CHRIST COMMUNITY HEALTH SERVICES OF AUGUSTA

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Robert Campbell stood on the sidewalk in downtown Augusta, Georgia, looking at a building that would be perfect for his new health clinic. The Widow's Home was the site of the first City Hospital for the "sick poor," and Dr. Campbell's mission was to provide affordable quality health care to the underserved. The clinic was fast outgrowing its current facilities, and the 16,104 square feet Widow's Home could provide much needed room for expansion, although it would involve costly renovations. Moreover, the clinic was in no financial position to buy the home even if the current owner was willing to sell. In addition, if the Widow's Home was generously donated, millions of dollars more would be needed before the building would be operational. These thoughts were daunting, but Robert Campbell was not ready to give up. How could Dr. Campbell fulfill his dream?

Introduction

Robert Campbell grew up in a Christian home in Peoria, IL. He attended Vanderbilt University in Tennessee aiming to follow in his father's footsteps and become a physician. Despite numerous religious and philosophy classes it was not until he met with the University's Pastor, Hal Farnsworth, that "God put his heart in a teachable frame" (to paraphrase John Calvin). At this time he came to love God and was ready to follow His commands. Wishing to know more about God and His commandments, Robert attended Covenant Seminary but thought his God-given talents would be best used as a physician.

During his first year at the University of Illinois Medical School his sister sent him a newspaper article about four doctors in South Memphis who had started a Christian practice. Robert invited one of the doctors, Rick Donlon, to speak at a Christian Medical and Dental Associates meeting he was organizing. Dr. Donlon told the audience to "use your gifts to care for the poor," a message that resonated with Robert. During his fourth year of medical school he was able to work for two weeks at Dr. Donlon's Christ Community Health Services in Memphis.

During his combined internal medicine/pediatrics residency at the University of Tennessee, Dr. Campbell struggled with the conflicting hopes and dreams he had. Should he pursue the more traditional path of a fellowship and private practice, or dedicate himself to caring for the poor? He felt in his heart that God's commandment to him was to care for the poor but unfortunately, God had not provided the roadmap.

After residency Dr. Campbell joined a private practice in Augusta, Georgia with the understanding that he would leave after three years to start his own clinic caring for the urban poor. During this time Dr. Campbell spent many hours expounding his idea to other doctors he knew nationwide. Emotionally, these were hard years: he had a vision that he wanted so desperately to pursue, but needed a partner to bring those dreams to fruition.

Dr. Grant Scarborough had been praying about his career direction while finishing his residency (also at University of Tennessee – Grant was in his first year when Robert was in his final year).

Dr. Scarborough, a graduate of University of Georgia and Mercer Medical School, had also been a Young Life Leader in Atlanta. “I need an answer today” Dr. Campbell required on a hot summer Tennessee night in 2006. “I’m in,” replied Dr. Scarborough. While Dr. Scarborough finished his last year of residency, they drew up their vision and mission statements and organized their board of directors.

Christ Community Health Services of Augusta, Inc. (CCHSA) began operations providing affordable primary health care for patients in urban Augusta, Georgia in November 2007 at 1226 D’Antignac Street, near downtown Augusta. CCHSA was classified as a 501(c)3 nonprofit organization. Not-for-profits classified as 501(c)3 organizations were eligible for federal exemption from payment of corporate income tax, and contributions to the organization were tax-deductible. A building was leased free of charge from University Hospital, Augusta’s largest hospital. Additionally, donations of office furniture and medical equipment, along with numerous volunteers, made it possible for CCHSA to open its doors. Financial support came from University Hospital in order to reduce the number of visits to its emergency room. Additional financial support was provided by many local churches, individuals, and businesses as well as the CCHS of Memphis.

In CCHSA’s first year of operations (2008), the clinic had over 3,500 patient visits, more than all the free clinics in Augusta. In 2009, the clinic had 6,554 patient visits, 75% of whom had no health insurance and were charged on a sliding-fee scale starting at twenty five dollars based on income and household size. Completely free medical care was provided to the homeless. Figure 1 shows the payments received from self-paying patients compared to the payments received from patients with insurance. In 2008, insurance payments made up 41% of medical service fees with patient payments making up 59%. Both of these revenue sources more than doubled the next year. With the increase in patient visits, insurance payments also became a larger percentage of the total revenue. In 2009, insurance payments amounted to 44% and patient payments accounted for 56% of the total patient revenue.

A Turning Point

This booming demand for their services was far outstripping supply and led to Dr. Campbell standing on the sidewalk on Greene Street imagining moving into the Widow’s Home. He had heard that a local businessman and property developer, Clay Boardman, currently owned the building. With some trepidation, Dr. Campbell looked up his phone number in the directory and invited Mr. Boardman to coffee at a local café. Dr. Campbell was not a seasoned fund raiser, but he did have a vision and a business plan he believed in. Mr. Boardman replied that using the Widow’s Home for a clinic serving the urban poor was a “great idea” especially since it fitted in with his strategy of renovating historic buildings to maintain their original character while putting old buildings back into everyday use (see Figure 2 for CCHSA’s mission and vision).

Figure 1: Payor Mix of CCHSA

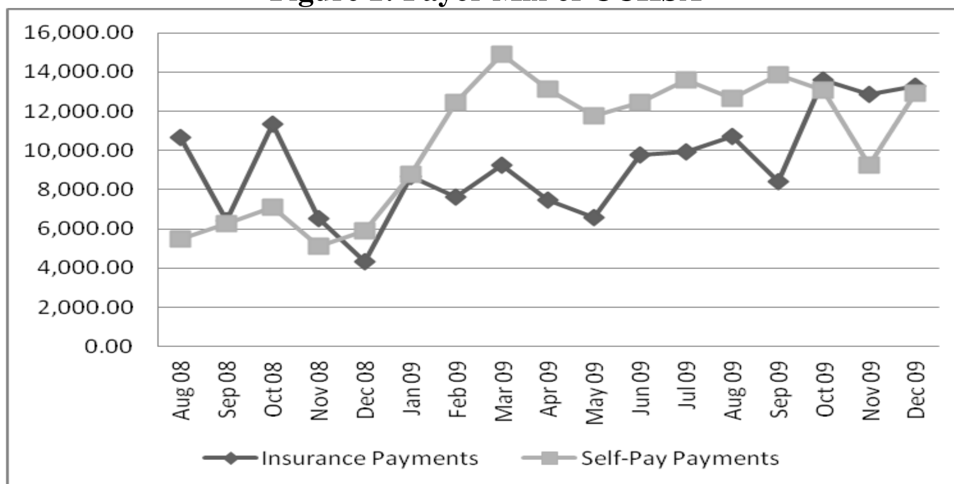


Figure 2: Mission and Vision Statements

CHRIST COMMUNITY HEALTH SERVICES OF AUGUSTA
MISSION

Christ Community Health Services of Augusta (CCHSA) exists to proclaim Jesus Christ as Lord and to demonstrate His love by providing affordable quality primary healthcare to the underserved of Augusta

CHRIST COMMUNITY HEALTH SERVICES OF AUGUSTA
VISION STATEMENT

In response to God's grace we desire to be a part of the redemptive work of Christ to the economically, socially and spiritually impoverished communities of Augusta. We envision an incarnational ministry through a community of Believers who use their particular gifts to care for the poor and who bring them into their fellowship.

Our primary means for accomplishing this goal is through a health clinic which provides excellent care physically, emotionally and spiritually. We work hand-in-hand with existing ministries as well as help create new ministries as needed to bring Christ to the poor, crippled, blind and lame.

As a community of Believers, we envision and earnestly long for the heart of Christ to be developed in us so that we might truly love our neighbor and redeem lives in urban Augusta -- for if our hearts are not first healed by Christ, our labor will be in vain. All this is for the Glory of God.

Objectives

The opportunity to move into the Widow's Home Society was one of four complementary

objectives of CCHSA:

1. Expanding into a larger facility: The Widow's Home was founded in 1871 to care for Confederate widows on land acquired from the city of Augusta. It is on the site of Augusta's first city hospital for the "sick poor" which was founded in 1818. It was also the site of Georgia's first school of medicine.

   The present structure was built in 1886-1887. It contains 42 rooms which served to care for "needy women" from its opening in 1887 until 2003 when it was closed. In 2007, the Widow's Home Foundation still existed and was still active in furthering the cause of women in need. CCHSA's website stated "Because of this site's historic connection with medical care for the 'sick poor', education of health professionals, and care for those in need, we feel honored to link our goals to those who walked these grounds before us."

   Architectural drawings were produced portraying a renovated Widow's Home. When completed, it would include offices for six physicians, twelve exam rooms, a laboratory, a 2,000-square foot pediatric physical therapy suite, classrooms, a resource center, and a counselor's office. It would have the capacity of treating 25,000 to 30,000 patient visits per year. This project would also facilitate the use of student volunteers from The Medical College of Georgia (MCG) whose campus was located nearby.

   Although Mr. Boardman donated the building to CCHSA, it was estimated that it would take $2.5 million to renovate the building to make it suitable for a clinic. A further $300,000 endowment was budgeted to cover annual operating costs. Executive Director Jeff Drake was employed to manage the Widow's Home Project Capital Campaign. Jeff had over thirteen years experience in engineering after graduating from Georgia Tech. Showing that God moves in mysterious ways, he had just been laid off in November 2008 from his last firm. A deacon at the same church attended by Drs. Campbell and Scarborough, Jeff felt a calling to support their ministry to the underserved of Augusta. Grants, individuals, businesses, churches and fundraising campaigns provided the initial capital. The majority of the funds came from individual donations (43% in 2008) followed by grants (30%) while businesses and churches together contributed less than 10 percent. The inaugural Sporting Clays Tournament netted over $6,500. By August 2010, $1.8 million had been raised or pledged and a groundbreaking ceremony was held on the grounds of the Widow's Home. The ground floor renovations were completed for a ribbon cutting event in July 2011 and the clinic became fully operational at the new site. They continued to raise funds to renovate the second and third floors.

2. Caring for all of the underserved of the Central Savannah River Area (CSRA): The major objective of CCHSA was to meet the physical, emotional, and spiritual needs of the underserved of the Augusta area. Dr. Scarborough and Dr. Campbell believed that, regardless of income level, everyone – those that do and do not have health insurance - should receive the best health care available.

3. Encouraging medical students to serve those in need: Another focus of Drs. Scarborough and Campbell was to influence other medical personnel, especially medical students. They

asserted that “We aim to disciple students by demonstrating how to glorify God with the gifts He has given us by loving our neighbors in deed and truth.” They firmly believed that a medical center could serve those in need while providing competitive wages to all employees. They aspired to demonstrate that such a business model was practical and could be successful.

Dr. Campbell recalled “I saw a young medical student talking to a patient about high blood pressure and the treatment plan. The student gave the patient a high five, there was laughing and happiness in both their faces. I thought: Mission accomplished!”

4. Compensation: Unlike other private medical practices, the physicians took a flat salary rather than being partners or being paid based on insurance billing. In the future, they wanted to have the ability to compensate four additional physicians they planned on bringing on board once construction of the new facility was completed. In August 2009 Russ Ayers, a family practice doctor, started work as the third physician. Two more family practice doctors were due to begin work in August 2011, bringing the total number of physicians to five.

Values

As shown in Figure 3, CCHSA’s principal values were declared in its “Philosophy of Ministry.” The founders saw this health care clinic as a spiritual calling. The organization’s philosophy of ministry clearly indicated that Drs. Scarborough and Campbell believed that their faith should be demonstrated through their actions.

Figure 3: Philosophy of Ministry

CHRIST COMMUNITY HEALTH SERVICES OF AUGUSTA
PHILOSOPHY OF MINISTRY

Our philosophy of ministry further describes what we strive to become and achieve both individually and corporately at Christ Community.

1. All our actions will be guided by the love of Christ – knowing “if we give all our possessions to feed the poor . . . but do not have love, it profits us nothing.” (1Corinthians 13:3)

2. All our actions will be in response to the work of Christ - knowing that “He himself bore our sins in his body on the tree, that we might die to sin and live to righteousness. By his wounds you have been healed.” (1Pet 2:24)

3. All our actions will be bound in prayer – knowing we have a Father in heaven who hears our prayers and that Jesus said you have not because you have asked not. (James 4:2)

4. All our actions will be done in humility – knowing that James wrote to “humble yourself before the Lord, and he will lift you up.” (James 4:10)

5. All our actions will be performed as a servant – knowing that Jesus "did not come to be served, but to serve" (Matthew 20:28) and knowing that when "Jesus showed them the full extent of his love" (John 13:1) he took off his outer garment, wrapped a towel around him, and washed his disciples' feet.

6. All our actions will be done from a heart that has been in solitude with Christ – Knowing Jesus himself, would often get up in the morning "while it was still dark" (Mark 1:35) to be with his Heavenly Father.

7. All our actions will be done as if doing them to Jesus himself – knowing that "whatever you did for one of the least of these brothers of mine, you did for me." (Matthew 25:40)

8. All our actions will be done to the glory of God, that He alone will be praised – knowing that Scripture says, "whether you eat or drink or whatever you do, do it all for the glory of God." (1Corinthians 10:31)

Key Success Factors in the Industry

In 2009, the key success factors for physician practices summarized below were standard for most practices and could be used to benchmark success. For CCHSA, charitable contributions and grants played a significant role in the success of the practice and were important factors when comparisons to other practices were made.

1. Profitability and cost management: A medical practice must generate revenues sufficient to cover its costs. Most physician practices focus on a patient/payer mix to ensure profitable level of revenue. As a charitable organization targeting the medically underserved population in the area, CCHSA's ability to obtain financial support through contributions from other organizations, foundations and individuals was paramount to its success. At the same time, the practice had to continuously maintain tight control of operating expenses.

2. Productivity, capacity and staffing: Productivity was important for two reasons: (1) to ensure all patients who needed care received it, and (2) to ensure the physicians' time was not wasted. Both were essential for generating needed revenues and sustaining operations. Therefore, to maximize productivity, the practice had to have sufficient facilities and staff to generate required revenues. It had to have the appropriate space to conduct business efficiently and the appropriate number of employees to support the practice.

3. Accounts receivable and collections: As any other business, physician practices were dependent on receiving prompt payment for their services. Receiving timely payment for services was very important for the practice to continue operations. Appropriate staff had to be hired and trained to ensure the billing and collections process was efficient and effective. This was even more important for CCHSA than other practices because their fees often did not cover the cost of providing services.

4. Patient satisfaction: The reputation of a practice's physicians for providing quality care was very important to success. This included appropriate medical care as well as the overall experience the patient had with the practice. To ensure patient satisfaction, Dr. Campbell and Dr. Scarborough continued to provide medical care to their patients if they were admitted to University Hospital, thus providing true continuity of care. In contrast, many private practices turned over inpatient care to hospitalists.

Strategies

CCHSA's strategy may be described as one of concentrated growth. With such a strategy, a firm directs its resources to the profitable growth of a single product, in a single market, with a single dominant technology. CCHSA focused on their future growth. This was evident by their renovating the Widow's Home, increasing the number of health personnel, and having the ability of paying the doctors a salary. The founders believed that since CCHSA was the only business of its kind in the area, a concentrated growth strategy suited them well. They continually worked towards growing their business at a reasonable pace.

Business level strategy often asks "how can we compete in our industry?" For CCHSA, there were three distinct ways to compete. First, CCHSA desired to be a cost leader in the industry. In addition, it followed a differentiation business strategy. It set itself apart from many in the healthcare industry by being centered on "Faith in Christ" and opening its doors to the homeless and underserved of the area. Finally, it offered its patients a sliding fee scale, which was based on their ability to pay and, if they had any, their type of health insurance coverage.

Functional level strategy addresses the question "how can we support our business level strategies?" To accomplish this strategy, CCHSA relied upon grants, fundraisers, and the strong support of many volunteers throughout the community. In 2009, they received $105,596 in donations for operations from individuals, churches, and local businesses. These donations amounted to nearly 13% of their total income. CCHSA also received grants and contributions from foundations of more than $440,000, which represented 54% of their total sources of revenue. Grants from University Hospital and others allowed CCHSA to hire more staff and pay them competitive salaries.

The Internal Environment

The two physicians, Dr. Robert Campbell and Dr. Grant Scarborough, were the primary strength of the clinic. CCHSA would not have existed without their vision, enthusiasm, and their foregoing of the prevailing physicians' compensation. As co-founders, Dr. Campbell and Dr. Scarborough approached their careers as a "calling". For the first year of the clinic they took no salary, supporting their families by working extra shifts at two local hospitals. Both were doubly "board certified" in Internal Medicine and Pediatrics. Although board certifications are not required to practice medicine, they indicated that these physicians had expertise in their specializations through additional training and had passed additional exams.

The clinic was financially able to pay the rest of its staff market-level wages; thus the staff did not need to make the same financial sacrifice as the physicians. CCHSA used a state-of-the-art

electronic medical records system, which provided a high level of efficiency and effective medical care. Healthcare providers who used qualified e-prescribing systems earned bonus payments of up to 2% from the Centers for Medicare and Medicaid Services.

CCHSA's organizational chart is shown in Figure 4, and its financial statements are displayed in Exhibits 5 and 6. The clinic's board of directors was chosen for their expertise as well as their commitment to the overall vision and mission of the clinic and served three year terms. In fact, all potential directors were first interviewed by Dr. Campbell and stated their profession of faith. Directors brought skills that helped in the operation of the clinic, whether that was finance, legal or medical knowledge, or as patients. With an eye on the future, and applying for Federally Qualified Health Center, over fifty percent of the board lived or worked in the area served by the clinic, or were patients of the clinic. The clinic's staff included a Director of Community Outreach/Pastoral Care. This reinforced the CCHSA's mission of demonstrating Christ's love by providing in-house prayer with patients and staff. The clinic did not have the financial burden of having to make a monthly rent or mortgage payment to University Hospital. Mr. Boardman's donation of the Widow's Home allowed CCHSA to expand without incurring a mortgage. On the other hand, CCHSA was heavily reliant on grants for its business model. This carried the risk that grants would not be renewed. An additional constraint on CCHSA was that they were faith-based, which limited the options regarding grant-making organizations that CCHSA could apply to.

With only three med/peds or family practice physicians on the staff, there were major gaps in the types of services the clinic was able to provide. There were plans to address this weakness by bringing in a specialist in obstetrics and gynecology. However, the malpractice insurance associated with Obstetrics was formidably high. One solution pursued was to become a Federally Qualified Health Center which meant the federal government would cover malpractice insurance. Moreover, Dr. Campbell expected certain difficulties in finding physicians who possessed the same missionary orientation required to accept a below-market salary in return for the satisfaction of helping those who were in need.

The External Environment

An assessment of its external environment revealed a number of opportunities and potential threats Christ Community Health Services needed to consider closely. Some of these factors were beyond the control of the practice and needed to be addressed with plans to maximize opportunities and minimize the inherent risks.

1. The rising number of uninsured persons provided a major opportunity for CCHSA. The uninsured reached 18% of the Augusta area (Richmond County) residents, an increase from 13% in 2003.[i] This included both low-income and middle-income individuals. This trend was expected to continue and accelerate because of the 2009 economic downturn. In addition to the uninsured, the Augusta area was experiencing one of the highest concentrations of low-income persons in the United States. According to the Brookings Institute, the poverty rate in the Central City of Augusta/Richmond County increased from 19.6 % in 1999 to 22.9% (38.2% for children) in 2005.[ii]

In 2007, there were over 28,000 visits to regional emergency departments by uninsured patients, mostly for problems better served in a primary care setting. Additionally, individuals without health insurance were likely to forego medical screening and treatment until their condition became critical and they ended up visiting local hospitals' emergency departments. These departments provided a significant amount of care to the uninsured. The cost was considerably higher than care at a clinic or physician practice. By collaborating with and providing financial and operational resources to a practice oriented toward the underserved, emergency departments' expenses could be reduced thus lowering overall healthcare cost. Furthermore, there was the potential to provide ancillary services such as obstetrics, gynecology, laboratory tests, physical therapy, and diet and fitness programs.

Many individuals were temporarily uninsured. As uninsured patients gained insurance coverage, there was an opportunity to retain these patients. Moreover, studies showed that 40% of homeless people have been homeless less than six months, and 70% have been homeless less than two years. Attracting and retaining these patients provided an opportunity to generate revenue. In addition, word of mouth from satisfied patients drew traditional paying family members. Finally, CCHSA attracted patients that had insurance and were able to pay based on their desire to receive service from a faith-based organization or to be associated with the practice.

CCHSA was heavily dependent on financial support from outside sources. The availability and amount of donated funds and grants would have an impact on the success or failure of the practice. For example, University Healthcare System was the primary supporter of CCHSA, contributing $180,000 in 2008 and $360,000 in 2009 and pledged $360,000 in 2010. A reduction of such support would have a severe impact on operations. Another concern was the economic slowdown in 2009 resulted in a reduction of charitable giving by both businesses and individual donors. There was also a lot of competition for charitable donations from other large projects in the Augusta metropolitan area including $20 million for a Salvation Army Kroc Center and $1.8 million for a new Fisher House on the grounds of the Veterans Administration hospital.

The clinic's current status as a 501(c)(3) organization was important to achieving its mission. Some individuals, organizations and foundations would not make any contributions unless a charitable entity had obtained this designation; this allowed them to claim a tax deduction. Further, CCHSA was granted exemption from federal income taxes. Therefore, CCHSA had to maintain this status; its loss would be devastating to the organization and threaten its existence.

Another factor considered by the clinic concerned the increase in the number of low-income workers and the recent surge in the number of the unemployed from a low of 4.8% in May 2007 to over 10% two years later. If this trend continued, such a development could overwhelm the healthcare system in Augusta, including CCHSA. Consequently, healthcare costs could rise due to an increase in indigent care and a reduction in healthcare-related revenues as previously paying patients became indigent patients.

Figure 4: Organizational Chart

Board of Directors
Executive Director
Medical Director
COO/CFO
Director of Community Outreach, Spiritual Development and Education
Providers
Practice Administrator
Assistant Practice Manager
Nurse Manager
Billing Manager
Front Office Manager
Resource Coordinator
Director of Communications and Development
Community Outreach/Pastoral Care
MA
Nurses
Billing Personnel
Front Office Personnel
Grant Writers
Volunteers

Another revenue-related factor concerned possible changes in reimbursement from government-sponsored programs such as Medicaid and Medicare. Changes in qualification criteria or reimbursement rates could have a negative impact on revenues from this patient population. Medicare reimbursement to physicians was estimated to be reduced by almost 5% each year through the end of 2012. Additionally, due to the nature of the practice and its honor-system pricing philosophy, there was the potential for some individuals to take advantage of this policy by seeking free services when in fact they could afford to pay for CCHSA's services. Finally, another challenge confronting CCHSA was due to the intrinsic nature of the patient base. Since many patients were homeless and at the poverty level, many were difficult to contact or were unreliable, resulting in a high no-show rate and a negative impact on physician productivity.

In spite of these challenges, Christ Community Health Service's business model was designed to offer a low-cost advantage with services equal to or of higher quality than those of other organizations, thus differentiating it from other physician practices in the Augusta area. CCHSA had a very compelling story, which drew likeminded churches, foundations, and individuals to provide financial support, thus enabling the organization to operate in what would normally be an unsupportable business model. Donors had provided the financial resources needed to start the practice and to expand the facility into the historic Widow's Home. Yet overcoming the enormous financial challenges that continually faced CCHSA was vital for its continued ability to survive and accomplish its noble mission.

Finances

As a not-for-profit organization CCHSA's goals were significantly different than that of a business enterprise. Unlike a business, the major goal of a not-for-profit was not to maximize net income, but rather to meet its mission. Nonetheless, the financial condition was critical to the survival and success of a not-for-profit organization. A financially sound not-for-profit had a better chance to accomplish its purpose, serve the community, and attract donors. The statements of financial position and operating statements are shown in Exhibits 5 and 6. Because a not-for-profit does not have owners, there was no owners' equity section. The equity section of the balance sheet is referred to as net assets. Donors often made a gift to a not-for-profit for a particular purpose. When this occurred, the organization used the asset for that purpose. The net assets were classified as temporarily restricted until used for the designated purpose. In the case of an endowment, where only the income and not the principal may be used for the not-for-profit organization, the net assets were permanently restricted. As of 2009, CCHSA had only two years of operations, both presented in Tables 1 and 2.

A continuing financial concern was how CCHSA would serve their uninsured and other clients and still meet their current obligations. Dr. Campbell and Dr. Scarborough also were expanding their operations and began to draw salaries from the organization. CCHSA had an operating loss of $241,321 for 2008, and even a larger operating loss of $583,960 in 2009. Grants and contributions, however, gave them an increase in net assets during each year. Figure 5 shows the relationship between the organization's expenses and its income from services for 2009.

Table 1

CHRIST COMMUNITY HEALTH SERVICES AUGUSTA, INC.
STATEMENT OF FINANCIAL POSITION

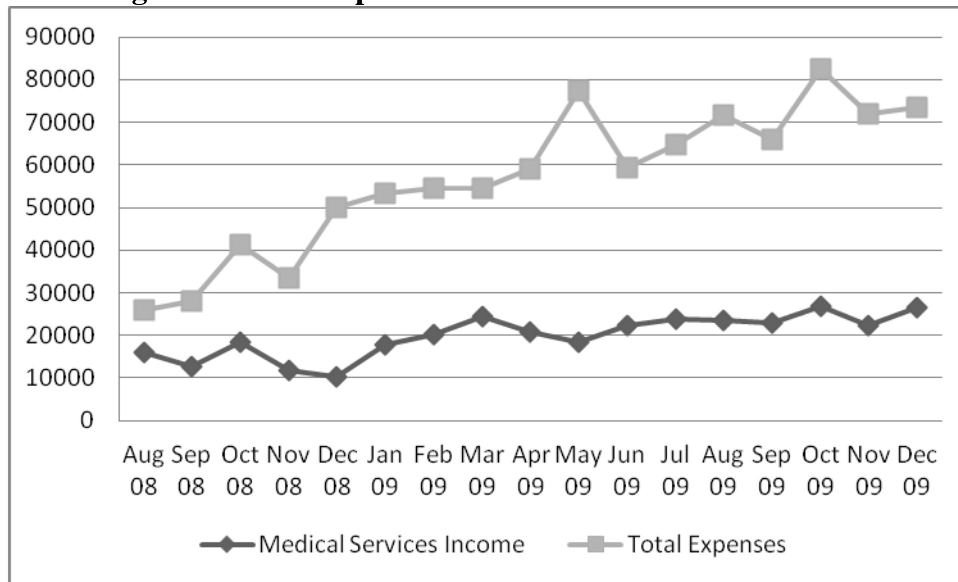
		DECMBER 31		
ASSETS		**2009**		**2008**
Current Assets:				
Cash	$	659,084	$	332,398
Accounts Receivable		188,700		2,650
Other Current Assets		0		370
Total Current Assets		847,784		335,418
Investments in Stocks		19,888		20,628
Property and Equipment:				
Widow's Home		511,954		485,407
Equipment and Furniture		70,035		55,908
Leasehold Improvements		15,239		15,730
Software		36,739		33,513
Property and Equipment, at Cost or Donated Value		633,967		590,558
Less Accumulated Depreciation and Amortization		(39,389)		(21,833)
Property and Equipment, net		594,578		568,725
Total Assets	$	1,462,250	$	924,771
Liabilities and Net Assets				
Current Liabilities:				
Accounts Payable	$	14,300	$	6,254
Accrued Liabilities		12,573		8,231
Deferred Revenue		188,700		23,000
Total Current Liabilities		215,573		37,485
Noncurrent Liabilities - Due to Clay Boardman		400,000		400,000
Total Liabilities		615,573		437,485
Net Assets - Unrestricted		846,677		487,286
Total Liabilities and Net Assets	$	1,462,250	$	924,771

Table 2

CHRIST COMMUNITY HEALTH SERVICES AUGUSTA, INC.
STATEMENT OF OPERATIONS

	YEAR ENDED DECEMBER 31	
	2009	**2008**
Revenues and Other Support		
Net Patient Service Revenue	$ 269,405	$ 115,058
Other Revenue	1,702	577
Total Operating Revenues	271,107	115,635
Operating Expenses		
Salaries and Benefits	558,978	188,295
Insurance Expense	69,927	50,136
Laboratory Fees	58,744	19,062
Medicine, Vaccines, & Medical Supplies	23,486	28,474
Depreciation and Amortization	18,324	14,516
Professional Fees	18,135	4,655
Advertising and Promotions	14,215	3,076
Computer, Software, and Internet	13,347	7,579
Dues and Subscriptions	10,906	10,555
Repairs and Maintenance	10,201	6,525
Printing and Reproductions	10,113	3,861
Property Taxes	5,465	5,455
Other Expenses	43,226	14,767
Total Operating Expenses	855,067	356,956
Operating Loss	(583,960)	(241,321)
Nonoperating Revenues (Expenses)		
Grants	385,000	217,000
Noncapital Contributions	289,577	45,396
Interest Income	7,972	833
Loss on Sale of Assets	(6,198)	(1,240)
Net Nonoperating Revenues	676,351	261,989
Excess of Revenues over Expenses before Capital Grants and Contributions	92,391	20,668
Capital Grants and Contributions	267,000	363,579
Increase in Net Assets	$ 359,391	$ 384,247

Figure 5: Total Expenses versus Medical Service Income



Conclusion

John F. Kennedy famously said "Ask not what your country can do for you, but what you can do for your country." Less famously, Dr. Campbell was known for saying "Ask not what your community can do for you, but what you can do for your community." In an age where recruitment drives emphasized the benefits of a particular community (major league sports team, climate, scenery, commutes, etc.), there was a missionary zeal about CCHSA's operations. All the staff members of CCHSA were selfless in their service, hence fulfilling God's promise to "deliver the needy who cry out, the afflicted who have no one to help" (Psalm 72:12).

Dr. Campbell believed that through medical care, mentorship and community talks and action, the staff of CCHSA could lead the people of Augusta to the heart of God. While patients were healed and their hearts and minds were being changed, Dr. Campbell also saw changes in young physicians. Through exposure to the clinic, they were choosing to specialize in the under-represented fields of primary care and were making lifestyle choices that reflect much more than money.

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[i] Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University, http://www.prosperousathens.org/meetingsevents/060626/Health%20Presentation%206.26.06.pdf

[ii] Two Steps Back: City and Suburban Poverty Trends 1999–2005", Alan Berube and Elizabeth Kneebone, Metropolitan Policy Program, The Brookings Institute, December 2006, http://www.brookings.edu/~/media/Files/rc/reports/2006/12poverty_berube/20061205_citysuburban.pdf