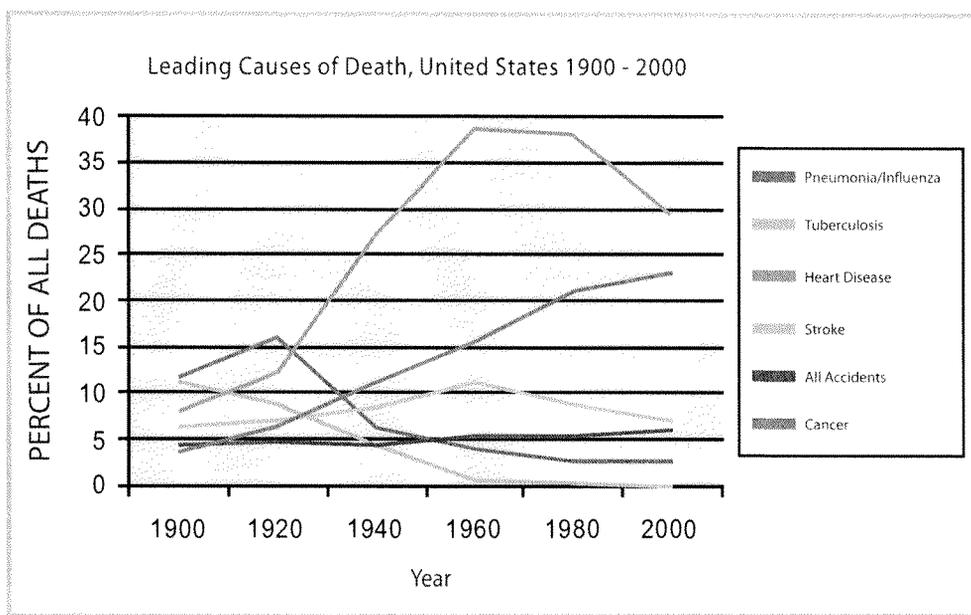
The bottom line is simple: implementing proven preventive strategies not only has a substantial positive impact on the health and well-being of our citizens, but it also results in a positive return on our health care investment. It is essential to remember this as we move forward.

## INTRODUCTION: THE NEED FOR PREVENTION

Today, Americans die prematurely from diseases linked largely to preventable causes. In general, they die after many years of unhealthy life, which further contributes to skyrocketing health care costs. Focusing our efforts and resources on prevention is essential to curbing these expenditures and to building healthy communities.

### **Americans are now more likely to die from consequences of chronic disease.**

In the past century, chronic diseases have overtaken communicable diseases as the leading causes of death, due both to advances in the control of infectious disease and to lengthened life spans. Although overall life expectancy continues a long-term upward trend, gains in the United States continue to lag behind other countries such as Canada and Japan.



Florida mirrors the United States in the shift from communicable diseases to chronic diseases as the leading causes of death. Chronic diseases – heart disease, stroke, cancer, diabetes, chronic respiratory disease – now comprise 62.5% of all deaths in Florida, compared to less than 20% 70 years ago.



## **Tobacco use, poor diet, and physical inactivity are the leading 'actual' causes of death in America.**

Chronic diseases develop over an extended period of time, often after prolonged exposure to one or more risky behaviors, particularly tobacco use, poor nutrition and insufficient physical activity. In a now-famous 1993 study of causes of death, these three behaviors were dubbed the leading 'actual' causes of death, because they are underlying factors in almost half of all deaths in the United States.<sup>1</sup> The 2004 updated version of that study finds that these behaviors, plus alcohol consumption, continue to account for nearly 40% of all deaths, with physical activity and diet quickly overtaking tobacco as the leading cause of death.<sup>2</sup>

Declines in tobacco use among American adults and adolescents have stalled while rates of obesity continue to skyrocket. The United States leads all other industrialized countries in the rate of adult obesity, increasing the risk for related health care problems and increased costs in years to come. Florida fares somewhat better, with improvement in tobacco use, but growing rates of obesity.

According to the 2007 Behavioral Risk Factor Surveillance Survey (BRFSS), one out of every five adult Floridians smokes. Prevalence of current smoking decreased from 22% of adults in 1998 to 18% in this most recent survey. Current cigarette use among high school students also declined from 1998 to 2007, but cigar and flavored tobacco smoking use are on the increase.<sup>3</sup> Over 62% of adult Floridians are overweight, and more than a third of that group qualifies as obese. Since 1986, the percentage of Floridians who are obese has doubled.

## **Health care related costs have skyrocketed.**

The United States spends a disproportionate share of its gross domestic product (GDP) on health care expenditures relative to other industrialized countries. Healthcare spending ballooned to over 16.7% of the nation's gross domestic product by 2007.<sup>4</sup> By 2015, health expenditures are expected to surpass \$4 trillion nationwide.<sup>5</sup> Since 1988, only 3% (\$9.1 billion) of those expenditures have been spent on public health.<sup>6</sup> ←

Florida's health care expenditures have also risen over the last two decades and healthcare is now a \$100+ billion industry. In 2007, personal health care expenditures in Florida reached \$119.7 billion, up from \$112.3 billion in 2006 (an increase of 6.6%), and \$104.5 billion in 2005 (an increase of 7.5%).<sup>7</sup> The consequences of increased smoking and obesity among Floridians of all ages can only lead to an explosion of chronic disease and its associated costs, both in terms of health care and of lost productivity.

It is not just health-related costs that will increase, however. The behaviors linked to serious health problems have also been found to contribute to many educational and social problems that confront the nation, including failure to complete high school, unemployment, and crime.<sup>8</sup>

## **Funding prevention is our best strategy.**

Providing adequate resources for core public health activities is essential to mitigating the effects of chronic disease on an increasingly aging and burgeoning population.<sup>9</sup> A strong public health system provides a range of services designed to decrease the onset and severity of chronic diseases, thereby improving the health of public. Simultaneously, it ensures timely emergency preparedness during disasters; safe food, air and water supplies; control of infectious disease outbreaks; and prevention of serious childhood illnesses. State and local health departments serve as the backbone of the public health system around which other community, religious, educational, and civic organizations build their efforts.<sup>10</sup> By utilizing evidence-based public health intervention and modifying the built environment to promote physical activity and access to healthy food, we can increase longevity, improve the quality of life, and be more productive.

This report summarizes current research on the value of prevention, and highlights potential benefits – in reduced health care costs, improved quality of life, decreased absenteeism and higher productivity – that can be reaped by focusing our resources on prevention.



# HIGH-RISK BEHAVIORS

The major causes of premature death and disability are related to high-risk behaviors, particularly tobacco use, over-eating, and inadequate physical activity. A reduction in these behaviors would not only reduce work and school absenteeism and thereby increase the productivity of Floridians, but also would save millions of dollars in averted health care costs.

## **Smoking**

Smoking is the leading cause of preventable death and disability in the United States.<sup>11</sup> Since smoking harms nearly every organ of the body, quitting has immediate and long-term health benefits for the smoker and family members. Cigarette-related lung cancer continues to be the leading cause of cancer death for men and women in Florida, in the United States and throughout the world.<sup>12</sup>

- Productivity losses in Florida from lives shortened by smoking totaled an estimated \$6.47 billion in 2008. This is in addition to sick days, disability, and productivity declines related to tobacco use.<sup>13</sup>
- National estimates show that every adult smoker who quits smoking reduces his lifetime health care costs by approximately \$9,500 (in 2004 dollars).<sup>14</sup>
- For Florida, this means that for every 1% decline in the smoking rate – 142,000 fewer smokers – there is \$1.3 billion savings in health care costs alone.<sup>15</sup>

## **Obesity: Nutrition and Physical Activity**

The major causes of obesity are poor diet and physical inactivity. Taken together, they are the second leading preventable causes of death in the United States.<sup>16</sup> Being overweight causes or aggravates a variety of conditions, including adult-onset diabetes, high blood pressure, high cholesterol, coronary heart disease, stroke, osteoarthritis, reproductive complications and some cancers. Obesity is also growing among the young. This increase is a public health concern, because most obese adolescents continue their obesity into adulthood with serious risk for chronic disease. Focus should therefore be on prevention programs that promote healthier lifestyles and physical activity.

- Florida is the 10th heaviest state in the nation; nearly two-thirds of all adults in Florida are overweight or obese, a figure which has increased by 29% over the last 15 years.
- The Centers for Disease Control and Prevention estimate that obesity is associated with 385,000 deaths annually in the United States.<sup>17</sup>
- Obesity in adolescence has increased significantly over the past 30-40 years. A recent international comparison study showed that the highest obesity rates in the world occurred in U.S. adolescents (12.6% in 13 year old boys, 10.8% in girls and 13.9% in 15 year old boys, 15.1% in girls).<sup>18</sup>
- It is estimated that the 2008 medical costs of overweight and obesity were \$147 billion nationally in the U.S. up from \$78 billion only 10 years earlier.<sup>19</sup>
- The average annual health care costs for adults who are obese are estimated to be 36% higher than for non-obese individuals.<sup>20</sup>



## INJURIES

Injuries are the leading cause of death among persons between ages 1 and 44 and overall the third leading direct cause of death after heart disease and cancer. Nearly 50 million injuries occur each year, placing a staggering burden on the U.S. health care system. State budgets share this burden through Medicaid, employee health benefits, health care for the uninsured, child welfare services, and lost tax revenue for the injured and their caregivers.

Florida's injury death rates are 17% higher than the national average, claiming 13,062 lives and accounting for 8% of all deaths to Florida residents.<sup>21</sup>

The misperception of injuries as simply accidents undermines its seriousness as a public health threat. Injuries are as understandable, predictable, and preventable as many other health problems. Effective interventions include the use of seat belts and bicycle helmets, laws establishing lower legal blood alcohol levels (0.08 rather than 0.10) for drunk driving, and residential smoke alarm and fire safety education programs. Helmeted bicycle riders are over 33 times less likely to sustain a major head injury than non-helmeted riders.<sup>22</sup>

- According to the Centers for Disease Control (CDC), injuries cost an estimated \$406 billion per year nationally in medical expenses and lost productivity.<sup>23</sup>
- The prevention of injuries would preserve more years of potential life before age 65 than the prevention of heart disease and cancer combined.<sup>24</sup>

## WOMEN'S HEALTH

In addition to the population-wide benefits to be realized by reducing chronic disease, there are additional long-term benefits related to improving the health of women of child-bearing age. Because healthy mothers have healthy babies, it is important to encourage sound nutrition and regular physical exercise, promote regular mammograms and pap tests, reduce sexually transmitted infections, and reduce unplanned pregnancies.

### **Cancers of the Reproductive System**

Cancer is the second leading cause of death for women in the United States and in Florida. Breast and cervical screening prevent premature deaths by detecting and treating these cancers early.

- 3,700 lives could be saved annually if 90% of women age 40 and older were screened with mammography every two years.<sup>25</sup>
- A mammogram every two years extends life for women aged 65 or older at a cost of about \$36,924 per year of life saved.<sup>26</sup>
- Pap screening every three years extends life at a cost of about \$5,392 per year of life saved.<sup>27</sup>

### **Unintended and Mistimed Pregnancies**

Nearly half of all pregnancies in Florida are unintended or mistimed.<sup>28</sup> For a first baby, this means women may not be in optimal health to deliver a healthy baby. For subsequent pregnancies, this may mean too-short time



period between births. In either case, there is increased risk of miscarriage, stillbirth, prematurity, birth defects and infant death. Well-woman care provides increased opportunities for preconception counseling and screening before women become pregnant. Interconception care can address risks identified by a previous adverse pregnancy outcome.

- Every \$1 spent on preconception care saves \$1.60 in maternal and infant care costs.<sup>29</sup>
- Women enrolled in preconception care have fewer congenital malformations (4.2% versus 13.5%) than women who do not get preconception care and their babies are 50% less likely to require neonatal intensive care unit stays.<sup>30</sup>
- In the United States, it is estimated that voluntary contraceptive services for young and low-income women prevent 1.94 million unintended pregnancies annually, including almost 400,000 teen pregnancies.<sup>31</sup>
- In the United States, it is estimated that contraceptive services would reduce abortion every year by two-thirds.<sup>32</sup>
- In 2006, approximately 43,000 Florida pregnancies were prevented as a direct result of services provided by the Florida Department of Health's statewide family planning program. If even half of these had resulted in a live birth, it would have cost Florida over \$220 million in prenatal care, delivery, postpartum care and one year of infant care costs; about \$205 million of this would have been in Medicaid expenditures.<sup>33</sup>

## MATERNAL AND INFANT HEALTH

It is crucial that our babies get the best possible start in life. To reduce the high fiscal and social costs of poor birth and infant outcomes and inadequately diagnosed problems, mothers should get early regular prenatal care, including WIC; babies should be breastfed from the start and screened for metabolic problems; and children found to have developmental delays should receive special services from birth through age three.

### **Prenatal Care**

Prenatal care affects the health of the mother and her unborn child by improving the health status of the mother and reducing the possibility of intrauterine infection and preterm birth or placental transmission of disease. Prenatal care allows for the infant's optimal health and development inside of the womb. Providing Regional Perinatal Intensive Care Centers (RPICCs) for high-risk pregnant women and their newborns, as Florida does, prevents problems and costs related to prematurity and very low birth weight.

- From 1995 to 2002, women who had no prenatal care consistently had approximately five times the risk of infant death as women who received prenatal care during any trimester.<sup>34</sup>
- In 2005, preterm birth cost the United States an estimated annual cost of \$51,600 for every infant born preterm, totaling approximately \$26.2 billion.<sup>35</sup>
- Raising birth weight by even half a pound for a low birth weight infant saves an estimated average of more than \$28,000 in first-year medical costs alone.<sup>36</sup>
- In 2007 and 2008, Florida served over 11,000 high-risk pregnant women through its Regional Perinatal Intensive Care Centers, averting an estimated \$30 million in neonatal intensive care costs.<sup>37</sup>



## **Special Supplemental Nutrition Program for Women, Infants and Children (WIC)**

The Special Supplemental Food Program for Women, Infants, and Children (WIC) is a federal nutrition program that provides nutritious foods, nutrition education, breastfeeding education, and access to health care to low income pregnant women, new mothers, infants and children at nutritional risk.

- It is estimated that every dollar spent on WIC results in savings of between \$1.77 and \$3.13 in Medicaid cost for newborns and their mothers.<sup>38</sup>
- Participation in the WIC and Food Stamp Programs reduces the risk of child abuse and neglect, as well as health problems such as anemia, failure to thrive, and nutritional deficiency.<sup>39</sup>
- WIC increases the number of women receiving prenatal care, which reduces the incidence of low birth weight and fetal mortality.<sup>40</sup>
- Medicaid funded women enrolled in WIC during their pregnancies have a reduced risk of infant and neonatal mortality and lower prevalence of low birth weight/very low birth weight.<sup>41</sup>
- WIC participants are more likely to breastfeed and their children are more likely to have at least four well-child visits than comparable women who did not receive WIC support.<sup>42</sup>

## **Breastfeeding**

A major focus of prenatal care, child health care and the WIC program is encouraging new mothers to breastfeed. Research shows that breastfeeding can decrease the occurrence or severity of diarrhea, ear infections and bacterial meningitis, and may offer protection against sudden infant death syndrome, diabetes, obesity and asthma. Breastfeeding reduces a mother's risk of ovarian cancer and breast cancer, and possibly decreases the risk of hip fractures and osteoporosis in the postmenopausal period.<sup>43</sup>

- The American Academy of Pediatrics estimates that increased breastfeeding has the potential for decreasing annual health costs in the U.S. by \$3.6 billion.<sup>44</sup>
- Breastfeeding reduces parental employee absenteeism because breastfeeding reduces childhood illnesses.<sup>45</sup>
- Breastfeeding decreases the environmental burden of disposal of formula cans and bottles, and reduces energy demands for production and transportation of formula.<sup>46</sup>

## **Newborn Screening**

Florida screens all newborns for hearing impairment and for 35 metabolic disorders that lead to death or significant developmental disability. Newborn screening has been demonstrated to prevent developmental disabilities and reduce the need for special education services.

- The Centers for Disease Control and Prevention report that the present value of lifetime costs of developmental disabilities that are prevented by newborn screening ranges from \$500,000 to \$1 million.<sup>47</sup> The lifetime savings for these conditions in Florida far exceed the costs of implementing and maintaining a statewide newborn screening program.

## **Early Intervention for Children with Developmental Delays**

Early Steps is Florida's program for infants and toddlers (birth to thirty-six months) with significant developmental delays. Because early intervention programs help these children to improve their thinking skills and develop socially, children lead more successful lives and are less dependent on future government assistance.



High-quality early childhood programs can keep children out of expensive special education programs, reduce the number of students who must repeat a grade in school, and increase high school graduation rates.

- Early identification and treatment of children who are at risk of developmental delay produces economic benefits up to \$17 for each \$1 spent on the programs. The earlier the intervention, the lower the overall cost.<sup>48</sup>

## CHILD HEALTH

### **Immunization**

Childhood immunization represents one of the greatest public health achievements of the 20th century. Immunizations are among the most important and cost effective (even cost saving) preventive interventions.<sup>49</sup>

- The standard childhood immunization series annually prevents approximately 10.5 million cases of infectious illness and 33,000 deaths in the United States.<sup>50</sup>
- Every dollar spent on immunization saves \$6.30 in direct medical costs, with an aggregate annual savings of \$10.5 billion nationally.<sup>51</sup>
- The additional cost of missed work, death and disability raises the figure to \$18.40 saved per dollar spent on immunization, producing an aggregate savings of \$42 billion in the United States.<sup>52</sup>

### **Fluoridated Public Drinking Water**

Fluoridated drinking water provides a safe and cost-effective means of delivering fluoride community-wide, thereby reducing tooth decay and tooth loss. It has been recognized as one of the top ten public health achievements of the 20th century.<sup>53</sup>

- Every \$1 invested in water fluoridation saves \$38 dollars in dental treatment costs.<sup>54</sup>
- Children residing in non-fluoridated communities have double the oral health care costs of children residing in fluoridated communities.<sup>55</sup>
- Medicaid-covered children between ages 1 and 5 residing in communities without fluoridated water were three times more likely to receive dental treatment in a hospital than Medicaid-covered children residing in communities with fluoridated water.<sup>56</sup>

## ADOLESCENT AND ADULT HEALTH

Adolescents put themselves at risk not only through a variety of high-risk behaviors, including those that lead to STDs and HIV. Adults put themselves at risk by lifestyle choices begun in adolescence and increase their risk when they do not take advantage of readily available screening for cancer, diabetes, hypertension and high cholesterol. The cost of treating advanced cancers, heart attacks, strokes and complications of diabetes far outweighs the cost of prevention and early treatment.



## Sexually Transmitted Diseases

Every year, there are approximately 19 million new sexually transmitted disease (STD) infections in the United States, almost half of them among youth aged 15 to 24. Because of their many serious complications and consequences, including infertility among women and their offspring, STDs are one of the leading causes for loss of healthy years of life in childbearing age women, surpassed only by maternity-related disorders.<sup>57</sup>

- STD prevention efforts averted over 32 million cases of gonorrhea between 1971-2003.<sup>58</sup>
- Reductions in syphilis and gonorrhea from 1990 to 2003 in the U.S. saved an estimated \$5 billion (2003 dollars).<sup>59</sup>

## HIV/AIDS

HIV screening decreases the likelihood of further HIV transmission. Prevention programs that offer HIV counseling and testing provide access to life saving care and treatment.

- From the beginning of the HIV/AIDS epidemic through 2006, these programs prevented approximately 362,000 HIV infections in the U.S., and saved over 3.3 million quality-adjusted years of life.<sup>60</sup>
- HIV care and treatment costs are approximately \$22,500 per year, and lifetime treatment costs can total over \$275,000. Since the beginning of the HIV epidemic, prevention programs and screenings saved about \$52,000 per infection, far less than the lifetime per-person cost of HIV care and treatment.<sup>61</sup>

## Cancer Prevention and Detection

The American Institute for Cancer Research reports that over 45% of colon cancers and 38% of breast cancers in the U.S. can be prevented by making changes in diet and physical activity and by controlling weight. A third of the most common cancers can be prevented by avoiding the single most important risk factor for cancer, tobacco.<sup>62</sup>

Cancer is the second leading cause of death in the United States and in Florida. Regular breast, cervical and colorectal cancer screening prevents premature deaths by detecting and treating cancer early.

- Nearly 40,000 Floridians died from cancer in 2007, resulting in an estimated \$21.1 billion cost from health care expenditures and lost productivity due to death and disability.
- Screening for colorectal cancer extends life at a cost of \$11,890 to \$29,725 per year of life saved.<sup>63</sup>
- 14,000 lives could be saved annually in the U.S. if 90% of adults age 50 and older kept up to date on their colorectal screenings.<sup>64</sup>

## Diabetes Prevention and Management

Almost 24 million Americans have diabetes, including 5.7 million who do not know they have the disease. Diabetes is the seventh leading cause of death in the United States and accounted for \$217.5 billion in total U.S. healthcare system costs in 2007 due to higher medical expenditures and lost productivity.<sup>65</sup> Lifestyle changes can both prevent the onset of type 2 diabetes among those at high risk and reduce the occurrence of diabetes complications, thus reducing premature death and disability. These changes include managing blood pressure, glucose, lipid levels, maintaining a healthy weight, and receiving routine preventive care.

- For those with pre-diabetes, lifestyle changes, including at least 7% weight loss and at least 150 minutes of physical activity per week, can reduce the onset of type 2 diabetes by 58%.<sup>66</sup>



- Blood pressure control reduces the risk for heart disease and stroke among people with diabetes anywhere from 33% to 50%. It also reduces the risk for eye, kidney, and nerve diseases among people with diabetes by 33%.<sup>67</sup>

### **Preventing Heart Attacks and Strokes**

In the United States, about 70 million people – one in four Americans – have cardiovascular disease. Every year, more than 927,000 of them will die. Heart disease and stroke alone account for nearly 40% of all deaths in the United States. Eliminating tobacco use, improving poor diet, increasing physical activity, and controlling high cholesterol and high blood pressure can all prevent heart attacks and strokes. Educating people at risk about the symptoms and signs of heart attack and stroke will further save lives and reduce disability. This is especially important among diabetics, as their risk for heart disease and stroke is double that of the general population.

- The National Institutes of Health (NIH) estimate that 1.6 million heart disease and stroke deaths have been averted since 1997. Forty-four percent of the decrease is attributable to prevention through risk-factors reduction in the population.
- In 2007, the American Heart Association estimates that the national direct and indirect costs for cardiovascular disease will be \$431.8 billion.<sup>68</sup>

## ENVIRONMENTAL HEALTH

Providing safe food and water, clean air to breathe and safe water to play in reduces illness-related costs and improves overall well-being.

### **Safe Drinking Water**

Ensuring access to safe drinking water and protecting the public from waterborne disease, chemical contaminants, and other health threats is a core public health function.

Beyond reducing water related diseases, providing better access to improved water and sanitation reduces illness-related costs and improves overall well-being. Increased productivity in homes and businesses relies on consistent access to a clean safe water supply.<sup>69</sup>

### **Air Quality**

Reducing exposure to air pollution contributed to significant and measurable improvements in life expectancy in the United States. A 2009 study comparing 211 United States counties over time found that reductions in air pollution accounted for as much as 15% of the overall increase in life expectancy in the study areas across socioeconomic and demographic groups, and above and beyond smoking prevalence.<sup>70</sup>

### **Safe Food**

Seventy-six million Americans fall ill each year from eating foods contaminated with bacteria, viruses, and parasites. These foodborne illnesses result in discomfort, pain, time lost from normal activities, forgone earning spending on medications, long-term medical treatment, and even death, with financial costs running to millions of dollars.<sup>71</sup>

- Foodborne diseases cause approximately 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths in the United States each year.<sup>72</sup>



- The USDA estimates the annual U.S. economic costs due to foodborne Salmonella infections alone at \$2.4 billion.

### **Safe Recreational Water**

Polluted recreational water can lead to gastrointestinal illness, acute respiratory disease and ear and eye infections.

Estimated economic burden in the United States per event:

- Gastrointestinal illness: \$36.58
- Acute respiratory disease: \$76.76
- Ear ailment: \$37.86
- Eye ailment: \$27.31

These costs can become a substantial public health burden when millions of exposures per year result in hundreds of thousands of illnesses.<sup>73</sup>

## CONCLUSION

We know that keeping people healthy through preventive public health measures reduces health care costs, improves quality of life, and increases productivity.<sup>74</sup> In this century, we have an unprecedented opportunity. The leading causes of death - chronic diseases - are also the most preventable.

We know what works to reduce the burden of chronic disease. We know how to protect our children through screening, early intervention, access to routine care that includes immunizations, and being born to healthy mothers. We know how to keep sexually transmitted infections from spreading among our adolescents and young adults and to prevent falls among our elderly. We know how to keep our food and water safe. And we know that it costs less to prevent disease and disability than to treat it.

The bottom line is simple: implementing proven preventive strategies not only has a substantial positive impact on the health and well-being of our citizens, but it also results in a positive return on our health care investment. The Trust for America's Health concluded that an investment of \$10 per person per year in proven community based programs just to increase physical activity, improve nutrition and prevent smoking and other tobacco use could save the country more than \$16 billion annually within five years. In Florida, that amounts to \$6.2 for every \$1 spent.<sup>75</sup> Allocating resources to prevention is important as we continue to discuss health care reform.

During this time of economic uncertainty, there are unlikely to be budget increases to meet burgeoning health care needs. It is even more important now to use scarce health resources efficiently and effectively, by focusing our efforts on prevention. We will pay now, or pay later. The choice is ours.



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## An Ounce of Prevention Costs A Pound of Cure

DrRich | April 6th, 2010 - 9:37 am

### Podcast:



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As DrRich has noted many times over the years, "preventive healthcare services" cost the healthcare system far more money than they can ever save, and for this reason, any healthcare system engaged in covert rationing is going to have to find a way to stifle these preventive services.

Now, dear reader, before you go away angry, DrRich understands that some preventive measures are indeed very cost-effective. In fact, DrRich will now engage in a bit of cost-effective preventive healthcare: Don't smoke. Don't eat so damned much. And get some exercise.

There. DrRich has just successfully administered pretty much all of the truly cost-effective preventive measures known to modern medicine. (And it's only cost-effective because the advice was free.)

All the other preventive stuff we do in medicine tends to bend the cost curve in the wrong direction.

Reasons that preventive healthcare services increase the cost of healthcare include: a) The preventive measure itself costs money. b) The preventive measure may not be effective. c) Many "preventive healthcare services" consist of some kind of screening test for "early detection," and these screening tests almost always produce more false positive results than true positive results – leading to the need for more definitive, more expensive, and often invasive confirmatory tests. d) "Early detection" of any medical condition often detects "occult" disease, that may or may not have become manifest if it had remained undetected. e) Treating the diagnosed – and often occult – medical condition is often very expensive, produces complications, and/or is ineffective. f) Successfully preventing the target medical condition may give patients more time to consume healthcare resources for all their other medical conditions.

Please note that DrRich is not arguing here that preventive services are useless or undesirable. Often they are quite useful and very desirable. Rather, he is arguing that the healthcare system will spend more money by offering these preventive services than if it did not offer them.

This fact ought to prove embarrassing to our leaders, who have spent the last few years assuring us otherwise. Indeed, they have doggedly insisted, not only are preventive healthcare services cost-effective, but also it is precisely because of such preventive services (delivered in the remarkably efficient manner which will be achieved by our new healthcare system) that we will enjoy tremendous cost savings over the next decades.

Like Nancy Pelosi says, it's all about "prevention, prevention, prevention."

And having taken this bold and very public stance on prevention, our leaders are going to have to walk very gingerly (now that they have finally been successful in giving us the gift of healthcare reform), as they seek ways of cutting back on those selfsame preventive services.

They know this, of course, and have taken steps to provide themselves with the tools they will need to accomplish this feat. Their chief tool, based on what DrRich can find in the new healthcare law, is our old friend, the United States Preventive Services Task Force (USPSTF).

Readers may remember that it was the USPSTF that released the controversial new "recommendations" on breast cancer screening last fall. Readers will also recall that the USPSTF's new recommendation, that women under 50 no longer need screening mammograms, proved quite shocking to many women – women who had been urged for over a decade by various cancer societies, by the government, and by their doctors to get regular mammograms beginning at age 40, because the early detection of breast cancer was the best way not to die from breast cancer. Indeed (readers will again recall), the outcry was so great that Secretary Sebelius quickly issued a statement reminding us that the recommendations of the USPSTF were merely that – non-binding recommendations – and that women should continue getting their screening mammograms as they and their doctors thought best.

DrRich wondered at that time whether Secretary Sebelius (who was simultaneously urging all of us to support the healthcare reform bills which were then making their way through the House and Senate) actually knew that both of those bills contained language making the recommendations of the USPSTF legally (and retrospectively) binding.

In any case, DrRich wishes to take this opportunity to remind his readers that the healthcare reform which is now the law of the land indeed makes the USPSTF the arbiter of which preventive services are to be covered by private insurers (Section 2713), by Medicare (Section 4105), and by Medicaid (Section 4106). To be sure, presumably to bail out Ms. Sebelius, new language was added (Section 2713) to say that the recent recommendations on mammography do not apply, at least not for



private insurance plans. (Similar language, however, does not appear in the Medicare or Medicaid sections [4105 and 4106], so patients covered by these programs may indeed be subject to the new mammography recommendations.) New mammography recommendations aside, for the rest of the preventive healthcare services that exist in the universe, only those that have achieved a grade of A or B by the USPSTF will be covered.

Now that the USPSTF has been officially converted from a panel that simply makes recommendations which doctors and insurance companies can take or leave alone, into a panel that determines definitively what is covered and what is not – and indeed, into the chief tool by which our leaders will seek ways to withhold expensive preventive services – DrRich would like to very briefly restate his objections to the USPSTF's recent mammography rulings.

In a word, DrRich's problem with the USPSTF's revised mammogram recommendations has nothing whatever to do with whether mammography is really useful or not, but rather, with the methodologies the panel used to make those recommendations. For, if those methodologies are deemed legitimate, unfortunate precedents will have been set. Specifically, by analyzing the USPSTF's own justifications for making its new mammogram recommendations, it is possible to derive at least four new "rules" under which the panel can operate in the future.

1) The USPSTF now recommends that breast cancer screening no longer be done for women under age 50. But by the panel's own words, screening mammography in women in the 40 – 49 age group appears as effective at reducing mortality as it is in women 50 and older, and the panel indicates this fact several times within its own document. And as nearly as DrRich can tell, the panel's only concrete rationale for dropping mammography for women under 50 is that it has found "a new systematic review, which incorporates a new randomized, controlled trial that estimates the 'number needed to invite for screening to extend one woman's life' as 1904 for women aged 40 to 49 years and 1339 for women aged 50 to 59 years."

This rationale implies the following rule, **Rule 1:** If you have a preventive measure which is equally effective across a large population of patients, you can withhold that preventive measure from any arbitrary subgroup within that large population, as long as performing the effective measure in that arbitrary subgroup is more costly than it is for some other arbitrary subgroup.

2) In its public justification for withholding mammogram screening for women aged 40 – 49, the USPSTF did not emphasize cost savings, but rather, emphasized the fact that screening in this age group results in more false positive tests than for older age groups, and thus in more unnecessary biopsies, and the potential for more unnecessary emotional trauma. While this is true, the traditional response to such a circumstance would be for doctors to carefully review the pros and cons of screening with each woman, so as to allow the individual to decide whether the possibility of needing an unnecessary biopsy outweighs the possibility of diagnosing breast cancer while it is still curable.

But instead, the panel established **Rule 2:** Rather than allowing individuals to apply their own values when weighing healthcare decisions which reasonable people could decide either way, it is legitimate for the panel to make those decisions from on high for all patients; and furthermore, it is legitimate for the panel to make different decisions for different and arbitrary subgroups of patients (e.g., one decision for women 40 – 49 years of age, another decision for women over 50).

3) The USPSTF now recommends that women not be taught breast self examination (BSE). In point of fact, since most doctors stopped teaching BSE a long time ago, this recommendation will probably have little actual impact. But the panel came to this recommendation based on clinical trials conducted in backward, 3rd world healthcare systems (Russia and China), where outcomes with breast cancer have little to do with outcomes in the U.S.

Perhaps more to the point, a similar tactic was used in deciding to withhold mammogram screening for women under 50. That is, the "new randomized controlled trial" the panel invoked to justify this decision was conducted in England, where outcomes for the treatment of breast cancer are substantially – and famously – worse than they are in the U.S.

So **Rule 3** is established: It is legitimate to take the results of clinical outcomes trials conducted in backward countries with poor healthcare systems, or in less backward countries which nonetheless have demonstrably inferior outcomes, and directly apply those results to coverage decisions affecting American patients who are being treated in the American healthcare system. This is like performing a careful statistical analysis of outcomes from a Pee Wee football league, then telling the New England Patriots to abandon the forward pass, because the percentages just aren't there.

4) The USPSTF now recommends that women 75 and older not get breast cancer screening, despite the fact that (from the panel's own words) breast cancer is the leading cause of death in this age group. The panel justifies this recommendation by noting that there are insufficient data from randomized trials in these patients, and further, that "women of this age are at much greater risk for dying of other conditions that would not be affected by breast cancer screening."

It is, perhaps, convenient that very few randomized clinical trials assessing preventive measures have ever been conducted in elderly populations, and further, that if such trials were conducted, any actual benefit that might accrue to the subset of relatively healthy older people would be diluted by the inclusion of large numbers of less healthy elderly patients. And, while doctors usually have little



problem identifying those healthy 75-year-olds who are likely to survive another 10 - 15 years, and in whom detecting early breast cancer would likely be beneficial, the large, long-term, randomized clinical trials "proving" to the satisfaction of the USPSTF that these women deserve screening will, for all practical purposes, never be done.

So, **Rule #4:** Preventive measures should not be offered to old people, because they're probably going to die soon anyway.

Those who want to criticize DrRich because they feel the USPSTF's actual recommendations on breast cancer screening are appropriate may, of course, do so. But you will be revealing yourself as a dunderhead. For, as DrRich has just made quite plain, he is not necessarily criticizing the substance of the new recommendations, but rather, the dangerous methodologies the panel used to reach those recommendations, and the four new rules those methodologies have established. These precedents are very troublesome indeed - especially now that we're no longer dealing with the quaint USPSTF of old. The new USPSTF has acquired broad new powers, and is no longer making mere "recommendations," but rather, definitive coverage decisions which will directly affect all of us.

And this, it appears, will be the primary means by which our leaders will get out of providing us with all those robust preventive healthcare services they always insisted they were dying to implement.



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From Journal of Community Health

## Diabetes Care and Outcomes: Disparities Across Rural America

Nathan L. Hale; Kevin J. Bennett; Janice C. Probst

Authors and Disclosures

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### Abstract and Introduction

#### Abstract

We examined differences in receipt of diabetes care and selected outcomes between rural and urban persons living with diabetes, using nationally representative data from the 2006 Behavioral Risk Factor Surveillance System (BRFSS). "Rural" was defined as living in a non-metropolitan county. Diabetes care variables were physician visit, HbA1c testing, foot examination, and dilated eye examination. Outcome variables were presence of foot sores and diabetic retinopathy. Analysis was limited to persons 18 and older self-reporting a diagnosis of diabetes ( $n = 29,501$ ). A lower proportion of rural than urban persons with diabetes reported a dilated eye examination (69.1 vs. 72.4%;  $P = 0.005$ ) or a foot examination in the past year (70.6 vs. 73.7%;  $P = 0.016$ ). Conversely, a greater proportion of rural than urban persons reported diabetic retinopathy (25.8 vs. 22.0%;  $P = 0.007$ ) and having a foot sore taking more than four weeks to heal (13.2 vs. 11.2%;  $P = 0.036$ ). Rural residence was not associated with receipt of services after individual characteristics were taken into account in adjusted analysis, but remained associated with an increased risk for retinopathy (OR = 1.20, 95% CI = 1.02–1.42). Participation in Diabetes Self-Management Education (DSME) was positively associated with all measures of diabetes care included in the study. Availability of specialty services and travel considerations could explain some of these differences.

#### Introduction

As the number of persons living with diabetes continues to increase,<sup>1,11</sup> providing care necessary to reduce associated morbidity and mortality will become increasingly important. Diabetes care requires screenings, preventive services, self-management education and counseling be integrated with primary care services for treating routine conditions.<sup>12</sup> Recommendations outlining care all persons living with diabetes should receive have been developed by the American Diabetes Association (ADA) and include routine physician visits, Hemoglobin A<sub>1c</sub> (HbA<sub>1c</sub>) testing, foot examinations by a health professional and dilated eye examinations.<sup>13</sup> These services are important for prevention and early detection of complications associated with diabetes, including retinopathy and ulcerated foot sores.

Studies using nationally representative survey data have tracked changes in diabetes care over time and disparities in care among certain sub-populations.<sup>14–18</sup> However, few have examined differences in diabetes care differed based on residence in rural areas. Meeting ADA recommendations for diabetes care can be challenging under optimal conditions, even more so for rural areas lacking the infrastructure to sustain processes needed to improve care and outcomes among persons living with diabetes.<sup>12</sup> Rural populations

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often lack adequate access to primary care and specialty care services,<sup>131</sup> which are critical for providing quality diabetes care. Studies conducted among rural or underserved populations noted difficulties in meeting the recommendations for diabetes care; however, results are localized and do not produce nationally representative estimates on differences in diabetes care among rural populations.<sup>132</sup>

The ADA recommends that all individuals diagnosed with diabetes participate in Diabetes Self-Management Education (DSME). The effectiveness of DSME in improving diabetes care has been demonstrated,<sup>17, 15-17</sup> however, studies of participation in DSME among rural populations have noted significant challenges related to the availability and sustainability of DSME.<sup>118-20</sup> The extent to which these relationships impact diabetes care has not been fully explored.

The purpose of the present study is to explore differences in diabetes care and selected outcomes associated with rural residence. Given the challenges rural populations face with access to adequate health care resources and utilizing DSME, it is believed that persons living with diabetes in rural areas will be less likely to receive recommended diabetes care than those residing in urban areas, resulting in worse outcomes.

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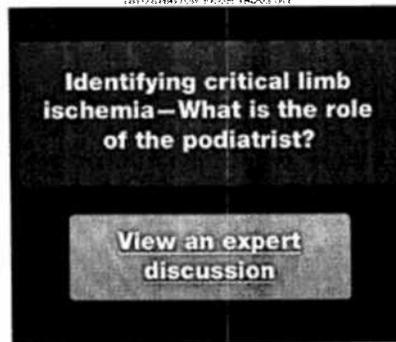
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### Diabetes Care and Outcomes: Disparities Across Rural America: Discussion

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#### Discussion

Our analysis confirmed that rural residents with diabetes differ from their urban counterparts. The prevalence of self-reported diabetes in adults is 17% higher in rural counties than in metropolitan areas (9.0 vs. 7.7%), across all race/ethnicity groups except Hispanics. The presence of rural disparities in diabetes prevalence echoes prior work using the 1988–1994 National Health and Nutrition Examination Survey.<sup>[25]</sup> Because rural residents suffer a higher burden from diabetes, they constitute an important public health target group.

Rural adults with diabetes differed from their urban counterparts in ways that affect planning for rural interventions. Rural adults were less well educated, more likely to report low incomes, more likely to lack health insurance, and correspondingly, more likely to report deferring care due to cost than urban adults. In addition, other research has shown that rural residents travel further for care.<sup>[26]</sup> Despite these disadvantages, rural persons with diabetes were no less likely to report receiving two HgA<sub>1c</sub> tests in the past year than urban residents, although only about two thirds of persons in either geographic area met this guideline. However, a smaller proportion of rural than urban adults with diabetes reported receipt of a foot exam or a dilated eye examination. Thus, it is not surprising that slightly more rural than urban respondents noted foot sores of more than one month's duration and a diagnosis of retinopathy.

The proportion of rural persons reporting a dilated eye exam in the present study (68.1%), is slightly higher than previous population estimates produced using 2002 and 2003 BRFSS data,<sup>[6,8]</sup> while similar to that in research among Medicare beneficiaries for the 1999–2001 period.<sup>[27]</sup> Nonetheless, performance on this measure remains below the Health People 2010 goal of 75%.<sup>[28]</sup> On all service receipt variables, lack of health insurance and reported deferring of care due to cost were strongly associated with reduced odds for service receipt in adjusted analysis, while rural residence alone ceased to have an association with services. This suggests that programs focusing on reducing cost barriers may improve service quality on this measure.

Retinopathy is a common result of diabetes, but receipt of recommended care can lower the risk of vision loss<sup>[29]</sup> and slow the resulting decline in health related quality of life.<sup>[30]</sup> The reduced rate at which rural residents receive dilated eye examinations compared to urban adults appears attributable to lower education and income levels in the rural population, both of which reduced the likelihood of receiving an examination. However, the higher prevalence of diabetic retinopathy among rural adults was virtually unchanged in adjusted analysis (OR 1.21; AOR 1.20). With the exception of income, access variables (insurance, deferred care) were not significantly associated with diabetic retinopathy, while risk factors were markedly linked, including insulin dependence, perceived fair/poor health, and age of 55 or higher. It is possible that rural practitioners, who typically see more patients and provide fewer preventive screening services than urban physicians<sup>[31]</sup> are not sufficiently aggressive in educating and monitoring patients with diabetes. A recent study found that counties with rural health clinics, which are required to incorporate a midlevel practitioner in

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addition to one or more physicians, have better population based rates for eye screening than other rural counties.<sup>132</sup> Increasing use of non-physician workforce, therefore, may be one approach for improving eye outcomes among rural patients.

The proportion of rural persons receiving a foot exam by a health professional in the past year was 70.9%, slightly less than among urban persons with diabetes (73.7%) and short of the Healthy People 2010 goal of 75%.<sup>128</sup> Since our study found no differences in the proportion of persons reporting a physician visit within the past year, and a foot examination does not require special equipment or access to specialty care, the shortfall is difficult to explain. With no differences in reported physician visits, it should be expected foot care and outcomes would not differ by residence. However, this is not the case.

Efforts to implement quality improvement initiatives to improve diabetes care among rural and underserved populations are critical for increasing the number of persons receiving preventive services and improving outcomes. Certain quality initiatives among rural and underserved populations have show improvements in diabetes care and warrant consideration. A group of 19 Midwestern community health centers implemented Plan-Do-Study-Act cycles to improve diabetes care provided to patients. Significant improvements in HbA<sub>1c</sub> testing, referrals for eye examinations and foot examinations were noted after one year.<sup>133</sup> Other examples of collaborative efforts between multiple partners to improve diabetes care have also been noted. The Montana diabetes prevention and control programs worked with the University of North Dakota to support 37 rural primary care practices to improve diabetes care. This collaborative effort also demonstrated improvements in HbA<sub>1c</sub> testing, eye and foot examinations among patients.<sup>121</sup>

Participation in DSME was positively associated with quality of care measures, including a reported physician visit in the past year, two or more HbA<sub>1c</sub> tests in the past year, an annual dilated eye exam and an annual foot exam by a health professional. This finding is consistent with previous studies examining participation in DSME among the general population.<sup>17, 173</sup> However, rural residents were less likely to have participated in DSME, with 52.0% of rural persons living with diabetes participated in DSME compared to 55.9% of urban persons ( $P = 0.003$ ), a finding that parallels previous research.<sup>113, 18, 201</sup> Given the strong positive relationship between participation in DSME and diabetes care, efforts should continue to ensure rural populations have adequate access and utilize DSME services. Various strategies to increase access to DSME among rural populations have shown promise. One state established a mentoring program to increase the number of Certified Diabetes Educators (CDE) in rural and frontier areas and increase the number certified education programs available in rural areas.<sup>119</sup> Others have implemented elements of a chronic care model by placing a CDE in a physician practice to support providers in diabetes management and provide patient education.<sup>134</sup> More recently, the expansion of telemedicine has created the opportunity to deliver DSME in rural areas. A Pilot project using telemedicine to deliver DSME demonstrated improved knowledge, self-efficacy and more frequent self care among participants.<sup>135</sup> The present study has several limitations. First, a cross-sectional study can only present associations among variables, not causal relationships. Next, all information is self-reported. Third, a broad definition of rural was used, potentially masking notable differences in diabetes care that may be present in very small or remote rural counties. Fourth, the study only considers the receipt of specific health services and does not account for the content or quality of care being provided, nor how well diabetes is being controlled through follow up activities. Next, participation in DSME demonstrated a strong positive relationship with diabetes care. However, individuals voluntarily participating in DSME might also be more inclined to take an active role in disease management, introducing selection bias. Finally, the BRFSS is a telephone survey of non-institutionalized adults; therefore, individuals such as those in nursing homes, or without a telephone could be excluded.<sup>177</sup>

Rural residents as a whole are more likely to report having diagnosis, less likely to receive recommended services, and more likely to suffer from diabetic retinopathy. The characteristics of rural populations such as lower reported levels of income, educational attainment and health insurance, rather than location alone, place them at increased risk. The combination of these factors underscores the importance of ensuring quality diabetes care extends to vulnerable populations, including those residing in rural areas. Promising practices in improving diabetes care have been noted; however, sustainability of quality initiatives can be elusive in the absence of organizational and technical support.<sup>134</sup> As national discussions regarding health care reform and quality of care continues, efforts to improve diabetes care among rural and underserved populations warrant consideration and should be supported.

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ALGEBRA ESICREENT



RX Assist Statistical Report											
	Qtr 1 2012	Qtr 1 2011	Qtr 2 2012	Qtr 2 2011	Qtr 3 2012	Qtr 3 2011	Qtr 4 2012	Qtr 4 2011	Total 2012	Total 2011	
New Patients	50	87		54		49		44		234	
Renewals	179	n/a		n/a		n/a		n/a		n/a	
Patients Disenrolled	91	302		59		139		131		631	
Patient Visits	817	631		574		546		520		2271	
Clinic Office Procedures	10	14		12		15		12		53	
Surgeries	12	13		17		8		10		48	
Volunteer Physician Hours	646	324.75		329		273		259		1,185.75	
Provider Values	192,109	123,751		133,784		108,796		113,751		480,082	
Medication/Prescription Value	132,446	38,700		44,957		42,171		35,376		161,204	
Mariners Services	917,095	n/a		n/a		n/a		n/a		n/a	
BHSF (includes Mariners) Services	1,465,377	1,827,198		1,658,010		1,717,744		1,369,894		6,552,703	
Surgery Value Outside of BHSF	56,220										

2012 Monetary Funding				
	Qtr 1	Qtr 2	Qtr 3	Total
BHSF	143,750	75%		
All Others	189,773			

October 1, 2011 to March 31, 2011			
	Total	YTD Comp	
BHSF	175,000	62,500	56%
All Others	298,321	108,978	

Patient Profile									
	2012	2011	2012	2011	2012	2011	2012	2011	
18-24									
25-34	16	9		10		8		10	
35-44	21	32		32		28		29	
45-64	21	49		42		42		50	
65 and over	224	214		203		184		175	
Gender	5	12		9		8		2	
Female									
Male	199	209		198		181		172	
No Answer	118	106		97		88		94	
Ethnic Origin	1	1		1		1		0	





