

Hilltown Community Health Center

**Board of Directors Meeting**

**November 11, 2021**

<https://hchcweb-org.zoom.us/j/97600369054?pwd=b2cyeUtm dHNlcGN1R2hINEpWUm90QT09>

Meeting ID: 976 0036 9054

Passcode: 627611

5:30 p.m. – 7:30 p.m.

**AGENDA**

<b><u>Time</u></b>	<b><u>Topic</u></b>	<b><u>Purpose</u></b>	<b><u>Presenter</u></b>
5:30 PM	Call to Order and Approval of Minutes	Vote Needed	Lee Manchester
5:35 PM	Finance Committee Report	Vote Needed	Treasurer John Melehov
5:50 PM	Committee Reports <ul style="list-style-type: none"><li>Executive Committee</li><li>Fundraising Committee</li><li>Personnel</li><li>Facilities</li><li>Recruitment Orientation and Nomination</li><li>Strategic Planning</li></ul>	Vote Needed	Lee Manchester Nancy Brenner John Follet Alan Gaitenby Wendy Long  Nancy Brenner
6:10 PM	Senior Management Reports <ul style="list-style-type: none"><li>Credentialing and Privileging Report</li><li>Quality Improvement Report</li><li>Risk Management</li><li>CEO Report</li><li>Employee Recognition(s)</li></ul>	Vote Needed Vote Needed Vote Needed Inform/Discussion Inform	Michael Purdy Vickie Dempsey Michael Purdy Eliza Lake Senior Managers
6:40 PM	Staff Presentation <ul style="list-style-type: none"><li>Staff Experience Survey</li></ul>	Inform	Eliza Lake
6:55 PM	New Business <ul style="list-style-type: none"><li>Clinical Policies</li><li>HIPAA Policies</li><li>Hours of Operation</li></ul>	Vote Needed Vote Needed Vote Needed	Eliza Lake Eliza Lake Eliza Lake
7:10 PM	Executive Session	Discussion	Lee Manchester
7:30 PM	Adjourn	Vote Needed	Lee Manchester

**Upcoming Meetings**

- Thursday, December 9, 2021 at 5:30 PM via Zoom
- Thursday, January 13, 2022 at 5:30 PM via Zoom
- Thursday, February 10, 2022 at 5:30 PM via Zoom

## HCHC BOARD OF DIRECTORS MINUTES

Date/Time: 10/14/2021 5:30pm

Zoom Meeting

**MEMBERS:** Lee Manchester, President; John Follet, Vice President; Nancy Brenner; Alan Gaitenby; Kathryn Jensen, Clerk; Carole Bergeron; Jennica Gallagher; Seth Gemme; Elizabeth Zuckerman;

**STAFF:** Eliza Lake, CEO; John Melehov, CFO; Vickie Dempsey, COO; Tabitha Griswold, Executive Assistant; Michael Purdy, CCCSO

**EXCUSED:** Matt Bannister; Wendy Long

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Minutes 9/9/2021	<p>Lee Manchester called the meeting to order at 5:34 pm.</p> <p>The September minutes were review and no amendments were noted.</p> <p><b>Kathryn Jensen moved to approve the September minutes. Nancy Brenner seconded the motion.</b></p>	The Board unanimously approved to the September 9 <sup>th</sup> minutes.
Finance Committee	<ul style="list-style-type: none"><li>John Follet reported on the Interim Financial Statement for August. John noted a positive \$48K net income, and positive cash flow of \$57K. The revenue is similar to previous months in 2021. This month is relatively typical as compared to last month where the PPP grant funds are seen. The comparison to 2019 still shows the deficits in the patient revenue, with a slight uptick in Optometry with a new Optometrist. Management is looking at potential productivity for 2022 in comparison to 2019 as opposed to 2020 and 2021. As we move to a capitated model of payment, we will no longer report on claims billed since we will be paid a capitated rate for every patient in the model; we will need to discuss how the committee will want to present those metrics. Salaries are relatively on budget and the same as last month. Balance sheet tracking relatively the same as last month with a current ratio of 3.4.</li></ul>	The Board voted unanimously to approve the Finance Committee report.

	<ul style="list-style-type: none"> <li>• John also noted that the committee approved expenses for capital projects that included the re-paving of Worthington and Huntington's parking lots for \$83K and the pouring of the rat slab in Worthington for \$105K out of the \$605K capital grant received.</li> <li>• The HVAC system was included in the budget of the capital grant, but the number was small and that project is still in the exploratory phase.</li> <li>• The application for CMS's Provider Relief Fund opened this month. Submitted an application that includes financial statements back to 2019. The reviewing agency will do the math to see what we may qualify for, but the exact numbers are unknown. Last time we received ~\$150K from this fund.</li> </ul> <p><b>Alan Gaitenby moved to approve the Finance Committee report. Jenicca Gallagher seconded the motion.</b></p>	
Executive Committee	<ul style="list-style-type: none"> <li>• This committee met briefly last month. The committee looked at a patient letter that was sent to the Board, to discuss a potential response. This will be discussed more during the Risk Management agenda item.</li> </ul>	
Fundraising Committee	<ul style="list-style-type: none"> <li>• This Committee met this month. The annual report was mailed to recent donors on September 24<sup>th</sup>, and an electronic version will be forward to more donors, patients, and community partners soon. Paper copies will be sent to all Board members but a link to the electronic version was emailed to the Board for the time being. The last quarter fundraising plan is for outreach to major and consistent donors by Eliza and Alex for relationship cultivation and a soft ask. The goal was to raise \$100,00 but purposefully have put that on hold this year due to the extensive grant funding received.</li> </ul>	
Personnel Committee	<ul style="list-style-type: none"> <li>• The Committee has not met, but the Staff Satisfaction Survey is being analyzed by the HR Dept. to identify the top areas to focus on and Management will create proposed action steps to address those issues.</li> </ul>	
Facilities Committee	<ul style="list-style-type: none"> <li>• Alan Gaitenby reported that the Committee met last month. The rat slab is scheduled to be poured this month. The re-paving of Worthington and Huntington is</li> </ul>	

	<p>hopeful before the winter and on a Saturday. The solar array is installed in Worthington, just waiting on electric inspection, and scheduling a ribbon cutting event. There is a leak in Worthington's roof in the older part of the building that is being looked into. As discussed above, the HVAC system repair and install is still in the exploratory phase with an architect developing a proposal. Eliza noted that there is potentially a USDA grant opportunity to pay up to \$1 million toward the HVAC project. The concrete handicap ramp in Worthington will need to be repaired, as well as some small painting projects.</p>	
RON Committee	<ul style="list-style-type: none"> <li>This committee has not met. Alan is still working to connect with a potential candidate.</li> </ul>	
Strategic planning	<ul style="list-style-type: none"> <li>Nancy Brenner reported that the committee will meet this month, more to come next month.</li> </ul>	
Committee Reports	<p><b>Nancy Brenner moved that the Committee reports be approved. Jenicca Gallagher seconded the motion.</b></p>	The Board voted unanimously to approve the Committee Reports.
Credentialing/ Privileging Report	<ul style="list-style-type: none"> <li>Michael Purdy presented a report on the following new employees for the month of September were credentialed and privileged: <ul style="list-style-type: none"> <li>Lily Caban, LPN</li> <li>Jessica Beaudry, Dental Assistant at BSBHC</li> <li>Crystal Tuft, Dental Assistant</li> <li>Amy Shaw, BH Intern</li> </ul> </li> </ul> <p><b>John Follet moved that the Credentialing and Privileging Report of the above employees be approved. Alan Gaitenby seconded the motion.</b></p>	The Board voted unanimously to approve the Credentialing and Privileging Report.
Quality Improvement/ Risk Management	<p>Vickie Dempsey reported that QI met and two department dashboards were presented. Furniture has been ordered for BH offices at each site. Full time Optometry services are offered now that Michael is able to step into more administrative roles. Another topic of discussion in the various methods of staff communication and looking at developing an employee portal on the website. The day and</p>	The Board voted unanimously to approve the Quality Improvement Report.

	<p>time of the QI committee may be moving to every other month meeting for two hours at a time.</p> <p>Vickie presented the 6-month QI reports. This a summary report of all the QI activities that has improved quality of care and mitigated risks. There was no further discussion on the reports as presented.</p> <p><b>Seth Gemme moved to accept the Quality Improvement report and the 6 month QI Summary Reports , Kathryn Jensen seconded that motion.</b></p> <ul style="list-style-type: none"> <li>• Michael Purdy reported on Risk Management on the areas of risk, which have not changed the last few months. Staffing continues to be an issue with employees for access and quality. There are staff trainings on vicarious trauma and de-escalation being scheduled.</li> <li>• Lee presented the letter that was received from a patient in September addressed to the Board. The patient makes some comments on his experience of his care at HCHC dating back to quite some time ago, some of those comments on medical providers that are no longer with HCHC. The letter praises the Dental Department. It expresses some frustration in his appointments being re-scheduled due to provider turn-over. The Board drafted a response that acknowledged receipt of the letter and directed the CEO, Eliza Lake, to respond to the patient. Eliza will follow up.</li> </ul> <p><b>Alan Gaitenby moved to accept the Risk Management report, Nancy Brenner seconded that motion.</b></p>	<p>The Board voted unanimously to approve the Risk Management Report.</p>
CEO Report	<ul style="list-style-type: none"> <li>• Eliza provided brief updates on the Board portal that will be up and ready to use at next month's meeting. The Epic EHR project had some slight changes in cost that were minimal. Eliza signed the official Letter of Intent and C3 has begun hiring staff for the new LLC it is creating to run the project.</li> <li>• A new medical provider will be starting soon in Worthington and SBHC.</li> </ul>	

	<ul style="list-style-type: none"> <li>• The DEI Committee met for the first time with DEI consultant to do an assessment and develop a plan to move forward.</li> <li>• The new legislative districts were announced this week, and they will mean a change of representation for most Hilltown communities. Eliza will work to develop relationships with the new legislators, once the new maps go into effect in 2023.</li> <li>• The room assessment project is ongoing and moving forward to use the spaces as efficiently as possible.</li> <li>• Eliza provided a presentation on the recent labor shortage and HCHC's response to that national issue. There was no further discussion on this topic.</li> </ul>	
New Business	<ul style="list-style-type: none"> <li>• Eliza Lake presented the School-Based Health Center policies recommended for approval. These policies have not changed. <ul style="list-style-type: none"> <li>○ School Based Health Center Process Policy</li> <li>○ School Based Health Center Administrative Policy</li> </ul> </li> </ul> <p><b>Alan Gaitenby motion to approve the above slate of Administrative Policies and Alan Nancy Brenner seconded the motion.</b></p>	The Board voted unanimously to approve the slate of SBHC Policies.
Old Business	<ul style="list-style-type: none"> <li>• The COVID-19 and Influenza Policy was put into effect and there has been a handful of medical and religious exemptions from staff. There is a committee reviewing those requests and there will likely be a few staff members that will resign. On the suggestion of legal counsel, those staff members still not in compliance will be put on a 30-day unpaid leave, and they may be able to re-join if they can demonstrate compliance in that time period.</li> <li>• There were no objections to the meeting being held on November 11<sup>th</sup>, which follows on Veteran's Day.</li> </ul>	
Adjourn	<p>The meeting was adjourned at 7:50 pm. The next scheduled meeting will be November 11, 2021, via Zoom.</p> <p><b>Alan Gaitenby moved the meeting be adjourned. Nancy Brenner seconded the motion.</b></p>	The Board voted unanimously to approve adjournment.

Respectfully submitted,  
Tabitha Griswold, Executive Assistant



# Hilltown Community Health Center

## Interim Financial Statement Presentation

September 2021 - Presented 11/10/2021



# Highlights

- ▶ **\$176K** Net Income
- ▶ **\$116K** cash flow

# Income Statement

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	Sept Actual	YTD Total Actual	PY YTD Actual	\$ Change	% Change	YTD Feb Budget	Variance	%
OPERATING ACTIVITIES																
Revenue																
Patient Services - Medical	\$135,440	\$144,778	\$192,632	\$202,177	\$169,384	\$167,088	\$147,433	\$169,260	\$181,349	\$1,509,541	\$1,321,851	\$187,690	14%	\$1,443,324	\$66,217	5%
Patient Services - Dental	\$106,182	\$97,030	\$137,833	\$118,194	\$122,025	\$120,310	\$121,297	\$120,651	\$140,417	\$1,083,940	\$571,982	\$511,958	90%	\$915,138	\$168,802	18%
Patient Services - Beh. Health	\$36,624	\$35,380	\$44,740	\$42,979	\$35,995	\$40,690	\$34,426	\$40,712	\$44,950	\$356,496	\$294,366	\$62,129	21%	\$313,013	\$43,483	14%
Patient Services - Optometry	\$9,337	\$8,577	\$11,981	\$12,558	\$16,778	\$16,583	\$14,991	\$18,032	\$27,548	\$136,385	\$97,508	\$38,876	40%	\$143,403	(\$7,019)	-5%
Patient Services - Optometry Hardware	\$6,162	\$6,444	\$8,379	\$7,537	\$5,192	\$8,823	\$8,582	\$11,411	\$13,471	\$76,000	\$38,887	\$37,113	95%	\$62,584	\$13,416	21%
Patient Services - Pharmacy	\$37,224	\$35,267	\$21,233	\$38,116	\$88,012	\$67,514	\$75,556	\$64,444	\$76,030	\$503,396	\$230,090	\$273,306	119%	\$487,500	\$15,896	3%
Quality & Other Incentives	\$3,776	\$9,268	\$6,325	\$80	\$7,495	\$235	\$2,442	\$597	\$12,290	\$42,508	\$33,789	\$8,719	26%	\$48,450	(\$5,942)	-12%
HRSA 330 & Other Grant	\$261,014	\$215,010	\$212,593	\$477,985	\$313,961	\$15,079	\$287,954	\$270,617	\$406,412	\$2,460,623	\$1,073,600	\$1,387,024	129%	\$1,364,774	\$1,095,849	80%
Other Grants & Contracts	\$49,817	\$119,646	\$107,004	\$113,668	\$105,608	\$94,683	\$1,557,290	\$76,148	\$116,600	\$2,340,465	\$1,275,998	\$1,064,467	83%	\$1,458,150	\$882,315	61%
Int., Dividends Gain /Loss Investmenst	(\$465)	\$11,231	\$9,823	\$16,568	\$3,452	\$7,501	\$3,151	\$10,718	(\$17,053)	\$44,926	\$8,887	\$36,039	-406%	\$26,523	\$18,403	69%
Rental & Misc. Income	\$2,577	\$2,567	\$2,577	\$2,938	\$4,632	\$2,587	\$4,137	\$1,352	\$2,583	\$25,952	\$25,029	\$922	4%	\$11,345	\$14,606	129%
Total Operating Revenue	\$647,688	\$685,199	\$755,120	\$1,032,797	\$872,534	\$541,096	\$2,257,259	\$783,942	\$1,004,596	\$8,580,232	\$4,971,987	\$3,608,245	73%	\$6,274,206	\$2,306,026	37%

- ▶ All patient revenues up over August
- ▶ All service-related revenue totals \$295K over budget
- ▶ HRSA charged extra in September due to 3<sup>rd</sup> payroll (not offset by payroll expense due to accrual)

## YTD 2021 vs 2019

OPERATING ACTIVITIES				Jan - Sep 2021	Jan -Sep 2019	Difference	%
Revenue							
	Patient Services - Medical			\$1,509,541	\$1,961,939	(\$452,398)	-23%
	Patient Services - Dental			\$1,083,940	\$1,442,506	(\$358,566)	-25%
	Patient Services - Beh. Health			\$356,496	\$279,226	\$77,270	28%
	Patient Services - Optometry			\$136,385	\$163,437	(\$27,052)	-17%
	Patient Services - Optometry Hardware			\$76,000	\$69,719	\$6,281	9%
	Patient Services - Pharmacy			\$503,396	\$96,378	\$407,018	422%
	Quality & Other Incentives			\$42,508	\$36,884	\$5,624	15%
	HRSA 330 & Other Grant			\$2,460,623	\$1,295,193	\$1,165,431	90%
	Other Grants & Contracts			\$2,340,465	\$638,223	\$1,702,242	267%
	Int., Dividends Gain /Loss Investmenst			\$44,926	\$40,968	\$3,958	10%
	Rental & Misc. Income			\$25,952	\$23,560	\$2,392	10%
	Total Operating Revenue			\$8,580,232	\$6,048,032	\$2,532,200	42%

(\$342K) net service-related deficiency from 2019

	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	Sept Actual	YTD Total Actual	PY YTD Actual	\$ Change	% Change	YTD Feb Budget	Variance	%
Compensation and related expenses																
Salaries and wages	(\$443,161)	(\$433,354)	(\$454,897)	(\$518,263)	(\$440,009)	(\$437,129)	(\$471,423)	(\$471,111)	(\$504,781)	(\$4,174,128)	(\$3,559,930)	(\$614,198)	-17%	(\$3,926,895)	(\$247,233)	-6%
Payroll taxes	(\$33,016)	(\$32,472)	(\$34,730)	(\$40,583)	(\$31,419)	(\$32,596)	(\$34,238)	(\$33,317)	(\$37,823)	(\$310,193)	(\$254,054)	(\$56,139)	-22%	(\$370,869)	\$60,675	16%
Fringe benefits	(\$47,695)	(\$42,289)	(\$44,019)	(\$44,255)	(\$34,574)	(\$47,233)	(\$43,855)	(\$44,773)	(\$48,494)	(\$397,187)	(\$306,668)	(\$90,519)	-30%	(\$355,208)	(\$41,978)	-12%
Total Compensation & related exp	(\$523,873)	(\$508,115)	(\$533,645)	(\$603,101)	(\$506,002)	(\$516,958)	(\$549,516)	(\$549,201)	(\$591,099)	(\$4,881,508)	(\$4,120,652)	(\$760,856)	-18%	(\$4,652,971)	(\$228,536)	-5%

- Payroll related expense increased due to new hires, salary adjustments, & OT



	Jan Actual	Feb Actual	Mar Actual	Apr Actual	May Actual	June Actual	Jul Actual	Aug Actual	Sept Actual	YTD Total Actual	PY YTD Actual	\$ Change	% Change	YTD Feb Budget	Variance	%
<b>Other Operating Expenses</b>																
Advertising and marketing	(\$10)	(\$223)	\$0	(\$500)	(\$20,358)	(\$1,560)	(\$603)	(\$359)	(\$875)	(\$24,488)	(\$1,496)	(\$22,991)	-1536%	(\$5,554)	(\$18,934)	-341%
Bad debt	(\$10,871)	(\$7,853)	(\$8,793)	(\$11,750)	(\$4,063)	(\$17,971)	(\$11,814)	(\$11,018)	(\$10,519)	(\$94,652)	(\$11,247)	(\$83,405)	-742%	(\$59,852)	(\$34,800)	-58%
Computer support	(\$8,840)	(\$15,246)	(\$7,868)	(\$17,719)	(\$18,855)	(\$8,487)	(\$8,218)	(\$11,996)	(\$11,991)	(\$109,220)	(\$83,710)	(\$25,509)	-30%	(\$98,854)	(\$10,366)	-10%
Conference and meetings	(\$2,087)	(\$440)	(\$1,910)	(\$35)	(\$607)	(\$5,235)	(\$65)	(\$2,375)	(\$664)	(\$13,417)	(\$5,510)	(\$7,908)	-144%	(\$5,880)	(\$7,537)	-128%
Continuing education	(\$1,522)	(\$7,870)	(\$281)	(\$5,171)	(\$1,678)	(\$880)	(\$1,150)	(\$1,196)	(\$828)	(\$20,576)	(\$6,491)	(\$14,086)	-217%	(\$27,000)	\$6,424	24%
Contracts and consulting	(\$13,540)	(\$8,482)	(\$12,971)	(\$10,791)	(\$11,736)	(\$27,756)	(\$8,878)	(\$17,847)	(\$9,907)	(\$121,908)	(\$205,394)	\$83,486	41%	(\$99,900)	(\$22,008)	-22%
Depreciation and amortization	(\$26,315)	(\$26,315)	(\$26,315)	(\$26,315)	(\$26,315)	(\$26,315)	(\$26,315)	(\$26,315)	(\$26,315)	(\$236,839)	(\$256,899)	\$20,060	8%	(\$256,899)	\$20,060	8%
Dues and membership	(\$6,731)	(\$1,857)	(\$4,579)	(\$4,841)	(\$7,571)	(\$3,181)	(\$4,111)	(\$2,849)	(\$2,039)	(\$37,758)	(\$32,630)	(\$5,128)	-16%	(\$36,544)	(\$1,214)	-3%
Equipment leases	(\$1,535)	(\$3,829)	(\$2,126)	(\$1,131)	(\$1,831)	(\$1,366)	(\$1,325)	(\$1,858)	(\$1,452)	(\$16,454)	(\$18,751)	\$2,296	12%	(\$19,999)	\$3,545	18%
Insurance	(\$2,206)	(\$2,319)	(\$2,330)	(\$2,364)	(\$2,364)	(\$2,364)	(\$2,364)	(\$2,364)	(\$2,364)	(\$21,042)	(\$19,683)	(\$1,359)	-7%	(\$19,768)	(\$1,274)	-6%
Interest	(\$354)	(\$350)	(\$313)	(\$342)	(\$327)	(\$2,240)	\$1,907	\$0	\$0	(\$2,019)	(\$10,526)	\$8,507	81%	(\$3,209)	\$1,251	38%
Legal and accounting	(\$2,630)	(\$4,167)	(\$2,501)	(\$2,508)	(\$2,433)	(\$4,620)	(\$8,833)	(\$2,908)	(\$6,835)	(\$37,438)	(\$23,189)	(\$14,249)	-61%	(\$31,393)	(\$6,045)	-19%
Licenses and fees	(\$5,283)	(\$1,628)	(\$2,347)	(\$6,149)	(\$5,744)	(\$6,208)	(\$5,377)	(\$4,583)	(\$4,745)	(\$42,063)	(\$36,526)	(\$5,537)	-15%	(\$35,325)	(\$6,738)	-19%
Medical & dental lab and supplies	(\$6,811)	(\$7,785)	(\$7,342)	(\$12,376)	(\$9,361)	(\$7,796)	(\$12,954)	(\$8,630)	(\$10,056)	(\$83,111)	(\$48,719)	(\$34,391)	-71%	(\$69,195)	(\$13,915)	-20%
Merchant CC Fees	(\$136)	(\$1,601)	(\$1,403)	(\$1,542)	(\$1,186)	(\$1,350)	(\$2,021)	(\$1,774)	(\$1,892)	(\$12,905)	(\$10,996)	(\$1,909)	-17%	(\$10,813)	(\$2,091)	-19%
Office supplies and printing	(\$4,214)	(\$1,759)	(\$6,798)	(\$1,340)	(\$2,352)	(\$3,393)	(\$2,900)	(\$2,943)	(\$4,824)	(\$30,522)	(\$51,977)	\$21,455	41%	(\$43,972)	\$13,450	31%
Postage	(\$2,189)	(\$1,701)	(\$165)	(\$63)	(\$2,190)	(\$450)	(\$2,067)	(\$1,801)	(\$2,342)	(\$12,969)	(\$11,437)	(\$1,533)	-13%	(\$12,600)	(\$369)	-3%
Program supplies and materials	(\$15,432)	(\$10,809)	(\$31,160)	(\$31,302)	(\$38,363)	(\$44,685)	(\$21,324)	(\$22,122)	(\$37,000)	(\$252,198)	(\$148,930)	(\$103,268)	-69%	(\$173,250)	(\$78,948)	-46%
Pharmacy & Optometry COGS	\$426	(\$14,659)	(\$9,127)	(\$10,043)	(\$7,757)	(\$12,263)	(\$17,663)	(\$18,717)	(\$57,767)	(\$147,570)	(\$96,272)	(\$51,298)	-53%	(\$220,292)	\$72,723	33%
Recruitment	\$0	(\$5,040)	\$0	\$0	(\$105)	\$0	(\$50)	\$0	\$0	(\$5,195)	(\$4,666)	(\$529)	-11%	\$0	(\$5,195)	
Rent	(\$9,927)	(\$9,227)	(\$10,053)	(\$12,919)	(\$12,152)	(\$11,665)	(\$10,595)	(\$9,681)	(\$10,727)	(\$96,946)	(\$110,653)	\$13,707	12%	(\$77,396)	(\$19,550)	-25%
Repairs and maintenance	(\$17,864)	(\$17,421)	(\$15,978)	(\$21,441)	(\$13,492)	(\$16,237)	(\$13,532)	(\$20,242)	(\$13,213)	(\$149,420)	(\$135,609)	(\$13,811)	-10%	(\$131,782)	(\$17,638)	-13%
Small equipment purchases	(\$7,898)	(\$1,595)	(\$38,441)	(\$30,619)	(\$11,501)	(\$14,891)	(\$10,194)	(\$1,568)	(\$30,166)	(\$146,874)	(\$28,008)	(\$118,865)	-424%	(\$38,911)	(\$107,963)	-277%
Telephone	(\$11,151)	(\$13,513)	(\$14,943)	(\$13,888)	(\$14,759)	(\$14,179)	(\$11,218)	(\$14,383)	(\$13,816)	(\$121,849)	(\$126,290)	\$4,441	4%	(\$129,607)	\$7,758	6%
Travel	(\$619)	(\$572)	(\$1,258)	(\$2,971)	(\$1,222)	(\$1,327)	(\$2,379)	(\$2,723)	(\$1,044)	(\$14,114)	(\$9,682)	(\$4,432)	-46%	(\$18,000)	\$3,886	22%
Utilities	(\$5,193)	(\$7,258)	(\$4,052)	(\$3,808)	(\$4,576)	(\$6,304)	(\$3,861)	(\$3,746)	(\$3,778)	(\$42,576)	(\$34,530)	(\$8,046)	-23%	(\$42,750)	\$174	0%
<b>Total Other Operating Expenses</b>	<b>(\$162,934)</b>	<b>(\$173,520)</b>	<b>(\$213,057)</b>	<b>(\$231,929)</b>	<b>(\$222,897)</b>	<b>(\$242,724)</b>	<b>(\$187,906)</b>	<b>(\$193,998)</b>	<b>(\$265,158)</b>	<b>(\$1,894,122)</b>	<b>(\$1,529,821)</b>	<b>(\$364,301)</b>	<b>-24%</b>	<b>(\$1,668,806)</b>	<b>(\$225,316)</b>	<b>-14%</b>
<b>NET OPERATING SURPLUS</b>	<b>(\$39,118)</b>	<b>\$3,564</b>	<b>\$8,418</b>	<b>\$197,767</b>	<b>\$143,635</b>	<b>(\$218,585)</b>	<b>\$1,519,837</b>	<b>\$40,744</b>	<b>\$148,340</b>	<b>\$1,804,602</b>	<b>(\$678,486)</b>	<b>\$2,483,088</b>	<b>366%</b>	<b>(\$47,572)</b>	<b>\$1,852,173</b>	<b>3893%</b>
<b>NON-OPERATING ACTIVITIES</b>																
Donations, Pledges & Contributions	\$1,870	\$1,549	\$640	\$50	\$2,755	\$150	\$175	\$7,000	\$20,432	\$36,921	\$107,162	(\$70,241)	-66%	\$78,750	(\$41,829)	-53%
	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$7,650	\$7,650	\$0	\$7,650	0%	\$0	\$7,650	
<b>NET NON-OPERATING SURPLUS</b>	<b>\$1,870</b>	<b>\$1,549</b>	<b>\$640</b>	<b>\$50</b>	<b>\$2,755</b>	<b>\$150</b>	<b>\$175</b>	<b>\$7,000</b>	<b>\$28,082</b>	<b>\$44,571</b>	<b>\$107,162</b>	<b>(\$70,241)</b>	<b>-66%</b>	<b>\$78,750</b>	<b>(\$34,179)</b>	<b>-43%</b>
<b>NET SURPLUS/(DEFICIT)</b>	<b>(\$37,248)</b>	<b>\$5,113</b>	<b>\$9,058</b>	<b>\$197,817</b>	<b>\$146,390</b>	<b>(\$218,435)</b>	<b>\$1,520,012</b>	<b>\$47,744</b>	<b>\$176,422</b>	<b>\$1,849,172</b>	<b>(\$571,324)</b>	<b>\$2,412,847</b>	<b>422%</b>	<b>\$31,178</b>	<b>\$1,817,994</b>	<b>5831%</b>

- Pharmacy COGS up by \$40K
- Grant funded purchases and deposits for projects

# Cash Flow

<b>CASH FLOWS FROM OPERATING ACTIVITIES</b>		
	NET SURPLUS/(DEFICIT) FOR PERIOD	176,422
	PROVIDED (USED) BY OPERATING ACTIVITIES	(17,162)
	NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES	159,260
<b>CASH FLOWS FROM INVESTING ACTIVITIES</b>		
	NET CASH PROVIDED (USED) BY INVESTING ACTIVITIES	(43,272)
	NET INCREASE/(DECREASE) IN CASH	115,989
	CASH AND CASH EQUIVALENTS AS OF 9/1/2021	3,606,498
	CASH AND CASH EQUIVALENTS AS OF 9/30/2021	3,722,487

- Cash on hand increased **\$116K**

# Balance Sheet

ASSETS		
	Total Current Assets	\$3,792,437
	Total Property and Equipment	\$7,240,779
	Less Accumulated Depreciation	(\$3,333,094)
	Net Property & Equipment	\$3,907,685
	Total Other Assets	\$400,691
	<b>TOTAL ASSETS</b>	<b>\$8,100,813</b>
<b>Liabilities &amp; Fund Balance</b>		
	Total Current Liabilities	\$1,013,451
	Total Long Term Liabilities	\$0
	<b>Total Liabilities</b>	<b>\$1,013,451</b>
	Fund Balance / Equity	
	Fund Balance Prior Periods	\$7,087,362
	Total Fund Balance / Equity	\$7,087,362
	<b>Total Liabilities &amp; Fund Balance</b>	<b>\$8,100,813</b>

▶ Current Assets = \$3.8 M

▶ Current Liabilities = \$1 M

▶ Current Ratio = 3.74



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 private foundations)

▶ Do not enter social security numbers on this form as it may be made public.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2020**Open to Public  
Inspection**A For the 2020 calendar year, or tax year beginning and ending****B** Check if applicable:

- ☐ Address change  
☐ Name change  
☐ Initial return  
☐ Final return/terminated  
☐ Amended return  
☐ Application pending

**C** Name of organization

HILLTOWN COMMUNITY HEALTH CENTERS, INC

Doing business as

Number and street (or P.O. box if mail is not delivered to street address)

58 OLD NORTH ROAD

Room/suite

City or town, state or province, country, and ZIP or foreign postal code

WORTHINGTON, MA 01098

**F** Name and address of principal officer: JOHN FOLLET

SAME AS C ABOVE

**D** Employer identification number

04-2161484

**E** Telephone number

(413) 238-5511

**G** Gross receipts \$

8,741,607.

**H(a)** Is this a group returnfor subordinates? ☐ Yes ☒ No**H(b)** Are all subordinates included? ☐ Yes ☐ No

If "No," attach a list. See instructions

**H(c)** Group exemption number ▶**I** Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) ( ) (insert no.) ☐ 4947(a)(1) or ☐ 527**J** Website: ▶ WWW.HCHCWEB.ORG**K** Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶**L** Year of formation: 1950**M** State of legal domicile: MA**Part I Summary**

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: SEE SCHEDULE O		
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	10
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	10
	<b>5</b> Total number of individuals employed in calendar year 2020 (Part V, line 2a)	<b>5</b>	135
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	0
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	0.
<b>b</b> Net unrelated business taxable income from Form 990-T, Part I, line 11	<b>7b</b>	0.	
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	<b>9</b> Program service revenue (Part VIII, line 2g)	223,584.	1,446,342.
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	7,798,206.	7,185,196.
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	5,350.	5,246.
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	179,788.	69,938.
<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	8,206,928.	8,706,722.
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0.	0.
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	6,325,627.	5,917,644.
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 18,723.	0.	0.
	<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	1,864,874.	2,014,009.
	<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	8,190,501.	7,931,653.
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	16,427.	775,069.	
<b>Net Assets or Fund Balances</b>	<b>20</b> Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	<b>21</b> Total liabilities (Part X, line 26)	5,468,257.	6,561,715.
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	1,099,287.	1,367,810.
		4,368,970.	5,193,905.

**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.

<b>Sign Here</b>	Signature of officer	Date
	JOHN FOLLET, PRESIDENT Type or print name and title	
<b>Paid Preparer Use Only</b>	Print/Type preparer's name	Preparer's signature
	CAROL J LEIBINGER-HEALEY	
	Date	Check <input type="checkbox"/> if self-employed
	10/28/21	PTIN P00849882
	Firm's name ▶ ADELSON & COMPANY PC	Firm's EIN ▶ 20-5711238
	Firm's address ▶ 100 NORTH STREET PITTSFIELD, MA 01201	Phone no. 413-443-6408

May the IRS discuss this return with the preparer shown above? See instructions ☒ Yes ☐ No



**Part III Statement of Program Service Accomplishments**

Check if Schedule O contains a response or note to any line in this Part III

☒

- 1**
- Briefly describe the organization's mission:

SEE SCHEDULE O

- 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 organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations 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 \$ 5,972,480. including grants of \$ ) (Revenue \$ 5,901,195.)**MEDICAL, DENTAL, BEHAVIORAL HEALTH AND OPTOMETRY SERVICES**

HILLTOWN COMMUNITY HEALTH CENTERS, INC. (HCHC) PROVIDES COMPREHENSIVE MEDICAL SERVICES TO RESIDENTS OF THE 11 HILLTOWN COMMUNITIES AND THE SURROUNDING AREAS. OUR TEAM OF BOARD-CERTIFIED PHYSICIANS, NURSE PRACTITIONERS, REGISTERED NURSES, AND MEDICAL ASSISTANTS PROVIDE PREVENTATIVE, ACUTE AND CHRONIC CARE TREATMENT FOR INFANTS, CHILDREN, ADULTS AND ELDERS AT ONE OF OUR THREE HEALTH CENTER SITES. THIS INCLUDES PHYSICAL EXAMS, WELL-CHILD EXAMS, CAMP AND SPORTS PHYSICALS, IMMUNIZATIONS, GYNECOLOGICAL EXAMS INCLUDING COLPOSCOPY WHEN INDICATED, LABORATORY TESTS, LIMITED PHARMACY SERVICES AND LIMITED PODIATRY SERVICES. THE MEDICAL DEPARTMENT SERVED 5,302 PATIENTS IN 2020.

**4b** (Code: ) (Expenses \$ 507,290. including grants of \$ ) (Revenue \$ 274,687.)**OUTREACH AND EDUCATION PROGRAMS**

HCHC PROVIDES A WIDE VARIETY OF OUTREACH AND EDUCATION PROGRAMS. WORKING CLOSELY WITH OUR MEDICAL DEPARTMENT WE OFFER WELLNESS PROGRAMS INCLUDING NUTRITION COUNSELING (BOTH INDIVIDUAL AND GROUP), SMOKING CESSATION SERVICES, STRESS REDUCTION AND PHYSICAL ACTIVITY PROGRAMS.

OUR FAMILY PROGRAMS INCLUDE WORKSHOPS FOR PARENTS OF INFANTS AND TODDLERS COVERING TOPICS SUCH AS CHILD-DEVELOPMENT, COMMUNICATION, HEALTH AND SAFETY ISSUES (SUCH AS FAMILY CPR AND FIRST AID), INFANT MASSAGE, BABY SIGN LANGUAGE, SETTING LIMITS AND POSITIVE DISCIPLINE, AND COPING WITH TOUGH MOMENTS. INDIVIDUAL CONSULTATION WITH PARENTS STRUGGLING WITH CHILD REARING ISSUES IS ALSO PROVIDED. HCHC ALSO

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

- 4d**
- Other program services (Describe on Schedule O.)

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

**4e** Total program service expenses **6,479,770.**Form **990** (2020)

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	<b>1</b> X	
<b>2</b> Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> ?	<b>2</b> X	
<b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>	<b>3</b>	X
<b>4</b> <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? <i>If "Yes," complete Schedule C, Part II</i>	<b>4</b>	X
<b>5</b> 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? <i>If "Yes," complete Schedule C, Part III</i>	<b>5</b>	X
<b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? <i>If "Yes," complete Schedule D, Part I</i>	<b>6</b>	X
<b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II</i>	<b>7</b>	X
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>	<b>8</b>	X
<b>9</b> Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X; or provide credit counseling, debt management, credit repair, or debt negotiation services? <i>If "Yes," complete Schedule D, Part IV</i>	<b>9</b>	X
<b>10</b> Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>	<b>10</b> X	
<b>11</b> 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.		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? <i>If "Yes," complete Schedule D, Part VI</i>	<b>11a</b> X	
<b>b</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? <i>If "Yes," complete Schedule D, Part VII</i>	<b>11b</b>	X
<b>c</b> 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? <i>If "Yes," complete Schedule D, Part VIII</i>	<b>11c</b>	X
<b>d</b> 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? <i>If "Yes," complete Schedule D, Part IX</i>	<b>11d</b>	X
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	<b>11e</b>	X
<b>f</b> 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)? <i>If "Yes," complete Schedule D, Part X</i>	<b>11f</b> X	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>	<b>12a</b> X	
<b>b</b> Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	<b>12b</b>	X
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>	<b>13</b>	X
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	X
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? <i>If "Yes," complete Schedule F, Parts I and IV</i>	<b>14b</b>	X
<b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? <i>If "Yes," complete Schedule F, Parts II and IV</i>	<b>15</b>	X
<b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? <i>If "Yes," complete Schedule F, Parts III and IV</i>	<b>16</b>	X
<b>17</b> 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? <i>If "Yes," complete Schedule G, Part I</i>	<b>17</b>	X
<b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II</i>	<b>18</b>	X
<b>19</b> Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>	<b>19</b>	X
<b>20a</b> Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	<b>20a</b>	X
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>20b</b>	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	<b>21</b>	X

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

	Yes	No
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III		X
<b>23</b> 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	X	
<b>24a</b> 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 25a		X
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		
<b>25a</b> <b>Section 501(c)(3), 501(c)(4), and 501(c)(29) 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		X
<b>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		X
<b>26</b> Did the organization report any amount on Part X, line 5 or 22, for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part II		X
<b>27</b> Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? If "Yes," complete Schedule L, Part III		X
<b>28</b> 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):		
<b>a</b> A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? If "Yes," complete Schedule L, Part IV		X
<b>b</b> A family member of any individual described in line 28a? If "Yes," complete Schedule L, Part IV		X
<b>c</b> A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? If "Yes," complete Schedule L, Part IV		X
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M		X
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M		X
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I		X
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II		X
<b>33</b> 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		X
<b>34</b> Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1		X
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
<b>b</b> If "Yes" to line 35a, 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		
<b>36</b> <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		X
<b>37</b> 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		X
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19?	X	

Note: All Form 990 filers are required to complete Schedule O

**Part V Statements Regarding Other IRS Filings and Tax Compliance**Check if Schedule O contains a response or note to any line in this Part V ☐

	Yes	No
<b>1a</b> Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable		
<b>b</b> Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable		
<b>c</b> Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	X	

**Part V** Statements Regarding Other IRS Filings and Tax Compliance (continued)

		Yes	No
<b>2a</b> 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>2a</b> 135		
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	<b>2b</b>	X	
<b>Note:</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year?	<b>3a</b>		X
<b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O	<b>3b</b>		
<b>4a</b> 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)?	<b>4a</b>		X
<b>b</b> If "Yes," enter the name of the foreign country			
See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	<b>5a</b>		X
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	<b>5b</b>		X
<b>c</b> If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	<b>5c</b>		
<b>6a</b> 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 as charitable contributions?	<b>6a</b>		X
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	<b>6b</b>		
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>			
<b>a</b> 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?	<b>7a</b>		X
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided?	<b>7b</b>		
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	<b>7c</b>		X
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year	<b>7d</b>		
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	<b>7e</b>		X
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	<b>7f</b>		X
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	<b>7g</b>		
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	<b>7h</b>		
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	<b>8</b>		
<b>9 Sponsoring organizations maintaining donor advised funds.</b>			
<b>a</b> Did the sponsoring organization make any taxable distributions under section 4966?	<b>9a</b>		
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	<b>9b</b>		
<b>10 Section 501(c)(7) organizations.</b> Enter:			
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12	<b>10a</b>		
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	<b>10b</b>		
<b>11 Section 501(c)(12) organizations.</b> Enter:			
<b>a</b> Gross income from members or shareholders	<b>11a</b>		
<b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	<b>11b</b>		
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?	<b>12a</b>		
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year	<b>12b</b>		
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>			
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state?	<b>13a</b>		
<b>Note:</b> See the instructions for additional information the organization must report on Schedule O.			
<b>b</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	<b>13b</b>		
<b>c</b> Enter the amount of reserves on hand	<b>13c</b>		
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year?	<b>14a</b>		X
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O	<b>14b</b>		
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year?	<b>15</b>		X
If "Yes," see instructions and file Form 4720, Schedule N.			
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income?	<b>16</b>		X
If "Yes," complete Form 4720, Schedule O.			

Form 990 (2020)

**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 on Schedule O. See instructions.

Check if Schedule O contains a response or note to any line in this Part VI

☒**Section A. Governing Body and Management**

	Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year ..... <b>1a</b> 10 If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O.		
<b>b</b> Enter the number of voting members included on line 1a, above, who are independent ..... <b>1b</b> 10		
<b>2</b> 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>2</b>		X
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person? ..... <b>3</b>		X
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? ..... <b>4</b>		X
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets? ..... <b>5</b>		X
<b>6</b> Did the organization have members or stockholders? ..... <b>6</b>		X
<b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? ..... <b>7a</b>		X
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? ..... <b>7b</b>		X
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b> The governing body? ..... <b>8a</b>	X	
<b>b</b> Each committee with authority to act on behalf of the governing body? ..... <b>8b</b>	X	
<b>9</b> 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 on Schedule O ..... <b>9</b>		X

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

	Yes	No
<b>10a</b> Did the organization have local chapters, branches, or affiliates? ..... <b>10a</b>		X
<b>b</b> If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes? ..... <b>10b</b>		
<b>11a</b> Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? ..... <b>11a</b>	X	
<b>b</b> Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
<b>12a</b> Did the organization have a written conflict of interest policy? If "No," go to line 13 ..... <b>12a</b>	X	
<b>b</b> Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? ..... <b>12b</b>	X	
<b>c</b> Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done ..... <b>12c</b>	X	
<b>13</b> Did the organization have a written whistleblower policy? ..... <b>13</b>	X	
<b>14</b> Did the organization have a written document retention and destruction policy? ..... <b>14</b>	X	
<b>15</b> 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?		
<b>a</b> The organization's CEO, Executive Director, or top management official ..... <b>15a</b>	X	
<b>b</b> Other officers or key employees of the organization ..... <b>15b</b>		X
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
<b>16a</b> 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>16a</b>		X
<b>b</b> If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements? ..... <b>16b</b>		

**Section C. Disclosure**

**17** List the states with which a copy of this Form 990 is required to be filed **MA**

**18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
☐ Own website ☒ Another's website ☒ Upon request ☐ Other (explain on Schedule O)

**19** Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

**20** State the name, address, and telephone number of the person who possesses the organization's books and records **►**  
**ELIZA LAKE - (413) 238-5511**  
**58 OLD NORTH ROAD, WORTHINGTON, MA 01098**

**Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**Check if Schedule O contains a response or note to any line 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.
- See instructions for the order in which to list the persons above.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(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) SHERI CHEUNG PHYSICIAN	40.00				X			173,338.	0.	1,980.
(2) ELIZA LAKE CHIEF EXECUTIVE OFFICER	37.50			X				123,822.	0.	22,660.
(3) JONATHAN LIEBMAN MEDICAL DIRECTOR	37.50				X			123,677.	0.	15,474.
(4) MICHAEL PURDY OPTOMETRIST & CHIEF CLINIC	37.50				X			136,262.	0.	1,102.
(5) MARISELA FERMIN-SCHON NURSE PRACTITIONER	40.00				X			119,623.	0.	1,132.
(6) BRENDA CHALOUX NURSE PRACTITIONER	39.50				X			100,108.	0.	2,487.
(7) JOHN FOLLET CHAIR	1.00	X		X				0.	0.	0.
(8) NANCY BRENNER VICE CHAIR	1.00	X		X				0.	0.	0.
(9) KATHRYN JENSEN CLERK	1.00	X		X				0.	0.	0.
(10) M. LEE MANCHESTER DIRECTOR	0.50	X						0.	0.	0.
(11) ALAN GAITENBY DIRECTOR	0.50	X						0.	0.	0.
(12) WENDY LONG DIRECTOR	0.50	X						0.	0.	0.
(13) MATTHEW BANNISTER DIRECTOR	0.50	X						0.	0.	0.
(14) SETH GEMME DIRECTOR	0.50	X						0.	0.	0.
(15) JENICCA GALLAGHER DIRECTOR	0.50	X						0.	0.	0.
(16) KATE ALBRIGHT-HANNA DIRECTOR	0.50	X						0.	0.	0.



**Part VIII Statement of Revenue**Check if Schedule O contains a response or note to any line in this Part VIII ☐

				(A)	(B)	(C)	(D)
				Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1 a</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>	1,323,334.			
	<b>f</b>	All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	123,008.			
	<b>g</b>	Noncash contributions included in lines 1a-1f	<b>1g</b>	\$			
	<b>h</b>	<b>Total.</b> Add lines 1a-1f		1,446,342.			
<b>Program Service Revenue</b>	<b>2 a</b>	<b>PATIENT FEES</b>	Business Code 621110	3,045,730.	3,045,730.		
	<b>b</b>	<b>GOVERNMENT DIRECT AND</b>	621110	2,904,363.	2,904,363.		
	<b>c</b>	<b>PROGRAM REVENUE</b>	624100	666,083.	666,083.		
	<b>d</b>	<b>PHARMACY INCOME</b>	446110	297,944.	297,944.		
	<b>e</b>	<b>STATE FREE CARE</b>	621110	271,076.	271,076.		
	<b>f</b>	All other program service revenue	621110				
	<b>g</b>	<b>Total.</b> Add lines 2a-2f		7,185,196.			
	<b>3</b>	Investment income (including dividends, interest, and other similar amounts)		5,630.			5,630.
<b>4</b>	Income from investment of tax-exempt bond proceeds						
<b>5</b>	Royalties						
<b>Other Revenue</b>	<b>6 a</b>	Gross rents	(i) Real (ii) Personal				
	<b>b</b>	Less: rental expenses					
	<b>c</b>	Rental income or (loss)					
	<b>d</b>	Net rental income or (loss)					
	<b>7 a</b>	Gross amount from sales of assets other than inventory	(i) Securities (ii) Other	10,429.	2,845.		
	<b>b</b>	Less: cost or other basis and sales expenses		10,113.	3,545.		
	<b>c</b>	Gain or (loss)		316.	-700.		
	<b>d</b>	Net gain or (loss)		-384.	-384.		
	<b>8 a</b>	Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18					
	<b>b</b>	Less: direct expenses					
	<b>c</b>	Net income or (loss) from fundraising events					
	<b>9 a</b>	Gross income from gaming activities. See Part IV, line 19					
	<b>b</b>	Less: direct expenses					
	<b>c</b>	Net income or (loss) from gaming activities					
<b>10 a</b>	Gross sales of inventory, less returns and allowances		58,050.				
<b>b</b>	Less: cost of goods sold		21,227.				
<b>c</b>	Net income or (loss) from sales of inventory		36,823.	36,823.			
<b>Miscellaneous Revenue</b>	<b>11 a</b>	<b>MISCELLANEOUS</b>	Business Code 900099	33,115.			33,115.
	<b>b</b>						
	<b>c</b>						
	<b>d</b>	All other revenue					
	<b>e</b>	<b>Total.</b> Add lines 11a-11d		33,115.			
	<b>12</b>	<b>Total revenue.</b> See instructions		8,706,722.	7,221,635.	0.	38,745.



**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).

Check if Schedule O contains a response or note to any line in this Part IX ☐

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.</b>				
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22				
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
<b>4</b> Benefits paid to or for members				
<b>5</b> Compensation of current officers, directors, trustees, and key employees	123,822.		123,822.	
<b>6</b> Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
<b>7</b> Other salaries and wages	4,761,562.	4,100,356.	648,251.	12,955.
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)				
<b>9</b> Other employee benefits	602,868.	378,160.	223,810.	898.
<b>10</b> Payroll taxes	429,392.	379,938.	48,844.	610.
<b>11</b> Fees for services (nonemployees):				
<b>a</b> Management				
<b>b</b> Legal	1,662.		1,662.	
<b>c</b> Accounting	37,060.		37,060.	
<b>d</b> Lobbying				
<b>e</b> Professional fundraising services. See Part IV, line 17				
<b>f</b> Investment management fees				
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)				
<b>12</b> Advertising and promotion	1,845.	716.	1,129.	
<b>13</b> Office expenses	513,920.	424,269.	89,651.	
<b>14</b> Information technology	114,730.	87,687.	26,803.	240.
<b>15</b> Royalties				
<b>16</b> Occupancy	362,057.	324,426.	37,631.	
<b>17</b> Travel	12,872.	9,281.	3,591.	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials				
<b>19</b> Conferences, conventions, and meetings	23,290.	18,931.	4,301.	58.
<b>20</b> Interest	10,686.	9,083.	1,603.	
<b>21</b> Payments to affiliates				
<b>22</b> Depreciation, depletion, and amortization	342,272.	294,617.	47,655.	
<b>23</b> Insurance	26,286.	16,980.	9,306.	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> <b>CONTRACTS/CONSULTING</b>	297,736.	233,931.	63,805.	
<b>b</b> <b>MEDICAL AND DENTAL SUPP</b>	126,169.	126,169.		
<b>c</b> <b>BAD DEBT (RECOVERIES)</b>	-21,201.	-21,201.		
<b>d</b>				
<b>e</b> All other expenses	164,625.	96,427.	64,236.	3,962.
<b>25</b> <b>Total functional expenses.</b> Add lines 1 through 24e	7,931,653.	6,479,770.	1,433,160.	18,723.
<b>26</b> <b>Joint costs.</b> Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here ☐ if following SOP 98-2 (ASC 958-720)

**Part X Balance Sheet**Check if Schedule O contains a response or note to any line in this Part X ☐

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash - non-interest-bearing .....	44,410.	<b>1</b>	907,566.
	<b>2</b> Savings and temporary cash investments .....	144,042.	<b>2</b>	413,429.
	<b>3</b> Pledges and grants receivable, net .....	187,254.	<b>3</b>	508,516.
	<b>4</b> Accounts receivable, net .....	381,527.	<b>4</b>	355,010.
	<b>5</b> Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) .....		<b>6</b>	
	<b>7</b> Notes and loans receivable, net .....		<b>7</b>	
	<b>8</b> Inventories for sale or use .....	11,684.	<b>8</b>	9,863.
	<b>9</b> Prepaid expenses and deferred charges .....	22,557.	<b>9</b>	39,590.
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a</b> 7,078,096.		
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 3,096,252.	<b>10c</b>	3,981,844.
	<b>11</b> Investments - publicly traded securities .....	300,693.	<b>11</b>	345,897.
	<b>12</b> Investments - other securities. See Part IV, line 11 .....		<b>12</b>	
	<b>13</b> Investments - program-related. See Part IV, line 11 .....		<b>13</b>	
	<b>14</b> Intangible assets .....		<b>14</b>	
	<b>15</b> Other assets. See Part IV, line 11 .....	53,709.	<b>15</b>	0.
<b>16</b> <b>Total assets.</b> Add lines 1 through 15 (must equal line 33) .....	5,468,257.	<b>16</b>	6,561,715.	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	588,377.	<b>17</b>	683,840.
	<b>18</b> Grants payable .....		<b>18</b>	
	<b>19</b> Deferred revenue .....	197,221.	<b>19</b>	552,019.
	<b>20</b> Tax-exempt bond liabilities .....		<b>20</b>	
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		<b>21</b>	
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties .....	313,689.	<b>23</b>	131,951.
	<b>24</b> Unsecured notes and loans payable to unrelated third parties .....		<b>24</b>	
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....		<b>25</b>	
	<b>26</b> <b>Total liabilities.</b> Add lines 17 through 25 .....	1,099,287.	<b>26</b>	1,367,810.
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here</b> <input checked="" type="checkbox"/> <b>and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions .....	4,317,367.	<b>27</b>	5,191,095.
	<b>28</b> Net assets with donor restrictions .....	51,603.	<b>28</b>	2,810.
	<b>Organizations that do not follow FASB ASC 958, check here</b> <input type="checkbox"/> <b>and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds .....		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building, or equipment fund .....		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds .....		<b>31</b>	
	<b>32</b> <b>Total net assets or fund balances</b> .....	4,368,970.	<b>32</b>	5,193,905.
	<b>33</b> <b>Total liabilities and net assets/fund balances</b> .....	5,468,257.	<b>33</b>	6,561,715.

Form 990 (2020)

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI ☐

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	8,706,722.
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	7,931,653.
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	775,069.
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	4,368,970.
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	49,866.
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain on Schedule O)	<b>9</b>	0.
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	5,193,905.

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☐

	Yes	No
<b>1</b> 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.		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed 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	<b>2a</b>	<b>X</b>
<b>b</b> Were the organization's financial statements audited by an independent accountant? _____ If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input checked="" type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	<b>2b</b>	<b>X</b>
<b>c</b> 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 on Schedule O.	<b>2c</b>	<b>X</b>
<b>3a</b> 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? _____	<b>3a</b>	<b>X</b>
<b>b</b> If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits _____	<b>3b</b>	<b>X</b>

Form 990 (2020)



**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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....						
<b>2</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>3</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>4 Total.</b> Add lines 1 through 3 .....						
<b>5</b> 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) .....						
<b>6 Public support.</b> Subtract line 5 from line 4.						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>7</b> Amounts from line 4 .....						
<b>8</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....						
<b>9</b> Net income from unrelated business activities, whether or not the business is regularly carried on .....						
<b>10</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....						
<b>11 Total support.</b> Add lines 7 through 10						
<b>12</b> Gross receipts from related activities, etc. (see instructions) .....					12	
<b>13 First 5 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> .....						

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

<b>14</b> Public support percentage for 2020 (line 6, column (f), divided by line 11, column (f)) .....	14	%
<b>15</b> Public support percentage from 2019 Schedule A, Part II, line 14 .....	15	%
<b>16a 33 1/3% support test - 2020.</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 .....		
<b>b 33 1/3% support test - 2019.</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 .....		
<b>17a 10% -facts-and-circumstances test - 2020.</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 VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....		
<b>b 10% -facts-and-circumstances test - 2019.</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 VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization .....		
<b>18 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 .....		

Schedule A (Form 990 or 990-EZ) 2020

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

(Complete only if you checked the box on line 10 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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .....	819,633.	1195890.	575,487.	223,584.	1446342.	4260936.
<b>2</b> 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 .....	7007289.	7212319.	7690512.	7882967.	7243246.	37036333.
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513 .....						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf .....						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge .....						
<b>6 Total.</b> Add lines 1 through 5 .....	7826922.	8408209.	8265999.	8106551.	8689588.	41297269.
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons .....						0.
<b>b</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 .....						0.
<b>c</b> Add lines 7a and 7b .....						0.
<b>8 Public support.</b> (Subtract line 7c from line 6.) .....						41297269.

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
<b>9</b> Amounts from line 6 .....	7826922.	8408209.	8265999.	8106551.	8689588.	41297269.
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources .....	9,133.	11,198.	8,706.	7,017.	5,630.	41,684.
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975 .....						
<b>c</b> Add lines 10a and 10b .....	9,133.	11,198.	8,706.	7,017.	5,630.	41,684.
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on .....						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) .....	46,637.	95,628.	44,376.	57,089.	33,115.	276,845.
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.) .....	7882692.	8515035.	8319081.	8170657.	8728333.	41615798.

**14 First 5 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**

<b>15</b> Public support percentage for 2020 (line 8, column (f), divided by line 13, column (f)) .....	<b>15</b>	99.23 %
<b>16</b> Public support percentage from 2019 Schedule A, Part III, line 15 .....	<b>16</b>	98.94 %

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

<b>17</b> Investment income percentage for 2020 (line 10c, column (f), divided by line 13, column (f)) .....	<b>17</b>	.10 %
<b>18</b> Investment income percentage from 2019 Schedule A, Part III, line 17 .....	<b>18</b>	.11 %

**19a 33 1/3% support tests - 2020.** 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 - 2019.** 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 Supporting Organizations**

(Complete only if you checked a box in line 12 on Part I. If you checked box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

	Yes	No
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.		
<b>2</b> Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? If "Yes," explain in <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).		
<b>3a</b> Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer lines 3b and 3c below.		
<b>b</b> Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? If "Yes," describe in <b>Part VI</b> when and how the organization made the determination.		
<b>c</b> Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.		
<b>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? If "Yes," and if you checked box 12a or 12b in Part I, answer lines 4b and 4c below.		
<b>b</b> Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.		
<b>c</b> Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? If "Yes," explain in <b>Part VI</b> what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.		
<b>5a</b> Did the organization add, substitute, or remove any supported organizations during the tax year? If "Yes," answer lines 5b and 5c below (if applicable). Also, provide detail in <b>Part VI</b> , including (i) the names and EIN numbers of the supported organizations added, substituted, or removed; (ii) the reasons for each such action; (iii) the authority under the organization's organizing document authorizing such action; and (iv) how the action was accomplished (such as by amendment to the organizing document).		
<b>b</b> <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
<b>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
<b>6</b> Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in <b>Part VI</b> .		
<b>7</b> Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).		
<b>8</b> Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).		
<b>9a</b> Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons, as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? If "Yes," provide detail in <b>Part VI</b> .		
<b>b</b> Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? If "Yes," provide detail in <b>Part VI</b> .		
<b>c</b> Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? If "Yes," provide detail in <b>Part VI</b> .		
<b>10a</b> Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? If "Yes," answer line 10b below.		
<b>b</b> Did the organization have any excess business holdings in the tax year? (Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)		

**Part IV Supporting Organizations** (continued)

	Yes	No
<b>11</b> Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b> A person who directly or indirectly controls, either alone or together with persons described in lines 11b and 11c below, the governing body of a supported organization?		
<b>11a</b>		
<b>b</b> A family member of a person described in line 11a above?		
<b>11b</b>		
<b>c</b> A 35% controlled entity of a person described in line 11a or 11b above? If "Yes" to line 11a, 11b, or 11c, provide detail in <b>Part VI</b> .		
<b>11c</b>		

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> Did the governing body, members of the governing body, officers acting in their official capacity, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's officers, directors, or trustees at all times during the tax year? If "No," describe in <b>Part VI</b> how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove officers, directors, or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.		
<b>1</b>		
<b>2</b> Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? If "Yes," explain in <b>Part VI</b> how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised, or controlled the supporting organization.		
<b>2</b>		

**Section C. Type II Supporting Organizations**

	Yes	No
<b>1</b> Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? If "No," describe in <b>Part VI</b> how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).		
<b>1</b>		

**Section D. All Type III Supporting Organizations**

	Yes	No
<b>1</b> Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
<b>1</b>		
<b>2</b> Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? If "No," explain in <b>Part VI</b> how the organization maintained a close and continuous working relationship with the supported organization(s).		
<b>2</b>		
<b>3</b> By reason of the relationship described in line 2, above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? If "Yes," describe in <b>Part VI</b> the role the organization's supported organizations played in this regard.		
<b>3</b>		

**Section E. Type III Functionally Integrated Supporting Organizations**

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).			
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.			
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.			
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in <b>Part VI</b> how you supported a governmental entity (see instructions).			
<b>2</b> Activities Test. Answer lines 2a and 2b below.			
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? If "Yes," then in <b>Part VI</b> identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.			
<b>2a</b>			
<b>b</b> Did the activities described in line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? If "Yes," explain in <b>Part VI</b> the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.			
<b>2b</b>			
<b>3</b> Parent of Supported Organizations. Answer lines 3a and 3b below.			
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? If "Yes" or "No" provide details in <b>Part VI</b> .			
<b>3a</b>			
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in <b>Part VI</b> the role played by the organization in this regard.			
<b>3b</b>			



**Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations**

- 1 ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (*explain in Part VI*). See instructions.  
All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3.	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	<b>Adjusted Net Income</b> (subtract lines 5, 6, and 7 from line 4)	8	

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d.	3	
4	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035.	6	
7	Recoveries of prior-year distributions	7	
8	<b>Minimum Asset Amount</b> (add line 7 to line 6)	8	

Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1.	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3.	4	
5	Income tax imposed in prior year	5	
6	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

Schedule A (Form 990 or 990-EZ) 2020

**Part V** Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations (continued)

Section D - Distributions		Current Year
<b>1</b> Amounts paid to supported organizations to accomplish exempt purposes	<b>1</b>	
<b>2</b> Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	<b>2</b>	
<b>3</b> Administrative expenses paid to accomplish exempt purposes of supported organizations	<b>3</b>	
<b>4</b> Amounts paid to acquire exempt-use assets	<b>4</b>	
<b>5</b> Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i> )	<b>5</b>	
<b>6</b> Other distributions ( <i>describe in Part VI</i> ). See instructions.	<b>6</b>	
<b>7</b> <b>Total annual distributions.</b> Add lines 1 through 6.	<b>7</b>	
<b>8</b> Distributions to attentive supported organizations to which the organization is responsive ( <i>provide details in Part VI</i> ). See instructions.	<b>8</b>	
<b>9</b> Distributable amount for 2020 from Section C, line 6	<b>9</b>	
<b>10</b> Line 8 amount divided by line 9 amount	<b>10</b>	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2020	(iii) Distributable Amount for 2020
<b>1</b> Distributable amount for 2020 from Section C, line 6			
<b>2</b> Underdistributions, if any, for years prior to 2020 (reasonable cause required - <i>explain in Part VI</i> ). See instructions.			
<b>3</b> Excess distributions carryover, if any, to 2020			
<b>a</b> From 2015			
<b>b</b> From 2016			
<b>c</b> From 2017			
<b>d</b> From 2018			
<b>e</b> From 2019			
<b>f</b> <b>Total</b> of lines 3a through 3e			
<b>g</b> Applied to underdistributions of prior years			
<b>h</b> Applied to 2020 distributable amount			
<b>i</b> Carryover from 2015 not applied (see instructions)			
<b>j</b> Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
<b>4</b> Distributions for 2020 from Section D, line 7: \$			
<b>a</b> Applied to underdistributions of prior years			
<b>b</b> Applied to 2020 distributable amount			
<b>c</b> Remainder. Subtract lines 4a and 4b from line 4.			
<b>5</b> Remaining underdistributions for years prior to 2020, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>6</b> Remaining underdistributions for 2020. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
<b>7</b> <b>Excess distributions carryover to 2021.</b> Add lines 3j and 4c.			
<b>8</b> Breakdown of line 7:			
<b>a</b> Excess from 2016			
<b>b</b> Excess from 2017			
<b>c</b> Excess from 2018			
<b>d</b> Excess from 2019			
<b>e</b> Excess from 2020			

Schedule A (Form 990 or 990-EZ) 2020

**Part VI** **Supplemental Information.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a, and 3b; Part V, line 1; Part V, Section B, line 1e; Part V, Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information.  
(See instructions.)

**SCHEDULE A, PART III, LINE 12, EXPLANATION FOR OTHER INCOME:****OTHER REVENUE**

2016 AMOUNT: \$ 46,637.

2017 AMOUNT: \$ 95,628.

2018 AMOUNT: \$ 44,376.

2019 AMOUNT: \$ 57,089.

2020 AMOUNT: \$ 33,115.

DRAFT

## Schedule B

(Form 990, 990-EZ,  
or 990-PF)

Department of the Treasury  
Internal Revenue Service

## Schedule of Contributors

- ▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

# 2020

Name of the organization

HILLTOWN COMMUNITY HEALTH CENTERS, INC

Employer identification number

04-2161484

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

☒ 501(c)( 3 ) (enter number) organization

☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

☐ 527 political organization

Form 990-PF

☐ 501(c)(3) exempt private foundation

☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation

☐ 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, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

### Special Rules

- ☐ For an organization described in section 501(c)(3) 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), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions 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 an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I (entering "N/A" in column (b) instead of the contributor name and address), II, and III.
- ☐ For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled 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. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ..... ▶ \$ \_\_\_\_\_

**Caution:** An organization that isn't covered by the General Rule and/or the Special Rules doesn't 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 its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization	Employer identification number
HILLTOWN COMMUNITY HEALTH CENTERS, INC	04-2161484

**Part I Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2		\$ 30,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
3		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4		\$ 5,000.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5		\$ 1,171,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6		\$ 152,134.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Employer identification number

04-2161484

## Part II

[illegible]

Name of organization	Employer identification number
HILLTOWN COMMUNITY HEALTH CENTERS, INC	04-2161484

**Part III** Exclusively religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this info. once.) ▶ \$

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee
	(e) Transfer of gift		
	Transferee's name, address, and ZIP + 4		Relationship of transferor to transferee

**SCHEDULE D**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Supplemental Financial Statements**

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.**

▶ **Attach to Form 990.**

▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No. 1545-0047

**2020**

**Open to Public Inspection**

Name of the organization

HILLTOWN COMMUNITY HEALTH CENTERS, INC

Employer identification number

04-2161484

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year .....		
2 Aggregate value of contributions to (during year) .....		
3 Aggregate value of grants from (during year) .....		
4 Aggregate value at end of year .....		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).

<input type="checkbox"/> Preservation of land for public use (for example, recreation or education)	<input type="checkbox"/> Preservation of a historically important land area
<input type="checkbox"/> Protection of natural habitat	<input type="checkbox"/> Preservation of a certified historic structure
<input type="checkbox"/> Preservation of open space	

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year.

	Held at the End of the Tax Year
a Total number of conservation easements .....	2a
b Total acreage restricted by conservation easements .....	2b
c Number of conservation easements on a certified historic structure included in (a) .....	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register .....	2d

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ▶ .....

4 Number of states where property subject to conservation easement is located ▶ .....

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? .....

☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ .....

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ▶ \$ .....

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? .....

☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

**Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under FASB 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 XIII the text of the footnote to its financial statements that describes these items.

b If the organization elected, as permitted under FASB 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) Revenue included on 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 FASB ASC 958 relating to these items:

a Revenue included on Form 990, Part VIII, line 1 .....

▶ \$ .....

b Assets included in Form 990, Part X .....

▶ \$ .....

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule D (Form 990) 2020



**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 make significant use of its collection items (check all that apply):

a ☐ Public exhibition

d ☐ Loan or exchange program

b ☐ Scholarly research

e ☐ Other \_\_\_\_\_

c ☐ Preservation for future generations

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

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" on 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 XIII 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, for escrow or custodial account liability? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII ☐

**Part V Endowment Funds.** Complete if the organization answered "Yes" on 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	38,193.	36,125.	36,580.	35,388.	35,184.
b Contributions					
c Net investment earnings, gains, and losses		2,068.	-317.	1,192.	204.
d Grants or scholarships					
e Other expenditures for facilities and programs			138.		
f Administrative expenses	38,193.				
g End of year balance		38,193.	36,125.	36,580.	35,388.

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ☐ %

b Permanent endowment ☐ .0000 %

c Term endowment ☐ %

The percentages on lines 2a, 2b, and 2c should equal 100%.

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)		X
3a(ii)		X
3b		

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

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

**Part VI Land, Buildings, and Equipment.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		204,506.		204,506.
b Buildings		3,543,396.	1,647,674.	1,895,722.
c Leasehold improvements		1,933,674.	322,279.	1,611,395.
d Equipment		1,396,520.	1,126,299.	270,221.
e Other				
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				3,981,844.

Schedule D (Form 990) 2020

**Part VII Investments - Other Securities.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. 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) .....		
<b>Total.</b> (Col. (b) must equal Form 990, Part X, col. (B) line 12.) ▶		

**Part VIII Investments - Program Related.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

**Part IX Other Assets.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

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

**Part X Other Liabilities.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 11e or 11f. See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) .....	
(3) .....	
(4) .....	
(5) .....	
(6) .....	
(7) .....	
(8) .....	
(9) .....	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	

2. Liability for uncertain tax positions. In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII... ☒

Schedule D (Form 990) 2020

**Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

<b>1</b>	Total revenue, gains, and other support per audited financial statements	<b>1</b>	8,756,588.
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12:		
<b>a</b>	Net unrealized gains (losses) on investments	<b>2a</b>	49,866.
<b>b</b>	Donated services and use of facilities	<b>2b</b>	
<b>c</b>	Recoveries of prior year grants	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII.)	<b>2d</b>	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b>	<b>2e</b>	49,866.
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b>	<b>3</b>	8,706,722.
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line 1:		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII.)	<b>4b</b>	
<b>c</b>	Add lines <b>4a</b> and <b>4b</b>	<b>4c</b>	0.
<b>5</b>	Total revenue. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12.)	<b>5</b>	8,706,722.

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 12a.

<b>1</b>	Total expenses and losses per audited financial statements	<b>1</b>	7,931,653.
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25:		
<b>a</b>	Donated services and use of facilities	<b>2a</b>	
<b>b</b>	Prior year adjustments	<b>2b</b>	
<b>c</b>	Other losses	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII.)	<b>2d</b>	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b>	<b>2e</b>	0.
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b>	<b>3</b>	7,931,653.
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII.)	<b>4b</b>	
<b>c</b>	Add lines <b>4a</b> and <b>4b</b>	<b>4c</b>	0.
<b>5</b>	Total expenses. Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18.)	<b>5</b>	7,931,653.

**Part XIII Supplemental Information.**

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, lines 2d and 4b; and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

**PART X, LINE 2:**

MANAGEMENT HAS EVALUATED SIGNIFICANT TAX POSITIONS AGAINST THE CRITERIA ESTABLISHED BY PROFESSIONAL STANDARDS AND BELIEVES THERE ARE NO SUCH TAX POSITIONS REQUIRING ACCOUNTING RECOGNITION. THE ORGANIZATION'S TAX RETURNS ARE SUBJECT TO EXAMINATION BY TAXING AUTHORITIES FOR ALL YEARS ENDING ON OR AFTER DECEMBER 31, 2017.

**SCHEDULE J  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Compensation Information**

- For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees
- ▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**
- ▶ **Attach to Form 990.**
- ▶ **Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.**

OMB No. 1545-0047

**2020**

Open to Public  
Inspection

Name of the organization

HILLTOWN COMMUNITY HEALTH CENTERS, INC

Employer identification number

04-2161484

**Part I Questions Regarding Compensation**

**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- |  |  |
|--|--|
| <input type="checkbox"/> First-class or charter travel             | <input type="checkbox"/> Housing allowance or residence for personal use   |
| <input type="checkbox"/> Travel for companions                     | <input type="checkbox"/> Payments for business use of personal residence   |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees     |
| <input type="checkbox"/> Discretionary spending account            | <input type="checkbox"/> Personal services (such as maid, chauffeur, chef) |

**b** If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

**2** Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

**3** Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Compensation committee   | <input checked="" type="checkbox"/> Written employment contract                     |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study                               |
| <input type="checkbox"/> Form 990 of other organizations     | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

**4** During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

**a** Receive a severance payment or change-of-control payment?

**b** Participate in or receive payment from a supplemental nonqualified retirement plan?

**c** Participate in or receive payment from an equity-based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

**Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.**

**5** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

**a** The organization?

**b** Any related organization?

If "Yes" on line 5a or 5b, describe in Part III.

**6** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

**a** The organization?

**b** Any related organization?

If "Yes" on line 6a or 6b, describe in Part III.

**7** For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III

**8** Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

**9** If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

Yes No

<b>1b</b>		
<b>2</b>		
<b>4a</b>		X
<b>4b</b>		X
<b>4c</b>		X
<b>5a</b>		X
<b>5b</b>		X
<b>6a</b>		X
<b>6b</b>		X
<b>7</b>		X
<b>8</b>		X
<b>9</b>		

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2020



Part III	Supplemental Information
----------	--------------------------

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

DRAFT

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

Department of the Treasury  
Internal Revenue Service

**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.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2020**

Open to Public  
Inspection

Name of the organization

HILLTOWN COMMUNITY HEALTH CENTERS, INC

Employer identification number  
04-2161484

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

TO PROVIDE MEDICAL, DENTAL, OPTOMETRY AND BEHAVIORAL HEALTH CARE, AND  
RELATED SERVICES TO PEOPLE IN THE WESTERN MASSACHUSETTS HILLTOWNS AND  
SURROUNDING AREAS.

FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

HILLTOWN COMMUNITY HEALTH CENTER'S MISSION IS TO PROVIDE HIGH QUALITY,  
ACCESSIBLE MEDICAL, DENTAL, OPTOMETRY AND BEHAVIORAL HEALTH CARE, AND  
RELATED SERVICES TO PEOPLE IN THE WESTERN MASSACHUSETTS HILLTOWNS AND  
SURROUNDING AREAS. WE SEEK TO UNDERSTAND AND RESPOND TO THE NEEDS OF  
OUR COMMUNITY. ALL SERVICES WILL BE DELIVERED IN A CARING AND  
PROFESSIONAL MANNER WITHIN A CONTEXT OF A PARTNERSHIP BETWEEN PERSONS  
SERVED AND STAFF. TO ACHIEVE OUR MISSION WE PROMOTE EMPLOYEE GROWTH  
AND JOB SATISFACTION AND WE OFFER CONTINUITY OF CARE THROUGH OUR  
RELATIONSHIPS WITH OTHER ORGANIZATIONS.

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

HCHC'S DENTAL DEPARTMENT, STAFFED BY A TEAM OF BOARD-CERTIFIED  
DENTISTS, DENTAL HYGIENISTS AND DENTAL ASSISTANTS, PROVIDES  
PREVENTATIVE AND ACUTE CARE INCLUDING CLEANINGS AND FILLINGS, ROOT  
CANALS, DENTAL IMPLANTS, DENTURES, BRIDGES, PERIODONTAL WORK, EMERGENCY  
AND ORAL SURGERY. THE DENTAL DEPARTMENT SERVED 2,447 PATIENTS IN 2020.

HCHC'S BEHAVIORAL HEALTH AND SUBSTANCE ABUSE DEPARTMENT, STAFFED BY

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

Schedule O (Form 990 or 990-EZ) 2020

Name of the organization

HILLTOWN COMMUNITY HEALTH CENTERS, INC

Employer identification number

04-2161484

LICENSED PRACTITIONERS, PROVIDES INDIVIDUAL, COUPLE, FAMILY AND GROUP TREATMENT FOR CHILDREN, ADOLESCENTS, ADULTS AND THE ELDERLY. THE BEHAVIORAL HEALTH AND SUBSTANCE ABUSE DEPARTMENT SERVED 999 PATIENTS IN 2020.

HCHC'S OPTOMETRY DEPARTMENT, STAFFED BY A LICENSED OPTOMETRIST, BEGAN SEEING PATIENTS IN OCTOBER 2010. SERVICES PROVIDED BY THE DEPARTMENT INCLUDE: VISION TESTING, VISUAL FIELD TESTS, OPTICAL SCANS AND OFFERS A VARIETY OF FRAMES AND CONTACT LENSES. THE OPTOMETRIST WORKS CLOSELY WITH THE MEDICAL PROVIDERS TO INSURE DIABETIC PATIENTS RECEIVE THE NECESSARY VISUAL SCREENINGS. THE OPTOMETRY DEPARTMENT SERVED 989 PATIENTS IN 2020.

FORM 990, PART III, LINE 4B, PROGRAM SERVICE ACCOMPLISHMENTS: PROVIDES CHILDBIRTH EDUCATION PROGRAMS AND BREASTFEEDING EDUCATION AND SUPPORT. HCHC ALSO HAS A FAMILY CENTER WHICH PROVIDES PLAYGROUPS FOR YOUNG CHILDREN, FAMILY-ORIENTED ACTIVITIES AND PARENTING EDUCATION SUPPORT AS WELL AS A PRE-SCHOOL SCHOOL READINESS PROGRAM.

HCHC ALSO PROVIDES ASSISTANCE WITH HEALTH ACCESS (HELPING PEOPLE DETERMINE ELIGIBILITY FOR AND ENROLLING IN PUBLICALLY FUNDED HEALTH INSURANCE PROGRAMS) AND ASSISTANCE IN ACCESSING FUEL ASSISTANCE, HEALTH CARE, HOUSING REFERRALS, ADULT EDUCATION PROGRAMS, JOB READINESS PROGRAMS AND MUCH MORE.

THE HOPE (HEALTH OUTREACH PROGRAM FOR ELDERS) PROGRAM PROVIDES PREVENTATIVE AND HEALTH MAINTENANCE CARE TO SENIORS IN THEIR HOMES.

THE HOPE NURSE CAN DO VITAL SIGN AND BLOOD PRESSURE CHECKS; HOME SAFETY



Name of the organization

HILLTOWN COMMUNITY HEALTH CENTERS, INC

Employer identification number

04-2161484

ASSESSMENTS; MEDICATION MANAGEMENT; FLU SHOTS; ASSISTANCE IN COMPLETING HEALTH CARE PROXY FORMS; ARRANGING APPOINTMENTS WITH PHYSICIANS AND SPECIALISTS; REFERRALS FOR HOMEMAKER HELP AND MUCH MORE. THE PROGRAM ALSO PROVIDES OUTREACH VISITS BY PHYSICIANS WHEN CALLED FOR.

FORM 990, PART VI, SECTION B, LINE 11B:

FORM 990 IS REVIEWED BY THE FINANCE COMMITTEE AND PRESENTED TO THE FULL BOARD OF DIRECTORS.

FORM 990, PART VI, SECTION B, LINE 12C:

A QUESTIONNAIRE MUST BE COMPLETED ANNUALLY BY OFFICERS, DIRECTORS AND KEY EMPLOYEES DISCLOSING ANY RELATIONSHIPS PRESENTING POTENTIAL CONFLICTS OF INTEREST.

FORM 990, PART VI, SECTION B, LINE 15A:

THE EXECUTIVE COMMITTEE MEETS ANNUALLY TO REVIEW THE EXECUTIVE DIRECTOR'S COMPENSATION AND COMPARE IT TO FOUR SIMILARLY-SIZED MASSACHUSETTS HEALTH CARE ORGANIZATIONS. THE EXECUTIVE COMMITTEE'S RECOMMENDATION IS BROUGHT TO THE BOARD OF DIRECTORS FOR FURTHER DISCUSSION AND FINAL APPROVAL.

FORM 990, PART VI, SECTION C, LINE 18:

FORM 990 IS AVAILABLE AT GUIDE STAR WEBSITE AND PROVIDED UPON REQUEST.

FORM 990, PART VI, SECTION C, LINE 19:

THE ORGANIZATION PROVIDES ITS GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS TO THE PUBLIC UPON REQUEST.

**THE COMMONWEALTH OF MASSACHUSETTS**  
**OFFICE OF THE ATTORNEY GENERAL**  
**NON-PROFIT ORGANIZATIONS/PUBLIC CHARITIES DIVISION**  
**ONE ASHBURTON PLACE**  
**BOSTON, MASSACHUSETTS 02108**

(617) 727-2200, ext. 2101  
[www.mass.gov/ago/charities](http://www.mass.gov/ago/charities)

## Form PC

Report for the Fiscal Period: 01/01/20 to 12/31/20AG Account #: 009831 Federal ID #: 04-2161484

Electronic Payment Confirmation #: \_\_\_\_\_

Attach printout of electronic payment confirmation.

Electronic Payment Date: \_\_\_\_\_

When did the organization first engage in charitable work in Massachusetts? 10/03/1950

Has the organization applied for or been granted IRS tax exempt status?

☒ Yes ☐ No

If yes, date of application OR date of determination letter:

05/31/1968

IRS Exemption under 501(c):

3

If exempt under 501(c), are contributions to the organization tax deductible as charitable contributions?

☒ Yes ☐ No**Organization Data**Name: HILLTOWN COMMUNITY HEALTH CENTERS, INCMailing Address: 58 OLD NORTH ROADCity: WORTHINGTONState: MAZIP: 01098Phone Number: (413) 238-5511Fax Number: 413-238-5358Email: \_\_\_\_\_ Website: WWW.HCHCWEB.ORG

In the table below, please enter the appropriate codes from the corresponding tables found in the instructions.  
 Enter **up to 2** codes from Table 3 for your organization's main purpose(s)

Category	Code	Category	Code
County (Table 1)	8	Organization Purpose Code 1	12
Type of Organization (Table 2)	5	Organization Purpose Code 2	13

Please check box if final return prior to dissolution: ☐**Check all items attached**

(if applicable)

- ☒ Filing Fee or Printout of Electronic Payment Confirmation
- ☒ Copy of IRS Return
- ☒ Audited Financial Statements/Review
- ☐ Amended Articles/By-Laws
- ☒ Schedule A-1
- ☒ Schedule A-2
- ☐ Schedule RO
- ☐ Schedule VCO
- ☐ Probate Account

All questions must be completed in their entirety whether or not similar questions are answered in an attached federal form. See instructions and definition section for guidance.

1. On what date was the organization created? 10/03/1950
2. Where was the organization created? WORTHINGTON, MA
3. What is the form of organization? (check one)

Corporation <input checked="" type="checkbox"/>	Testamentary Trust <input type="checkbox"/>
Unincorporated Association <input type="checkbox"/>	Inter Vivos Trust <input type="checkbox"/>

Other (please describe): \_\_\_\_\_

4. Was your organization related to any other organization(s) during the reporting year (see definition "Related Organization")? If yes, please complete the Schedule RO on pages 13 and 14. ☐ Yes ☒ No
5. Enter your summary of financial data:

Financial Data		Amounts
A.	Contributions, gifts, grants, and similar amounts received	1,446,342.
B.	Gross support and revenue	8,707,106.
C.	Program services and similar amounts paid out	6,479,770.
D.	Fundraising expenses	18,723.
E.	Management and general expenses	1,433,160.
F.	Payments to affiliates	0.
G.	Total expenses	7,931,653.
H.	Net assets or fund balances at the end of the year	5,193,905.

6. List the total compensation you provided to your five highest paid employees:

	Name/Title	Hrs/ Week	Salary and Other Income	Benefit Plans	Other Compensation
1.	SHERI CHEUNG PHYSICIAN	40.00	173,338.	1,221.	759.
2.	MICHAEL PURDY OFFICER	37.00	136,262.	962.	140.
3.	ELIZA LAKE EXECUTIVE DIRECTOR	37.00	123,822.	15,407.	7,253.
4.	JON LIEBMAN MEDICAL KDIRECTOR	37.00	123,677.	9,799.	5,675.
5.	MARISELA FERMIN-SCHON NURSE PRACTITIONER	40.00	119,623.	631.	500.

7. Was any compensation provided to any of the individuals listed in question 6 above which was not quantified in your response to 6? If yes, please provide explanation (attach separate sheet). ☐ Yes ☒ No

8. List the name, amount of compensation paid, and the nature of services rendered by each of the organization's five highest paid consultants providing professional services (e.g. attorneys, architects, accountants, management companies, investment advisors, professional solicitors, professional fundraising counsel).

	Name/Title	Amount of Compensation	Type(s) of Service
1.	ADELSON & COMPANY PC	37,060.	ACCOUNTANT
2.	KYOCERA	18,665.	IT SUPPORT
3.	JENNIFER COSCIA	15,630.	ACCOUNTING
4.	PACIFIC INTERPRETERS	6,397.	CONSULTANT
5.	JULIA BARNES	5,000.	INTERPRETATION SERVICES TRAINING CONSULTANT

9. Bank(s) in which the organization's funds are deposited (include bank addresses and phone number):

Bank	Address	Phone Number
FLORENCE SAVINGS BANK	ONE MAIN STREET, WILLIAMSBURG, MA 01096	413-586-1300

10. What is the organization's accounting method? ☐ Cash ☒ Accrual

☐ Other (specify): \_\_\_\_\_

11. If organization's mailing address is a P.O. Box, list the organization's full street address:

Address: NOT APPLICABLE

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

12. Contact Person Name: ELIZA LAKE

Street Address: 58 OLD NORTH ROAD

City: WORTHINGTON State: MA ZIP Code: 01098

Phone Number: 413-238-5511

13. During the fiscal year reported here, did your organization solicit contributions or have funds solicited on its behalf?

☒ Yes ☐ No

14. At any time during the fiscal year following the year reported here, will your organization, or others acting on its behalf, solicit contributions?

☒ Yes ☐ No

*If you answered yes to Question 13 or 14, you must complete Schedule A-1 and/or Schedule A-2 unless you are exempt from the solicitation certificate requirement.*

15. If you are claiming an exemption from the solicitation certificate requirement, please indicate by checking the box to the right to identify which exemption applies to your organization.

a religious organization	<input type="checkbox"/>
an organization which: (a) does not raise more than \$5,000 during a calendar year OR does not receive contributions from more than ten persons during a calendar year; AND (b) carries out all of its activities, including fundraising, through unpaid volunteers. (The conditions at both (a) and (b) must be met for your organization to qualify for this exemption.)	<input type="checkbox"/>

16. Attach a list of names, addresses (street and/or mailing), and telephone numbers of other offices/chapters/branches/affiliates.

**STATEMENT 1**

17. Attach a list of names, titles, and addresses (street and/or mailing) of officers, directors, trustees, and the principal salaried executives of organization.

**STATEMENT 2**

18. Attach a list of names, titles, and addresses (street and/or mailing) of any individual(s) authorized to sign checks, and any individual(s) responsible for: custody of funds; distribution of funds; fundraising; and custody of financial records.

**STATEMENT 3**

19. Has this organization or any of its officers, directors, employees or fundraisers solicited funds in any other state?

☐ Yes ☒ No

*If yes attach list of states where solicitation was conducted, including registered agency, dates of registration, registration numbers, any other names under which the organization was/is registered, and the dates and type (mail, telephone, door to door, special events, etc.) of the solicitation conducted.*

20. Has this organization or any of its officers, directors, or employees:

*If yes, please attach an explanation.*

(a) Been enjoined or otherwise prohibited by a government agency/court from operating or soliciting contributions?

☐ Yes ☒ No

(b) Ever been refused registration or had its registration or tax exemption denied, suspended, modified or revoked by a governmental agency?

☐ Yes ☒ No

(c) Been the subject of a proceeding regarding any solicitation or registration?

☐ Yes ☒ No

(d) Entered into a voluntary agreement of compliance or consent judgment with, any government agency or in a case before a court or administrative agency?

☐ Yes ☒ No

21. Have any restrictions been removed during the year from donor-restricted funds?

*If yes, please attach an explanation.*

☒ Yes ☐ No

**STATEMENT 4**

22. Have donor-restricted funds been loaned to unrestricted funds?

*If yes, please attach an explanation.*

☐ Yes ☒ No

23. This question involves "Termination of Employment or Changes of Control Compensatory Arrangements" with certain "Related Parties" (see *instructions and definition sections*). Report only if payments made or promised to any individual are in excess of four months salary or \$100,000, whichever dollar amount is less.

(a) Did you make actual payments or otherwise transfer value under such an arrangement to any individual described in Related Party definition, sections (a) or (b), which payments are not reported in Question 6 or 7 above?

☐ Yes ☒ No

(b) Do you have an agreement with any individual described in Related Party definition, sections (a) or (b), containing such an agreement?

☐ Yes ☒ No

*If you answered yes for Question 23(a) or 23(b) above, please attach an explanation identifying the individual(s) involved, stating the amount of any payments made or value transferred, and describing the terms of each agreement.*

FORM PC	NAME, ADDRESS, PHONE OF OTHER OFFICES	STATEMENT	1
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NAME AND ADDRESSPHONE NUMBER

HUNTINGTON HEALTH CENTER  
73 RUSSELL ROAD  
HUNTINGTON, MA 01050

413-238-5511

GATEWAY SCHOOL-BASED HEALTH CTR  
12 LITTLEVILLE ROAD  
HUNTINGTON, MA 01050

413-667-0142

HILLTOWN SOCIAL SERVICES  
9 RUSSELL ROAD  
HUNTINGTON, MA 01050

413-667-2203

JOHN P. MUSANTE HEALTH CENTER  
70 BOLTWOOD WALK  
AMHERST, MA 01002

413-835-4980

DRAFT

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FORM PC	OFFICERS, DIRECTORS, TRUSTEES AND EXECUTIVES	STATEMENT	2
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NAME AND ADDRESSTITLE

ELIZA LAKE  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

CHIEF EXECUTIVE OFFICER

JOHN FOLLET  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

CHAIR

NANCY BRENNER  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

VICE CHAIR

KATHRYN JENSEN  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

CLERK

M. LEE MANCHESTER  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

DIRECTOR

ALAN GAITENBY  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

DIRECTOR

WENDY LONG  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

DIRECTOR

MATTHEW BANNISTER  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

DIRECTOR

SETH GEMME  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

DIRECTOR

JENICCA GALLAGHER  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

DIRECTOR

KATE ALBRIGHT-HANNA  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

DIRECTOR



FORM PC

PAGE 4, LINE 18

STATEMENT 3

NAME AND ADDRESSAREA OF RESPONSIBILITY

JOHN MELEHOV  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

RESPONSIBLE FOR CUSTODY OF FUNDS

ELIZA LAKE  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

RESPONSIBLE FOR CUSTODY OF FUNDS

FRANK W. MERTES  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

RESPONSIBLE FOR DISTRIBUTION OF FUNDS

ELIZA LAKE  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

RESPONSIBLE FOR DISTRIBUTION OF FUNDS

BOARD OF DIRECTORS  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

RESPONSIBLE FOR FUNDRAISING

JOHN MELEHOV  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

CUSTODY OF FINANCIAL RECORDS

ELIZA LAKE  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

CUSTODY OF FINANCIAL RECORDS

ELIZA LAKE  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

AUTHORIZED TO SIGN CHECKS

JOHN MELEHOV  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

AUTHORIZED TO SIGN CHECKS

JOHN S. FOLLET  
58 OLD NORTH ROAD  
WORTHINGTON, MA 01098

AUTHORIZED TO SIGN CHECKS

FORM PC	EXPLANATION FOR PAGE 5, LINE 21	STATEMENT	4
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AN ENDOWMENT IN THE AMOUNT OF \$38,193 WAS RELEASED FROM RESTRICTION  
WITH THE APPROVAL OF THE MASSACHUSETTS ATTORNEY GENERAL AFTER A REVIEW  
OF THE UNDERLYING DOCUMENTATION.

DRAFT

24. This question applies to related party transactions, which include transactions with officers, directors, trustees, certain employees, relative, and organizations they own or control. Please consult the instructions and definition sections for the definition of a "Related Party" and "Indebtedness" before answering. Note that transactions involving related parties must be reported even when there is no accounting recognition (e.g. in-kind gifts, waiver or interest not otherwise reported).

*If the answer to any part of Question 24 is **yes**, attach a schedule stating the name and address of the related party, the nature of the transaction, the value or the amounts involved in the transaction, and the procedure followed in authorizing the transaction.*

During the year:		
A.	Has your organization sold or transferred assets to or purchased assets from or exchanged assets with a related party?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
B.	Has your organization leased assets to or leased assets from a related party?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
C.	Has your organization been indebted to a related party?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
D.	Has your organization allowed a related party to be indebted to it?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
E.	Has your organization made or held an investment in a related party?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
F.	Has your organization furnished goods, services, or facilities to a related party?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
G.	Has your organization acquired goods, services, or facilities from a related party who received compensation or other value in return?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
H.	Has your organization paid or became obligated to pay wages, salary, or other compensation to a related party?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
I.	Has your organization transferred income or assets to or for use by a related party?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
J.	Was your organization a party to any transaction in which any of its officers, directors, or trustees has a material financial interest, or did any officer, director or trustee receive anything of value not reported as compensation?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
K.	Has your organization invested in any corporate stock of a company in which any officer, director, or trustee owns more than 10% of the outstanding shares?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
L.	Is any property of the organization held in the name of or commingled with the property of any other person or organization?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
M.	Did your organization make a grant award or contribution to any other organization in which any of this organization's officers, directors or trustees has a relationship?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

**Signature Required**

Under penalty of perjury, I declare that the information furnished in this report, including all attachments, is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: JOHN FOLLET

Title: PRESIDENT

Name of Preparer: ADELSON & COMPANY PC

Address 100 NORTH STREET

City PITTSFIELD

State MA

ZIP Code 01201

Phone Number 413-443-6408

**Schedule A-1**  
**Solicitation Activities During Fiscal Year Covered By This Report**

List any names which will be used by the organization in connection with the solicitation of funds, other than the official name which appears on page 1.

NONE

Types of solicitation activities in which you expect to engage (check all that apply):

Mass Mailing	<input type="checkbox"/>	Via the Internet	<input checked="" type="checkbox"/>
Door-to-door	<input type="checkbox"/>	Raffle, beano, bingo or gaming event	<input type="checkbox"/>
Entertainment event	<input type="checkbox"/>	Sale of goods other than by telephone	<input type="checkbox"/>
Telemarketing without sale of goods or ads	<input type="checkbox"/>	Individual Mailings	<input checked="" type="checkbox"/>
Telemarketing with sale of goods	<input type="checkbox"/>	Corporate solicitations	<input checked="" type="checkbox"/>
Telemarketing with sale of ads	<input type="checkbox"/>	Grant Proposals	<input checked="" type="checkbox"/>
<input type="checkbox"/> Other (specify): _____			

Identify the method or methods you expect to use for the fundraising (check all that apply):

Professional solicitor*	<input type="checkbox"/>	Own employees	<input checked="" type="checkbox"/>
Professional fundraising counsel*	<input checked="" type="checkbox"/>	Volunteers	<input checked="" type="checkbox"/>
Commercial co-venturer*	<input type="checkbox"/>		

\* Provide applicable names and addresses:

Professional Solicitor Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Professional Fundraising Counsel Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Commercial Co-Venturer Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

## Schedule A-1 ctd.

## Solicitation Activities During Fiscal Year Covered By This Report

Identify the individuals who will have final responsibility for the charity's custody of contributions:

JOHN MELEHOV

Name and Title: CHIEF FINANCIAL OFFICER

Address 58 OLD NORTH ROAD

City WORTHINGTON

State MA

ZIP Code 01098

ELIZA LAKE

Name and Title: CHIEF EXECUTIVE OFFICER

Address 58 OLD NORTH ROAD

City WORTHINGTON

State MA

ZIP Code 01098

Name and Title:

Address

City

State

ZIP Code

Identify the individuals who will have final responsibility for the charity's distribution of contributions:

JOHN MELEHOV

Name and Title: CHIEF FINANCIAL OFFICER

Address 58 OLD NORTH ROAD

City WORTHINGTON

State MA

ZIP Code 01098

ELIZA LAKE

Name and Title: CHIEF EXECUTIVE OFFICER

Address 58 OLD NORTH ROAD

City WORTHINGTON

State MA

ZIP Code 01098

Name and Title:

Address

City

State

ZIP Code

## Schedule A-2

## Solicitation Activities Planned for Fiscal Year Which Follows the Reporting Year

List any names which will be used by the organization in connection with the solicitation of funds, other than the official name which appears on page 1.

NONE

Types of solicitation activities in which you expect to engage (check all that apply):

Mass Mailing	<input type="checkbox"/>	Via the Internet	<input checked="" type="checkbox"/>
Door-to-door	<input type="checkbox"/>	Raffle, beano, bingo or gaming event	<input type="checkbox"/>
Entertainment event	<input type="checkbox"/>	Sale of goods other than by telephone	<input type="checkbox"/>
Telemarketing without sale of goods or ads	<input type="checkbox"/>	Individual Mailings	<input checked="" type="checkbox"/>
Telemarketing with sale of goods	<input type="checkbox"/>	Corporate solicitations	<input checked="" type="checkbox"/>
Telemarketing with sale of ads	<input type="checkbox"/>	Grant Proposals	<input checked="" type="checkbox"/>
<input type="checkbox"/> Other (specify): _____			

Identify the method or methods you expect to use for the fundraising (check all that apply):

Professional solicitor*	<input type="checkbox"/>	Own employees	<input checked="" type="checkbox"/>
Professional fundraising counsel*	<input type="checkbox"/>	Volunteers	<input checked="" type="checkbox"/>
Commercial co-venturer*	<input type="checkbox"/>		

\* Provide applicable names and addresses:

Professional Solicitor Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Professional Fundraising Counsel Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Commercial Co-Venturer Name: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Credentialing and Privileging Update for HCHC BOD

**Month: October**

Name	Position/ Credentials	Start date	Credential Date	Special Certifications	Privileging Requests	Special Privileging Requests	Any items pending?	Other Info
Andrea Reed	LPN	re-hire 9/20/2021	10/20/2021	none	Privileging for Medical Staff: LPN	none	none	none
Kyleigh Golembeski	NP	10/12/2021	10/7/2021	none	Privileging for Medical Staff: NP	new NP, interested in learning privileges requested	none	none
Sarah Gallant	CHW	10/13/2021	10/13/2021	none	Privileging for Community Health Worker	none	CPR	none
Mark Stein	LPN	10/27/2021	10/20/2021	none	Privileging for Medical Staff: LPN	none	none	none





<b>Policy Title:</b> HIPPA Privacy Management Policy	<b>Policy Number:</b> HIPPA-01
<b>Department:</b> Clinical	<b>Policy status:</b> Active
<b>Regulatory Reference:</b> Title 45 CFR 164.500 – 534(e)	
<b>Date Published:</b> April 2003	
<b>Dates Reviewed:</b> October 2021	
<b>Dates Revised:</b> March 2020	

### **PURPOSE:**

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for ensuring the confidentiality and privacy of its patients and to establish procedures to prevent, detect, contain, and correct violations.

### **POLICY:**

1. HCHC's patient privacy process must include policies and procedures for the following:
  - a. Assignment of Security Responsibilities
  - b. Disclosure of PHI with and without patient consent
  - c. HIPAA Documentation requirements
  - d. HIPAA privacy safeguards
  - e. HIPAA training requirements
  - f. A patient's right to access and copy
  - g. Handling requests for confidential communication and access restrictions
  - h. Handling requests for amendments to records
  - i. Safeguarding deceased patient information
  - j. Use of Business Associate Agreements
  - k. Procedures for reporting violations
2. This policy will serve as the overarching HIPAA Privacy Policy. Its approval by the Board of Directors signifies subsequent approval of all underlying policies as identified in the above listing.

Questions regarding this policy or any related procedure should be directed to the HIPAA Privacy Officer at 413-238-4128.

Approved by Board of Directors on: \_\_\_\_\_

Approved by:

---

\_\_\_\_\_  
Chief Executive Officer, HCHC

\_\_\_\_\_  
HCHC Board of Directors





<b>Policy Title:</b> Security Management Process Policy	<b>Policy Number:</b> HIPAA-02
<b>Department:</b> Clinical	<b>Policy status:</b> Active
<b>Regulatory Reference:</b> 45 CFR 164.308(a)(1)(i)	
<b>Date Published:</b> September 2012	
<b>Dates Reviewed:</b> October 2021	
<b>Dates Revised:</b> March 2020	

### **PURPOSE:**

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for ensuring the confidentiality, integrity, and availability of its information systems containing EPHI (Electronic Protected Health Information) by implementing policies and procedures to prevent, detect, contain, and correct security violations.

### **POLICY:**

1. HCHC's security management process must include policies and procedures for the following:
  - a. Assignment of Security Responsibilities
  - b. Defining the appropriate access, control and supervision of workforce members
  - c. Contingency planning, data backup planning and media controls
  - d. Facility and Information Access Controls
  - e. Risk Analysis & Management
  - f. Policy violation sanction
  - g. Security Awareness Training
  - h. Security Incident Reporting
  - i. Workforce Clearance and Security
  - j. Acceptable Use of company-owned workstations
2. This policy will serve as the overarching Information Security Policy. Its approval by the Board of Directors signifies subsequent approval of all underlying policies as identified in the above listing.

Questions regarding this policy or any related procedure should be directed to the Information Security Officer at 413-238-4128.

Approved by Board of Directors on: \_\_\_\_\_  
Approved by:

\_\_\_\_\_

Chief Executive Officer, HCHC

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HCHC Board of Directors





<b>Policy Title:</b> Dismissal of Patients from Practice	<b>Policy Number:</b> MED-01
<b>Department:</b> Clinical Departments	<b>Policy status:</b> Active- formally Patient Termination
<b>Resources/related policies:</b> Patients at Risk of Discharge Due to Threatening Behavior, Reference: PP-03	
<b>Date Published:</b> Feb 2014	
<b>Dates Reviewed:</b> Mar 2016, April 2019, OCT 2020, OCT 2021	
<b>Dates Revised:</b> Mar 2016, May 2019, OCT 2020	

### **PURPOSE:**

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process for providing safe, effective health care through a mutual trust and respect between the health center staff and the patient.

### **POLICY**

It is the policy of HCHC that the following situations may warrant termination of a patient from any of the clinical sites:

1. Tampering, altering, improper or illegal use of prescriptions or medications.
2. Willful fraudulent behavior, furnishing false information or misrepresentation of the truth.
3. Failure to obey or comply with the Patient Code of Conduct.
4. Violent or aggressive behavior or threats directed toward staff members, patients or visitors.

Recommendations for termination from care or termination of eligibility for care will be addressed in writing by concerned staff members and forwarded to clinical leadership for review.

Patients who are dismissed from one department will be considered dismissed from all HCHC services and departments.

Patients who are involved with agencies or insurances that prohibit dismissal or have greater restrictions for dismissal are exempt from this policy and the policy of the agency or insurance will be followed.

Patients have the right to appeal this decision and will follow the procedure attached to this policy to request an appeal.

Approved by Board of Directors on: \_\_\_\_\_

Approved by:

\_\_\_\_\_

Chief Executive Officer, HCHC President

\_\_\_\_\_

HCHC Board of Directors

## **Procedure for Dismissal of Patients from Practice Procedure (TBD)**

### **PURPOSE:**

The purpose of this protocol is to outline the procedure to be followed after all attempts to retain a patient within the health center have been unsuccessful and dismissal from the practice has been deemed appropriate by leadership.

### **PROCEDURE:**

If patient is at risk for being dismissed from the practice due to disruptive behavior, please see policy and procedures for Patients at Risk of Discharge Due to Threatening Behavior prior to following this process.

1. The recommendation for dismissal from care or termination of eligibility will be addressed in writing by concerned staff members and given to the manager of the department. This recommendation will include a summary of circumstances and copies of any correspondence or other documentation relevant to the situation. Care will be taken to ensure that patient confidentiality is appropriately respected under HIPAA.
2. Upon review of the recommendation for termination of care or termination of eligibility and if appropriate, the department director will meet with all department leadership from which the patient receives services and a final decision to terminate the patient from HCHC will be determined.
3. If termination of care is not deemed necessary, a plan to accommodate the patient and continue to provide a safe effective work environment for HCHC staff will be determined.
4. If termination of care is deemed necessary, the patient will receive a letter stating the dismissal from care and outlining the reasons for the action. It shall include:
  - a. A statement of the reason for dismissal.
  - b. The date on which dismissal becomes effective.
  - c. Definition of the grace period that will be allowed for the patient to find an alternative source(s) of care with written stipulation of the circumstances and process the patient must follow if he/she wishes to be seen during that period. Staff members must ensure the patient's/clients health care is not in immediate danger and must assist with outside medical care as appropriate.
  - d. A patient discharged from one of the Health Center's services will be automatically discharged from all other services of the Health Center and at all sites.
  - e. The patient's written authorization to forward a copy of his/her medical record will be signed and the records sent to new care provider.
  - f. Information regarding the process to file an appeal of the dismissal decision.
5. When appropriate, the patient's health insurance will be notified of such termination.



6. If the patient does not agree with the decision for dismissal, the patient can perform the following procedure to request to have the decision appealed:
  - a. The appeal must be in writing and directed to the Executive Director of the Health Center
  - b. A decision will be made within one week of receiving the appeal and as long as the “grace period” has not expired



<b>Policy Title:</b> Diagnostic Imaging/ Lab Tracking Procedure	<b>Policy Number:</b> MED-02
<b>Department:</b> Clinical	<b>Policy Status:</b> Active
<b>Regulatory Reference:</b>	
<b>Date Published:</b> November 2012	
<b>Dates Reviewed:</b> May 2018, June 2019, July 2020, Oct 2021	
<b>Dates Revised:</b> July 2020	

### **PURPOSE:**

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this procedure to have a formal documented process to ensure that diagnostic imaging (DI)/ lab orders are completed, and results are received to improve patient care.

### **POLICY:**

1. Care team staff will reconcile DI orders/lab orders on a weekly basis during Pre-Visit planning Time.
2. Urgent Diagnostic Imaging appointments will be made by referrals specialist and tracked by the Team MA.
3. The scanner will attach results to DI orders/ lab orders and send to ordering provider.
4. Provider will make arrangements to contact the patient with results.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Approved by Board of Directors on: \_\_\_\_\_

Approved by:

\_\_\_\_\_

Chief Executive Officer, HCHC

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HCHC Board of Directors

### **PROCEDURE:**

**Care team staff will reconcile diagnostic imaging orders on a weekly basis during pre-visit planning time.**

1. On a weekly basis Care team staff will track all outstanding diagnostic imaging/ lab orders during pre-visit planning time.

2. When ordering diagnostic imaging/ labs, providers (or other staff depending on standing orders or protocols) will use the “internal notes” field of the order to enter where the patient would like to have the imaging/ labs done. If the order is printed for the patient to take to radiology, the staff member who prints the order will enter “printed” and where the patient is going for the test in the “internal notes” field of the order.
3. Certain orders (MRI, CT Scans, Ultrasounds, etc.) will likely require processing by the Referrals Specialist. Once the Referrals Specialist has processed the order, they will document in the “internal notes” field and reassign to the Team MA. The Referrals Specialist will make appointments for all DI, except x-rays, mammograms, colonoscopies, bone density. They will note the appointment date and time in the “internal notes” field.
4. The Team MA will monitor the orders to ensure results have been received and have been linked to the original order. If not linked, the report will be returned to the scanner for linking and assignment to the appropriate provider.
5. If the DI/ lab result is not received, the Team MA will contact the location where the order was sent and request the DI/ lab results to be faxed to the electronic fax (413-923-9355) and will document in internal notes “results requested”.
  - a. If the patient did not go to the appointment or non-scheduled testing, the Team MA will contact the patient via phone or letter and ask the patient if they are still planning on doing the testing. Team MA will attempt to contact the patient 2 times. If no reply from the patient within 14 days, the Team MA will contact the patient again via letter or phone call. If no call back after 7 days, the Team MA will send a telephone encounter (TE) to the provider regarding outreach to patient.
  - b. If the patient is going to do the testing, the MA will reschedule appointment if needed.
  - c. If the patient refuses/declines/ no-shows for the testing, the Team MA/Referrals Specialist will note in the “internal notes” field “declined” and create a TE to send to the provider.
  - d. The provider will address if further action is needed. If no further action is needed, the provider will note in the TE and the DI/ lab order and cancel the order. If further action is required, the provider will arrange for contacting the patient.
  - e. The provider should send TE back to Team MA letting the Team MA know the DI/ lab order can be cancelled.

**Urgent Diagnostic Imaging appointments will be made by referrals specialist and tracked by the Team MA.**

1. A provider will mark a diagnostic imaging order as high priority. The diagnostic imaging order will be assigned to HCHC referral specialist.
2. For tracking purposes, a high priority telephone encounter will be created by the referral specialist and assigned to REFERRALS.
3. If necessary the referral specialist will obtain an insurance authorization.
4. The referral specialist will schedule an appointment for the patient and notify the patient of the appointment date and time.
5. Once the patient is aware of the appointment, the diagnostic imaging order and telephone encounter will be forwarded to the team medical assistant to track.
6. The medical assistant will request the consult notes or test results and hold the telephone encounter open until the notes are received.
7. If the notes or test results are received Front Desk will scan them into the patient’s chart and assign them to the provider to review.
8. The team medical assistant will address the telephone encounter once the consult notes or test results have been received.

9. If the patient cancels the appointment, the telephone encounter should be assigned to the provider as FYI.
10. If the appointment is rescheduled, the team medical assistant will keep the telephone encounter until the new date.

**The scanner will attach all DI/ lab orders and send to ordering provider.**

1. When we receive results for DI/ lab, the scanner will attach the report to the order.
2. The scanner will then assign the DI to the ordering provider to review.

**Provider will make arrangements to contact the patient with results.**

1. If DI/ lab results are normal, the provider will make arrangements to contact the patient within 5 business days.
2. If the DI/ lab results are abnormal, the provider will make arrangements to contact the patient within 12 hrs.





<b>Policy Title:</b> Hospital/ ER Follow Up	<b>Policy Number:</b> MED-03
<b>Department:</b> Clinical	<b>Policy status:</b> Active
<b>Regulatory Reference:</b> NONE	
<b>Date Published:</b> JUN 2012	
<b>Dates Reviewed:</b> MAY 2018, OCT 2020, OCT 2021	
<b>Dates Revised:</b> JUNE 2019	

### **PURPOSE:**

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for identifying and contacting HCHC patients following an Emergency Room visit or a hospitalization.

### **POLICY:**

1. HCHC will maintain a protocol for ensuring patients are contacted within 2 business days following discharge from a hospital or an emergency room.
2. HCHC will document follow up patient contact in the electronic medical record (EMR).

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Approved by Board of Directors on: \_\_\_\_\_

Approved by:

\_\_\_\_\_

Chief Executive Officer, HCHC

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HCHC Board of Directors

## **PROCEDURE:**

1. Nursing will be notified of all Hospital / ER visits
  - a. When scanners receive Hospital or ER records, they will create a telephone encounter (TE) and send to nursing queue.
  - b. When providers receive hospital/ER lab or DI results, they will create TE and send to nursing queue.
  - c. Prior to creating a new TE, ensure that one doesn't already exist for the incident.
2. Team or covering team nurse will contact the patient by phone or letter within 2 business days.
  - a. If contact made by phone, nurse will assess the patient and complete the appropriate template. This includes reviewing the discharge instructions with the patient
  - b. Patient will be sent a letter ONLY if it is clear that no follow up is needed and will complete the appropriate template
  - c. Nursing will ensure that all pertinent medical information is received from the hospital or ED, including discharge summaries, lab reports, diagnostic imaging reports, etc.
  - d. Nursing will arrange follow up visit, if needed or enter a referral if patient is to follow up with outside specialist.
3. TE will be forwarded to the PCP for review.



<b>Policy Title:</b> Periodic Record Review for Quality Assurance and Improvement	<b>Policy Number:</b> MED-04
<b>Department:</b> Clinical	<b>Policy status:</b> Active
<b>Regulatory Reference:</b> None	
<b>Date Published:</b> APR 2017	
<b>Dates Reviewed:</b> MAY 2018, AUG 2019, OCT 2020, OCT 2021	
<b>Dates Revised:</b> OCT 2020	

### **PURPOSE:**

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to ensure quality care and accurate documentation of patient encounters.

### **POLICY:**

All providers, physicians, nurse practitioners, physician assistants, dentist, licensed clinical social workers, and optometrist, will have a sample of their charts reviewed on a periodic basis to promote the maintenance of high-quality health care at HCHC., It is the intent that this process be used in a constructive way to assess and improve the quality of care, and in general, to identify systemic issues without any punitive intent directed at a clinician. In addition, the process is intended to be simple and efficient so that it may be easily continued over time without unduly burdening clinical staff.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Approved by Board of Directors on: \_\_\_\_\_  
Approved by:

\_\_\_\_\_  
Chief Executive Officer, HCHC

\_\_\_\_\_  
HCHC Board of Directors



## **PROCEDURE:**

### Routine Peer Review Process

All providers will have a sample of their records reviewed on a periodic basis. At a minimum, a quarterly sample of four records from each clinical provider will be reviewed. These records will include a sampling of services for which the provider is credentialed. For those clinicians who see both adult and pediatric patients, the selected records will include both.

The chart review will be conducted by HCHC using a department specific standard form. These will be returned to the Director of Quality Improvement for review and analysis. A summary of the review will be presented to the QI Committee and to the department head. Copies of the record review forms will be maintained by the Director of Human Resources.

Following this review, the Director of Quality Improvement may choose to meet with any clinician who appears to be having difficulty meeting appropriate quality measures, and at their discretion, may choose to communicate any concerns to the department head or senior management. In general, however, the focus of review will be on identifying systemic issues, training needs, changes in collaboration/consultation and other issues which will directly lead to improved quality of care. If a need for disciplinary action is suggested in the course of the review process, this will be addressed by the Director of Quality Improvement with the QI Committee, department head, and Chief Clinical and Community Services Officer.

#### 1. New Providers

It is appropriate that new clinicians joining HCHC, whether they are experienced or recently out of training, be more closely monitored for no less than the first three months of employment. The Director of Quality Improvement will be responsible for developing a plan for this review, appropriate to the individual clinician. It is expected that new clinicians will initially have charts reviewed no less than monthly for a period of at least three months.



<b>Policy Title:</b> Reproductive Health Services Policy	<b>Policy Number:</b> Med-05
<b>Department:</b> Clinical	<b>Policy status:</b> Active- Replaces Women’s Reproductive Health Services Policy
<b>Regulatory Reference:</b> Section 330 of the US Public Health Service Act; Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, §§ 506-507, 129 STAT. 2242, 2649 (2015); M.G.L. c. 111, § 70E	
<b>Date Published:</b> DEC 2016	
<b>Dates Reviewed:</b> MAY 2018, MAY 2019, OCT 2020, OCT 2021	
<b>Dates Revised:</b> MAY 2019	

## **PURPOSE:**

The purpose of this policy is to provide a documented processes of the safeguards utilized to offer comprehensive reproductive care and to ensure HCHC’s compliance with laws and regulations relating to the provision of reproductive health services.

## **DEFINITIONS:**

**Voluntary Family Planning Services:** HRSA defines Voluntary Family Planning Services as, “...appropriate counseling on available reproductive options consistent with Federal, state, local laws and regulations. These services may include management/treatment and procedures for a patient's chosen method (e.g., vasectomy, subdermal contraceptive placement, IUD placement, tubal ligation).”

**Hyde Amendment:** The Hyde Amendment is a statutory provision included as part of the annual HHS Appropriations legislation, which prohibits health centers from using federal funds to provide abortions (except in cases of rape or incest, or where a woman patient suffers from a physical disorder, physical injury, or physical illness, including a life- endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman patient in danger of death unless an abortion is performed). The Hyde Amendment prohibits the performance of abortion procedures, as well as the administration.

## **POLICY:**

HCHC’s ensures compliance with laws and regulations relating to the provision of reproductive health services affecting health centers that receive federal grant funds under Section 330 of the Public Health Service Act (“Section 330”) through the U.S. Department of Health and Human Services (“HHS”) as follows:

### **Compliance with Section 330**

Under Section 330, Health Center is required to provide, either directly or through contracts or formal written referral arrangements, voluntary family planning services. As neither “appropriate counseling” nor “available reproductive options” are defined in Section 330, the implementing regulations, or HHS Health Resources and Services Administration (“HRSA”) guidance, HCHC will use the criteria established under the Family Planning Program regulations authorized under Title X of the Public Health Service Act for guidance on how best to provide appropriate family planning options counseling to HCHC’s patients.

#### **Compliance with the Hyde Amendment**

HCHC does not provide abortion services. Therefore, in providing reproductive health services as a component of its Section 330-supported health center program, HCHC will assure compliance with the Hyde Amendment. The Hyde Amendment prohibits the performance of abortion procedures, as well as the administration of drugs and devices that are used for “medication” abortions that terminate an early pregnancy (up to 70 days from the date of the patient’s last menstrual cycle) rather than prevent implantation, including, but are not limited to, administration of the combination of RU-486 (Mifepristone or Mifeprex) and Misoprostol, unless the abortion procedure or medication abortion fits within one of those explicit Hyde Amendment exceptions.

#### **Compliance with Public Health Service Regulations**

HCHC does not provide abortion services directly, but if HCHC furnishes an abortion referral in the event the patient is the survivor of rape or incest or if the patient’s life would be endangered, HCHC will maintain adequate documentation and certifications as required under 42 C.F.R. §§50.304, 50.306 and 45 C.F.R. Part 75.

#### **Compliance with Prohibition on Coercion**

In providing reproductive health services as a component of its Section 330-supported health center program, HCHC will assure compliance with statutory requirements, as set forth in 42 U.S.C. §300a-8, which prohibits all HCHC employed and contracted staff from coercing or endeavoring to coerce any person to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services. HCHC will also assure that HCHC employed and contracted staff do not coerce or endeavor to coerce any person not to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services, consistent with guidelines to provide only neutral, factual information and nondirective options counseling.

#### **Providing Access to FDA-Approved Contraceptive Methods**

HCHC will ensure that its patients have access to the full range of Food and Drug Administration (“FDA”)-approved contraceptive methods designed to prevent a pregnancy.

All Health Center employees and contractors who provide clinical services and non-clinical support services are required to comply with this ’s Reproductive Health Services Policy and Procedure by signing and returning the certification attached to this document as Exhibit A.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Approved by Board of Directors on: \_\_\_\_\_

Approved by:

\_\_\_\_\_

Chief Executive Officer, HCHC

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HCHC Board of Directors

## **Guidelines for Reproductive Health Services Procedure**

### **PURPOSE:**

The purpose of this procedure is to provide guidelines for the providing comprehensive reproductive care while ensuring compliance with laws and regulations relating to the provision of reproductive health services.

### **CONTACTS**

<b>Role</b>	<b>Name</b>	<b>Phone#</b>	<b>Email</b>
Medical Director			
Assistant Medical Director			

### **PROCEDURE:**

- 1. Voluntary Family Planning Services Training.** All HCHC Staff, regardless of their specific job or position descriptions, duties performed or services provided, will be trained on Section 330 requirements applicable to voluntary family planning services including, but not limited to, the required scope of voluntary family planning services, as well as prohibitions and limitations on providing abortions within the Section 330-supported health center program and coercing or endeavoring to coerce any person to undergo an abortion. HCHC shall maintain records indicating the completion of such training in each employee's and contractor's personnel file.
- 2. Complying with the Hyde Amendment.** All HCHC Staff agree that HCHC shall not provide abortion services, either directly or by contract, within HCHC's Section 330-supported health center program, unless the abortion fits within a Hyde Amendment exception, as described in Section II (3). All HCHC Staff agree that this prohibition includes the administration of "medication" abortions that terminate an early pregnancy (up to 70 days from the date of the woman patient's last menstrual cycle) rather than prevent implantation. Medication abortions include, but are not limited to, administering the combination of RU-486 (Mifepristone or Mifeprex) and Misoprostol which results in the termination of a pregnancy.
- 3. Providing Abortion Referrals Under the Hyde Amendment Exceptions.** If HCHC provides an abortion referral in the event that the woman patient is a survivor of rape or incest, HCHC will secure and maintain documentation from a law enforcement agency or public health service stating:
  - a. that the person upon whom the medical procedure was performed was reported to have been the survivor of an incident of rape or incest;
  - b. the date on which the incident occurred;
  - c. the date on which the report was made, which must have been within 60 days of the date on which the incident occurred;
  - d. the name and address of the survivor and the name and address of the person making the report (if different from the survivor); and

e. that the report included the signature of the person who reported the incident. If HCHC provides an abortion referral in cases where a woman patient suffers from a physical disorder, physical injury, or physical illness, including a life- endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a provider, place the woman patient in danger of death unless an abortion is performed, HCHC will secure and maintain a written certification from a physician provider who has found that on the basis of his or her professional judgement, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient.

4. **Options Counseling.** HCHC Staff providing options counseling shall offer the pregnant patient the opportunity to be provided information and counseling regarding each of the following options:

- a. prenatal care and delivery;
- b. infant care, foster care, or adoption; and
- c. pregnancy termination.

If requested to provide such information and counseling, HCHC Staff will provide neutral, factual information and nondirective counseling on each of the options, and referral upon request (subject to Section 7 below), except with respect to any option(s) about which the pregnant woman patient indicates that they do not wish to receive such information and counseling.

5. **Prohibition on Coercion.** HCHC Staff are strictly prohibited from coercing or endeavoring to coerce any person to undergo or not to undergo an abortion by threatening such person with the loss of, or disqualification for the receipt of, any benefit or other health center services.

6. **Contraceptive Methods.** HCHC Staff, upon request, will provide patients with information regarding the management/treatment, as appropriate, for a patient's chosen family planning method. Such management/treatment information may address vasectomy, tubal ligation, and placement of long-acting reversible contraception (e.g., IUDs and implants). In addition, HCHC Staff will ensure that its patients have access to the full range of FDA-approved contraceptive methods designed to prevent a pregnancy.

As required by Massachusetts law, female rape survivor's survivors at risk of pregnancy have the right to receive written information about emergency contraception, to be promptly offered emergency contraception, and to be provided with emergency contraception upon request.

HCHC providers are required, at a minimum, to provide such written information, and they must offer and initiate emergency contraception if They requests.

The 's Reproductive Health Services Policy and Procedure shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, HCHC's senior management, federal and state law and regulations, and applicable accrediting and review organizations.



<b>Policy Title:</b> Tracking Patient Referrals	<b>Policy Number:</b> MED-06
<b>Department:</b> Clinical	<b>Policy status:</b> Active
<b>Regulatory Reference:</b> NONE	
<b>Date Published:</b> NOV 2012	
<b>Dates Reviewed:</b> MAY 2018, OCT 2020, OCT 2021	
<b>Dates Revised:</b> MAY 2019, OCT 2020	

### **PURPOSE:**

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for ensuring that referrals to other Providers are received and to identify patients who do not follow through with specialty referrals to improve care.

### **POLICY:**

1. Open referrals will be tracked by the Team Medical Assistant (MA).
2. Referrals will be reconciled every 2 weeks or at pre-visit planning time by the Team MA.
3. Urgent referral appointments will be made by the Referrals Specialist and tracked by the Team MA.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Approved by Board of Directors on: \_\_\_\_\_

Approved by:

\_\_\_\_\_  
Chief Executive Officer, HCHC

\_\_\_\_\_  
HCHC Board of Directors

## **PROCEDURE:**

### **The Team MA/Referrals Specialist will track patient appointments for referrals.**

1. The provider will place a referral in the Patient's EMR. Relevant Clinical Information should be included in the referral such as:
  - a. Current Medications
  - b. Diagnoses, including mental health
  - c. Allergies
  - d. Medical and Family history
  - e. Substance abuse
  - f. Behaviors that affect the patient's health
  - g. Clinical findings and current treatment
  - h. Any testing/ results that already have been done
  - i. Follow up communication
  - j. Patient demographics- communication needs, Primary language, DOB, Sex, Contact information, Health insurance information, relevant cultural or ethnic information.
2. If the consult note is not received within three months, the Team MA will contact the specialist office and assess if the patient has made an appointment.
  - a. If the patient has made an appointment and the visit has been completed, request the consult notes to be sent to the electronic fax.
  - b. If the patient's appointment is at a future date, the Team MA/Referrals Specialist will note the appointment date in the appointment field in the referral.
  - c. If the patient does not have an appointment, the Team MA will note that in the referral in the notes or reason section of the referral.
3. The Team MA will call patient and ask them about their appointment for the referral.
4. If the Patient agrees to book the referral appointment, the Team MA will document in referral in the notes section that the patient will book appointment with the specialist. The Team MA will give referral information to the Patient again.
5. If the Patient has not responded to 2 calls or if the patient does not agree to book the referral, the Team MA will create a TE and send to the Provider.
  - a. The Team MA will make 1 phone call, if no response from patient after 1 month, the Team MA will make a 2<sup>nd</sup> call.
6. The Provider will assess. If no further action is needed, the Provider will document in the telephone encounter (TE) and send the TE back to Team MA to address the referral.
7. If the Provider feels that patient needs to be seen by the specialist, he/she will contact the patient.

### **Referrals will be reconciled every two weeks or at Pre-Visit Planning time by Team MA.**

1. On a bi-weekly basis, the Team MA will assess if consult notes have been received for pending referrals in the last 90 days.
2. When consult note is received, scanners will upload them to patient documents and assign the consult note to the provider and address the referral.
  - a. Scanners will check the "Received date" box and go into the structured data and click on the "received consult note from specialist" box and a date will populate.
3. During reconciliation, if consult note has been received and the referral is not addressed the Team MA will enter the date received from the scanned document in the "received date" box and "received consult note from specialist" in the structured data tab.

**Urgent referral appointments will be made by Referrals Specialist and tracked by the Team MA.**

1. A Provider will mark a referral as urgent or high priority. The referral will be assigned to an HCHC Referrals Specialist.
2. For tracking purposes, a high priority telephone encounter will be created by the Referrals Specialist and assigned to REFERRALS.
3. If necessary, the Referrals Specialist will obtain an insurance authorization.
4. The Referrals Specialist will schedule an appointment for the patient and notify the patient of the appointment date and time.
5. Once the patient is aware of the appointment, the referral and telephone encounter will be forwarded to the Team MA to track.
6. The MA will request the consult notes or test results and hold the telephone encounter open until the notes are received.
7. If the notes or test results are received, Front Desk will scan them into the patient's chart and assign them to the Provider to review.
8. The Team MA will address the telephone encounter once the consult notes or test results have been received.
9. If the patient cancels the appointment, the telephone encounter should be assigned to the Provider as FYI.
10. If the appointment is rescheduled, the Team MA will keep the telephone encounter until the new date.





<b>Policy Title:</b> Employee Exposure to Blood or Other Potentially Infectious Material- “Needle Stick” Policy	<b>Policy Number:</b> MED-07
<b>Department:</b> Clinical	<b>Policy status:</b> Active
<b>Regulatory Reference:</b>	
<b>Date Published:</b> FEB 2016	
<b>Dates Reviewed:</b> JUL 2021	
<b>Dates Revised:</b> JUL 2021	

### **Purpose:**

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to minimize risk of infection when an employee is exposed to a potentially infectious material.

### **Policy:**

Definition of terms:

- 1) Occupational Exposure: Contact between open skin, eye, or mucus membranes and blood or other potentially infectious material that may result from the performance of an employee’s duties.
- 2) Other potentially infectious materials include: Any bodily fluid visibly contaminated with blood or any bodily fluids in situations where it is difficult to differentiate between body fluids: semen, vaginal secretions, cerebrospinal fluid, and fluid from sterile body cavity or contaminated saliva.

When an exposure as defined above occurs:

After an exposure:

- Immediately wash needle sticks and cuts with soap and water
- Irrigate eyes with clean water or saline
- Flush splashes to nose, mouth, or skin with water

**Incident Reporting:**

After appropriate washing/ flushing employee must:

- Notify the supervisor of the exposure
- Supervisor should contact Clinical Medical Operations Manager, Jaime Gogol or Dental Operations Manager Cynthia McGrath
- Operations Managers should notify Medical Director, Marisela Fermin-Schon
- Employee should fill out an incident report form
- Employee should identify the source of the exposure
- Collect and test the source individual's blood for HBV, HCV, and HIV as soon as consent is obtained (see "Pathogen Exposure Handout")

Within 4 hours of an exposure incident, the exposed employee(s) receives the following:

- Confidential medical evaluation with a medical provider
- Lab tests ordered and drawn for employee with consent
- Treatment and post-exposure PEP drugs when appropriate (e.g., antiretroviral agents, HBIG [hepatitis B immune globulin], the hepatitis B vaccination series, and other drugs)

We also make immediately available to the exposed employee(s):

- Counseling
- Follow-up testing (if an antibody-only test is negative, repeat HIV testing should occur at six weeks, three months, and six months following the exposure)

Our organization ensures that post-exposure evaluation and follow-up are:

- Made available at no cost to our employees or patients and are at a reasonable time and place

Questions regarding this policy or any related procedure should be directed to the Medical Director at 413-667-3009.

Approved by Board of Directors, Date: \_\_\_\_\_

Approved by:

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Eliza B. Lake  
Chief Executive Officer, HCHC

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M. Lee Manchester  
Chair, HCHC Board of Directors

**Procedure:**

1. When an exposure as defined above occurs, the employee will perform first aid to the affected area immediately as follows:
  - a. Needle sticks and cuts should be washed with soap and water promptly for 3-5 minutes;
  - b. Splashes to the nose, mouth or skin should immediately be flushed with water for 3-5 minutes;
  - c. Eyes should be irrigated immediately with clean water, saline or sterile irrigate for 3-5 minutes.
2. A nurse should be notified immediately. This nurse will be responsible for coordinating the immediate care for the employee and the patient. In the event that a nurse is not on site, the employee will contact a working medical provider or call the on-call provider and furnish the incident report to nursing the following morning.
3. The nurse will speak to the patient and request permission for testing the patient for HIV ab/ag, Hepatitis C ab, Hepatitis B surface ag, Hepatitis B surface ab, and Hepatitis B core ab. If the patient agrees to testing, consent forms for Release of Medical Information will be completed to allow the reporting of test results to the employee's primary care provider or another medical provider who will be caring for the employee, and to the patient's primary care provider.
4. The patient will be directed to the laboratory for the requested blood work. If the lab is closed, arrangements will be made to facilitate testing, via standing orders, as quickly as possible, and the nurse will follow up as appropriate to assure that testing is performed. The patient can provide a receipt for the requested lab fees to HCHC for reimbursement.
5. The medical director or his/her designee will coordinate with the Front Desk to manage other patients who may need to be rescheduled;
6. The nurse will assist the employee in completing an incident report form, a copy of which will be forwarded to the appropriate department Director, and in arranging prompt evaluation by the employee's primary care provider or by the Emergency Department at Cooley Dickinson Hospital. If the employee opts to be evaluated at the Emergency Department, the nurse will call to alert them that the employee is to be seen for evaluation and consideration of post-exposure prophylaxis. The employee should be evaluated within 24 hours of the incident.
7. If the exposed person is a student, the student will inform their academic institution within 24 hours and follow any additional guidelines from that institution.
8. The Department Director will be responsible for informing the QI Committee of the incident, and for promptly informing the Human Resource department of the incident. The original Incident Report form will be transferred to the Human Resource department for OSHA reporting.
9. The employee is responsible for notifying the Human Resource department as to whether post-exposure prophylaxis was initiated, whether there is evidence of acquisition of infection with HIV, HCV or HBV by the employee, and when all follow-up testing has been completed.