UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES MEETINGS

WHIDDON ADMINISTRATION BUILDING – PRESIDENT'S OFFICE (STE. 130), BOARD ROOM

SEPTEMBER 4, 2025
1:30 P.M.

AUDIT COMMITTEE MEETING – STEVE STOKES, M.D., CHAIR

1 Roll Call
2 Approve: Minutes
3 Report: KPMG Auditors
4 Report: Independent Audit of the USA Foundation Consolidated Financial Statements and Disproportionate Share Hospital Funds Combined Financial Statements, Years Ended June 30, 2025 and 2024
5 Report: Alabama Department of Examiners of Public Accounts Compliance Report, Years Ended September 30, 2023 and 2024
6 Approve: Audit Plan for Fiscal Year 2026
7 Report: Office of Internal Audit

DEVELOPMENT, ENDOWMENT AND INVESTMENTS COMMITTEE MEETING – MIKE WINDOM, CHAIR

8 Roll Call
9 Approve: Minutes
10 Report: Endowment and Investment Performance
11 Recommendation to Approve: Commendation of Mrs. Barbara Bush and Mr. Leonard Bush
12 Report: Development and Alumni Relations

HEALTH AFFAIRS COMMITTEE MEETING – JIMMY SHUMOCK, CHAIR

13 Roll Call
14 Approve: Minutes
15 Recommendation to Approve: USA Health Hospitals Medical Staff Appointments and Reappointments for May, June and July 2025
16 Recommendation to Approve: Department of Urology Waiver Request
17 Recommendation to Approve: Department of Urology Waiver Request
18 Recommendation to Approve: Department of Internal Medicine Waiver Request
19 Recommendation to Approve: Community Health Needs Assessment
20 Report: USA Health and Whiddon College of Medicine

ACADEMIC EXCELLENCE AND STUDENT SUCCESS COMMITTEE MEETING – CHANDRA BROWN STEWART, CHAIR

21 Roll Call
22 Approve: Minutes
23 Report: Academic Affairs
24 Report: Student Affairs
25 Report: Research and Economic Development

BUDGET AND FINANCE COMMITTEE MEETING – LENUS PERKINS, CHAIR

26 Roll Call
27 Approve: Minutes
28 Report: Quarterly Financial Statements for the Nine Months Ended June 30, 2025
29 Recommendation to Approve: University of South Alabama Fiscal Year 2026 Budget
30 Report: University Facilities

LONG-RANGE PLANNING COMMITTEE MEETING – RON GRAHAM, CHAIR

31 Roll Call
32 Approve: Minutes
33 Report: Institutional Planning and Assessment

COMMITTEE OF THE WHOLE MEETING – ALEXIS ATKINS, CHAIR

34 Roll Call
35 Approve: Minutes
36 Recommendation to Approve: Board of Trustees Executive Committee
37 Approve: Executive Session

SEPTEMBER 5, 2025
10:30 A.M.

BOARD OF TRUSTEES MEETING – ALEXIS ATKINS, CHAIR PRO TEMPORE

1 Roll Call
2 Approve: Minutes
3 Approve: Board of Trustees Executive Committee
4 Report: University President
5 Report: Faculty Senate President
6 Report: Student Government Association President
7 Approve: Consent Agenda Items:
USA Health Hospitals Medical Staff Appointments and Reappointments for May, June and July 2025
Department of Urology Waiver Request
Department of Urology Waiver Request
Department of Internal Medicine Waiver Request
Community Health Needs Assessment
8 Report: Audit Committee
9 Report: Development, Endowment and Investments Committee
10 Report: Health Affairs Committee
11 Report: Academic Excellence and Student Success Committee
12 Report: Budget and Finance Committee
13 Approve: University of South Alabama Fiscal Year 2026 Budget
14 Report: Long-Range Planning Committee
15 Approve: Commendation of Mrs. Barbara Bush and Mr. Leonard Bush
16 Unveil: Portrait of Mrs. Arlene Mitchell, Chair Pro Tempore Emerita

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

MEETING SCHEDULE

THURSDAY, SEPTEMBER 4, 2025:

1:30 p.m.	**Committee Meetings (consecutive)**	**Whiddon Administration Bldg.** **President's Office (Ste. 130), Board Room**

FRIDAY, SEPTEMBER 5, 2025:

10:30 a.m.	**Board of Trustees Meeting**	**Whiddon Administration Bldg.** **President's Office (Ste. 130), Board Room**

UNIVERSITY OF SOUTH ALABAMA
FLAGSHIP OF THE GULF COAST.

BOARD OF TRUSTEES

STANDING COMMITTEES
2025-2028

EXECUTIVE COMMITTEE:

- Katherine Alexis Atkins, **Chair** ***pro tempore***
- Lenus M. Perkins, **Vice Chair**
- William Ronald Graham, **Secretary**
- Chandra Brown Stewart
- Arlene Mitchell
- James H. Shumock
- Michael P. Windom

ACADEMIC EXCELLENCE AND STUDENT SUCCESS CTE.:

- Chandra Brown Stewart, **Chair**
- Scott A. Charlton, M.D.
- Steven P. Furr, M.D., **Vice Chair**
- Luis Gonzalez
- Robert D. Jenkins III
- Bill W. Lewis II
- Michael P. Windom

AUDIT COMMITTEE:

- Scott A. Charlton, M.D.
- Steven P. Furr, M.D.
- Meredith Mitchell Hamilton
- Bill W. Lewis II, **Vice Chair**
- Lenus M. Perkins
- Steven H. Stokes, M.D., **Chair**

BUDGET AND FINANCE COMMITTEE:

- Chandra Brown Stewart
- William Ronald Graham
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- Lenus M. Perkins, **Chair**
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- Chandra Brown Stewart
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- Luis Gonzalez
- Robert D. Jenkins III
- Steven H. Stokes, M.D., **Vice Chair**
- Michael P. Windom, **Chair**
- James A. Yance

EVALUATION AND COMPENSATION COMMITTEE:

- Steven P. Furr, M.D.
- Luis Gonzalez
- Robert D. Jenkins III, **Chair**
- Bill W. Lewis II, **Vice Chair**
- Arlene Mitchell
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- James H. Shumock

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- Steven P. Furr, M.D.
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- Meredith Mitchell Hamilton
- Arlene Mitchell, **Vice Chair**
- James H. Shumock, **Chair**
- Steven H. Stokes, M.D.
- James A. Yance

LONG-RANGE PLANNING COMMITTEE:

- Scott A. Charlton, M.D.
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- Meredith Mitchell Hamilton
- Robert D. Jenkins III
- Bill W. Lewis II
- James A. Yance, **Vice Chair**

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

MEETING AGENDA
AND MINUTES

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES MEETINGS

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SEPTEMBER 5, 2025
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11 Report: Academic Excellence and Student Success Committee
12 Report: Budget and Finance Committee
13 Approve: University of South Alabama Fiscal Year 2026 Budget
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15 Approve: Commendation of Mrs. Barbara Bush and Mr. Leonard Bush
16 Unveil: Portrait of Mrs. Arlene Mitchell, Chair Pro Tempore Emerita

UNIVERSITY OF SOUTH ALABAMA

MEMORANDUM

Board of Trustees

DATE: August 26, 2025

TO: USA Board of Trustees

FROM: Ron Graham Ron Graham
Secretary, Board of Trustees

SUBJECT: Meeting Minutes

Included herein are the unapproved minutes for the Board of Trustees and standing committee meetings held on June 5 and 6, 2025. Please review these documents for amendment or approval at the meetings on September 4 and 5, 2025.

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

June 6, 2025
10:30 a.m.

A meeting of the University of South Alabama ("USA," "University") Board of Trustees was duly convened by Ms. Arlene Mitchell, Chair *pro tempore*, on Friday, June 6, 2025, at 10:32 a.m. in the Board Room of the Frederick P. Whiddon Administration Building. Meeting attendance was open to the public.

Members:	Alexis Atkins, Chandra Brown Stewart, Scott Charlton, Luis Gonzalez, Ron Graham, Ron Jenkins, Bill Lewis, Arlene Mitchell, Lenus Perkins, Jimmy Shumock, Steve Stokes, Mike Windom and Jim Yance were present.
Members Absent:	Steve Furr, Meredith Mitchell and Kay Ivey.
Administration & Guests:	Owen Bailey, Jim Berscheidt, Joél Billingsley, Janée and Jo Bonner, Ashley Bosarge, Rick Carter, Nolan Crawford, Scott Crow, KC Crusoe (SGA), Joel Erdmann, Monica Ezell, Natalie Fox, Charlie Guest, Emma Harrod, Kali Johnston, Buck Kelley, Andi Kent, Andrew Kent, Mary Elizabeth Kent, Spence Larche, Alfred Lynaum, Nick Lawkis, James Lawrence (BSU), John Marymont, Abe Mitchell, Mike Mitchell, Allen Parrish, Kristen Roberts, Ansley Simmons, Ronnie Stallworth, Sandra Stenson and Donna Streeter (Faculty Senate), Margaret Sullivan, Peter Susman, Laura Vrana and Christina Wassenaar (Faculty Senate) and Bri Wilson.

Upon calling the meeting to order and following the attendance roll call, **Item 1**, Chair Mitchell welcomed everyone; thanked Dr. Marymont and Mr. Bailey for facilitating a tour for Trustees and guests at the Mitchell Cancer Institute the evening prior; conveyed sympathy to Dr. Charlton on behalf of the Board for the recent passing of his father; and congratulated President Bonner for being honored for his contributions to the community with the Drug Education Council's *2025 Joseph Treadwell Award* in April. She called for consideration of the minutes for a Board of Trustees meeting held on March 14, 2025, **Item 2**. On motion by Dr. Charlton, seconded by Justice Lewis, the Board voted unanimously to adopt the minutes.

Chair Mitchell called for consideration of **Item 3** as follows. (To view additional documents authorized, refer to Appendix A.) On motion by Justice Lewis, seconded by Mr. Shumock, the Board voted unanimously to approve the resolution:

RESOLUTION
REVISED BYLAWS OF THE BOARD OF TRUSTEES OF THE UNIVERSITY OF SOUTH ALABAMA

WHEREAS, Article VIII of the *Bylaws of the University of South Alabama Board of Trustees* (the "Bylaws") provides that the Bylaws "may be amended or repealed at any meeting of the Board by eight members of the Board voting in favor of same, but no such action shall be taken unless notice of the substance of such proposed adoption,

amendment or repeal shall have been given at a previous meeting or notice in writing of the substance of the proposed change shall have been served upon each member of the Board at least thirty (30) days in advance of the final vote upon such change," and

WHEREAS, a draft of the proposed revised Bylaws, which is attached hereto and incorporated by reference herein, was provided to each member of the Board on May 7,2025, in compliance with the notice requirements of Article VIII of the Bylaws that pertain to amendment of the Bylaws, and

WHEREAS, the proposed revised Bylaws is presented for the Board's consideration and approval, and

WHEREAS, the Board, after due consideration and deliberation, has determined that the amendments proposed are in the best interest of the efficient operation of the Board in carrying out its role and responsibilities to the University,

THEREFORE, BE IT RESOLVED, the Board of Trustees approves and adopts the revised *Bylaws of the University of South Alabama Board of Trustees* as submitted.

Chair Mitchell called for consideration of **Item 4** as follows. On motion by Mr. Graham, seconded by Mr. Yance, the Board voted unanimously to approve the resolution:

RESOLUTION
BOARD OF TRUSTEES MEETING SCHEDULE FOR 2025-2026

WHEREAS, Article II, Section 1, of the *Bylaws of the Board of Trustees of the University of South Alabama* provides that the Board shall schedule annually, in advance, regular meetings of the Board to be held during the ensuing year and may designate one of such meetings as the annual meeting of the Board,

THEREFORE, BE IT RESOLVED that the regular meetings of the University of South Alabama Board of Trustees shall be held on the following dates:

- Friday, September 5, 2025
- Thursday, December 4, 2025
- Friday, March 6, 2026
- Friday, June 5, 2026,

FURTHER, BE IT RESOLVED that the meeting on June 5, 2026, shall be designated as the annual meeting of the University of South Alabama Board of Trustees for 2025-2026.

Chair Mitchell yielded to President Bonner for the President's Report, **Item 5**. President Bonner noted it was the 81st anniversary of D-Day and acknowledged the brave Americans who made a difference for the world. He recognized Dr. Christina Wassenaar, Mr. KC Crusoe and Mr. James Lawrence III, presidents representing the Faculty Senate ("Senate"), Student Government Association ("SGA") and Black Student Union ("BSU"), respectively; Mr. Ronnie Stallworth, USA National Alumni Association President; Ms. Bri Wilson and Mr. Andrew Kent, Southerner ambassadors; and Mr. Abe Mitchell, Honorary Trustee.

President Bonner noted that Chair Mitchell's term as leader of the Board was ending and he thanked her for her service of 18 years on the Board thus far. He recognized her late husband, Mr. Mayer Mitchell, as one of the Board's longest-serving members with 32 years of service – a record he noted was rivalled only by the 32 years served by Dr. Stokes thus far.

President Bonner congratulated Justice Lewis for his recent appointment by Governor Ivey to serve on the Alabama Supreme Court and cited the other distinguished judicial roles Justice Lewis had held during his time on the Board.

President Bonner shared words on the origin of *The USA Way* philosophy expressive of the University's culture and impact on education, research, healthcare and service. He introduced a video that articulated *The USA Way.*

Among the array of other topics discussed by President Bonner were University accomplishments, such as USA being designated as a *Purple Heart University* and *Gold Star Military Friendly School* for the attention given to military students and their families, as well as activities having recently occurred and taking place over the summer months, such as orientations for new and transfer students and work on numerous capital projects. President Bonner also asserted the important mission of USA Health and conveyed his appreciation to Dr. Marymont and Mr. Bailey for their leadership, and to Dr. Natalie Fox, who he noted had assumed the role of Interim Chief Executive Officer of USA Health.

President Bonner turned to Provost Kent, who also shared heartfelt words of appreciation with Chair Mitchell for her leadership. Provost Kent then asked Dr. Rick Carter, Associate Vice President for Global Engagement, to join her, as well as students who accompanied them for an executive leadership study abroad trip to Greece. Dr. Carter discussed the program, stating it had been nominated for a NAFSA Association of International Educators *GoAbroad Innovation Award.* The students – Ms. Emma Harrod, Ms. Mary Elizabeth Kent, Mr. Nolan Crawford, Ms. Ansley Simmons and Ms. Kali Johnston – recounted their experiences, which included a chance meeting with a local whose father had traveled to the University decades earlier to attend the dedication of USA's *Tholos*, a replica of the ancient Greek structure that was donated to USA.

Provost Kent introduced Dr. Erdmann, who provided an update on the impending ratification of the *House vs. NCAA* settlement and preparations for a July 1 implementation. He added that USA Athletics was also navigating transfer portals for football, women's basketball and spring sports and he credited the coaches and the administrative team for their proactive supervision. He advised that USA Athletics had dissolved the *Jags Impact* third-party collective and created the *Loyal, Strong and Faithful Fund*, to be managed in-house for the support of student athletes and programs. He concluded his remarks with an update on sports programming.

President Bonner recognized Mr. Bailey, noting his plans to retire soon. He thanked Mr. Bailey for his leadership and said he would be formally recognized for his service at a future meeting.

President Bonner invited Mr. Alfred Lynaum, Groundskeeper II with the Division of Finance and Administration, to join him and Provost Kent, advising of his selection as *Employee of the Quarter* for the second quarter of 2025. Also joining them were Ms. Ashley Bosarge, Groundskeeper II and Mr. Lynaum's nominator, and Mr. Scott Crow, Associate Director - Landscape/Grounds. President Bonner read an excerpt from the nomination application and presented Mr. Lynaum with a certificate commemorating the award.

Chair Mitchell called for a report from the President of the Faculty Senate, **Item 6**. Dr. Christina Wassenaar, 2025-2026 Senate President, discussed her second term; introduced Dr. Donna Streeter, Dr. Laura Vrana and Dr. Sandra Stenson, Senate Past President, Vice President and Secretary, respectively; and shared her vision for the new academic year, noting that the Senate would address faculty sustainability and wellbeing, the Senate bylaws, and faculty-alumni engagement, among other matters.

Chair Mitchell called for a report from the SGA President, **Item 7**. Mr. KC Crusoe, 2025-2026 SGA President, discussed his background and academic journey; provided a summary on the SGA's accomplishments during his term as SGA Vice President; and explained that his platform for the year ahead would center around communication, brand, community and change. He stated it was a pleasure to have the opportunity to speak to the Board and to advocate for students, and ended his presentation by taking the traditional photo with Board members.

Concerning the **Item 8** consent agenda resolutions following, which were unanimously recommended for Board approval by the committees that met the preceding day, Chair Mitchell noted that one of the resolutions required correction and stated the revised resolution had been given to Board members for their consideration. On motion by Mr. Graham, seconded by Mr. Shumock, the Board voted unanimously to approve the resolutions:

RESOLUTION
USA HEALTH HOSPITALS MEDICAL STAFF APPOINTMENTS AND REAPPOINTMENTS
FOR FEBRUARY, MARCH AND APRIL 2025

WHEREAS, the Medical Staff appointments and reappointments for February, March and April 2025 for the USA Health Hospitals are recommended for Board approval by the Medical Executive Committees and the USA Health Credentialing Board,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the appointments and reappointments as submitted.

RESOLUTION
USA HEALTH HOSPITALS MEDICAL STAFF BYLAWS AND ASSOCIATED DOCUMENTS

WHEREAS, revisions to the USA Health Hospitals Medical Staff Bylaws and to associated documents, approved April 18, 2025, by the active voting General Medical Staff members, are recommended for approval by the Medical Executive Committees and the Executive Committee of the USA Health Hospitals,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the revisions as submitted.

RESOLUTION
NOMINATION OF CANDIDATESFOR THE MOBILE COUNTY HOSPITAL BOARD OF DIRECTORS

WHEREAS, the term of office of Dr. Bernard H. Eichold II as a director of the Mobile County Hospital Board ("Corporation") will expire on September 30, 2025, and

WHEREAS, the Certificate of Incorporation of the Mobile County Hospital Board requires (a) a nomination by the Board of Trustees of the University of South Alabama of two (2) alternative candidates for consideration by the Mobile County Commission and (b) election by the Mobile County Commission of one of the alternative candidates to serve as director of the Corporation for a term of six (6) years, and

WHEREAS, the leadership of USA Health has requested that the Board of Trustees nominate Maryann Mbaka, M.D., USA Health trauma surgeon, and Mr. Tom Myers, USA Health Chief Transformation Officer, as the two (2) alternative candidates for consideration by the Mobile County Commission, both of whom meet the criteria for service as director of the Corporation,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby nominates Maryann Mbaka, M.D. and Mr. Tom Myers as two (2) alternative candidates for consideration by the Mobile County Commission for the position of director of the Mobile County Hospital Board.

Chair Mitchell turned to Ms. Brown Stewart, Chair of the Long-Range Planning Committee, for a report, **Item 16**. Ms. Brown Stewart advised of a Committee meeting held on June 5, 2025, and she provided an overview on the business that occurred.

Chair Mitchell called for a report from the Audit Committee, **Item 9**. Mr. Graham, Committee Chair, advised of a Committee meeting held on June 5, 2025, and gave a summation on the proceedings.

Chair Mitchell called for a report from the Development, Endowment and Investments Committee, **Item 10**. Mr. Yance, Committee Chair, stated that a Committee meeting took place on June 5, 2025, and provided a recap of the work accomplished.

Chair Mitchell called for a report from the Health Affairs Committee, **Item 11**. Mr. Shumock, Committee Chair, noted that the Committee met on June 5, 2025, and shared an overview on the matters addressed. He also discussed highlights from an educational session held on May 29, 2025.

Chair Mitchell called for a report from the Academic Excellence and Student Success Committee, **Item 12**. Judge Windom, Committee Chair, presented a summary of the actions and reports that took place at a Committee meeting on June 5, 2025. He added that the resolution following, **Item 13**, was unanimously recommended for Board approval. On motion by Capt. Jenkins, seconded by Ms. Atkins, the Board voted unanimously to approve the resolution:

RESOLUTION
TENURE AND PROMOTION

WHEREAS, in accordance with University of South Alabama policy, faculty applications for tenure and promotion have been reviewed by the respective peer review committee, department chair and college dean, the Executive Vice President and Provost or the Vice President for Medical Affairs, and the President, and the candidates named herein are recommended for tenure and/or promotion effective August 15, 2025,

THEREFORE, BE IT RESOLVED, the University of South Alabama Board of Trustees hereby approves and grants tenure and/or promotion as recommended.

COLLEGE OF ARTS AND SCIENCES:

Tenure:
- Jeremiah A. Henning
- Christina L. Johnson
- Nancy J. Kelley
- Dakota Lindsey
- Hans-Jorg Schanz
- Stephen B. Scyphers

Promotion to Senior Instructor
- Melissa R. Walter

Promotion to Associate Professor:
- Jeremiah A. Henning
- Christina L. Johnson
- Dakota Lindsey
- Hans-Jorg Schanz

Promotion to Professor:
- Brian Dzwonkowski
- Henry M. McKiven, Jr.
- Andrei Pavelescu

Promotion to Professor of Instruction:
- Richard A. O'Brien

COLLEGE OF EDUCATION AND PROFESSIONAL STUDIES:

Tenure:
- Kelly O. Byrd
- Craig A. Parkes

Promotion to Associate Professor:
- Kelly O. Byrd
- Craig A. Parkes

LIBRARIES:

Promotion to Senior Librarian
- Rachel F. Fenske
- Elizabeth R. Shepard

COLLEGE OF NURSING:

Promotion to Associate Professor:
- Jennifer Anderson
- Ashleigh F. Bowman

Promotion to Associate Professor, Research:
- Candice N. Selwyn

MITCHELL COLLEGE OF BUSINESS:

Tenure:
- Tristan B. Johnson
- Hua "Christine" Xin

Promotion to Senior Instructor:
- R. Mark Foster

Promotion to Associate Professor:
- Tristan B. Johnson

Promotion to Professor:
- Matthew C. Howard
- Khandokar Istiak
- Hua "Christine" Xin

PAT CAPPS COVEY COLLEGE OF ALLIED HEALTH PROFESSIONS:

Promotion to Senior Instructor:
- Mary Curtis
- Alison K. Henry
- Brent L. Wiles

SCHOOL OF COMPUTING:

Promotion to Senior Instructor:
- Ricky E. Green, Jr.

Promotion to Associate Professor:
- Michael Black

Promotion to Professor:
- Ryan G. Benton

WHIDDON COLLEGE OF MEDICINE:

Tenure:
- Santanu Dasgupta
- Meghan E. Hermance

Promotion to Associate Professor:
- Santanu Dasgupta
- Nita S. Davis
- Luis del Pozo-Yauner
- Christopher M. Francis
- Meghan E. Hermance
- Robert P. Kobelja
- Yann-Leei L. Lee
- Brett S. Martin
- Brett S. Martin (Joint)
- Maryann I. Mbaka
- Benjamin R. Niland

Promotion to Associate Professor continued:
- Karen J. Parsell
- William M. Perez
- Walker B. Plash
- Jai D. Thakur
- Ashley Y. Williams

Promotion to Professor:
- Charles W. Hartin, Jr.
- Charles W. Hartin, Jr. (Joint)
- Nicolette P. Holliday
- Terry J. Hundley, Jr.
- Rosemary J. Klecker

Promotion to Professor, Research:
- Viktor G. Solodushko

Judge Windom advised that the resolution following, **Item 14**, was also unanimously recommended for Board approval. On motion by Dr. Stokes, seconded by Mr. Shumock, the Board voted unanimously to approve the resolution:

ACADEMIC INFRASTRUCTURE AND TECHNOLOGY FEE, COLLEGE OF MEDICINE TUITION, AND HOUSING AND DINING RATES FOR 2025-2026

WHEREAS, the University of South Alabama is committed to maintaining high-quality educational and student services programs at a competitive cost, and

WHEREAS, the University Strategic Planning Priorities provide guidance and direction to faculty, staff, and administrators for future planning and continued growth and improvement of the University, and

WHEREAS, the University has an Academic Infrastructure and Technology Fee that supports instruction and learning through strategic investments in academic and technological resources, and

WHEREAS, the University has determined that an increase to this fee is necessary to allocate financial resources toward the attainment of University Strategic Planning Priorities, and

WHEREAS, an increase to the College of Medicine tuition is necessary to address rising operational costs and remain consistent with peer institutions, and

WHEREAS, housing and dining services must account for increased operating and food costs and make facility improvements to enhance campus life for students,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the Academic Infrastructure and Technology Fee, College of Medicine tuition, and housing and dining rates for the 2025-2026 academic year, as set forth in the attached schedules.

Chair Mitchell called for a report from the Budget and Finance Committee, **Item 15**. Mr. Perkins, Committee Chair, advised of a Committee meeting held on June 5, 2025, and he briefed the Board on the proceedings.

Concerning **Item 17**, a report from the Nominating Committee, Chair Mitchell advised that the Committee, on which she, Justice Lewis, Mr. Shumock, Dr. Stokes and Mr. Yance served, had deliberated on a slate of officers to serve three-year terms and unanimously agreed to nominate Ms. Atkins, Mr. Perkins and Mr. Graham to serve as Chair *pro tempore*, Vice Chair and Secretary, respectively. She made a motion to adopt the slate of officers, Mr. Shumock seconded, and the Board voted unanimously to elect the Trustees nominated to serve as officers of the Board, **Item 18**.

Chair Mitchell expressed her thanks to her fellow Board members for their support, love and friendship during her term as Board Chair and she joined Mr. Shumock, President Bonner and Provost Kent for the presentation of **Item 19** as follows. President Bonner recognized the Mitchell family members in attendance and yielded to Mr. Shumock, who read the resolution and moved for its approval. Mr. Yance seconded and the Board voted unanimously to approve the resolution. President Bonner talked about the extraordinary impact Chair Mitchell and the Mitchell family had made in the life of the University, and he and Provost Kent presented her a framed resolution, the gavel she used with a pedestal commemorating her service, and a glass art vase created by the Department of Visual Arts. Board members conveyed their appreciation to Chair Mitchell for her leadership and example, and Chair Mitchell stated it was a pleasure working with everyone:

RESOLUTION
COMMENDATION OF MRS. ARLENE MITCHELL FOR SERVICE AS CHAIR PRO TEMPORE AND CONFERRAL OF THE TITLE CHAIR PRO TEMPORE EMERITA

WHEREAS, Mrs. Arlene Mitchell has served faithfully as a member of the Board of Trustees of the University of South Alabama since her appointment in 2007 to the seat representing Mobile County that was previously held by her beloved husband and trusted partner, Mr. Mayer "Bubba" Mitchell, and

WHEREAS, Mrs. Mitchell was elected as Chair Pro Tempore of the Board of Trustees (the "Board") in 2022, making her the first female Chair in the history of the University of South Alabama (the "University"), and, previous to this role, she served as Vice Chair from 2019-2022 and Secretary from 2016-2019, and

WHEREAS, Mrs. Mitchell's service on the Board has been critical to the University's growth and progress, as demonstrated through her membership on the Budget and Finance Committee; Development, Endowment and Investments Committee; Evaluation and Compensation Committee, Health Affairs Committee, Long-Range Planning Committee, and Executive Committee, and

WHEREAS, the positive results of Mrs. Mitchell's leadership as Board Chair will be realized in perpetuity, made possible by the strategic initiatives she has championed that have led to two consecutive years of enrollment growth, improved retention, the expansion of academic programs, record fundraising, construction of a new Frederick P. Whiddon College of Medicine building, and the continued advancement of USA Health, enabled with the acquisition of Providence Hospital and its clinics, the establishment of the Kelly Butler ALS Center, and the renovation and expansion of the USA Health Children's & Women's Hospital Pediatric Emergency Center, among other enhancements, and

WHEREAS, Mrs. Mitchell is a loyal supporter of the University of South Alabama and, over the years, has donated generously to numerous initiatives, such as the Pediatric Emergency Center project, Neonatal Intensive Care Unit (the "NICU") renovation and da Vinci surgical system acquisition at USA Health Children's & Women's Hospital, and has supported campaigns, endowments and scholarships, including the USA Health Mitchell Cancer Institute's *Arlene and Mayer Mitchell Chair in Medical Oncology Endowment Fund*, as well as the *Mayer Mitchell Quarterback Endowment Fund*, which she founded, and

WHEREAS, Mrs. Mitchell has devoted her time and energy to support those in need of encouragement and compassion, as exemplified by her years of visiting the NICU to rock babies and recent donation of *Bed of Flowers* to Children's & Women's Hospital, a beautiful new sculpture by internationally renowned artist and Mobile native Gay Outlaw, installed to brighten spirits and inspire hope among patients and their families, and

WHEREAS, Mrs. Mitchell, a member of Congregation Ahavas Chesed, has been an active community servant, whose civic work has benefited organizations including the Exploreum Science Center, Senior Citizens Services of Mobile, and the Boys and Girls Clubs of South Alabama, and, thereby, the entire Gulf Coast region has greatly benefited from her stewardship and generosity, and

WHEREAS, for her exceptional contributions, Mrs. Mitchell has received numerous awards, including being named *Mobilian of the Year*, *Distinguished Friend of Education* by the Council for Advancement and Support of Education, and *Awesome Octogenarian*, and, recently, she and Mayer were celebrated by the United Way of Southwest Alabama for their philanthropy spanning decades that enriched the lives of countless people throughout the Gulf Coast region,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama expresses its sincere appreciation to Mrs. Arlene Mitchell for her many contributions and invaluable service to the Board, to the entire University community, and to the people of the state of Alabama, all of whom have benefited from her knowledge, kindness and generosity, and confers upon her the honorary title of *Chair Pro Tempore Emerita* of the

University of South Alabama Board of Trustees, as well as the gavel she used during her tenure as Chair.

There being no further business, the meeting was adjourned at 12:17 p.m.

Respectfully submitted:

Lenus M. Perkins, Vice Chair

Respectfully submitted:

Arlene Mitchell, Chair *pro tempore*

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

AUDIT COMMITTEE

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

Audit Committee

June 5, 2025
1:30 p.m.

A meeting of the Audit Committee of the University of South Alabama ("USA," "University") Board of Trustees was duly convened by Mr. Ron Graham, Chair, on Thursday, June 5, 2025, at 1:31 p.m. in the Board Room of the Frederick P. Whiddon Administration Building. Meeting attendance was open to the public.

Members:	Alexis Atkins, Ron Graham, Ron Jenkins, Bill Lewis and Lenus Perkins were present.
Member Absent:	Meredith Hamilton.
Other Trustees:	Chandra Brown Stewart, Luis Gonzalez, Arlene Mitchell, Jimmy Shumock, Steve Stokes, Mike Windom and Jim Yance.
Administration & Guests:	Owen Bailey, Jim Berscheidt, Joél Billingsley, Jo Bonner, Joel Erdmann, Monica Ezell, Charlie Guest, Buck Kelley, Andi Kent, Spence Larche, Nick Lawkis, Sara Beth Magette (Warren Averett), John Marymont, Mike Mitchell, Allen Parrish, Kristen Roberts, Donna Streeter (Faculty Senate), Margaret Sullivan, Peter Susman and Christina Wassenaar (Faculty Senate).

Following the attendance roll call, **Item 1**, Mr. Graham called for consideration of the minutes for a meeting held on March 13, 2025, **Item 2**. On motion by Capt. Jenkins, seconded by Ms. Atkins, the Committee voted unanimously to adopt the minutes.

Mr. Graham called on Mr. Susman to address **Item 3**, a report on the activities of the Office of Internal Audit (OIA). Mr. Susman introduced Ms. Sarah Beth Magette of Warren Averett, OIA Acting Director, who provided an update on the audit engagements in progress and planned for the general University and USA Health sectors, pointing out that some engagements regarded information technology. She added that an organization-wide risk assessment would be performed over the summer and that the results would inform development of the audit plan for fiscal year 2026, which she noted would be considered at the next meeting.

There being no further business, the meeting was adjourned at 1:37 p.m.

Respectfully submitted:

William Ronald Graham, Chair

UNIVERSITY OF SOUTH ALABAMA FOUNDATION

Consolidated Financial Statements as of and for the
Years Ended June 30, 2025 and 2024, and
Independent Auditor's Report

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

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Deloitte.

Deloitte & Touche LLP
420 North 20th Street
Suite 2400
Birmingham, AL 35203-3289
USA

Tel:+1 205 321 6000
Fax:+1 205 322 2828
www.deloitte.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
University of South Alabama Foundation:

Opinion

We have audited the consolidated financial statements of the University of South Alabama Foundation (the "Foundation"), which comprise the consolidated statements of financial position as of June 30, 2025 and 2024, and the related consolidated statements of activities and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Foundation as of June 30, 2025 and 2024, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Foundation and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Foundation's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and

therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Foundation's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Foundation's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte + Touche LLP

August 15, 2025

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION
AS OF JUNE 30, 2025 AND 2024
(Dollars in thousands)

	2025	2024
ASSETS		
CASH AND CASH EQUIVALENTS	$ 1,147	$ 1,819
INVESTMENTS AT FAIR VALUE:		
Equity securities	276,295	262,850
Timber and mineral properties	179,692	178,218
Real estate	6,436	6,375
Other	5,822	5,815
OTHER ASSETS	470	504
TOTAL	$ 469,862	$ 455,581
LIABILITIES AND NET ASSETS		
LIABILITIES:		
Accounts payable	$ 100	$ 162
Other liabilities	888	876
Total liabilities	988	1,038
NET ASSETS:		
Without donor restrictions	60,408	61,833
With donor restrictions	408,466	392,710
Total net assets	468,874	454,543
TOTAL	$ 469,862	$ 455,581

See notes to consolidated financial statements.

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

CONSOLIDATED STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEAR ENDED JUNE 30, 2025
(Dollars in thousands)

	Without Donor Restrictions	With Donor Restrictions	Total
REVENUES, GAINS, AND OTHER SUPPORT:			
Net realized and unrealized gains on investments	$ 4,680	$ 28,509	$ 33,189
Rents, royalties, and timber sales	3,372	163	3,535
Interest and dividends	1,195	2,112	3,307
Gifts	-	113	113
Interfund interest	(840)	840	-
Other income	37	-	37
Net assets released from program restrictions (Note 9)	15,981	(15,981)	-
Total revenues, gains, and other support	24,425	15,756	40,181
EXPENDITURES:			
Program services:			
Faculty support	3,735	-	3,735
Scholarships	1,259	-	1,259
Other academic programs	13,323	-	13,323
Total program services	18,317	-	18,317
Management and general	3,098	-	3,098
Other investment expense	1,191	-	1,191
Depletion expense	3,198	-	3,198
Depreciation expense	46	-	46
Total expenditures	25,850	-	25,850
(DECREASE) INCREASE IN NET ASSETS	(1,425)	15,756	14,331
NET ASSETS—Beginning of year	61,833	392,710	454,543
NET ASSETS—End of year	$ 60,408	$ 408,466	$468,874

See notes to consolidated financial statements.

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

CONSOLIDATED STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEAR ENDED JUNE 30, 2024
(Dollars in thousands)

	Without Donor Restrictions	With Donor Restrictions	Total
REVENUES, GAINS, AND OTHER SUPPORT:			
Net realized and unrealized gains on investments	$ 7,675	$ 48,900	$ 56,575
Rents, royalties, and timber sales	3,200	161	3,361
Interest and dividends	893	2,163	3,056
Gifts	3	9	12
Required match of donor contributions	(4)	4	-
Interfund interest	(892)	892	-
Other income	43	-	43
Transfer of net assets	(24)	24	-
Net assets released from program restrictions (Note 9)	13,022	(13,022)	-
Total revenues, gains, and other support	23,916	39,131	63,047
EXPENDITURES:			
Program services:			
Faculty support	3,380	-	3,380
Scholarships	1,231	-	1,231
Other academic programs	11,942	-	11,942
Total program services	16,553	-	16,553
Management and general	2,936	-	2,936
Other investment expense	1,105	-	1,105
Depletion expense	3,631	-	3,631
Depreciation expense	48	-	48
Total expenditures	24,273	-	24,273
(DECREASE) INCREASE IN NET ASSETS	(357)	39,131	38,774
NET ASSETS—Beginning of year	62,190	353,579	415,769
NET ASSETS—End of year	$ 61,833	$ 392,710	$ 454,543

See notes to consolidated financial statements.

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

CONSOLIDATED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2025 AND 2024
(Dollars in thousands)

	2025	2024
OPERATING ACTIVITIES:		
Increase in net assets	$ 14,331	$ 38,774
Adjustments to reconcile increase in net assets to net cash used in operating activities:		
Net realized and unrealized gains on investments	(33,189)	(56,575)
Gift of equity securities	(99)	(3)
Contribution of real estate	-	1,920
Depletion	3,198	3,631
Depreciation	46	48
Changes in operating assets and liabilities:		
Other assets	28	84
Accounts payable	(62)	59
Other liabilities	12	14
Net cash used in operating activities	(15,735)	(12,048)
INVESTING ACTIVITIES:		
Purchase of equity securities	(3,980)	(903)
Sale of equity securities	19,541	13,500
Reforestation of timber property	(477)	(305)
Purchase of timberland	-	(120)
Other	(21)	(23)
Net cash provided by investing activities	15,063	12,149
NET (DECREASE) INCREASE IN CASH AND CASH EQUIVALENTS	(672)	101
CASH AND CASH EQUIVALENTS—Beginning of year	1,819	1,718
CASH AND CASH EQUIVALENTS—End of year	$ 1,147	$ 1,819

See notes to consolidated financial statements.

1. ORGANIZATION

The University of South Alabama Foundation (the "Foundation") was incorporated in March 1968 for the purpose of promoting education, scientific research, and charitable purposes, and to assist in developing and advancing the University of South Alabama (the "University") in furthering, improving, and expanding its properties, services, facilities, and activities. Revenues are derived principally from investment income.

2. SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation—The accompanying consolidated financial statements include the accounts of the Foundation's wholly owned subsidiaries Knollwood Development, Inc. and Shubuta Timber Services, Inc. All significant intercompany transactions have been eliminated in consolidation.

Net Assets—In order to ensure observance of limitations and restrictions placed on the use of the resources available to the Foundation, the accounts of the Foundation are maintained on the accrual basis in accordance with the principles of "fund accounting." Thus, resources for various purposes are classified into funds that are in accordance with activities or objectives specified. The Foundation presents its net assets and its revenues, expenses, gains, and losses, based on the existence or absence of donor-imposed restrictions in accordance with Accounting Standards Update ("ASU") 2016-14, *Not for Profit Entities (Topic 958): Presentation of Financial Statements of Not-For-Profit Entities*, as described in this note and summarized as follows.

- Net assets with donor restrictions contain donor-imposed restrictions that stipulate that resources be maintained permanently but permit the Foundation the use or expenditure of part or all of the income derived from the donated assets for specified or unspecified purposes. Net assets with donor restrictions also contain donor-imposed restrictions that permit the use or expenditure of the donated assets as specified or by the actions of the Foundation.

- Net assets without donor restrictions are not restricted by donors or the donor-imposed restrictions have expired.

The Foundation considers all of its assets to be endowment assets for the support of the University. It, therefore, classifies all of its assets as "endowment funds" for purpose of required disclosures for such funds. In the absence of directions imposed by donors to utilize such funds for specific programs or purposes at the University, the Foundation classifies the net assets of such funds as "without donor restrictions."

Support and Expenses—Contributions received and unconditional promises to give are measured at their fair values and are reported as increases in net assets at the date of receipt. The Foundation reports gifts of cash and other assets as donor restricted support if they are received with donor stipulations that limit the use of the donated assets or if they are designated as support for future periods. When a donor restriction expires; i.e., when a stipulated time restriction ends or purpose restriction is accomplished, donor restricted net assets are reclassified to net assets without donor restrictions and reported in the consolidated statements of activities and changes in net assets as net assets released from program restrictions.

The Foundation sometimes receives restricted contributions that are conditional on the Foundation matching the contribution. Upon approval of the Board of Directors, such matches are reported as a reclassification of net assets without donor restrictions to net assets with donor restrictions.

Cash and Cash Equivalents—The Foundation considers temporary cash investments with an original maturity date of three months or less when purchased to be cash equivalents. The carrying amounts reported in the accompanying consolidated statements of financial position for cash and cash equivalents approximate their fair value.

Investments in Securities—Investments in marketable equity securities with readily determinable fair market values are maintained and administered in a common pool and are recorded at fair value based on quoted market prices of each security in the accompanying consolidated statements of financial position. Separate accounts are maintained for each fund, as applicable. The Foundation has elected to include in investments cash held temporarily by a custodian for investment purposes.

Investments in Commonfund—The Commonfund for Nonprofit Organizations ("Commonfund") is a membership corporation that operates endowment funds for the exclusive benefit of institutions eligible for membership in the Commonfund. The Foundation holds investments in the Multi-Strategy Equity Fund of the Commonfund. The objective of the Multi-Strategy Equity Fund is to offer an investment in a single fund to provide all of the strategy and manager diversification that an endowment would normally require for equity allocation. The fund is designed to add value over long periods of time and to reduce volatility.

The Foundation's units in the Multi-Strategy Equity Fund are valued at their net asset value ("NAV") as a practical expedient as determined by Commonfund. Commonfund generally determines the unit values of each of its funds by reference to the fair values of the underlying investments, the majority of which consists of exchange-traded equity securities. Commonfund redemptions are paid on the last day of the month, with the request or notification required by the 20th day of the month. Further information about Commonfund's valuation procedures is as follows:

In the Multi-Strategy Equity Fund, as managed by the Commonfund, equity securities listed on securities exchanges are valued at the last sale price, except for those securities reported through the National Association of Securities Dealers Automated Quotation (NASDAQ) system, for which the NASDAQ official closing price is used. In the absence of either, the current bid price is used. Unlisted securities are valued at the current bid prices obtained from reputable brokers. Certain investments held by the funds may be traded by a market maker who may also be utilized to provide pricing information used to value such investments. Investments in units of other funds within Commonfund (known as "crossfund investments") are carried at the unit value of the crossfund investment.

In these funds, investments in limited partnerships and other investment funds are valued at fair value, which is generally the latest NAV made available by the fund manager or administrator prior to the valuation date. Other securities that are not readily marketable are also valued at fair value as deemed appropriate by management of Commonfund in consultation with the respective investment manager, with consideration given to the financial condition and operating results of the issuer, meaningful third-

party transactions in the private market, and other factors deemed relevant. The amounts realized upon disposition of these investments may differ from the value reflected in the consolidated financial statements, and the differences could be material.

Timber—Timber and timberlands, including logging roads, are stated at fair value, based on an independent appraisal, derived from the application of the cost approach, the sales comparison approach, and the income capitalization approach, less the accumulated depletion for timber when harvested. The Foundation capitalizes timber and timberland purchases and reforestation costs and other costs associated with the planting and growing of timber, such as site preparation, seedling purchases, planting, herbicide application, and thinning of tree stands to improve growth. Timber costs, such as real estate taxes, forest management personnel salaries and fringe benefits, and other costs related to the timberlands are expensed as incurred.

Timber sale revenues for clear-cut or lump-sum sales are recognized when legal ownership of the timber transfers to the purchaser. Timber deeds set forth the legal rights and responsibilities of the buyer, and at closing, the full amount of the sale is due and payable and recognized at that time. Revenues from thinning of tree stands to improve growth are recognized as revenue as the buyer harvests the timber that is to be thinned. Timberland depletion is calculated on a unit cost basis and recognized when the related revenue is recognized.

Mineral Properties—Mineral properties are stated at estimated fair market value as determined by independent appraisals. Depletion of mineral properties is recognized over the remaining producing lives of the properties based on total estimated production and current-period production.

Real Estate—Real estate held for investment is stated at its estimated fair value based on independent appraisals.

Common Investment Pool—On June 5, 2006, the Board of Directors of the Foundation approved the establishment of a new investment pool, which consists of (1) all marketable equity securities held by the Foundation and (2) the Foundation's interest in land and timber, consisting of approximately 55,600 acres of timberland, known as the Equitable Tract, which the Foundation acquired in 1997 with financing that was provided, in part, from the Disproportionate Share Hospital Funds (the "DSH Funds") to the Foundation's Equitable Timber Fund.

Investment Income—Investment income or loss (including realized and unrealized gains and losses on investments, interest, dividends, rents, royalties, and timber sales) is included in the accompanying consolidated statements of activities and changes in net assets as increases or decreases in net assets without donor restrictions, unless the income or loss is restricted by donor or law, in which case, it is classified as donor restricted. Interfund interest is recorded at prevailing market rates on loans between funds to maintain the integrity of each fund's net assets.

Income Tax Status—The Internal Revenue Service has determined that the Foundation is a tax-exempt organization under Internal Revenue Code Section 501(c)(3).

Estimates—The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America ("U.S. GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates. The Foundation's investments include marketable equity securities, valued by reference to quoted market prices; investments in Commonfund portfolios valued at unit values based on the fair values of the underlying investments; and timberland, mineral properties, and other real estate valued by appraisals. Such assets are subject to fluctuation in value due to normal market volatility and to estimation risk in the case of assets for which quoted market

values are not available. The values ultimately realized by the Foundation for all such assets may be different from the values reported and these fluctuations may impact the Foundation's consolidated financial statements.

3. FAIR VALUE OF FINANCIAL INSTRUMENTS AND OTHER INVESTMENTS

The following methods and assumptions were used by the Foundation in estimating the fair value of its investments:

- **Cash and Cash Equivalents**: The carrying amount reported in the accompanying consolidated statements of financial position for cash and cash equivalents approximates their fair value.

- **Equity Securities**: Includes investments in marketable equity securities and investments in Commonfund.

  Marketable Equity Securities: Fair values are based on quoted market prices of each security that is actively traded in a public market. The Foundation's investment in such marketable equity securities was $163,451 and $160,615 at June 30, 2025 and 2024, respectively.

  Investments in Commonfund: Fair values are based on NAV, as determined by Commonfund. As more fully described in Note 2, Commonfund determines unit values for each of its portfolios based on the fair values of the underlying assets. The Foundation's investment in Commonfund portfolios was $112,844 and $102,235 at June 30, 2025 and 2024, respectively.

- **Timber, Mineral Properties, and Real Estate**: Fair values of timberland, mineral properties, and real estate are determined by independent third-party appraisers using standard appraisal practices particular to the investment being appraised.

- **Other**: Other consists primarily of the Foundation's interest in the Stallworth Land Company (the "Management Company"), a timberland management company (see Note 4).

4. INVESTMENTS

Investment income (loss) includes not only realized gains, but also unrealized gains (losses) in securities, timberland investments, and real estate.

Investment income for the years ended June 30, 2025 and 2024, consisted of the following:

	2025	2024
Unrealized gains	$ 16,278	$ 50,890
Realized gains	16,911	5,685
Net realized and unrealized gains on investments	33,189	56,575
Timber sales	2,689	2,576
Rents	758	697
Royalties	88	88
Rents, royalties, and timber sales	3,535	3,361
Interest and dividends	3,307	3,056
Total investment income	$ 40,031	$ 62,992

Investments consisted of participation in the Foundation's pooled investment funds. Investment-related expenses of $487 and $440 are included in the Foundation's management and general expenses in the accompanying consolidated statements of activities and changes in net assets for the years ended June 30, 2025 and 2024, respectively.

On June 5, 2006, the Board of the Foundation approved the establishment of a New Investment Pool, which consisted of (1) all marketable equity securities held by the Foundation and (2) the Foundation's interest in the land and timber consisting of approximately 55,600 acres of timberland known as the Equitable tract, which the Foundation acquired in 1997 with financing that was provided, in part, from the DSH Funds to the Foundation's Equitable Timber Fund. Effective June 30, 2006, upon establishment of the Pool, the interest in the Pool allocated to the DSH Funds was equal in value to the sum of (1) the value of the interest that was allocated to the DSH Funds in the Foundation's existing securities pool at June 30, 2006, and (2) the amount of the aggregate receivable in principal and interest owed by the Equitable Timber Fund to the DSH Funds at June 30, 2006. All pooled investment activity subsequent to June 30, 2006 is allocated between DSH Funds and other Foundation funds based on each fund's initial share of the Pool, adjusted for subsequent contributions and distributions.

In August 2023, the Board of the Foundation approved a gift of approximately 63 acres on Dauphin Island, Alabama to support research and a living classroom for the Stokes School of Marine and Environmental Sciences and related programs. The property contributed was valued at $1,920.

Real estate as of June 30, 2025 and 2024 consisted of the following property held:

	2025	2024
Land and land improvements—held for investment	$ 5,361	$ 5,314
Building and building improvements—held for investment	1,075	1,061
Total	$ 6,436	$ 6,375

Other—Investments at June 30, 2025 and 2024 include an equity interest in a timberland management company. The Management Company's primary asset consists of timberland. The Foundation's proportionate share of the fair value of the Management Company is based upon the valuation of the

trustee responsible for the management of the Company and the timber valuation. The equity interest resulted from a bequest known as the Stallworth Gift, which was received through bequest and devise under the Will of N. Jack Stallworth.

The fair value hierarchy classifies the inputs to valuation techniques used to measure fair value as either observable or unobservable inputs. Observable inputs are derived from quoted market prices for investments traded on an active exchange or in dealer markets where there is sufficient activity and liquidity to allow price discovery by substantially all market participants. The Foundation's observable inputs consist of investments in exchange-traded equity securities with a readily determinable market price. Other observable inputs are fair value measurements derived either directly or indirectly from quoted market prices. Investments that are not traded on an active exchange and do not have a quoted market price are classified as unobservable. The Foundation's unobservable inputs consist of investments in timber and real estate with fair values based on independent third-party appraisals performed by qualified appraisers specializing in timber and real estate investments.

In accordance with U.S. GAAP, the investment in Commonfund is not classified in the fair value hierarchy because such investment is measured at fair value using the NAV per share (or its equivalent) as a practical expedient. For purposes of the reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position, the fair value amounts of the investment in Commonfund are presented as a reconciling item in the tables as "Investment in Commonfund."

The Foundation's investment assets as of June 30, 2025 and 2024 are summarized as follows:

	Fair Value Measurements at June 30, 2025			
Description	**Observable Inputs Based on Quoted Prices**	**Other Observable Inputs**	**Unobservable Inputs**	**Total**
Marketable equity securities	$ 163,451	$ -	$ -	$ 163,451
Timber and mineral properties	-	-	179,692	179,692
Real estate	-	-	6,436	6,436
Other investments	-	-	5,822	5,822
Total	$ 163,451	$ -	$ 191,950	355,401
Investment in Commonfund, measured at NAV				112,844
Total investment assets at fair value				$ 468,245

Description	Fair Value Measurements at June 30, 2024 Observable Inputs Based on Quoted Prices	Other Observable Inputs	Unobservable Inputs	Total
Marketable equity securities	$ 160,615	$ -	$ -	$ 160,615
Timber and mineral properties	-	-	178,218	178,218
Real estate	-	-	6,375	6,375
Other investments	-	-	5,815	5,815
Total	$ 160,615	$ -	$ 190,408	351,023
Investment in Commonfund, measured at NAV				102,235
Total investment assets at fair value				$ 453,258

For the year ended June 30, 2025, activity in investments valued at fair value based on unobservable inputs is as follows:

	Timber and Mineral Properties	Real Estate	Other Investments	Total
Beginning balance	$178,218	$ 6,375	$5,815	$190,408
Net realized and unrealized gains	4,195	80	7	4,282
Reforestation	477	-	-	477
Purchase of building improvements	-	14	-	14
Depreciation/depletion	(3,198)	(33)	-	(3,231)
Ending balance	$179,692	$ 6,436	$5,822	$191,950

For the year ended June 30, 2024, activity in investments valued at fair value based on unobservable inputs is as follows:

	Timber and Mineral Properties	Real Estate	Other Investments	Total
Beginning balance	$ 176,002	$ 9,064	$ 5,814	$ 190,880
Net realized and unrealized gains (losses)	5,422	(759)	1	4,664
Reforestation	305	-	-	305
Purchase of timberland	120	-	-	120
Purchase of building improvements	-	23	-	23
Contribution of real estate	-	(1,920)	-	(1,920)
Depreciation/depletion	(3,631)	(33)	-	(3,664)
Ending balance	$ 178,218	$ 6,375	$ 5,815	$ 190,408

Endowment—The Foundation's endowment funds consist of individual funds established for a variety of purposes. Endowment funds include both donor-restricted endowment funds and board-designated endowment funds. Net assets associated with endowments are classified and reported based on the existence or absence of donor-imposed restrictions.

Interpretation of the Law—The Foundation conducts the operations of the Foundation in accordance with the Alabama Uniform Prudent Management of Institutional Funds Act (UPMIFA), effective January 1, 2009, and continuing thereafter, unless otherwise determined by the Foundation. The Board of Directors and management of the Foundation interpret UPMIFA as obligating the Foundation to preserve, as donor-restricted assets, each original gift received by the Foundation as donor-restricted endowment funds. The Foundation, accordingly, classifies (for legal purposes) each such original gift, and any subsequent gifts, as permanently restricted. The remaining portion of any donor-restricted endowment that is not classified as permanently restricted is classified as temporarily restricted net assets, until such time as any of such remaining portion is appropriated for expenditure. In managing each endowment fund held by it, the Foundation considers, if relevant, the duration and preservation of the fund, the purposes of the Foundation and the fund, general economic conditions, any restrictions imposed by the donor, the possible effect of inflation or deflation, the expected total return from income and appreciation of investments, the other resources of the Foundation, and the investment policy of the Foundation.

Endowment net asset composition as of June 30, 2025, by type of fund is as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
Donor-Restricted Endowment Funds	$ 43,761	$ 408,466	$ 452,227
Board-Designated Endowment Funds	16,647	-	16,647
Total	$ 60,408	$ 408,466	$ 468,874

Endowment net asset composition as of June 30, 2024, by type of fund is as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
Donor-Restricted Endowment Funds	$ 44,895	$ 392,710	$ 437,605
Board-Designated Endowment Funds	16,938	-	16,938
Total	$ 61,833	$ 392,710	$ 454,543

Changes in endowment net assets during the year ended June 30, 2025, are as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
Beginning balance	$ 61,833	$ 392,710	$ 454,543
Investment return:			
Investment income	4,567	2,275	6,842
Net realized and unrealized gains	4,680	28,509	33,189
Other income	37	-	37
Interfund interest	(840)	840	-
Total investment return	8,444	31,624	40,068
Gifts	-	113	113
Net assets released from restrictions	15,981	(15,981)	-
Expenditures	(25,850)	-	(25,850)
Net change	(1,425)	15,756	14,331
Ending balance	$ 60,408	$ 408,466	$ 468,874

Changes in endowment net assets during the year ended June 30, 2024, are as follows:

	Without Donor Restrictions	With Donor Restrictions	Total
Beginning balance	$ 62,190	$ 353,579	$ 415,769
Investment return:			
Investment income	4,093	2,324	6,417
Net realized and unrealized gains	7,675	48,900	56,575
Other income	43	-	43
Interfund interest	(892)	892	-
Total investment return	10,919	52,116	63,035
Gifts	3	9	12
Required match	(4)	4	-
Transfer of net assets	(24)	24	-
Net assets released from restrictions	13,022	(13,022)	-
Expenditures	(24,273)	-	(24,273)
Net change	(357)	39,131	38,774
Ending balance	$ 61,833	$ 392,710	$ 454,543

5. LIQUIDITY AND AVAILABILITY OF RESOURCES

The Foundation's financial assets available to meet cash needs for general expenditures within one year of June 30, 2025 were as follows:

Financial assets:	
Cash and cash equivalents	$ 1,147
Other assets	2
Equity securities appropriated for spending in the following year	14,000
Total financial assets available within one year	$ 15,149

As part of the Foundation's liquidity management, the Foundation structures its financial assets to be available as its general expenditures, liabilities, and other obligations come due. Cash withdrawals from the Foundation's managed investments coincide with the Foundation's spending obligations, but may be adjusted higher or lower based on the timing of when investment income is received and expenditures become due. In addition to financial assets available within one year, the Foundation receives investment income from timber sales, rents and royalties, and interest and dividends that are used to meet the Foundation's general expenditures within one year as set forth in Note 4. The Foundation believes it has sufficient assets to meet its obligations.

6. FUNCTIONAL EXPENSES

The tables below present expenses of the Foundation by both their nature and function for fiscal years ended June 30, 2025 and 2024.

	June 30, 2025			
	Program Services	Management and General	Fundraising	Total
Grants to supporting organization	$ 18,317	$ -	$ -	$ 18,317
Depletion	3,198	-	-	3,198
Salaries and benefits	1,523	372	21	1,916
Professional services	354	94	-	448
Other expenses	377	97	-	474
Investment management expense	487	-	-	487
Property taxes	255	7	-	262
Insurance	258	60	-	318
Forestry	384	-	-	384
Depreciation	40	6	-	46
	$ 25,193	$ 636	$ 21	$ 25,850

	June 30, 2024			
	Program Services	Management and General	Fundraising	Total
Grants to supporting organization	$ 16,553	$ -	$ -	$ 16,553
Depletion	3,631	-	-	3,631
Salaries and benefits	1,415	329	21	1,765
Professional services	442	112	-	554
Other expenses	395	95	-	490
Investment management expense	440	-	-	440
Property taxes	247	7	-	254
Insurance	245	59	-	304
Forestry	234	-	-	234
Depreciation	41	7	-	48
	$ 23,643	$ 609	$ 21	$ 24,273

The majority of expenses are directly attributable to the various program services of the Foundation. Certain expenses are attributable to several activities including program services, management and general, and fundraising. Costs not directly attributable to a function are salaries and benefits, professional services, other expenses, and insurance. Such expenses are allocated on a reasonable basis that is consistently applied and based on the Foundation's historical understanding of time and effort associated with each function.

7. FUNDING FOR MEDICAL EDUCATION AND RESEARCH

In the Fall of 2021, the University requested that the Foundation provide funding in the amount of $30,000 to facilitate the construction of a state-of-the-art center for medical and scientific education for future physicians and research. On October 20, 2021, the Foundation approved by resolution a $30,000 gift, determining that the request for funding the medical school facility would be for the benefit of the University's hospitals and clinics and the programs of the University that benefit such hospitals and clinics and in accordance with the September 9, 2010, resolution pertaining to DSH Funds.

The contribution by the Foundation to be distributed from the DSH Funds was approved as follows: $10,151 to be provided within 45 days of the adoption of the resolution; $11,000 through assignment to the University of the purchase and sale agreement between a wholly owned subsidiary of the Foundation, Brookley Bay Front Properties, LLC ("BBFP") and the City of Mobile, dated December 1, 2020, along with the transfer of the property owned by BBFP ("Brookley Complex") to the University; and $1,770 in each of the fiscal years 2023 through 2027, all in accordance with the resolution. The BBFP property was the property at the Brookley Complex that remained following the sale of 196.6 acres of the Brookley Complex by BBFP to the City of Mobile and consisted of two tracts of 45 acres and 50 acres. The purchase of the Brookley Complex by BBFP from the University in 2010 provided support for an expansion of the University of South Alabama Children's and Women's Hospital.

In fiscal year 2025, the Foundation Board approved accelerating funding of the medical school gift by providing the fiscal year 2025 and 2027 payments in the fiscal year 2025. The Foundation provided $3,540 toward the construction of the medical school facility, the Frederick P. Whiddon College of Medicine, in fiscal year 2025.

In addition to funding provided to facilitate construction of a state-of-the-art center for medical and scientific education and research, during the fiscal years ended June 30, 2025 and 2024, in accordance with the intent of the Board of the Foundation and with the applicable resolutions, the Board of the Foundation approved a total distribution of DSH Funds of $7,800 and $6,635 that included $5,600 and

$4,500 for projects supporting University of South Alabama Health hospitals and clinics, $1,386 and $1,346 for the Clinical Support Fund, and $814 and $789 for the Hospital Equipment Fund, respectively. Therefore, total distributions from the DSH Funds were $11,340 and $8,405 for the fiscal years 2025 and 2024, respectively.

8. NET ASSETS WITH DONOR RESTRICTIONS

At June 30, 2025 and 2024, net assets with donor restrictions were for the following purposes:

	2025	2024
Hospital, clinics, and related programs	$ 236,953	$ 229,957
Instruction	89,342	85,362
College of medicine—other than instruction	38,349	35,300
Student aid	32,278	31,124
Other	11,544	10,967
Total	$ 408,466	$ 392,710

Net assets with donor restrictions consist of temporarily restricted net assets and permanently restricted net assets. The amount of temporarily and permanently restricted net assets were $224,829 and $183,637 at June 30, 2025, and $209,189 and $183,521 at June 30, 2024, respectively.

At June 30, 2025 and 2024, net assets with board designated restrictions were for the following purposes:

	2025	2024
College of medicine—other than instruction	$ 9,665	$ 10,110
Instruction	5,114	4,975
Student aid	944	971
Other	924	882
Total	$ 16,647	$ 16,938

9. NET ASSETS RELEASED FROM PROGRAM RESTRICTIONS

Expenses were incurred that met temporary purpose-related restrictions on the use of certain net assets, resulting in a reclassification of net assets with donor restrictions to net assets without donor restrictions during the years ended June 30, 2025 and 2024, as follows:

	2025	2024
Instruction	$ 15,591	$ 12,633
Student aid	344	355
Other	46	34
Total	$ 15,981	$ 13,022

10. OTHER RELATED-PARTY TRANSACTIONS

At June 30, 2025 and 2024, net assets held by the Foundation, irrevocably for the benefit, as determined by the Foundation, of the University's hospitals, clinics, and related programs (DSH Funds) were $236,953 and $229,957 respectively.

11. RETIREMENT PLANS

The Foundation sponsors a contributory defined-contribution retirement plan for certain employees. The Foundation's contributions to the retirement plan were approximately $194 and $190 for the years ended June 30, 2025 and 2024, respectively.

12. SUBSEQUENT EVENTS

The Foundation evaluated subsequent events through August 15, 2025, which represents the date the consolidated financial statements were available to be issued, and made the determination that no events occurred subsequent to June 30, 2025 that would require disclosure in or would be required to be recognized in the consolidated financial statements.

* * * * * *

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

Disproportionate Share Hospital Funds
Combined Financial Statements as of and
for the Years Ended June 30, 2025 and 2024, and
Independent Auditor's Report

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

DISPROPORTIONATE SHARE HOSPITAL FUNDS
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Deloitte & Touche LLP
420 North 20th Street
Suite 2400
Birmingham, AL 35203-3289
USA

Tel:+1 205 321 6000
Fax:+1 205 322 2828
www.deloitte.com

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
University of South Alabama Foundation:

Opinion

We have audited the combined financial statements of the Disproportionate Share Hospital Funds (the "DSH Funds") of the University of South Alabama Foundation, which comprise the combined statements of financial position as of June 30, 2025 and 2024, and the related combined statements of activities and changes in net assets and cash flows for the years then ended, and the related notes to the combined financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the DSH Funds as of June 30, 2025 and 2024, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the DSH Funds and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the DSH Funds' ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the DSH Funds' internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the DSH Funds' ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte + Touche LLP

August 15, 2025

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

DISPROPORTIONATE SHARE HOSPITAL FUNDS
COMBINED STATEMENTS OF FINANCIAL POSITION
AS OF JUNE 30, 2025 AND 2024
(Dollars in thousands)

	2025	2024
ASSETS		
INVESTMENTS:		
New Investment Pool—interest in	$ 233,039	$ 226,061
Real estate	3,330	3,330
RECEIVABLE FROM AFFILIATES	584	566
TOTAL	$ 236,953	$ 229,957
NET ASSETS		
NET ASSETS:		
Without donor restrictions	$ -	$ -
With donor restrictions	236,953	229,957
Total net assets	236,953	229,957
TOTAL	$ 236,953	$ 229,957

See notes to combined financial statements.

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

DISPROPORTIONATE SHARE HOSPITAL FUNDS
COMBINED STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEAR ENDED JUNE 30, 2025
(Dollars in thousands)

	Without Donor Restrictions	With Donor Restrictions	Total
REVENUES, GAINS, AND OTHER SUPPORT:			
Net realized and unrealized gains on investments	$ 19	$ 16,626	$ 16,645
Interest and dividends	-	1,206	1,206
Interfund interest	-	504	504
Net assets released from program restrictions	11,340	(11,340)	-
Total revenues, gains, and other support	11,359	6,996	18,355
EXPENDITURES:			
Program Services—other academic programs	11,340	-	11,340
Other investment expense	19	-	19
Total expenditures	11,359	-	11,359
INCREASE IN NET ASSETS	-	6,996	6,996
NET ASSETS AT BEGINNING OF YEAR	-	229,957	229,957
NET ASSETS AT END OF YEAR	$ -	$ 236,953	$ 236,953

See notes to combined financial statements.

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

DISPROPORTIONATE SHARE HOSPITAL FUNDS
COMBINED STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
FOR THE YEAR ENDED JUNE 30, 2024
(Dollars in thousands)

	Without Donor Restrictions	With Donor Restrictions	Total
REVENUES, GAINS, AND OTHER SUPPORT:			
Net realized and unrealized gains on investments	$ 18	$ 28,632	$ 28,650
Interest and dividends	-	1,249	1,249
Interfund interest	-	537	537
Net assets released from program restrictions	8,405	(8,405)	-
Total revenues, gains, and other support	8,423	22,013	30,436
EXPENDITURES:			
Program Services—other academic programs	8,405	-	8,405
Other investment expense	18	-	18
Total expenditures	8,423	-	8,423
INCREASE IN NET ASSETS	-	22,013	22,013
NET ASSETS AT BEGINNING OF YEAR	-	207,944	207,944
NET ASSETS AT END OF YEAR	$ -	$ 229,957	$ 229,957

See notes to combined financial statements.

UNIVERSITY OF SOUTH ALABAMA
FOUNDATION

DISPROPORTIONATE SHARE HOSPITAL FUNDS
COMBINED STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2025 AND 2024
(Dollars in thousands)

	2025	2024
OPERATING ACTIVITIES:		
Increase in net assets	$ 6,996	$ 22,013
Adjustments to reconcile increase in net assets to net cash used in operating activities:		
Net realized and unrealized gains on investments	(16,645)	(28,650)
Changes in operating assets and liabilities:		
Receivable from affiliate	(18)	(63)
Net cash used in operating activities	(9,667)	(6,700)
INVESTING ACTIVITIES:		
Purchases of securities	(1,679)	(1,795)
Sale of securities	11,346	8,495
Net cash provided by investing activities	9,667	6,700
NET CHANGE IN CASH AND CASH EQUIVALENTS	-	-
CASH AND CASH EQUIVALENTS—Beginning of year	-	-
CASH AND CASH EQUIVALENTS—End of year	$ -	$ -

See notes to combined financial statements.

1. ORGANIZATION

The University of South Alabama Foundation (the "Foundation") was incorporated in March 1968 for the purpose of promoting education, scientific research, and charitable purposes, and to assist in developing and advancing the University of South Alabama (the "University") in furthering, improving, and expanding its properties, services, facilities, and activities. Revenues are derived principally from investment income and contributions.

The Disproportionate Share Hospital Funds (the "DSH Funds") were matching funds disbursed by the Health Care Financing Administration of the U.S. Department of Health and Human Services to the states through their Medicaid agencies for the purpose of compensating hospitals, such as those operated by the University, that provided medical care and treatment to a disproportionate share of indigent patients in their respective areas.

Access to the DSH Funds for Alabama was made possible by the University of South Alabama Foundation Board, beginning in October 1989, when the Board of the Foundation approved the entry into the matching program. Over a one-year period, the Foundation made a monthly revolving contribution of $2 million, which yielded approximately $24 million in federal grant monies. The Board of Trustees of the University adopted a resolution in March 1990 authorizing the transfer of the DSH Funds to the Foundation to be held by it to preserve and ensure the continued viability of the University of South Alabama Hospitals ("University Hospitals") and their overall mission.

Litigation relating to the transfer of the DSH Funds was settled in November 1993, when an agreement was reached among the Department of Examiners of Public Accounts of the State of Alabama, the Board of Trustees of the University, and the Board of Directors of the Foundation, which required that all Medicaid DSH Funds received through September 30, 1994 be transferred to the Foundation and held irrevocably for the benefit, as determined by the Foundation, of the University Hospitals and clinics and the other programs of the University that benefit such hospitals and clinics which amount was $131,586. Further, the agreement recognized the Foundation as the lawful holder and owner of the DSH Funds and that the investment and management of the DSH Funds were solely within the authority of the Foundation's Board.

2. SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation—The accompanying combined financial statements include the DSH Funds and Knollwood Development, Inc., a wholly owned subsidiary of the Foundation and an affiliate originally funded by DSH Funds. All significant interfund transactions have been eliminated in combination.

Net Assets—In order to ensure observance of limitations and restrictions placed on the use of the resources available to the DSH Funds, the accounts of the DSH Funds are maintained on the accrual basis in accordance with the principles of "fund accounting". Thus, resources for various purposes are classified into funds that are in accordance with activities or objectives specified. The Foundation presents its net assets and its revenues, expenses, gains, and losses based on the existence or absence of donor-imposed restrictions in accordance with Accounting Standards Update ("ASU") 2016-14, *Not for Profit Entities (Topic 958)*: *Presentation of Financial Statements of Not-For- Profit Entities*, as described in this note and summarized as follows.

- Net assets with donor restrictions contain donor-imposed restrictions that stipulate that resources be maintained permanently but permit the use or expenditure of part or all of the income derived from the donated assets for specified or unspecified purposes. Net assets with donor restrictions also contain donor-imposed restrictions that permit the use or expenditure of the donated assets as specified or by the actions of the Foundation.

- Net assets without donor restrictions are not restricted by donors or the donor-imposed restrictions have expired.

Support—Contributions received and unconditional promises to give are measured at their fair values and are reported as increases in net assets at the date of receipt. Gifts of cash and other assets are reported as donor restricted support if they are received with donor stipulations that limit the use of the donated assets or if they are designated as support for future periods. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, donor restricted net assets are reclassified to net assets without donor restrictions and reported in the combined statements of activities and changes in net assets as net assets released from program restrictions.

Investments in Securities—Investments in equity securities are maintained and administered in a common pool by the Foundation. Amounts presented in these combined financial statements represent the DSH Funds' proportionate share of the Foundation's investments.

Investments in Commonfund—The Commonfund for Nonprofit Organizations ("Commonfund") is a membership corporation that operates investment funds for the exclusive benefit of institutions eligible for membership in the Commonfund. The Foundation holds investments in the Multi-Strategy Equity Fund of the Commonfund. The objective of the Multi-Strategy Equity Fund is to offer an investment in a single fund to provide all of the strategy and manager diversification that an endowment would normally require for equity allocation. The fund is designed to add value over long periods of time and to reduce volatility.

The Foundation's units in the Multi-Strategy Equity Fund are valued at their net asset value ("NAV") as a practical expedient as determined by Commonfund. Commonfund generally determines the unit values of each of its funds by reference to the fair values of the underlying investments, the majority of which consists of exchange-traded equity securities. Commonfund redemptions are paid on the last day of the month with the request or notification required by the 20th day of the month. Further information about Commonfund's valuation procedures is as follows:

In the Multi-Strategy Equity Fund, as managed by Commonfund, equity securities listed on securities exchanges are valued at the last sale price, except for those securities reported through the National Association of Securities Dealers Automated Quotation (NASDAQ) system, for which the NASDAQ official closing price is used. In the absence of either, the current bid price is used. Unlisted securities are valued at the current bid prices obtained from reputable brokers. Certain investments held by the funds may be traded by a market maker who may also be utilized to provide pricing information used to value such investments. Investments in units of other funds within Commonfund (known as "crossfund investments") are carried at the unit value of the crossfund investment.

In these funds, investments in limited partnerships and other investment funds are valued at fair value, which is generally the latest NAV made available by the fund manager or administrator prior to the valuation date. Other securities that are not readily marketable are also valued at fair value as deemed appropriate by management of Commonfund in consultation with the respective investment manager, with consideration given to the financial condition and operating results of the issuer, meaningful third-party transactions in the private market, and other factors deemed relevant. The amounts realized upon disposition of these investments may differ from the value reflected in the combined financial statements, and the differences could be material.

Investment Income—Investment income or loss (including realized and unrealized gains and losses on investments, interest, dividends, rents, royalties, and timber sales) is included in the accompanying combined statements of activities and changes in net assets as increases or decreases in net assets without donor restrictions, unless the income or loss is restricted by donor or law, in which case it is classified as donor restricted. Interfund interest is recorded at prevailing market rates on loans between funds to maintain the integrity of each fund's net assets.

Income Allocation—The DSH Funds participate in the New Investment Pool (the "Pool") as described in Note 4. Funds that participate in the Pool, including DSH Funds, receive a monthly allocation of income and loss experienced by the Pool. Allocations made by the Pool to its participants are based on the relative participation levels of investment in the Pool by each participating fund.

Income Tax Status—The Internal Revenue Service has determined that the Foundation is a tax-exempt organization under Internal Revenue Code Section 501(c)(3).

Estimates—The preparation of combined financial statements in conformity with accounting principles generally accepted in the United States of America ("U.S. GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenditures during the reporting period. Actual results could differ from those estimates. The DSH Funds participate in the Foundation's New Investment Pool (see Note 4). The New Investment Pool consists of the Foundation's investment in marketable equity securities, valued by reference to quoted market prices; investments in Commonfund portfolios valued at unit values based on the fair values of the underlying investments; and timberland, mineral properties, and other real estate valued by appraisals. Such assets are subject to fluctuation in value due to normal market volatility and to estimation risk in the case of assets for which quoted market values are not available. The values ultimately realized by the Foundation for all such assets may be different from the values reported and these fluctuations may impact the DSH Funds' combined financial statements.

3. FAIR VALUE OF FINANCIAL INSTRUMENTS AND OTHER INVESTMENTS

The following methods and assumptions were used by the Foundation in estimating the fair value of its investments:

- **Cash and Cash Equivalents:** The carrying amount reported in the accompanying combined statements of financial position for cash and cash equivalents approximates their fair value.

- **Equity Securities:** Includes investments in marketable equity securities and investments in Commonfund:

  Marketable Equity Securities: Fair values are based on quoted market prices of each security with readily determinable fair values.

Investments in Commonfund: Fair values are based on NAV, as determined by Commonfund. As more fully described in Note 2, Commonfund determines unit values for each of its portfolios based on the fair values of the underlying assets.

- **Timberland, Mineral Properties, and Real Estate:** Fair values of timberland, mineral properties, and real estate are determined by independent third-party appraisers using standard appraisal practices particular to the investment being appraised.

4. INVESTMENTS

Investment income for the years ended June 30, 2025 and 2024, consisted of the following:

	2025	2024
Unrealized gains	$ 8,899	$ 27,488
Realized gains	7,746	1,162
Interest and dividends	1,206	1,249
Interfund interest	504	537
Total investment income	$ 18,355	$ 30,436

Investments consisted of participation in the Foundation's pooled investment funds.

On June 5, 2006, the Board of the Foundation approved the establishment of a New Investment Pool, which consisted of (1) all marketable equity securities held by the Foundation and (2) the Foundation's interest in the land and timber consisting of approximately 55,600 acres of timberland known as the Equitable tract, which the Foundation acquired in 1997 with financing that was provided, in part, from the DSH Funds to the Foundation's Equitable Timber Fund. Effective June 30, 2006, upon establishment of the Pool, the interest in the Pool allocated to the DSH Funds was equal in value to the sum of (1) the value of the interest that was allocated to the DSH Funds in the Foundation's existing securities pool at June 30, 2006, and (2) the amount of the aggregate receivable in principal and interest owed by the Equitable Timber Fund to the DSH Funds at June 30, 2006. All pooled investment activity subsequent to June 30, 2006, is allocated between DSH Funds and other Foundation funds based on each fund's initial share of the Pool, adjusted for subsequent contributions and distributions.

The fair value hierarchy classifies the inputs to valuation techniques used to measure fair value as either observable or unobservable inputs. Observable inputs are derived from quoted market prices for investments traded on an active exchange or in dealer markets where there is sufficient activity and liquidity to allow price discovery by substantially all market participants. The New Investment Pool's observable inputs consist of investments in exchange-traded equity securities with a readily determinable market price. Other observable inputs are fair value measurements derived either directly or indirectly from quoted market prices. Investments that are not traded on an active exchange and do not have a quoted market price are classified as unobservable. The DSH Funds' unobservable inputs consist of its interest in the New Investment Pool's timberland and real estate with fair values based on independent third-party appraisals performed by qualified appraisers specializing in timber and real estate investments.

The New Investment Pool also includes an investment in Commonfund which is found in the fair value table as "Investment in Commonfund."

In accordance with U.S. GAAP, the investment in Commonfund is not classified in the fair value hierarchy because such investment is measured at fair value using the NAV per share (or its equivalent) as a practical expedient. For purposes of the reconciliation of the fair value hierarchy to the amounts presented in the combined statements of financial position, the fair value amounts of the investment in Commonfund are presented as a reconciling item in the tables as "Investment in Commonfund."

The Foundation's Investment Pool assets as of June 30, 2025 and 2024, are summarized as follows:

	Fair Value Measurements at June 30, 2025			
Description	**Observable Inputs Based on Quoted Prices**	**Other Observable Inputs**	**Unobservable Inputs**	**Total**
New Investment Pool interest in marketable equity securities	$ 163,451	$ -	$ -	$ 163,451
New Investment Pool interest in timber	-	-	128,600	128,600
Real estate	-	-	3,330	3,330
Total	$ 163,451	$ -	$ 131,930	295,381
Investment in Commonfund, measured at NAV				112,844
Total assets at fair value				$ 408,225

	Fair Value Measurements at June 30, 2024			
Description	**Observable Inputs Based on Quoted Prices**	**Other Observable Inputs**	**Unobservable Inputs**	**Total**
New Investment Pool interest in marketable equity securities	$ 160,615	$ -	$ -	$ 160,615
New Investment Pool interest in timber	-	-	127,300	127,300
Real estate	-	-	3,330	3,330
Total	$ 160,615	$ -	$ 130,630	291,245
Investment in Commonfund, measured at NAV				102,235
Total assets at fair value				$ 393,480

For the year ended June 30, 2025, activity in the Foundation's Pooled Investment assets valued at fair value based on unobservable inputs is as follows:

	Investment Pool Interest in Timber	Investment Pool Interest in Real Estate	Real Estate	Total
Beginning balance	$ 127,300	$ -	$ 3,330	130,630
Net realized and unrealized gains	4,100	-	-	4,100
Reforestation	398	-	-	398
Depletion	(3,198)	-	-	(3,198)
Ending balance	$ 128,600	$ -	$ 3,330	$ 131,930

For the year ended June 30, 2024, activity in the Foundation's Pooled Investment assets valued at fair value based on unobservable inputs is as follows:

	Investment Pool Interest in Timber	Investment Pool Interest in Real Estate	Real Estate	Total
Beginning balance	$ 126,600	$ -	$ 3,700	130,300
Net realized and unrealized gains (losses)	4,015	-	(370)	3,645
Reforestation	173	-	-	173
Depletion	(3,488)	-	-	(3,488)
Ending balance	$ 127,300	$ -	$ 3,330	$ 130,630

The DSH Funds hold a proportionate interest in the value of the Foundation's Investment Pool. On June 30, 2025, the value of DSH Funds units in the Pool was $233,039 and on June 30, 2024, the value of DSH Funds units in the Pool was $226,061.

5. LIQUIDITY AND AVAILABILITY OF RESOURCES

The DSH Funds are restricted for support of hospitals, clinics, and health related programs of the University as stated in Note 8. The DSH Funds provide the University a target distribution of no less than three percent of the average net assets over the previous three year period.

6. FUNCTIONAL EXPENSES

All expenses are program services for the benefit of University hospitals, clinics, and health related programs.

7. RELATED-PARTY TRANSACTIONS

At June 30, 2025 and 2024, receivables from affiliated entities totaled $584 and $566, respectively. These amounts are due to the DSH Funds from other entities owned by the Foundation. These receivables earn interest at a standard market rate, based on the applicable federal rates (rates used for federal tax purposes). Interest income was $504 and $537 for the years ended June 30, 2025 and 2024, respectively. As described in Note 4, effective June 30, 2006, the DSH Funds participate in the Pool of the Foundation and the DSH Funds earn a proportionate share of investment income of the Pool.

In the Fall of 2021, the University requested that the Foundation provide funding in the amount of $30,000 to facilitate the construction of a state-of-the-art center for medical and scientific education for future physicians and research. On October 20, 2021, the Foundation approved by resolution a $30,000 gift, determining that the request for funding the medical school facility would be for the benefit of the University's hospitals and clinics and the programs of the University that benefit such hospitals and clinics and in accordance with the September 9, 2010, resolution pertaining to DSH Funds.

The contribution by the Foundation to be distributed from the DSH Funds was approved as follows: $10,151 to be provided within 45 days of the adoption of the resolution; $11,000 through assignment to the University of the purchase and sale agreement between a wholly owned subsidiary of the Foundation, Brookley Bay Front Properties, LLC ("BBFP") and the City of Mobile, dated December 1, 2020, along with the transfer of the property owned by BBFP ("Brookley Complex") to the University; and $1,770 in each of the fiscal years 2023 through 2027, all in accordance with the resolution. The BBFP property was the property at the Brookley Complex that remained following the sale of 196.6 acres of the Brookley Complex by BBFP to the City of Mobile and consisted of two tracts of 45 acres and 50 acres. The purchase of the Brookley Complex by BBFP from the University in 2010 provided support for an expansion of the University of South Alabama Children's and Women's Hospital.

In fiscal year 2025, the Foundation Board approved accelerating funding of the medical school gift by providing the fiscal year 2025 and 2027 payments in the fiscal year 2025. The Foundation provided $3,540 toward the construction of the medical school facility, the Frederick P. Whiddon College of Medicine, in fiscal year 2025.

In addition to funding provided to facilitate construction of a state-of-the-art center for medical and scientific education and research, during the fiscal years ended June 30, 2025 and 2024, in accordance with the intent of the Board of the Foundation and with the applicable resolutions, the Board of the Foundation approved a total distribution of DSH Funds of $7,800 and $6,635 that included $5,600 and $4,500 for projects supporting University of South Alabama Health hospitals and clinics, $1,386 and $1,346 for the Clinical Support Fund, and $814 and $789 for the Hospital Equipment Fund, respectively. Therefore, total distributions from the DSH Funds were $11,340 and $8,405 for the fiscal years 2025 and 2024, respectively

8. NATURE AND AMOUNT NET ASSETS WITH DONOR RESTRICTIONS

At June 30, 2025 and 2024, net assets with donor restrictions were $236,953 and $229,957 from which may be used for the support of hospitals, clinics, and related programs of the University in accordance with board action as described in Note 7, herein.

9. ENDOWMENT

Interpretation of the Law—The University of South Alabama Foundation conducts the operations of the Foundation in accordance with the Alabama Uniform Prudent Management of Institutional Funds Act (UPMIFA), effective January 1, 2009, and continuing thereafter unless otherwise determined by the Foundation. The Board of Directors and management of the Foundation interpret UPMIFA as obligating the Foundation to preserve, as donor-restricted assets, each original gift received by the Foundation as donor-restricted endowment funds.

The Foundation, accordingly, classifies (for legal purposes) each such original gift, and any subsequent gifts, as permanently restricted. The remaining portion of any donor-restricted endowment that is not classified as permanently restricted is classified as temporarily restricted net assets, until such time as any of such remaining portion is appropriated for expenditure. In managing each endowment fund held by it, the Foundation considers, if relevant, the duration and preservation of the fund, the purposes of the Foundation and the fund, general economic conditions, any restrictions imposed by the donor, the possible effect of inflation or deflation, the expected total return from income and appreciation of investments, the other resources of the Foundation, and the investment policy of the Foundation.

10. SUBSEQUENT EVENTS

The DSH Funds evaluated subsequent events through August 15, 2025, which represents the date the combined financial statements were available to be issued, and made the determination that no events occurred subsequent to June 30, 2025 that would require disclosure in or would be required to be recognized in the combined financial statements.

* * * * * *

University of South Alabama

Mobile, Alabama

October 1, 2022 through September 30, 2024

Filed: July 18, 2025

ALABAMA DEPARTMENT OF
EXAMINERS of Public Accounts

Rachel Laurie Riddle, *Chief Examiner* | 334-777-0500 | www.alexaminers.gov

State of Alabama
Department of
Examiners of Public Accounts
P.O. Box 302251, Montgomery, AL 36130-2251
401 Adams Avenue, Suite 280
Montgomery, Alabama 36104-4338
Telephone (334) 777-0500
FAX (334) 242-1775

Rachel Laurie Riddle
Chief Examiner

Honorable Rachel Laurie Riddle
Chief Examiner of Public Accounts
Montgomery, Alabama 36130

Dear Madam:

An examination was conducted on the University of South Alabama, Mobile, Alabama, for the period October 1, 2022 through September 30, 2024. Under the authority of the ***Code of Alabama 1975***, Section 41-5A-19, I hereby swear to and submit this report to you on the results of the examination.

Respectfully submitted,

Phillipe Walker

Phillipe Walker
Examiner of Public Accounts

rb

25-470

Table of Contents

Department of
Examiners of Public Accounts

EXAMINER'S SUMMARY

University of South Alabama
October 1, 2022 through September 30, 2024

PURPOSE AND SCOPE OF THE EXAMINATION

This report presents the results of an examination of the University of South Alabama (hereinafter referred to as the "University") and a review of the University's compliance with applicable laws and regulations of the State of Alabama in accordance with the requirements of the Department of Examiners of Public Accounts under the authority of the ***Code of Alabama 1975***, Section 41-5A-12.

The firm of KPMG, LLP, conducted the financial audits of the University for the fiscal years ended September 30, 2023, and 2024.

The mission and purpose of the University are described in the accompanying Agency Overview.

RESULTS OF THE EXAMINATION

An instance of noncompliance with state laws and regulations and other matters was found during the examination as shown on the Schedule of State Compliance and Other Findings, and it is summarized below:

Finding

- 2024-001: The University did not follow the established provisions of the ***Code of Alabama 1975***, Title 39, relating to the advertisement of completion of public works projects.

EXIT CONFERENCE

The following officials/employees were invited to an exit conference to discuss the results of the examination: Kristen Roberts, Chief Financial Officer and Crystal Taylor, Assistant Chief Financial Officer and Controller. The following individuals attended the exit conference: Kristen Roberts, Chief Financial Officer; Crystal Taylor, Assistant Chief Financial Officer and Controller; and Brittney Vick, Director of Financial Compliance. Representing the Department of Examiners of Public Accounts was Phillipe Walker, Examiner. Annette G. Williams, Audit Manager, attended virtually.

Department of
Examiners of Public Accounts

AGENCY OVERVIEW

University of South Alabama
October 1, 2022 through September 30, 2024

The University of South Alabama (the "University") is a public institution of higher learning and awards baccalaureate, masters, educational specialist, doctor of education, doctor of nursing practice, doctor of physical therapy, doctor of audiology, doctor of occupational therapy, doctor of philosophy, and doctor of medicine degrees. The University offers studies in ten colleges/schools: Allied Health Professions, Arts and Sciences, Business, Education and Professional Studies, Engineering, Honors, Medicine, Nursing, Computing, and the Graduate School. A joint pharmacy program between the University and Auburn University has also been established. The University owns and operates University Hospital, University of South Alabama Children's and Women's Hospital, University of South Alabama Mitchell Cancer Institute, and University of South Alabama Health Physicians Enterprise.

More information on the University can be found at www.southalabama.edu.

Schedule of State Compliance and Other Findings

Ref. No.	Finding/Noncompliance
2024-001	**Finding:** The ***Code of Alabama 1975***, Title 39, commonly referred to as the Public Works Law, contains various legal requirements for public works contracts. For contracts of $50,000 or more let prior to October 2023, Section 39-1-1(f)(1) of the Public Works Law required the contractor to immediately give notice of completion of the project by an advertisement in a newspaper of general circulation in the county or counties in which the work was done for a period of four successive weeks. Section 39-1-1(f)(3) of the Public Works Law indicates final payment on the contract cannot be made until 30 days after the completion of the notice. The contractor must provide to the awarding authority proof of publication by affidavit of publisher and a printed copy of the notice published. Three of thirteen Public Works bids reviewed did not include appropriate documentation of the notice of completion of the project and final payment was made without the notice of completion advertisement. As a result, the University was not in compliance with the ***Code of Alabama 1975***, Section 39-1-1(f). **Recommendation:** The University should implement adequate policies and procedures to ensure compliance with all aspects of the ***Code of Alabama 1975***, Title 39.

Additional Information

Board Members and Officials
October 1, 2022 through September 30, 2024

Board Members		**Term Expires**
Hon. Kay Ivey, Governor	President, Ex-Officio	
Hon. Arlene Mitchell	Chair Pro Tempore	2027
Hon. Katherine A. Atkins	Vice-Chair	2025
Hon. Lenus M. Perkins	Secretary	2029
Hon. Luis Gonzalez	Member	2029
Hon. Steven P. Furr, M.D.	Member	2029
Hon. William R. Graham	Member	2029
Hon. Steven H. Stokes, M.D.	Member	2029
Hon. Scott A. Charlton, M.D.	Member	2027
Hon. James H. Shumock	Member	2027
Hon. James A. Yance	Member	2027
Hon. Robert D. Jenkins, III	Member	2025
Hon. Bill W. Lewis, II	Member	2025
Hon. Chandra B. Stewart	Member	2025

Board Members and Officials
October 1, 2022 through September 30, 2024

Board Members		**Term Expires**
Hon. Michael P. Windom	Member	2025
Hon. E. Thomas Corcoran	Member	2024
Hon. Margie M. Tuckson	Member	2023

Officials

Jo Bonner	President
Kristin Roberts	Chief Financial Officer (Effective June 1, 2023)
Polly Stokley	Vice-President for Finance and Administration (Retired May 31, 2023)
Benny Stover	USA Health Chief Financial Officer

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

DEVELOPMENT, ENDOWMENT AND INVESTMENTS COMMITTEE

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

Development, Endowment and Investments Committee

June 5, 2025
1:37 p.m.

A meeting of the Development, Endowment and Investments Committee of the University of South Alabama ("USA," "University") Board of Trustees was duly convened by Mr. Jim Yance, Chair, on Thursday, June 5, 2025, at 1:37 p.m. in the Board Room of the Frederick P. Whiddon Administration Building. Meeting attendance was open to the public.

Members:	Chandra Brown Stewart, Luis Gonzalez, Jimmy Shumock, Steve Stokes, Mike Windom and Jim Yance were present.
Member Absent:	Scott Charlton.
Other Trustees:	Alexis Atkins, Ron Graham, Ron Jenkins, Bill Lewis, Arlene Mitchell and Lenus Perkins.
Administration & Guests:	Owen Bailey, Jim Berscheidt, Joél Billingsley, Jo Bonner, Joel Erdmann, Monica Ezell, Charlie Guest, Buck Kelley, Andi Kent, Spence Larche, Nick Lawkis, John Marymont, Mike Mitchell, Allen Parrish, Norman Pitman, Kristen Roberts, Donna Streeter (Faculty Senate), Margaret Sullivan, Peter Susman and Christina Wassenaar (Faculty Senate).

Following the attendance roll call, **Item 4**, Mr. Yance called for consideration of the minutes for a meeting held on March 13, 2025, **Item 5**. On motion by Judge Windom, seconded by Mr. Shumock, the committee voted unanimously to adopt the minutes.

Mr. Yance called for a report on endowment and investment performance, **Item 6**. Mr. Drew Underwood, Executive Director of Treasury Management, provided an overview on strategic initiatives, investment allocations, fund results, and manager performance through the second quarter of fiscal year 2025. He noted a fund downturn of approximately 0.3 percent, an outperformance of the benchmark of close to one percent. Mr. Norman Pitman, the University's investment consultant, shared perspective on market conditions.

Mr. Yance called on Ms. Sullivan to report on the activities of the Division of Development and Alumni Relations, **Item 7**. Ms. Sullivan advised of just over $28.5 million in new gifts and commitments recorded through June 3 of fiscal year 2025, and also shared the positive results of the 2025 E*mployee and Retiree Giving* and *Giving Week* campaigns. She presented information on the alumni and friends nationwide travel program and detailed recent and future fundraising and networking events. As to USA's capital campaign, she indicated that more than $318 million had been raised toward the $340 million campaign goal. Also highlighted was the Flagship Society,

formed to recognize campaign donors who give $100,000 or more during the campaign quiet phase.

There being no further business, the meeting was adjourned at 2:01 p.m.

Respectfully submitted:

James A. Yance, Chair

University of South Alabama Endowment Fund
Investment Performance Summary

Fiscal Year 2025

USA Endowment Fund Performance - Fiscal Year to Date
October 1, 2024 to June 30, 2025

- The USA Endowment Fund is up 5.9%, while the blended benchmark is up 5.5%.

USA Endowment Fund Manager Performance - Fiscal Year to Date
October 1, 2024 to June 30, 2025

Individual Manager versus Benchmark performance:

- Mutual Funds (USA Treasury and N.D. Pitman) are up 7.1%, while the blended benchmark is up 6.4%.
- Gerber Taylor Hedge is up 6.6%, while its blended benchmark is up 4.5%.
- Gerber Taylor International is up 4.6%, while its benchmark is up 9.8%.
- Hancock Whitney is up 4.9%, while its benchmark is up 5.3%.
- Commonfund is up 1.0%, while its benchmark is up 0.8%.
- JP Morgan is up 9.7%, while its benchmark is up 5.6%.
- Jaguar Investment Fund (Student Investment Fund) is up 5.5%, while its benchmark is up 8.8%.

RESOLUTION

COMMENDATION OF MRS. BARBARA BUSH AND MR. LEONARD BUSH

WHEREAS, the University of South Alabama (the "University") is the Flagship of the Gulf Coast and is committed to its mission of making a difference in the lives of those it serves through promoting discovery, health, and learning, and

WHEREAS, the mission of the College of Nursing (the "College") is to provide quality, innovative educational programs to a diverse student body, to participate in research and scholarly activities, and to provide service to the University, the profession, and the public, and the College accomplishes this by providing a caring, engaging environment for the empowerment of student learning potential, the professional development of faculty, and the promotion of the nursing profession, and

WHEREAS, Mrs. Barbara Bush and her husband, Mr. Leonard Bush, had impactful careers in healthcare prior to retiring, with Mrs. Bush working in nurse leadership positions within hospital systems, and Mr. Bush making his impact through cytotechnology, and, together, they have demonstrated a deep commitment to supporting the future of healthcare and healthcare professionals, and

WHEREAS, Mrs. Bush credits the University of South Alabama's College of Nursing and its faculty as the foundation of her professional success, and, with this in mind, the Bush family has made a legacy gift of $1 million to the University of South Alabama to show their appreciation for the College of Nursing and to establish two endowed scholarships of $500,000 each, which will support nursing students who are pursuing a master's degree and a bachelor's degree,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby recognizes and commends Mrs. Barbara Bush and Mr. Leonard Bush for their extraordinary generosity and commitment and joins the University President, faculty, staff, students and alumni in extending sincere gratitude to the Bush family for their transformative gift to the University.

UNIVERSITY OF SOUTH ALABAMA

MEMORANDUM

Development, Alumni Relations and Special Events

DATE: July 24, 2025

TO: Jo Bonner
President

FROM: Mrs. Margaret Sullivan Margaret M. Sullivan
Vice President for Development and Alumni Relations

SUBJECT: Resolution of Commendation for Ms. Barbara and Mr. Leonard Bush

---

As you know, Ms. Barbara Bush and Mr. Leonard Bush have generously agreed to an estate gift of $1,000,000.00 for the University of South Alabama's College of Nursing. Ms. Barbara Bush is a two-time graduate of the College of Nursing, earning both a bachelor's and master's degree. The Bush family wishes to give back to the University of South Alabama with this gift which will create two scholarships within the College of Nursing: The Barbara A. & Leonard C. Bush Endowed Scholarship in Bachelor's of Nursing Fund and the Barbara A. and Leonard C. Bush Endowed Scholarship in Master's of Nursing Fund. With this generous gift, the Bush family is committed to helping students within the College, as well as the future leaders in healthcare.

To recognize this transformative commitment from Ms. Barbara and Mr. Leonard, I request your approval of the attached resolution of commendation by the Board of Trustees.

Cc: Mrs. Monica Ezell

Jo Bonner

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

HEALTH AFFAIRS
COMMITTEE

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

Health Affairs Committee

June 5, 2025
2:01 p.m.

A meeting of the Health Affairs Committee of the University of South Alabama ("USA," "University") Board of Trustees was duly convened by Mr. Jimmy Shumock, Chair, on Thursday, June 5, 2025, at 2:01 p.m. in the Board Room of the Frederick P. Whiddon Administration Building. Meeting attendance was open to the public.

Members:	Chandra Brown Stewart, Jimmy Shumock, Steve Stokes and Jim Yance were present.
Members Absent:	Scott Charlton, Steve Furr and Meredith Hamilton.
Other Trustees:	Alexis Atkins, Luis Gonzalez, Ron Graham Ron Jenkins, Bill Lewis, Arlene Mitchell, Lenus Perkins and Mike Windom.
Administration & Guests:	Owen Bailey, Robert Barrington, Jim Berscheidt, Joél Billingsley, Jo Bonner, Joel Erdmann, Monica Ezell, Charlie Guest, Ashton Hennig, Buck Kelley, Andi Kent, Liz Kirby, Spence Larche, Nick Lawkis, John Marymont, Mike Mitchell, Allen Parrish, Kristen Roberts, Donna Streeter (Faculty Senate), Margaret Sullivan, Peter Susman and Christina Wassenaar (Faculty Senate).

Following the attendance roll call, **Item 8**, Mr. Shumock called for consideration of the minutes for a meeting held on March 13, 2025, **Item 9**. On motion by Dr. Stokes, seconded by Ms. Brown Stewart, the Committee voted unanimously to adopt the minutes.

Mr. Shumock called on Mr. Bailey to present **Item 10**, a resolution authorizing the USA Health Hospitals medical staff appointments and reappointments for February, March and April 2025. (To view resolutions, policies and other documents authorized, refer to the minutes of the Board of Trustees meeting held on June 6, 2025.) On motion by Dr. Stokes, seconded by Mr. Yance, the Committee voted unanimously to recommend approval of the resolution by the Board of Trustees.

Mr. Bailey explained **Item 11**, a resolution authorizing revisions to the USA Health Hospitals Medical Staff Bylaws and to associated documents. On motion by Mr. Yance, seconded by Dr. Stokes, the Committee voted unanimously to recommend approval of the resolution by the Board of Trustees.

Mr. Bailey shared background on **Item 12**, a resolution nominating Maryann Mbaka, M.D., USA Health trauma surgeon, and Mr. Tom Myers, USA Health Chief Transformation Officer, as two alternative candidates for consideration by the Mobile County Commission for the position of director of the Mobile County Hospital Board. On motion by Dr. Stokes, seconded by Ms. Brown Stewart, the Committee voted unanimously to recommend approval of the resolution by the Board of Trustees.

Concerning an update on the activities of USA Health and the Whiddon College of Medicine (WCOM), **Item 13**, Dr. Marymont called on Dr. Robert Barrington, Associate Professor of Microbiology and Immunology, for a report. Dr. Barrington, who also serves as Director of the WCOM's *Medical Student Summer Research Program*, provided an overview on the program for students of various classifications, including high school students, designed to strengthen their understanding of research and promote critical thinking, data analysis and scientific writing skills. Also discussed was the *Research Honors* tract for medical students, led by Dr. Barrington as well. Charts reflective of the growth and impact of the programs were shown.

Dr. Marymont turned to Mr. Bailey, who expressed pride for USA Health's involvement in addressing the rural healthcare crisis in Alabama. He recognized Ms. Liz Kirby, USA Health Executive Director of Virtual Care and Rural Initiatives, discussing her background in healthcare management with USA Health and Monroe County Hospital. He introduced Ms. Ashton Hennig, USA Health Director of Outreach and Special Projects, for a report on a new initiative as part of a partnership with 10 rural hospitals in Mobile County. Ms. Hennig discussed the acquisition of three telehealth vans the collaborative would share, made possible via a $1.5 million grant from the Alabama Department of Finance, as well as with federal funding through the American Rescue Plan Act. She indicated the first unit had been delivered and detailed design aspects.

There being no further business, the meeting was adjourned at 2:25 p.m.

Respectfully submitted:

James H. Shumock, Chair

UNIVERSITY OF SOUTH ALABAMA

MEMORANDUM

USA Health

DATE: August 6, 2025

TO: Jo Bonner
President

FROM: Natalie Fox
Interim Chief Executive Officer

SUBJECT: Board Meeting Documents

Attached for review and approval by the Health Affairs Committee and the Board of Trustees are the following items:

Resolution – USA Health Hospitals Medical Staff Appointments and Reappointments for May, June and July 2025

- USA Health Hospitals Medical Staff Appointments and Reappointments Board of Trustees Report

Resolutions – Department of Urology Waiver Requests

- Dimple Kumar Chanamolu, MD
- Tarek Ajami Fardoun, MD

Resolution – Department of Internal Medicine Waiver Request

- Amber Bokhari, MD

NF/kh

Attachments

RESOLUTION

USA HEALTH HOSPITALS MEDICAL STAFF APPOINTMENTS AND REAPPOINTMENTS FOR MAY, JUNE AND JULY 2025

WHEREAS, the USA Health Hospitals medical staff appointments and reappointments for May, June and July 2025 are recommended for Board approval by the Medical Executive Committees and the USA Health Credentialing Board,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the appointments and reappointments as submitted.

USA BOARD OF TRUSTEES REPORT
USA HEALTH HOSPITALS MEDICAL STAFFS
APPOINTMENTS APPROVED IN MAY, JUNE, AND JULY 2025

The following is a listing of recommendations for approval of new appointments, reappointments and other status changes of physicians and APP staff professionals. These have been reviewed and are recommended by the Medical Executive Committees of the respective hospitals.

Initial Appointments	USA Health Children's & Women's Hospital			USA Health University Hospital			USA Health Ambulatory Care		
Name	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**
Abdelmoneim, Mona H., MD	Initial Appointment	Active USA	Pediatrics	Initial Appointment	Active USA	Pediatrics	Initial Appointment	Active USA	Pediatrics
Atkinson, Erica R., CRNP	Initial Appointment	APP USA	Ped. Emerg. Med.	N/A	N/A	N/A	N/A	N/A	N/A
Barrett, Haley, CRNP	Initial Appointment	APP USA	Internal Medicine	Initial Appointment	APP USA	Internal Medicine	Initial Appointment	APP USA	Internal Medicine
Beauchamp, Luanna L., MD	Initial Appointment	Contract Locums	OBGYN	Initial Appointment	Contract Locums	OBGYN	N/A	N/A	N/A
Candelaria, Noelani A., DO	N/A	N/A	N/A	Initial Appointment	Active USA	Emergency Medicine	N/A	N/A	N/A
Carter, Emma G., MD	Initial Appointment	Consulting	Neurology	Initial Appointment	Consulting	Neurology	N/A	N/A	N/A
Clement, Cynthia E., RN	Initial Appointment	APP	OBGYN	Initial Appointment	APP	OBGYN	N/A	N/A	N/A
Crowe, Emily, CRNP	N/A	N/A	N/A	Initial Appointment	APP USA	Emergency Medicine	N/A	N/A	N/A
Donald, Joel W., CRNA	Initial Appointment	APP	Anesthesiology	Initial Appointment	APP	Anesthesiology	N/A	N/A	N/A
Duke, Jonathan, CRNA	Initial Appointment	APP	Anesthesiology	N/A	N/A	N/A	N/A	N/A	N/A
Evans, Alicia D., MD	Initial Appointment	Active USA	Family Medicine	Initial Appointment	Active USA	Family Medicine	Initial Appointment	Active USA	Family Medicine
Graves, Mary, PA	N/A	N/A	N/A	Initial Appointment	APP USA	Emergency Medicine	N/A	N/A	N/A
Grazette, Luanda P., MD	Initial Appointment	Active USA	Internal Medicine	Initial Appointment	Active USA	Internal Medicine	Initial Appointment	Active USA	Internal Medicine
Huddleston, Kaeli M., CRNP	Initial Appointment	APP USA	Pediatrics	N/A	N/A	N/A	Initial Appointment	APP USA	Pediatrics
Johnson, Brian J., MD	Initial Appointment	Consulting	Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Jurisic, Marisa D., CRNP	Initial Appointment	APP USA	Internal Medicine	Initial Appointment	APP USA	Internal Medicine	Initial Appointment	APP USA	Internal Medicine
Keeler, Leanne A., CRNP	N/A	N/A	N/A	Initial Appointment	APP USA	Surgery	Initial Appointment	APP USA	Surgery
Knight, Kristan B., CRNP	Initial Appointment	APP USA	Pediatrics	N/A	N/A	N/A	Initial Appointment	APP USA	Pediatrics
Latiolais, Caitlyn, PA	Initial Appointment	APP USA	Neurosurgery	Initial Appointment	APP USA	Neurosurgery	Initial Appointment	APP USA	Neurosurgery
McNair, Cierra P., MD	Initial Appointment	Consulting	Radiology	Initial Appointment	Consulting	Radiology	N/A	N/A	N/A
Meaux, Sydney R., PA	Initial Appointment	APP	Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Monaco, David A., MD	N/A	N/A	N/A	Initial Appointment	Active USA	Emergency Medicine	N/A	N/A	N/A
Morris, Hannah T., CRNP	N/A	N/A	N/A	Initial Appointment	APP USA	Surgery	Initial Appointment	APP USA	Surgery
Murray, Adrian H., MD	Initial Appointment	Active	Radiology	Initial Appointment	Active	Radiology	N/A	N/A	N/A
Nguyen, Ian H., MD	Initial Appointment	Contract Locum	OBGYN	N/A	N/A	N/A	N/A	N/A	N/A
Nielsen, Brian W., MD	Initial Appointment	Contract Locum	OBGYN	Initial Appointment	Contract Locum	OBGYN	Initial Appointment	Contract Locum	OBGYN
Pallekonda, Vinay A., MD	Initial Appointment	Active USA	Anesthesiology	Initial Appointment	Active USA	Anesthesiology	N/A	N/A	N/A
Pashayan, II, Edward, CRNP	Initial Appointment	APP USA	Internal Medicine	Initial Appointment	APP USA	Internal Medicine	Initial Appointment	APP USA	Internal Medicine
Perumal, Shankar, MD	Initial Appointment	Consulting	Neurology	Initial Appointment	Consulting	Neurology	N/A	N/A	N/A
Peterson, Sarah Lisa, CRNP	Initial Appointment	APP USA	OBGYN	Initial Appointment	APP USA	OBGYN	Initial Appointment	APP USA	OBGYN
Sexson, James A., MD	Initial Appointment	Active USA	Internal Medicine	Initial Appointment	Active USA	Internal Medicine	Initial Appointment	Active USA	Internal Medicine
Simmons, Steven, PA	N/A	N/A	N/A	Initial Appointment	APP USA	Internal Medicine	Initial Appointment	APP USA	Internal Medicine
Smith, Megan K., CRNP	Initial Appointment	APP USA	Pediatrics	N/A	N/A	N/A	Initial Appointment	APP USA	Pediatrics
Staples, Micah, DO	Initial Appointment	Active	Family Medicine	N/A	N/A	N/A	N/A	N/A	N/A
Thomas, Jr., George P., MD	N/A	N/A	N/A	Initial Appointment	Consulting	Neurology	N/A	N/A	N/A
Wojtaka, Evan J., CRNA	Initial Appointment	APP USA	Anesthesiology	Initial Appointment	APP USA	Anesthesiology	N/A	N/A	N/A
Wood, Robert, MD	Initial Appointment	Contract Locums	OBGYN	N/A	N/A	N/A	N/A	N/A	N/A

Reappointments	USA Health Children's & Women's Hospital			USA Health University Hospital			USA Health Ambulatory Care		
Name	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**
Abraham, Ryan T., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Adams, Mason G., MD	Reappointment	Consulting USA	Internal Medicine	Reappointment	Active USA	Internal Medicine	Reappointment	Consult. USA/ Active USA	Internal Medicine
Agagan, Caesar C., MD	N/A	N/A	N/A	Reappointment	Consulting	Internal Medicine	N/A	N/A	N/A
Almalouf, Philip, MD	Reappointment	Courtesy USA	Internal Medicine	Reappointment	Active USA	Internal Medicine	Reappointment	Court. USA/Active USA	Internal Medicine
Altun, Osman, MD	Reappointment	Active USA	Pediatrics	Reappointment	Coverage USA	Pediatrics	Reappointment	Active USA/Coverage USA	Pediatrics
Babston, Michael W., DMD, MD	Reappointment	Consulting	Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Banerjee, Sara, MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Barouqa, Mohammad I., MD	Reappointment	Active USA	Pathology	Reappointment	Active USA	Pathology	Reappointment	Active USA	Pathology
Bartel, Melissa M., MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Beakley, Lindsey, MD	Reappointment	Courtesy	Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Bedsole, Rhonda R., MD	Reappointment	Community Staff	Pediatrics	N/A	N/A	N/A	N/A	N/A	N/A
Bender, Stephanie M., MD	Reappointment	Consulting HCA/JAG	Internal Medicine	Reappointment	Active HCA/JAG	Internal Medicine	Reappointment	Consult HCA/Active HCA	Internal Medicine
Bier, Samantha J., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Black, Jeffrey R., MD (*)	Reappointment	Active	Radiology	Reappointment	Active	Radiology	N/A	N/A	N/A
Butts, Charles C., MD	Reappointment	Consulting USA	Surgery	Reappointment	Actuve USA	Surgery	Reappointment	Consult. USA/ Active USA	Surgery

Reappointments (Continued)	USA Health Children's & Women's Hospital			USA Health University Hospital			USA Health Ambulatory Care		
Name	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**
Carter, Amanda E., RN (*)	Reappointment	APP Non-Privileged	OBGYN	Reappointment	APP Non-Privileged	OBGYN	N/A	N/A	N/A
Cepeda, Matthew E., MD	Reappointment	Community Staff	Pediatrics	N/A	N/A	N/A	N/A	N/A	N/A
Chapman, Zack R., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Clarke, Ronald W., MD	Reappointment	Active	OBGYN	Reappointment	Active	OBGYN	N/A	N/A	N/A
Clayton, Brandi, CRNP	Reappointment	APP	Pediatrics	N/A	N/A	N/A	N/A	N/A	N/A
Cook, Taylor R., MD	N/A	N/A	N/A	Reappointment	Active HCA/JAG	Internal Medicine	Reappointment	Active HCA/JAG	Internal Medicine
Cornelius, Emily D., CRNP	Reappointment	APP USA	Surgery	Reappointment	APP USA	Surgery	Reappointment	APP USA	Surgery
Dean, II, James A., DO	N/A	N/A	N/A	Reappointment	Consulting	Internal Medicine	N/A	N/A	N/A
DeLavallade, Dawn N., MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Dolma, Kalsang, MD	Reappointment	Active USA	Pediatrics	Reappointment	Coverage USA	Pediatrics	Reappointment	Active USA/Coverage USA	Pediatrics
Ehlers, Scott D., CRNP	Reappointment	APP USA	Pediatrics	N/A	N/A	N/A	Reappointment	APP USA	Pediatrics
Eyal, Fabien G., MD	Reappointment	Active USA	Pediatrics	Reappointment	Consulting USA	Pediatrics	Reappointment	Active USA/Cons. USA	Pediatrics
Francavilla, Michael L., MD	Reappointment	Active USA	Radiology	Reappointment	Active USA	Radiology	Reappointment	Active USA	Radiology
Franklin, Garrett B., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Garri, Richard F., MD	Reappointment	Active USA	Ped. Emerg. Med.	Reappointment	Active USA	Emergency Medicine	N/A	N/A	N/A
Gilbert, Robert A., MD	Reappointment	Courtesy USA	Radiology Oncology	Reappointment	Active USA	Radiology Oncology	Reappointment	Court. USA/Active USA	Radiology Oncology
Green, III, John A., DO	Reappointment	Active USA	Internal Medicine	Reappointment	Active USA	Internal Medicine	Reappointment	Active USA	Internal Medicine
Gundlach, Ronnie M., DO	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Gupta, Sunil, MD	Reappointment	Consulting	Surgery	Reappointment	Consulting	Surgery	N/A	N/A	N/A
Gutstein, Laurie L., MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Hansell Dyess, Morgan N., CRNP	N/A	N/A	N/A	Reappointment	APP USA	Emergency Medicine	N/A	N/A	N/A
Hastings, Matthew M., MD	Reappointment	Consulting	Neurology	Reappointment	Consulting	Neurology	N/A	N/A	N/A
Henbest, Victoria S., CCC-SLP	Reappointment	APP USA	Surgery	Reappointment	APP USA	Surgery	Reappointment	APP USA	Surgery
Hollensworth, Laura K., MD (*)	Reappointment	Community Staff	Family Medicine	Reappointment	Community Staff	Family Medicine	N/A	N/A	N/A
Horner, Joseph D., DO	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Huettemann, Catherine W., MD	Reappointment	Community Staff	Pediatrics	N/A	N/A	N/A	N/A	N/A	N/A
Hunt, Karras R., CRNP	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Hyatt, Victoria K., PA	Reappointment	APP USA	Neurosurgery	Reappointment	APP USA	Neurosurgery	Reappointment	APP USA	Neurosurgery
Ikeri, Kelechi C., MD	Reappointment	Active USA	Pediatrics	Reappointment	Coverage USA	Pediatrics	Reappointment	Active USA/Coverage USA	Pediatrics
Jacob, Mina A., MD	N/A	N/A	N/A	Reappointment	Consulting	Internal Medicine	N/A	N/A	N/A
Jacob, Roy G., MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Jasti, Rahul, MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Keinath, Kyle V., DO	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
King, Lauren S., CRNP	Reappointment	APP USA	Surgery	Reappointment	APP USA	Surgery	Reappointment	APP USA	Surgery
Kirkland, III, Charles E., MD	Reappointment	Community Staff	Family Medicine	N/A	N/A	N/A	N/A	N/A	N/A
Kiviat, Leah N., MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Lane, Clayton G., MD	Reappointment	Coverage	Orthopaedics	Reappointment	Consulting	Orthopaedics	N/A	N/A	N/A
LePage, Jr., James R., DO	Reappointment	Consulting	Psychiatry	Reappointment	Consulting	Psychiatry	N/A	N/A	N/A
Mattei, Mary Lucy W., CRNP	Reappointment	APP USA	Gynecology	Reappointment	APP USA	Gynecology	Reappointment	APP USA	Gynecology
Menefee, Judson K., MD	Reappointment	Coverage HCA	Internal Medicine	Reappointment	Active HCA	Internal Medicine	Reappointment	Cover. HCA/Active HCA	Internal Medicine
Merritt, Brandy E., MD	Reappointment	Active USA	Pediatrics	Reappointment	Coverage USA	Pediatrics	Reappointment	Active USA/Coverage USA	Pediatrics
Mondry, Martin G., MD	Reappointment	Contract/Locums	Anesthesiology	Reappointment	Contract/Locums	Anesthesiology	N/A	N/A	N/A
Morais, Joshua D., MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Motykiewicz, Stacy L., CRNP	N/A	N/A	N/A	Reappointment	APP USA	Internal Medicine	Reappointment	APP USA	Internal Medicine
Mueller, Luke M., DO	Reappointment	Courtesy USA	Internal Medicine	Reappointment	Active USA	Internal Medicine	Reappointment	Court. USA/Active USA	Internal Medicine
Munir, Ayesha, MD (*)	Reappointment	Active USA	Internal Medicine	Reappointment	Active USA	Internal Medicine	Reappointment	Active USA	Internal Medicine
Munn, Mary B., MD	Reappointment	Active USA	OBGYN	Reappointment	Active USA	OBGYN	Reappointment	Active USA	OBGYN
Murphree, Marlee B., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Musselwhite, Charles E., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Myc, Lukasz A., MD	N/A	N/A	N/A	Reappointment	Community Staff	Internal Medicine	N/A	N/A	N/A
Naylor, Rick J., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Normand, Robin S., CRNP	Reappointment	APP USA	Internal Medicine	Reappointment	APP USA	Internal Medicine	Reappointment	APP USA	Internal Medicine
O'Connor, Ramona S., CRNP	Reappointment	APP HCA	Internal Medicine	Reappointment	APP HCA	Internal Medicine	Reappointment	APP HCA	Internal Medicine
Paragone, Christine M., PA	Reappointment	APP USA	Surgery	Reappointment	APP USA	Surgery	Reappointment	APP USA	Surgery
Parcha, Siva P. MD	Reappointment	Consulting USA	Internal Medicine	Reappointment	Active USA	Internal Medicine	Reappointment	Consult. USA/ Active USA	Internal Medicine
Park, John, CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Parker, Sandra K., MD	Reappointment	Consulting	Psychiatry	Reappointment	Consulting	Psychiatry	N/A	N/A	N/A
Parnell, Katelyn B., MD	Reappointment	Active HCA	OBGYN	N/A	N/A	N/A	Reappointment	Active HCA	OBGYN
Perez Garcia, Eliana M., MD	Reappointment	Active USA	Pediatrics	N/A	N/A	N/A	Reappointment	Active USA	Pediatrics
Perez, William M., MD	Reappointment	Active USA	OBGYN	Reappointment	Consulting USA	OBGYN	Reappointment	Active USA/Consulting USA	OBGYN
Ponnambalam, Ananthasekar, MD	Reappointment	Active USA	Pediatrics	Reappointment	Consulting USA	Pediatrics	Reappointment	Active USA/Consulting USA	Pediatrics
Pruett, Wesley C., MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	NA	N/A	N/A
Rebowe, Ryan E., MD	Reappointment	Consulting	Surgery	Reappointment	Consulting	Surgery	N/A	N/A	N/A
Rehder, Dirk, MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	NA	N/A	N/A
Rider, Jr., Paul F., MD	Reappointment	Active USA	Surgery	Reappointment	Active USA	Surgery	Reappointment	Active USA	Surgery
Roca Garcia, Maria R., MD	Reappointment	Active USA	Pediatrics	N/A	N/A	N/A	Reappointment	Active USA	Pediatrics
Rogers, IV, Charles Max, MD	Reappointment	Community Staff	OBGYN	N/A	N/A	N/A	N/A	N/A	N/A

Reappointments (Continued)	USA Health Children's & Women's Hospital			USA Health University Hospital			USA Health Ambulatory Care		
Name	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**
Rohe Lutkins, Megan E., CRNP	N/A	N/A	N/A	Reappointment	APP HCA/JAG	Internal Medicine	Reappointment	APP HCA/JAG	Internal Medicine
Rowell, Jr., Frederick W., MD	Reappointment	Active USA	Pediatrics	N/A	N/A	N/A	Reappointment	Active USA	Pediatrics
Rudd, Alison, CRNP	Reappointment	APP USA	Ped. Emerg. Med.	Reappointment	APP USA	Emergency Medicine	N/A	N/A	N/A
Rudd, Alison, CRNP	Reappointment	APP	OBGYN	Reappointment	APP	OBGYN	N/A	N/A	N/A
Sanchez Villanueva, Omar A., MD	Reappointment	Active USA	Pediatrics	Reappointment	Consulting USA	Pediatrics	Reappointment	Active USA/Consult. USA	Pediatrics
Sanchez, Jose A., MD	Reappointment	Active USA	Neurology	Reappointment	Active USA	Neurology	Reappointment	Active USA	Neurology
Schneider, Robert A., MD	Reappointment	Active USA	Ped. Emerg. Med.	Reappointment	Active USA	Emergency Medicine	N/A	N/A	N/A
Schrubbe, Benjamin P., MD	Reappointment	Community Staff	Family Medicine	N/A	N/A	N/A	N/A	N/A	N/A
Shrestha, Diksha, MD	Reappointment	Active HCA	Pediatrics	Reappointment	Coverage HCA	Pediatrics	Reappointment	Active HCA/Consulting HC	Pediatrics
Sibley, Jr., Darvin L., CRNA	Reappointment	APP Contract Locums	Anesthesiology	Reappointment	APP Contract Locums	Anesthesiology	N/A	N/A	N/A
Sindel, Campbell B., MD	N/A	N/A	N/A	Reappointment	Coverage	Internal Medicine	N/A	N/A	N/A
Thomas, Rebecca M., RN	Reappointment	APP	OBGYN	Reappointment	APP	OBGYN	N/A	N/A	N/A
Trussell, Jr., Raymond C., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Verde, Ranya K., CRNP	Reappointment	APP USA	Internal Medicine	Reappointment	APP USA	Internal Medicine	Reappointment	APP USA	Internal Medicine
Vial, Sheila F., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Ward, Michael J., CRNA	Reappointment	APP USA	Anesthesiology	Reappointment	APP USA	Anesthesiology	N/A	N/A	N/A
Weinacker, Elizabeth S., MD	Reappointment	Community Staff	Pediatrics	N/A	N/A	N/A	N/A	N/A	N/A
Welsh, Raymond H., MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Wentworth, Mary J., DA	Reappointment	APP	Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Wood, Amanda, CRNP	Reappointment	APP USA	Pediatrics	N/A	N/A	N/A	Reappointment	APP USA	Pediatrics
Woodall, Cassie B., PA	Reappointment	APP USA	Pediatrics	N/A	N/A	N/A	N/A	N/A	N/A
Yontz, Dustin L., MD	Reappointment	Active USA	Radiology	Reappointment	Active USA	Radiology	Reappointment	Active USA	Radiology
Zacharias, Claudia, MD	Reappointment	Consulting	Radiology	Reappointment	Consulting	Radiology	N/A	N/A	N/A
Zhao, Jun, MD	Reappointment	Consulting	Neurology	Reappointment	Consulting	Neurology	N/A	N/A	N/A

Change Requests	USA Health Children's & Women's Hospital			USA Health University Hospital			USA Health Ambulatory Care		
Name	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**	**Type/Status**	**Category**	**Department**
Clark, Savannah, PA	Chg. Department	APP USA	Surgery	Chg. Department	APP USA	Surgery	Chg. Department	APP USA	Surgery
Miller, Steven G., MD	N/A	N/A	N/A	Added Privileges	Active USA	Surgery	Added Privileges	Active USA	Surgery
O'Connor, Ramona S., CRNP	Chg. Collaborative	APP HCA	Internal Medicine	Chg. Collaborative	APP HCA	Internal Medicine	Chg. Collaborative	APP HCA	Internal Medicine
Qureshi, Javed A., MD	Added Privileges	Contract Locums	Radiology	Added Privileges	Contract Locums	Radiology	N/A	N/A	N/A

Resigned/Retired	USA Health Children's & Women's Hospital			USA Health University Hospital			USA Health Ambulatory Care		
Name	**Reason**	**Date**	**Department**	**Reason**	**Date**	**Department**	**Reason**	**Date**	**Department**
Allen, Scott T., MD	Resigned	04/10/2025	Radiology	Resigned	04/10/2025	Radiology	N/A	N/A	N/A
Adams, Ben B., DO	N/A	N/A	N/A	Resigned	05/27/2025	Anesthesiology	N/A	N/A	N/A
Allen, Scott T., MD	Resigned	04/10/2025	Radiology	Resigned	04/10/2025	Radiology	N/A	N/A	N/A
Anderson, Chasidy S., PA	Resigned	5/19/2025	Pediatrics	N/A	N/A	N/A	Resigned	05/19/2025	Pediatrics
Ashbee, Susan A., MD	Resigned	07/01/2025	Pediatrics	N/A	N/A	N/A	N/A	N/A	N/A
Carlyle, Megan E., PA	Resigned	05/23/2025	Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Dean, Sarah J., MD	Resigned	07/01/2025	Pediatrics	Resigned	07/01/2025	Pediatrics	N/A	N/A	N/A
Duke, Jonathan B., CRNA	Resigned	04/28/2025	Anesthesiology	Resigned	04/28/2025	Anesthesiology	N/A	N/A	N/A
Duke, Jonathan B., CRNA	Resigned	04/28/2025	Anesthesiology	Resigned	04/28/2025	Anesthesiology	N/A	N/A	N/A
Fuqua, Jessica K., PA	Resigned	07/02/2025	Orthopaedics	Resigned	07/02/2025	Orthopaedics	Resigned	07/02/2025	Orthopaedics
Hirsch, James R., MD	Resigned	04/10/2025	Surgery	Resigned	04/10/2025	Surgery	N/A	N/A	N/A
Hirsch, James R., MD	Resigned	04/10/2025	Surgery	Resigned	04/10/2025	Surgery	N/A	N/A	N/A
Keup, Christopher P., MD	Resigned	05/23/2025	Radiology	Resigned	05/23/2025	Radiology	Resigned	05/23/2025	Radiology
Lewis, Emma J., PA	Resigned	05/15/2025	Neurosurgery	Resigned	05/15/2025	Neurosurgery	Resigned	05/15/2025	Neurosurgery
McBride, Byron M., CRNA	N/A	N/A	N/A	Resigned	04/28/2025	Anesthesiology	N/A	N/A	N/A
McBride, Byron M., CRNA	N/A	N/A	N/A	Resigned	04/28/2025	Anesthesiology	N/A	N/A	N/A
Miller, Laird, CRNA	Resigned	06/18/2025	Anesthesiology	Resigned	06/18/2025	Anesthesiology	N/A	N/A	N/A
Richards, Kenneth J., MD	Resigned	06/21/2025	Radiology	Resigned	06/21/2025	Radiology	N/A	N/A	N/A
Roberts, Norma Faye, MD	Retired	06/06/2025	Pediatrics	N/A	N/A	N/A	N/A	N/A	N/A
Roveda, Mary Kelly P., MD	Retired	06/01/2025	Pathology	Retired	06/01/2025	Pathology	N/A	N/A	N/A
Smith, Allessa A., MD	Resigned	07/01/2025	OBGYN	N/A	N/A	N/A	N/A	N/A	N/A
Smith, Emily M., MD	Resigned	07/01/2025	Surgery	Resigned	07/01/2025	Surgery	Resigned	07/01/2025	Surgery
Walker, Marshall K., MD	Resigned	07/02/2025	Radiology	Resigned	07/02/2025	Radiology	Resigned	07/02/2025	Radiology
Walks, Debra M., MD	Resigned	05/16/2025	Pediatrics	Resigned	05/16/2025	Pediatrics	N/A	N/A	N/A
White, Stanley D., PA	N/A	N/A	N/A	Resigned	05/16/2025	Surgery	N/A	N/A	N/A
Wilson, Richard C., MD	Resigned	05/21/2025	Radiology	Resigned	05/21/2025	Radiology	N/A	N/A	N/A

RESOLUTION

DEPARTMENT OF UROLOGY WAIVER REQUEST

WHEREAS, the Department of Urology is dedicated to delivering patient-centered urologic care to the men, women and children along the Gulf Coast and it is vital to have a physician with expertise in endourology, and

WHEREAS, recruitment for this specialty has been difficult in the last three years, and

WHEREAS, Kumar Chanamolu, MD, is an outstanding candidate who would be a valuable addition to the Department of Urology and is a foreign medical graduate who is certified by the Educational Commission for Foreign Medical Graduates and has completed an accredited urology fellowship through the Accreditation Council for Graduate Medical Education, and

WHEREAS, Dr. Chanamolu does not meet the eligibility criteria to join the medical staff because he is not eligible for the American Board of Urology's alternative pathway for board certification, which requires maintaining a faculty appointment for seven years, and

WHEREAS, the Medical Executive committees and Credentialing Board of USA Health Hospitals recommend approval of the board certification waiver request for Dr. Chanamolu,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the waiver request as submitted.

Dear Credentialing Board and Board of Trustees Members,

The Medical Executive Committees at USA Health Hospitals recommend approval of the board certification waiver request submitted by Dr. Christopher Keel, Department Chair of Urology, on behalf of Dimple Kumar Chanamolu, M.D.

This recommendation is based on the department's need for Dr. Chanamolu's expertise in general urology and endourology.

Dr. Chanamolu completed his primary medical training in India, followed by a urologic oncology and robotic surgery fellowship from July 2020 to July 2022. He then completed an Endourological Society fellowship at the University of Miami from July 2022 to December 2022. Since January 2023, he has served on the faculty at West Virginia University.

Dr. Chanamolu is a foreign medical graduate, ECFMG certified, and has completed an ACGME accredited urology fellowship. He will become board eligible through the American Board of Urology's Alternative Pathway after maintaining a faculty appointment for seven years.

We appreciate your consideration of this waiver request and your support of Dr. Chanamolu's contributions to the department during this extended certification period.

Dear Members of the Combined Credentials Committee,

I'm writing in support of credentials for Dr. Dimple Chanamolu in our hospital. Dr. Chanamolu is an accomplished urologist. He currently is on faculty at West Virginia University, where he practices General and Endourology. He did his primary training in India prior to doing an Endourological Society accredited fellowship at the University of Miami under the direction of fellowship director, Dr. Hemendra Shah. Hemendra describes Dr. Chanamolu as one of the best Endourologist he has trained regarding HoLEPs and that the OR staff continue to miss him several years after he completed his fellowship.

Dr. Chanamolu has an interest in Laser Prostate Enucleation and Single Port Robotics. Due to the dire need for his expertise and help, I'm requesting appointment to our medical staff. He will be Board Eligible through the American Board of Urology Alternate Pathway to board certification which he will qualify for after a faculty appointment of 7 years. Please contact me with any questions.

Respectfully,

Christopher E. Keel, DO, FACS, AME
Associate Professor and Chair
Department of Urology
University of South Alabama
Fredrick P. Whiddon College of Medicine
Mobile, AL

To Whom It May Concern,

I am writing to provide a comprehensive summary of my educational background and postgraduate training in the field of medicine and urology.

I earned my Bachelor of Medicine and Bachelor of Surgery (MBBS) degree from NRI Medical College, Dr. NTR University of Health Sciences, Guntur, India, completing the program in 2010. Following this, I pursued a Master of Surgery (MS) in General Surgery at the same university, graduating in 2016.

Subsequently, I completed my Urology Residency from 2016 to 2019 at KIMS, Narketpally, under Kaloji Narayana Rao University of Health Sciences, Telangana, India. During this time, I gained comprehensive training in various aspects of clinical and surgical urology.

In pursuit of further specialization, I undertook a series of fellowships, including:

• A Renal Transplant Fellowship at McMaster University, St. Joseph's Hospital, Hamilton, Ontario, Canada (August 2019 – July 2020).

• A Urologic Oncology and Robotic Surgery Fellowship at the University of Miami, Jackson Memorial Hospital, Miami, FL (July 2020 – July 2022).

• An Endourology-Oncology Fellowship also at the University of Miami, Jackson Memorial Hospital (July 2022 – December 2022).

Additionally, I am ECFMG certified and have completed all USMLE steps, which further demonstrates my qualifications for practicing medicine in the United States.

This extensive academic and clinical training has shaped me into a well-rounded urologist with a focus on endourology, urologic oncology, and advanced surgical techniques, including robotic and minimally invasive procedures.

Exceptional all round experience and training in urology will help support and develop unmatched urology program in Department of Urology, University of Alabama, under the leadership of Dr. Christopher E. Keel.

Please do not hesitate to reach out should you require any further information or documentation.

Sincerely,

Dr. Dimple Kumar Chanamolu
chanamoludimplekumar@gmail.com
Phone: 305-504-1232
Address: 1039 Rector Rd, Parkersburg, WV 26105

RESOLUTION

DEPARTMENT OF UROLOGY WAIVER REQUEST

WHEREAS, the Department of Urology is dedicated to delivering patient-centered urologic care to the men, women and children along the Gulf Coast and it is vital to have a physician with expertise in urologic oncology, and

WHEREAS, recruitment for this specialty has been difficult in the last three years, and

WHEREAS, Tarek Ajami Fardoun, MD, is an outstanding candidate who would be a valuable addition to the Department of Urology, and he is a foreign medical graduate who is certified by the Educational Commission for Foreign Medical Graduates and has completed an accredited urology followship through the Accreditation Council for Graduate Medical Education, and

WHEREAS, Dr. Fardoun does not meet the eligibility criteria to join the medical staff because he is not eligible for the American Board of Urology's alternative pathway for board certification, which requires maintaining a faculty appointment for seven years, and

WHEREAS, the Medical Executive committees and Credentialing Board of USA Health Hospitals recommend approval of the board certification waiver request for Dr. Fardoun,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the waiver request as submitted.

July 22, 2025

Dear Credentialing Board and Board of Trustee members:

The Medical Executive Committees at USA Health Hospitals recommend approval of the waiver request submitted by Dr. Christopher Keel, Clinical Chair of Urology, regarding board certification requirements for Tarek Ajami Fardoun, M.D. The specific basis for this recommendation is due to the urology department expanded growth around urological oncology. There have been active recruitment efforts for over 3 years for this expertise.

Dr. Ajami-Fardoun did his primary training in Barcelona Spain prior to doing a urologic oncology fellowship at the University of Miami (June 2022-July 2024). He will become Board Eligible through the American Board of Urology Alternative Pathway after a faculty appointment for 7 years.

In summary Dr. Ajami Fardoun is a foreign medical graduate, ECFMG certified, who completed an ACGME-accredited urology fellowship in 2024. He will become eligible to obtain Urology boards after a faculty appointment for 7 years.

We appreciate your consideration of this request and support her continued contributions to the department during this extended certification period.

Dear Members of the Combined Credentials Committee,

I'm writing in support of credentials for Dr. Tarek Ajami. Dr. Ajami is an accomplished urologist and physician scientist. He did his primary training in Barcelona Spain prior to doing a prestigious Society of Urological Oncology accredited fellowship at the University of Miami under the direction of a well-respected fellowship director, Dr. Mark Gonzalgo. Mark is a trusted friend and describes Dr. Ajami as "a skilled surgeon who is well liked by the faculty, residents and OR staff…who will be a leader in the field of Urologic Oncology".

Dr. Ajami has an interest in Bladder Cancer and Cystectomy. As the only urologist currently performing this procedure on the upper Gulf Coast I'm extremely excited that he will be joining us as my practice has exploded over the past 5 years and we have been recruiting for this position for over 3. Due to the dire need for his expertise and help, I'm requesting appointment to our medical staff. He will be Board Eligible through the American Board of Urology Alternate Pathway to board certification which he will qualify for after a faculty appointment of 7 years. Please contact me with any questions.

Respectfully,

Christopher E. Keel, DO, FACS, AME
Associate Professor and Chair
Department of Urology
University of South Alabama
Fredrick P. Whiddon College of Medicine
Mobile, AL

To Whom It May Concern:

I am writing to provide a summary of my medical training, including my residency and fellowship in urologic oncology.
I completed my residency in Urology at Hospital Clinic of Barcelona, Spain, from May 2015 to May 2020. During this comprehensive training program, I gained extensive clinical and surgical experience in all aspects of urology, including endourology, minimally invasive surgery, male and female urology, and urologic oncology. I actively participated in patient care, research, and resident education, which laid a strong foundation for my subspecialty training in uro-oncology.

Following residency, I pursued a Society of Urologic Oncology (SUO)-accredited fellowship in Urologic Oncology at University of Miami, which I completed from June 2022 to July 2024. This rigorous two-year fellowship provided advanced training in the multidisciplinary management of urologic cancers, including complex oncologic surgeries, clinical trials, collaboration in multidisciplanry teams and translational research. I was actively involved in high-volume open and mainly robotic oncologic procedures, and collaborated closely with medical and radiation oncologists as part of a comprehensive cancer care team (Sylverster Cancer Center).
My training through these programs has prepared me to provide high-level care in academic and clinical urologic oncology settings and to contribute meaningfully to research and education in this field.

Please feel free to contact me should you need any additional information or documentation.
Sincerely,

Tarek

RESOLUTION

DEPARTMENT OF INTERNAL MEDICINE WAIVER REQUEST

WHEREAS, Amber Bokhari, MD, is a foreign medical graduate who is certified by the Educational Commission for Foreign Medical Graduates and has completed two accredited fellowships in Infectious Diseases through the Accreditation Council for Graduate Medical Education, and, now that she has become eligible to pursue board certification in Internal Medicine, she intends to complete this requirement before pursuing board certification in Infectious Diseases, and

WHEREAS, Dr. Bokhari was hired in the Department of Internal Medicine in 2020 under an alternative pathway to board certification available to foreign medical graduates and she became eligible for American Board of Internal Medicine certification in 2023, yet she did not pass the exam on her first attempt, and, as a result, Dr. Bokhari will not meet the eligibility threshold criteria for reappointment in the fall of 2024 unless a waiver is granted, and

WHEREAS, a waiver request with an extension allowing Dr. Bokhari until December 2026 to obtain her Internal Medicine board certification is recommended by the Children's & Women's Hospital and University Hospital Medical Executive committees and the Credentialing Board of USA Health Hospitals,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the waiver request as submitted.

June 1, 2025

Dear Credentialing Board and Board of Trustees Members,

The Medical Executive Committees at USA Health Hospitals respectfully recommend approval of the waiver request submitted by the Chair of Internal Medicine, Dr. Nasser Lakkis, regarding board certification requirements for Dr. Amber Bokhari.

Dr. Bokhari was hired into the department in 2020 under an alternative pathway to board certification available to foreign medical graduates. According to Dr. Nasser Lakkis, Internal Medicine Chair, she was awarded the faculty pathway for the American Board of Internal Medicine board certification in 2024. Since Dr. Bokhari did not pass the exam on her first attempt in 2024, she will need the waiver to meet this medical staff eligibility threshold criteria for reappointment in the fall of 2025.

Both Medical Executive Committees recommend granting the waiver with an extension, allowing Dr. Bokhari until December 2026 to obtain her internal medicine board certification.

To summarize, Dr. Amber Bokhari is a foreign medical graduate, ECFMG certified, and has completed two ACGME-accredited fellowships in Infectious Diseases. Now that she has become eligible to pursue board certification in Internal Medicine, she intends to complete this requirement before pursuing board certification in Infectious Diseases.

We appreciate your consideration of this request and support her continued contributions to the department during this extended certification period.

February 5, 2025

Dear Members of the Combined Credentials Committee,

I am writing to request a waiver of board certification on behalf of Dr. Amber Bokhari, assistant professor in the Infectious Disease Division, Department of Medicine. Dr. Bokhari was hired into our department in 2020 through the Alternate Pathway for Board Certification for foreign medical graduates. Dr. Bokhari became eligible for board certification in Internal Medicine in 2024. She did not pass the exam on her first attempt. According to the American Board of Internal Medicine bylaws, she remains board eligible through 2031. Based on her board eligibility, I am requesting the reappointment of Dr. Bokhari especially that we have a dire need to grow our Infectious Disease Division at this time. Please let me know if any other documentation is needed.

Respectfully,

Nasser Lakkis, MD, FACC
Abraham A. Mitchell Professor and Chair of Medicine
University of South Alabama

UNIVERSITY OF SOUTH ALABAMA

MEMORANDUM

USA Health

DATE: August 20, 2025

TO: Jo Bonner
President

FROM: Natalie Fox
Interim Chief Executive Officer

SUBJECT: Community Health Needs Assessment

Under the provisions of the Patient Protection and Affordable Care Act, each hospital is to conduct a community health needs assessment at least once every three years. Furthermore, the governing board is required to adopt an implementation strategy proposed to meet the community needs identified through such assessment.

I am recommending for your approval and recommendation to the Board of Trustees the attached Community Health Needs Assessment conducted by USA Health for 2025, the proposed implementation strategies and the resolution for approval and adoption of same by the Board of Trustees.

NF/kh

Attachments

RESOLUTION

USA HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION STRATEGIES

WHEREAS, the Patient Protection and Affordable Care Act requires that not-for-profit hospitals conduct community health needs assessments, and

WHEREAS, USA Health has conducted the aforementioned assessment for 2025, and

WHEREAS, the Patient Protection and Affordable Care Act further requires that health system governing bodies adopt those implementation strategies developed by the health system to meet the community needs identified through such assessment,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the community health needs assessment conducted by USA Health and adopts the implementation strategies developed by USA Health as a result, both of which are attached hereto and incorporated herein.

2025 – 2027 COMMUNITY HEALTH NEEDS ASSESSMENT

Prepared by:
Thomas C. Shaw, Ph.D.
Jaclyn Bunch, Ph.D.
Dalten Fox, Ph.D.
Abigail Celuch, M.P.A.

TABLE OF CONTENTS

EXECUTIVE SUMMARY – 1

Introduction

The Patient Protection and Affordable Care Act, passed March 23, 2010, requires that not-for-profit hospitals conduct a Community Health Needs Assessment (CHNA) every three years. The assessment should define the community, solicit input regarding the health needs of the community, assess and prioritize those needs, identify relevant resources, and evaluate any actions taken since preceding CHNAs.

This executive summary presents the key elements of the 2025-2027 Infirmary Health Community Health Needs Assessment. This assessment was conducted between September and December, 2024. First USA Health and its constituent parts are described. Second, the community served by USA Health is defined. Next, the overall methodology of the CHNA is provided, and finally, a summary of the health needs identified in sections two, three, and four are presented.

USA Health

University Hospital (UH), USA Health Children's & Women's Hospital (USAC&W), and the USA Health Mitchell Cancer Institute (USAMCI) are each collectively part of the broader USA Health and are collaborating as part of this CHNA. Throughout this report each facility is referenced individually as appropriate or collectively as USA Health.

USA Health – Children's & Women's Hospital

USA Health Children's & Women's Hospital offers the most advanced care in the region and delivers more babies annually than any other hospital in Mobile. It offers among its specialized services the region's most advanced neonatal intensive care and pediatric intensive care units, which provide the most specialized care to critically ill and injured newborns and children. Its specialized staff also offers a variety of innovative programs for hospitalized children teens and their families to meet their developmental, educational, social and emotional needs.

USA Health – Mitchell Cancer Institute

Combining cutting-edge research with advanced care, the USA Health Mitchell Cancer Institute fights cancer from the laboratory bench to the patient's bedside. MCI is the only academic-based cancer research and treatment facility on the upper Gulf Coast. Its mission is to discover, develop and deliver innovative solutions to improve cancer outcomes.

USA Health – Providence Hospital

The recently acquired Providence Hospital is a full-service, 349-bed facility providing 24/7 emergency care and operating as a Level III trauma center. Known for its high-quality birthing services, surgical care, and specialized treatment, the hospital serves as the hub of the Providence Campus. This comprehensive health campus includes primary care clinics, outpatient specialty clinics, rehabilitation services, and a pharmacy. Providence offers a wide array of services such as minimally invasive procedures, imaging, lab testing, wound care, and

diabetes management, delivering coordinated and compassionate care to patients across the region.

USA Health – University Hospital

University Hospital is an acute care facility serving as the major referral center for southwest Alabama, southeast Mississippi and portions of northwest Florida. It offers centers for Level I trauma, burn, stroke, cardiovascular disease and sickle cell disease. As a teaching and research facility for the University of South Alabama College of Medicine, University Hospital plays a key role in the development of new technology, treatments and training of future health care professionals. The hospital also includes outpatient care services such as cardiology, medicine and surgery.

Community

USA Health has a far-reaching impact throughout the region including areas beyond southern Alabama in both northwestern Florida and southeast Mississippi. However, the primary community served by USA Health is the area of Mobile County.

Mobile County, Alabama is situated in southwest Alabama and is bordered by the following counties: Baldwin, Clark, Escambia, Monroe and Washington in Alabama and George, Greene, and Jackson in Mississippi. The population of Mobile County is 411,640. Forty-eight percent of the population is male and 52 percent are female. The percent of the population identifying as white only is 58 while 37 percent identify as African-American or Black only. The median age is 37 years old. The median household income is $45,802; 27 percent of the population have a Bachelor's Degree or higher; and 16 percent of the population are below the federal poverty level. Within the county there 9,283 employment establishments, and 184,441 housing units.[1]

Despite being primarily located in Mobile County, USA Health is starting to make inroads into Baldwin County. Consequently, the demographic profile information from Baldwin County is retained herein and used in the demographic profile as a one of several points of comparison for Mobile County.

CHNA Methodology

Having identified the relevant community, in this case Mobile County, Alabama, the key objective of the CHNA is to assess the health needs of that community. A three-pronged approach is used herein to assess Mobile County's health needs. First, a comprehensive demographic profile is developed using secondary data sources that provide insight into the composition and prevalent conditions within the community. Second, a telephone survey

[1] County information is taken from various census sources including 2017 Population Estimates, 2010 Demographic Profile, and 2012-2016 American Community Survey 5-Year Estimates.

was conducted of individuals living in the defined community in order to solicit their input regarding their health needs. Third, an Internet/E-mail survey was conducted of health leaders in Mobile County to get their input and to be able to compare and contrast the views of the community with those of the health leaders. Having assessed the current health needs of the community, the findings of the previous USA Health's CHNA are evaluated and then the current health needs are presented.

For the 2025-2027 fiscal period's CHNA, the two major health systems in Southwest Alabama, Infirmary Health and USA Health collaborated on the data collection efforts. The USA Polling Group collected the relevant data for all three facilities across the varying service areas concurrently. This collaboration provided cost efficiencies for both organizations and is in accordance with IRS regulations regarding the collaboration of organizations that share and/or overlap common service areas. Despite the collaboration, the data for each entity is tailored to its specific service area, e.g., Infirmary Health is the only facility whose service area includes Mobile and Baldwin counties. Further, each facility produces its own separate report based on the specifics of the findings in its service area.

Summary of Key Findings

Community Demographic Profile

The community demographic profile is an in-depth examination of secondary data indicators that compare Mobile and Baldwin counties to Alabama and the United States. Data for the profile were taken from many different sources including the US Census, the Alabama Department of Public Health, and Share Southwest Alabama. This report provides an in-depth analysis of the demographic, economic, and health characteristics of Mobile and Baldwin counties, Alabama, identifying key trends and disparities to guide community resource planning and health interventions.

Population by Age and Sex

Mobile County's population grew modestly from 408,620 in 2010 to 411,640 in 2023, with the 60+ age group experiencing the fastest growth and a significant decline in the 0-19 age bracket. Baldwin County reflects similar aging trends, with substantial growth in residents aged 60+ and stable younger populations. Gender distribution remains consistent, with females outnumbering males across both counties, though Baldwin County shows the most balanced gender ratios compared to state and national trends.

Population by Race and Ethnicity

Mobile County is more racially and ethnically diverse than Baldwin County. In 2023, Mobile County's population was 55.67% White and 35.71% Black, while Baldwin County had an 82.11% White majority. Hispanic and Asian populations represent smaller but growing demographics in both counties. These differences emphasize Baldwin's more homogeneous profile and Mobile's urban diversity.

Poverty

Mobile County consistently exhibits higher poverty rates than Baldwin County, Alabama, and national averages. In 2023, Mobile County had the highest proportion of residents living below the Federal Poverty Level (FPL) and between 100-149% FPL, highlighting persistent economic challenges. Conversely, Baldwin County reflects stronger economic conditions with the lowest poverty rates regionally.

Education

Educational attainment remains a challenge, particularly in Mobile County, where residents with bachelor's or higher degrees lag behind state and national averages. Baldwin County demonstrates higher levels of post-secondary education, reflecting its growing workforce of younger professionals and families.

Birth Trends and Maternal Health

Birth rates have declined significantly in Mobile County, with a steady decrease from 5,548 births in 2018 to 4,995 in 2022. Baldwin County, however, has seen an increase in births over the same period. Mobile County also reports higher rates of Medicaid-supported births and teenage pregnancies, emphasizing economic disparities. Low birth weight and neonatal mortality rates remain critical concerns in Mobile, requiring targeted maternal and infant health interventions.

Mortality and Causes of Death

Heart disease and cancer are the leading causes of death in both counties. Mobile County shows consistently higher mortality rates than Baldwin County for chronic diseases, particularly Alzheimer's and respiratory conditions, reflecting its aging population. Cancer-related deaths, including respiratory and colorectal cancers, highlight the need for enhanced screening and prevention.

Accidents are the leading cause of unintentional deaths, with motor vehicle accidents, poisoning, and falls being the primary contributors. Homicides and suicides show diverging trends, with Mobile County reporting higher homicide rates and Baldwin County experiencing higher suicide rates.

Community Health Survey

A random digit dialed telephone survey of Mobile County was conducted between September 18 and December 17, 2024. A total of 443 people were interviewed for a margin of error of +/-4.7%. The following represent the most important findings from the community health survey.

According to community members the most important features of a healthy community and the features that would be most important for improving the overall health of their community include:

1) A clean environment (including water, air, etc.)

2) Lower crime and safe neighborhoods
3) Cancer Care
4) Good schools
5) Mental health services
6) Support services to help people with natural disasters: flooding, hurricanes, tornadoes
7) Good places to raise children

The community respondents said that the following are the top six health issues that are a problem for Mobile County:

1) Child abuse and neglect
2) Cancers
3) Domestic violence
4) Mental Health Problems
5) Rape and sexual assault
6) Heart disease and stroke

These are the top health conditions that community members said they have been told by a doctor or other healthcare professional that they have:

1) High blood pressure
2) High cholesterol
3) Diabetes
4) Depression
5) Obesity
6) Heart Disease

Of the specific items mentioned by community members, the following are the top six healthcare services that they feel are difficult to obtain in Mobile County:

1) Mental health services
2) Services for the elderly
3) Specialty medical care (specialist doctors)
4) Dental care / dentures
5) Emergency medical care
6) Preventative healthcare (routine or wellness checkups)

Sixteen percent of Mobile County respondents indicated that they had delayed getting needed medical care sometime during the past 12 months. The following are the top-rated reasons identified for why someone delayed getting needed medical care:

1) Could not afford medical care
2) Could not get an appointment soon enough
3) Insurance problems, lack of insurance

Community Health Leaders Survey

An Internet/e-mail-based survey of community health leaders in Mobile County was conducted between November 12 and December 11, 2024. A total of 57 health leaders

responded to the survey. The following represent the most important findings from the community health leaders survey.

The community health leaders identified the following as the most important features of a health community:

1) Access to health services (e.g., family doctor, hospitals)
2) Low crime/safe neighborhoods
3) Affordable housing
4) Mental health services
5) Good employment opportunities
6) Quality education

Community health leaders went on to say that the most important health issues facing Mobile County include:

1) Mental health problems
2) Drug use abuse
3) Obesity/excess weight
4) Heart disease and stroke
5) Cancers
6) Homelessness

The unhealthy behaviors that concern health leaders the most are:

1) Drug abuse
2) Poor eating habits/poor nutrition
3) Homelessness
4) Excess weight
5) Not seeing a doctor or dentist
6) Alcohol abuse

The healthcare services identified by community health leaders as the most difficult to obtain in Mobile County include:

1) Mental health services
2) Alcohol or drug abuse treatment
3) Preventative healthcare (routine or wellness checkups)
4) Services for the elderly
5) Alternative therapies
6) Dental care including dentures
7) Primary medical care
8) Specialty medical care (specialist doctors)

An important aspect of the CHNA is comparing the priorities of the community health leaders with the priorities of the community to see where there is convergence or divergence between these two groups. As we have found in the past, there are areas of convergence and divergence among the top items identified by both groups. Priority rankings of these top items of course differed in many cases but it is notable that similar items made it in into the top six items for both community health leaders and community members. The following tables show where items converged and diverged between the two groups.

Table 1.1: Features of a Healthy Community[1]

Features mentioned in the top six by Community Health Leaders and Community Members	Features mentioned in the top six by Community Health leaders but not by Community Members	Features mentioned in the top six by Community Members but not by Community Health Leaders
Lower crime and safe neighborhoods (2/2)	1. Access to health services (e.g., family doctor, hospitals) (1)	1. Clean Environment including water, air, etc. (1)
	2.	2.
	3. Affordable Housing (3)	3. Cancer Care (3)
	4. Mental Health Services (4)	4. Good Schools (4)
	5. Good employment opportunities (5)	5. Support services to help people with natural disasters: flooding, hurricanes, tornados (5)
	6. Quality Education (6)	6. Good places to raise children (6)

[1] Numbers in parentheses in column one shows the priority ranking for each group. The first number is the priority ranking of the Community Health Leaders and the second number is the priority ranking of the Community Members.

Table 1.2: Most Important Health Issues[1]

Features mentioned in the top six by Community Health Leaders and Community Members	Features mentioned in the top six by Community Health leaders but not by Community Members	Features mentioned in the top six by Community Members but not by Community Health Leaders
Mental health problems (1/4)	1.	1. Child abuse and neglect
Cancers (5/2)	2. Drug use / abuse	2.
Heart disease and stroke (4/6)	3. Obesity / excess weight	3.. Domestic violence
	4.	4.
	5.	5. Rape and sexual assault
	6. Homelessness	6.

[1] Numbers in parentheses in column one shows the priority ranking for each group. The first number is the priority ranking of the Community Health Leaders and the second number is the priority ranking of the Community Members.

Table 1.3: Healthcare Services that are Difficult to Obtain[1]

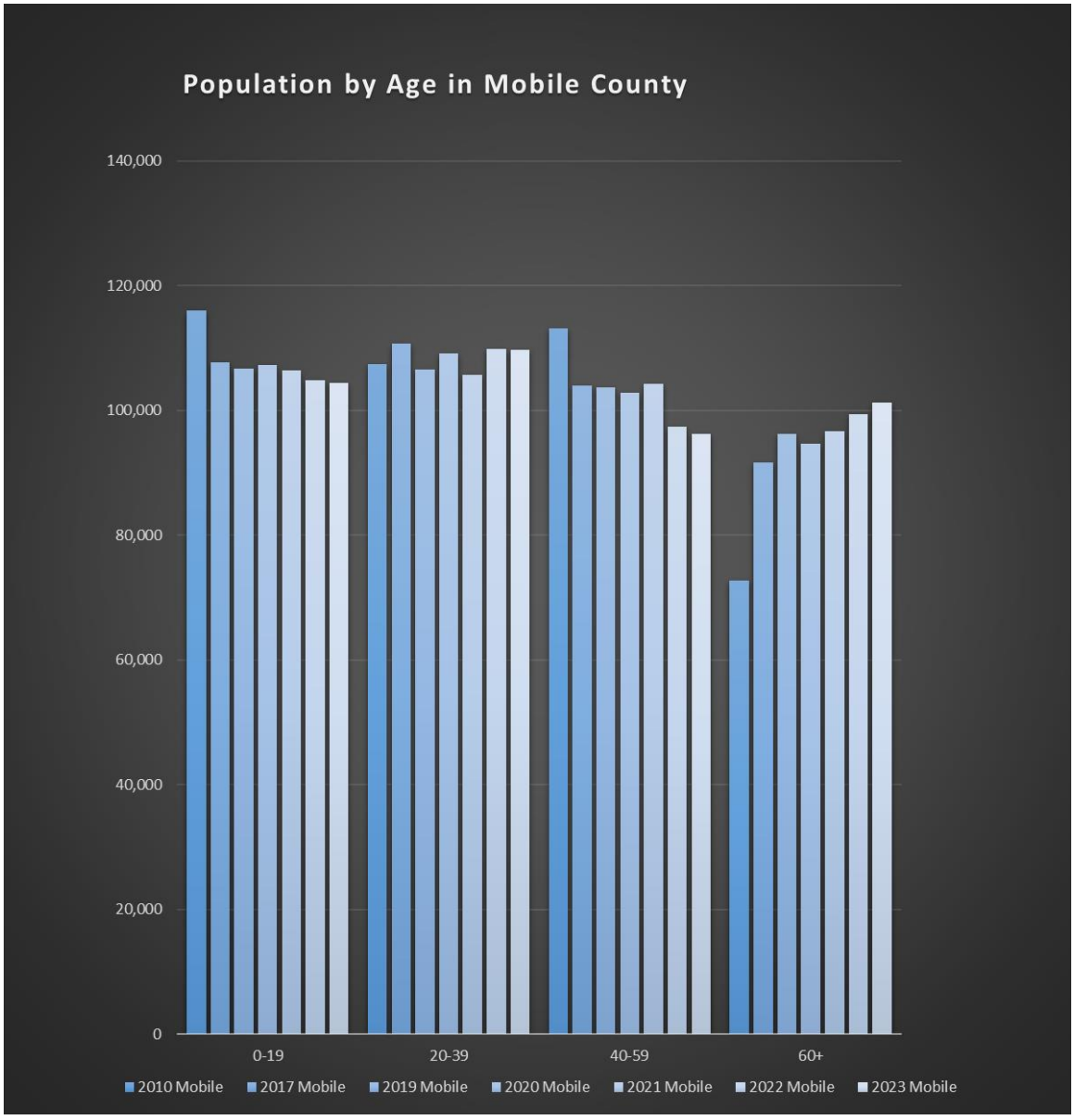
Features mentioned in the top six by Community Health Leaders and Community Members	Features mentioned in the top six by Community Health leaders but not by Community Members	Features mentioned in the top six by Community Members but not by Community Health Leaders
Mental health services (1/1)	1.	1.
Preventative healthcare (routine or wellness check-ups, etc.) (3/6)	2. Alcohol or drug abuse treatment	2.
Services for the elderly (4/2)	3.	3.
Dental care / dentures (6/4)	4.	4.
Specialty medical care (specialist doctors) (6/6)	5. Alternative therapies (acupuncture, herbals, etc.)	5. Emergency medical care
	6. Primary medical care (a primary doctor / clinic)	6.

[1] Numbers in parentheses in column one shows the priority ranking for each group. The first number is the priority ranking of the Community Health Leaders and the second number is the priority ranking of the Community Members.

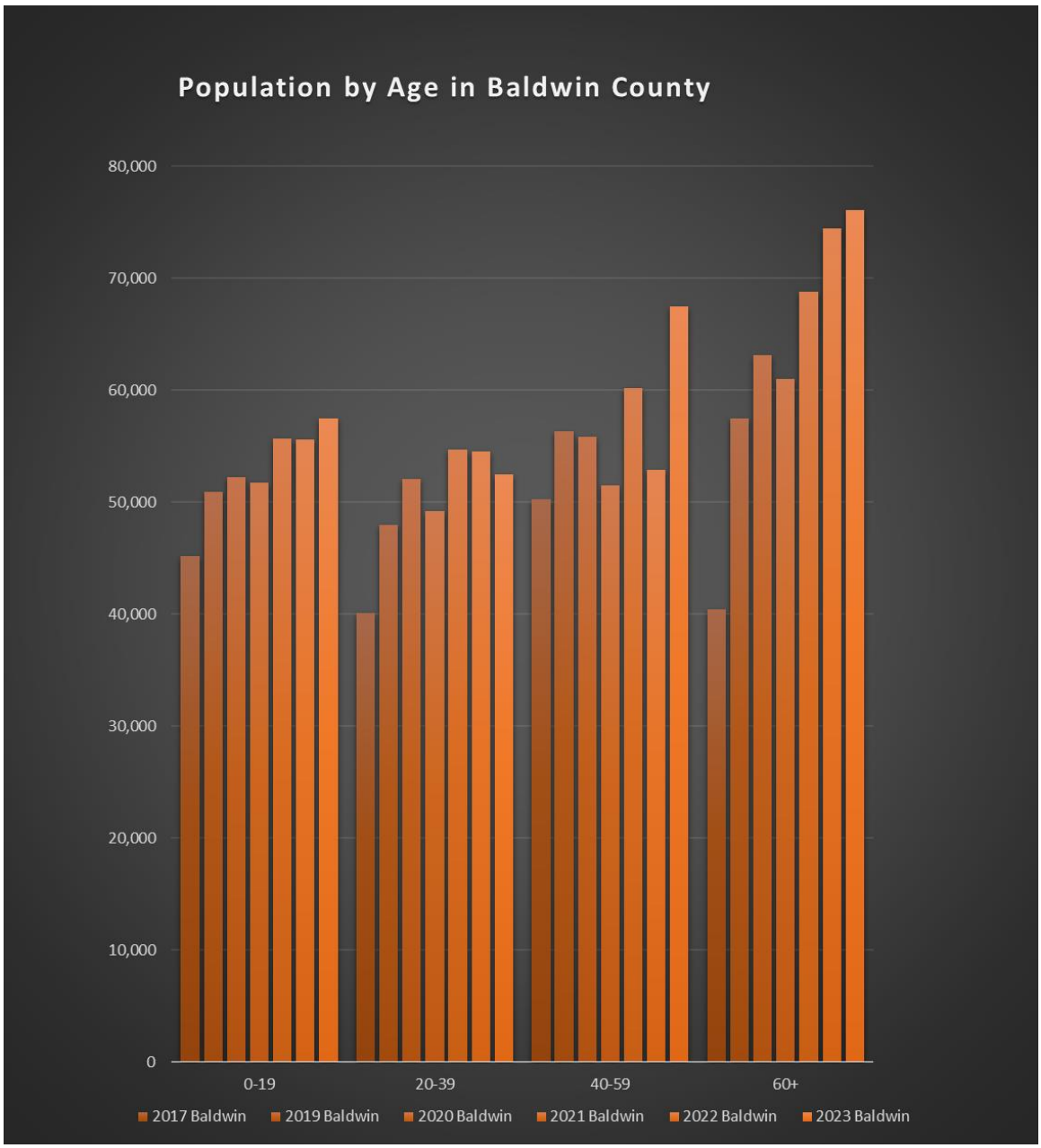
COMMUNITY DEMOGRAPHIC PROFILE – 2

Population by Age and Sex

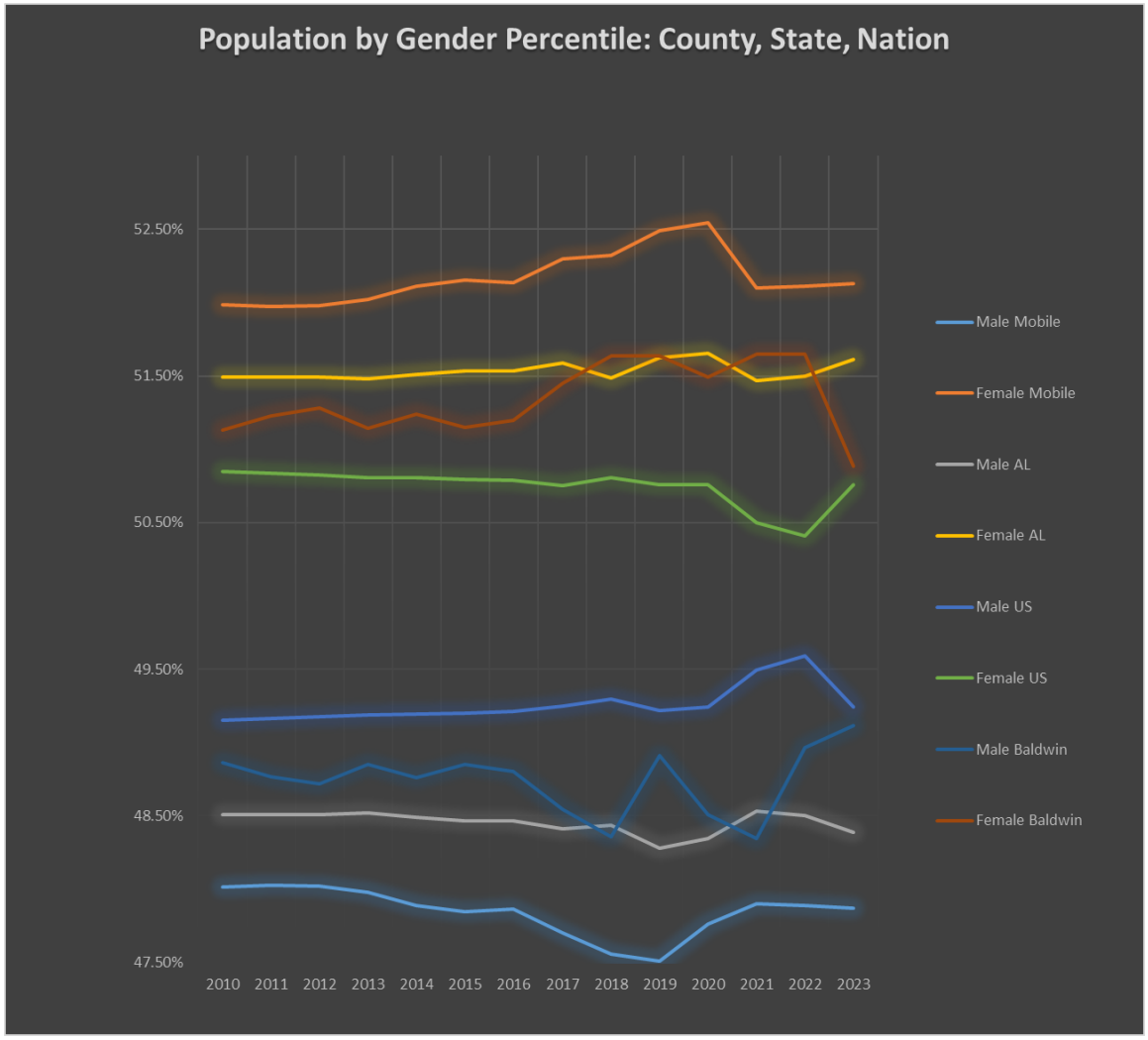
Population is an important characteristic to consider when assessing community needs, as it reflects the potential pool of patients and relative demand of the community. Population data was taken from the U.S Census Bureau. While an official census is only taken every ten years, the Census Bureau provides yearly estimates. According to this source, in 2010 the population of Mobile County was 408,620, but has reached 411,640 by 2023. The relative population growth is bracketed by age below, showing the stability of some groups (0-39) and the decline and growth in others (40-59 and 60+ respectively).



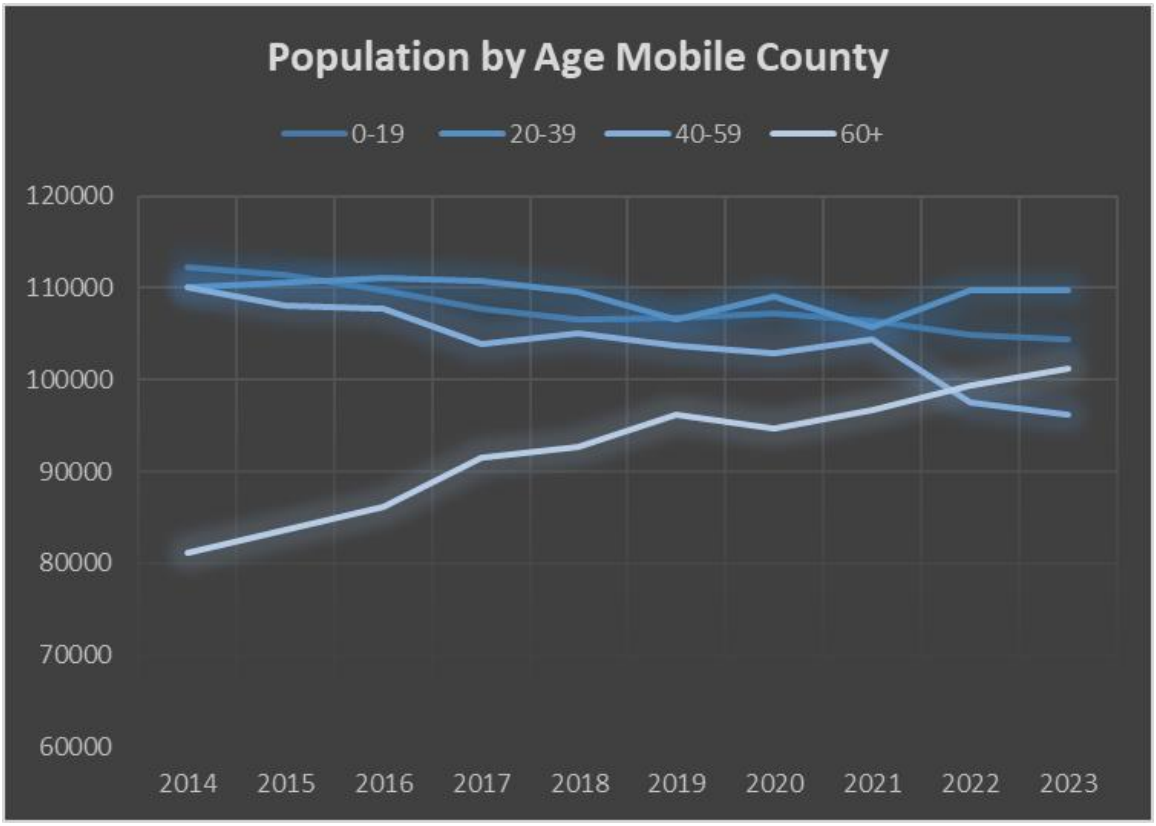
The data provided in the graph below highlights the age distribution and population trends in Baldwin County over this same time period. Between 2017 and 2023, the population has grown most significantly among individuals aged 60 and above, reflecting an aging population in the region. The 40-59 age group shows slight fluctuations, with moderate growth in recent years. Meanwhile, the younger age groups (0-19 and 20-39) have remained relatively stable, indicating consistent family and workforce presence in the county. This demographic composition underscores the growing demand for resources and services tailored to older residents, while also maintaining the needs of younger populations. These trends are critical for planning healthcare, education, and community services to meet the shifting demographic needs of Baldwin County.



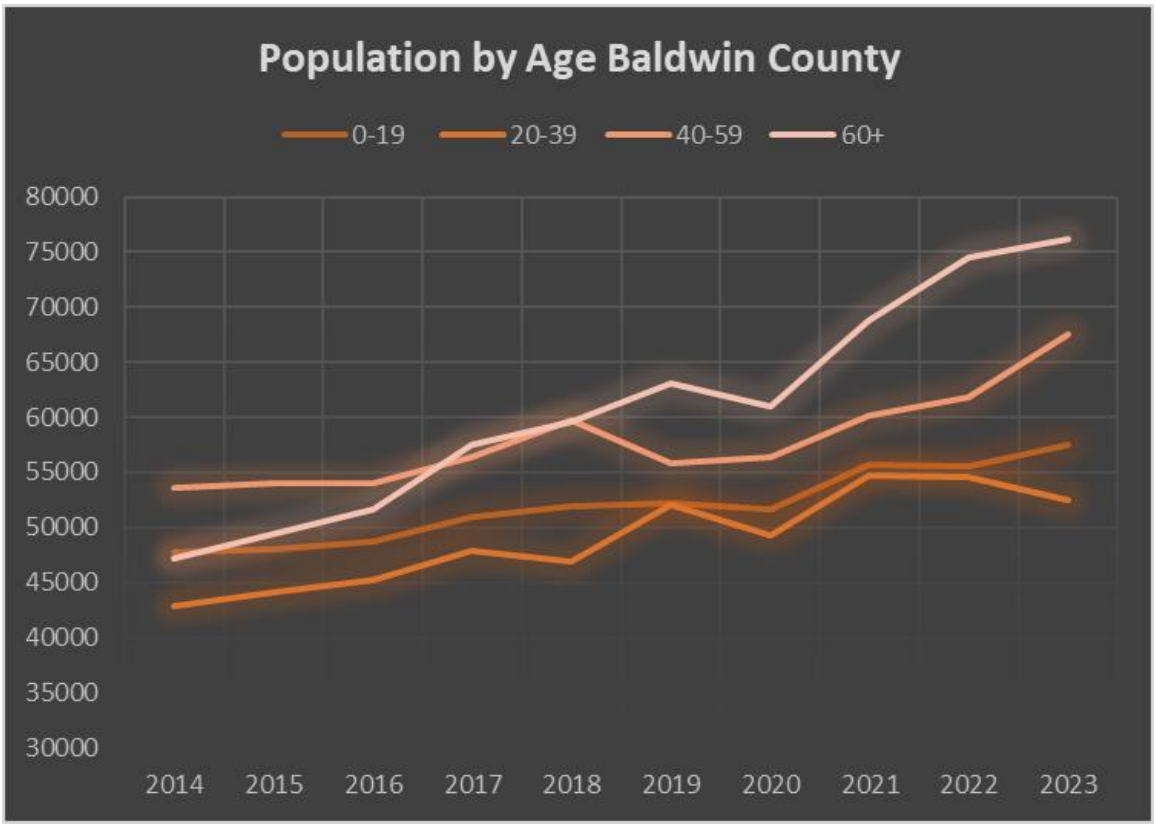
Generally, the distributions by age and sex are similar to statewide and nationwide comparisons. These averages have remained largely stagnant over the time period, with some exceptions. For instance, between 2019 and 2023 Mobile lost approximately 2,315 females while gaining 745 male residents. Some nuances in balance can be seen in the figure below depicting the gender distribution percentages across Mobile County, Baldwin County, Alabama (state level), and the United States (national level) from 2010 to 2023. Consistently, females outnumber males at all geographic levels, with a slight but steady gap between genders. Notably, Baldwin County shows the most balanced gender distribution compared to Mobile County, Alabama, and the national trends, where females maintain a marginally higher percentage. In contrast, Mobile County has a slightly more pronounced difference in favor of females. These patterns reflect broader demographic trends, potentially influenced by factors such as longevity differences between genders and regional population dynamics. Understanding these trends is crucial for tailoring gender-specific policies and resource allocations at the local, state, and national levels.



Another trend worth noting is the rise in elderly residents. As of 2023, Mobile was home to 104,456 residents aged 0-19, 109,733 residents aged 20-39, 96,174 residents aged 40-59, and 101,277 residents aged 60 and over. In comparison to 2010, this makes 60 and over the fastest growing age demographic for the county. In this same time period, there has been a significant loss in the 0-19 age bracket. This is unsurprising given national trends and generational birth rates. The trend can be found below.



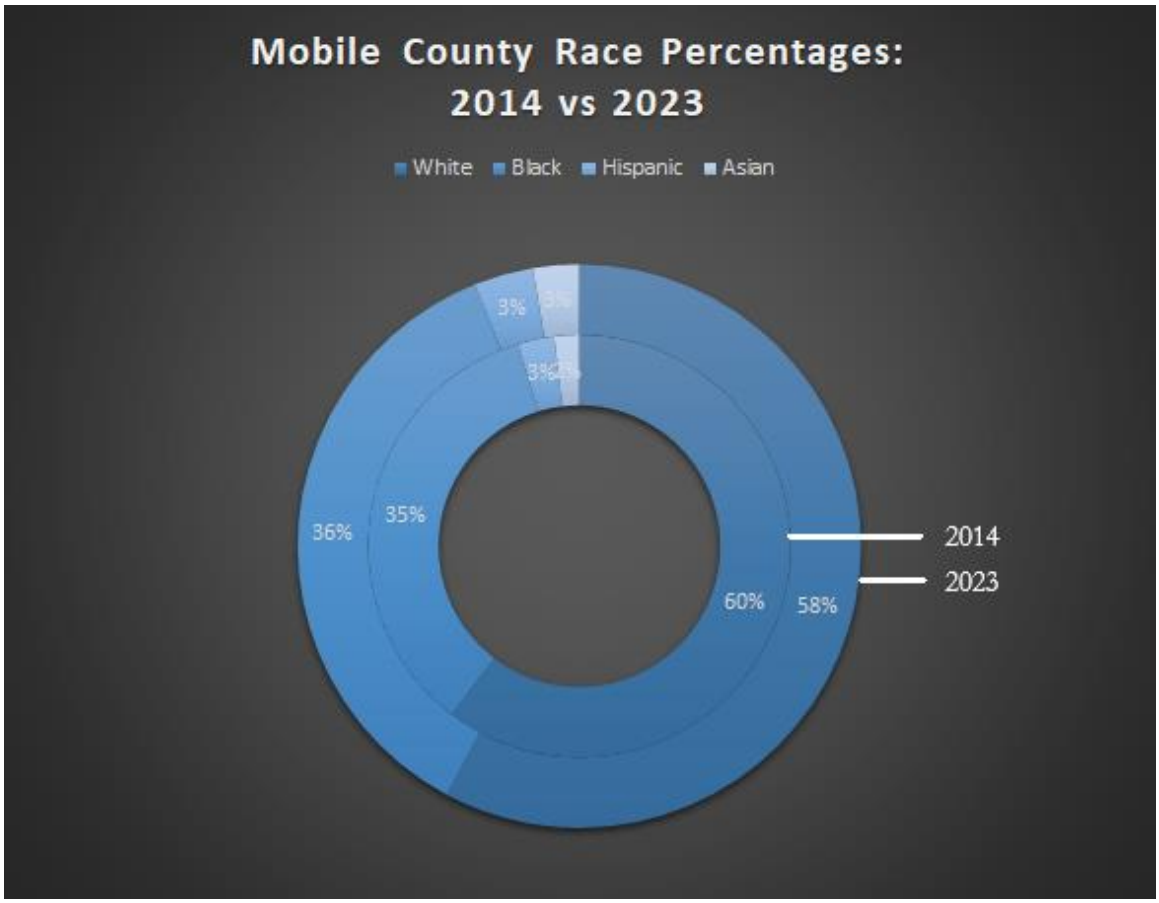
When analyzing the Baldwin County data, it must be noted that the 60+ age group has experienced significant and consistent growth, reflecting an aging population in Baldwin County. The 40-59 age group shows modest growth following a slight decline around 2018, indicating a stable working-age demographic. The 20-39 age group exhibits steady growth, suggesting the presence of younger professionals and families, while the 0-19 age group remains stable, reflecting consistent birth rates and retention of younger residents.

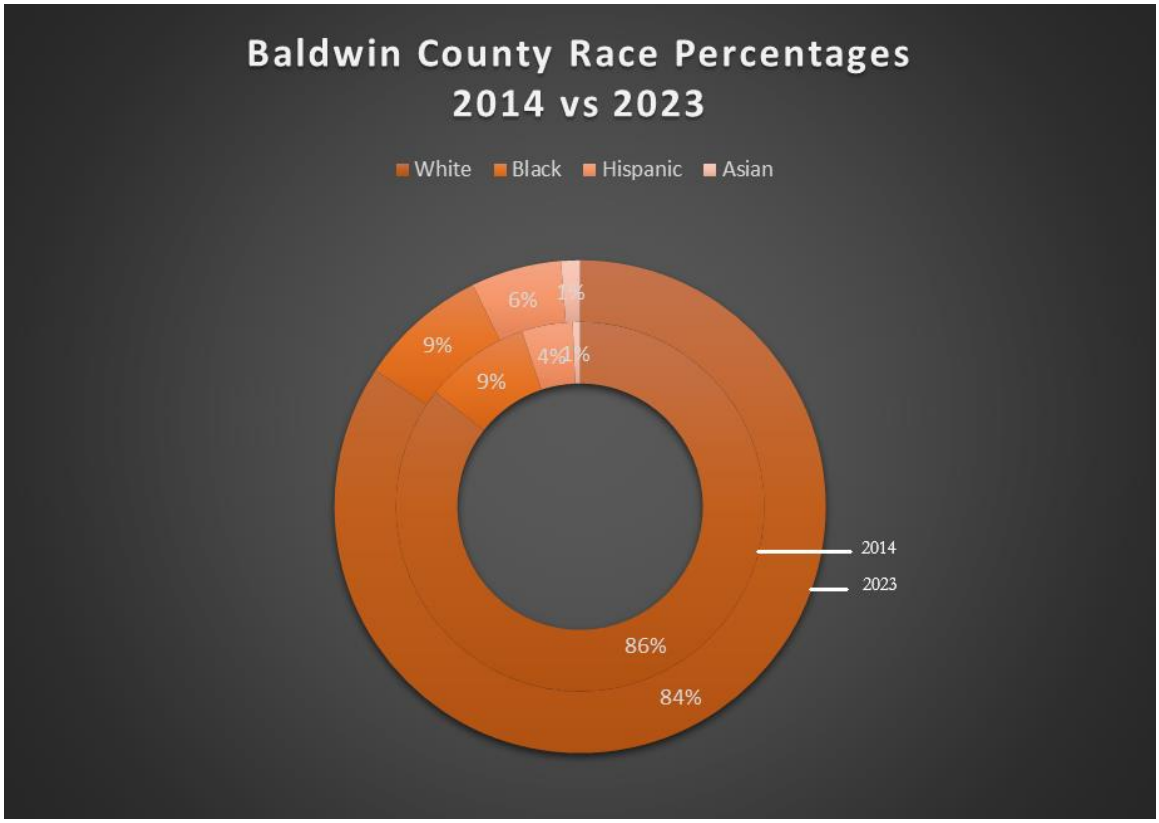


Population by Race and Ethnicity

Race and ethnicity are another important factor to consider when assessing community health. Studies have shown that specific racial groups are more susceptible to certain diseases and conditions. As such, it is important to know the racial makeup of a region in determining the needs of the community in regard to public health. Data was obtained by the U.S Census Bureau in 2010 with estimates through 2023 available. The Census asks individuals to self-identify, with the vast majority of respondents identifying as one race and ethnicity.

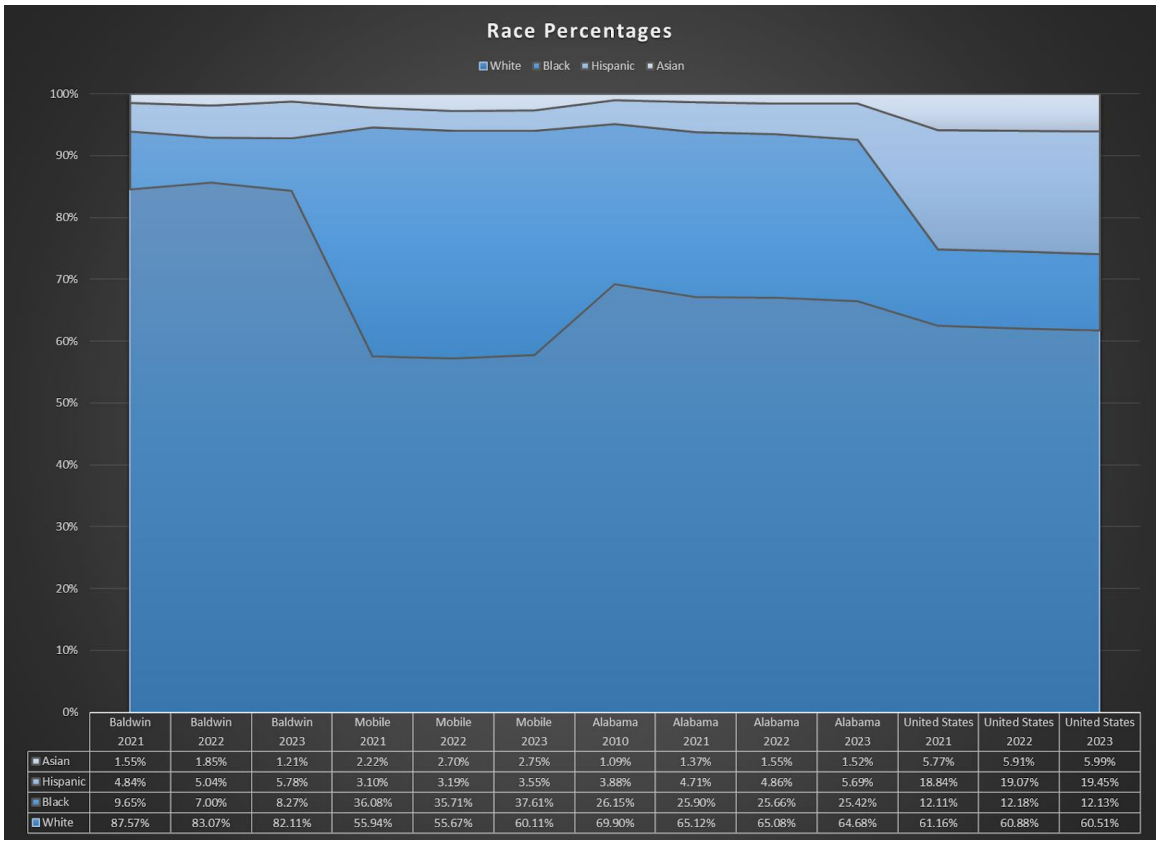
The two most predominant races in Mobile are White, with 247,420 residents in 2023, and Black, with 154,805 residents in 2023. Hispanic is the largest listed ethnicity with 14,595 residents in 2023, while the fourth largest demographic is Asian, with 11,340 residents. In Baldwin County, the demographic composition similarly highlights a majority White population, with 208,150 residents (82.11%) in 2023. Black residents account for 20,974 (8.27%) of the population, while Hispanics, as the largest ethnicity, represent 14,658 residents (5.78%). Asians make up a smaller demographic in Baldwin County, with 3,074 residents (1.21%). The population data for Baldwin County shows growth across all groups from 2021 to 2023, with significant changes in the Hispanic and Black populations. The demographic breakdowns for both counties in 2014 and 2023 are provided below.


Mobile County Race Percentages:
2014 vs 2023
White
Black
Hispanic
Asian
3%
3%
36%
35%
60%
58%
2014
2023



Baldwin and Mobile counties exhibit notable differences in their racial and ethnic compositions. Baldwin County remains predominantly White, with 82.11% of its population identifying as White in 2023. Black residents make up 8.27%, while Hispanic and Asian populations account for 5.78% and 1.21%, respectively. Compared to state and national averages, Baldwin County has a significantly higher proportion of White residents but lower diversity, particularly among Black, Hispanic, and Asian populations.

Mobile County presents a much more diverse racial and ethnic composition compared to Baldwin County and even the state of Alabama as a whole. In 2023, Mobile's population is 55.67% White, significantly lower than Baldwin County's 82.11% and Alabama's 64.68%. The Black population in Mobile stands at 35.71%, a stark contrast to Baldwin's 8.27% and much higher than Alabama's state average of 25.66%. Mobile also has a slightly higher percentage of Asian residents (2.70%) compared to Baldwin (1.21%) and Alabama (1.55%). However, its Hispanic population, at 3.55%, is notably lower than the national average of 19.45% but similar to Alabama's 5.69%. When compared to Alabama as a whole, Baldwin County has +17.43% Whites, -17.15% Blacks, -0.09% Hispanics, and -4.78% Asians. Relative to national averages, Baldwin County exhibits +21.6% Whites, -3.86% Blacks, -13.67% Hispanics, and -4.78% Asians. These disparities highlight Baldwin County's less diverse population and reflect regional variations in racial and ethnic demographics. These contrasts emphasize Baldwin County's more homogeneous and suburban profile versus Mobile County's urban and diverse demographic makeup. These differences underscore the need for tailored resources to meet the distinct needs of these neighboring counties. These trends can be observed below.



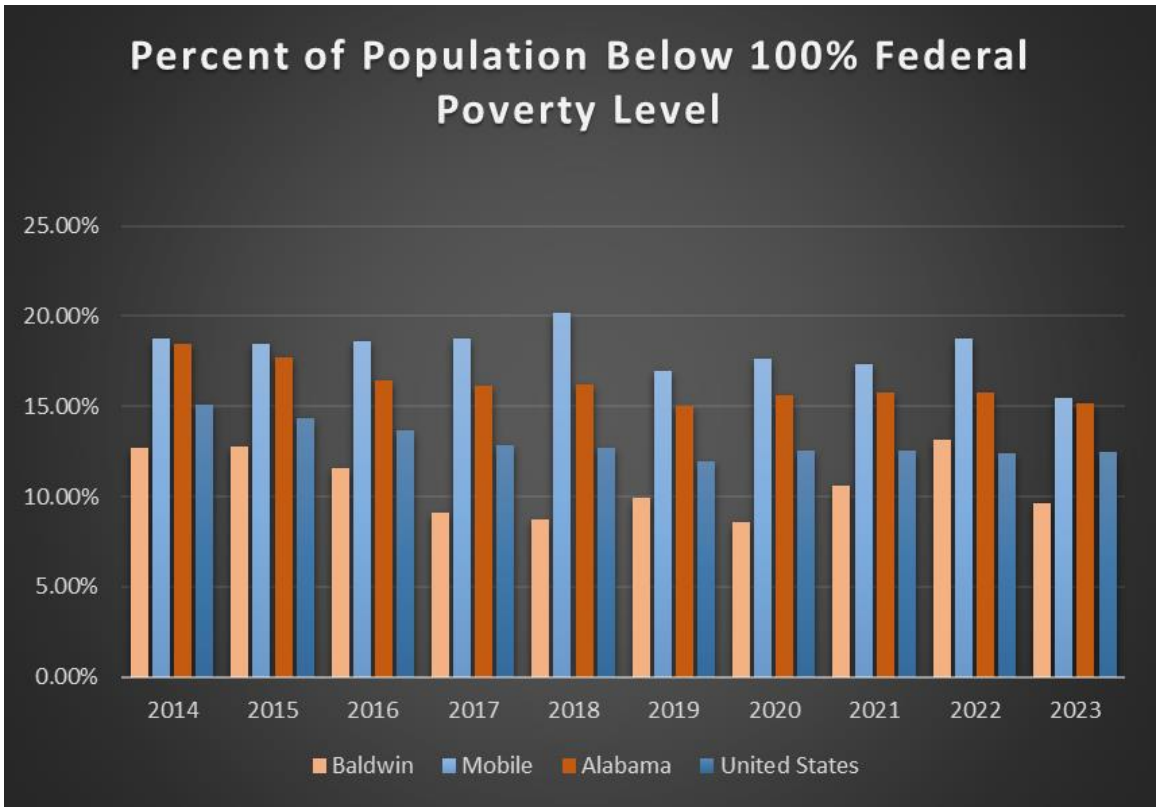
	Baldwin 2021	Baldwin 2022	Baldwin 2023	Mobile 2021	Mobile 2022	Mobile 2023	Alabama 2010	Alabama 2021	Alabama 2022	Alabama 2023	United States 2021	United States 2022	United States 2023
Asian	1.55%	1.85%	1.21%	2.22%	2.70%	2.75%	1.09%	1.37%	1.55%	1.52%	5.77%	5.91%	5.99%
Hispanic	4.84%	5.04%	5.78%	3.10%	3.19%	3.55%	3.88%	4.71%	4.86%	5.69%	18.84%	19.07%	19.45%
Black	9.65%	7.00%	8.27%	36.08%	35.71%	37.61%	26.15%	25.90%	25.66%	25.42%	12.11%	12.18%	12.13%
White	87.57%	83.07%	82.11%	55.94%	55.67%	60.11%	69.90%	65.12%	65.08%	64.68%	61.16%	60.88%	60.51%

Poverty

Socio-economic status is an extremely important indicator of community need, especially in regard to health. Studies have consistently demonstrated a link between wealth, poverty, and individual health. Adults in poverty are more likely to experience poor health, neglect routine doctor visits, utilize emergency services as primary care, fail to possess health insurance, and die at a younger age. Additionally, these ramifications extend to children as children in poverty are more likely to experience poor physical and mental health as well as, experience cognitive impairments. The impacts extend beyond health, and studies have shown that poverty increases the likelihood of school failure and teen pregnancy. Finally, it should be noted that poverty rates are often tied to race and ethnic identification. Previous community health needs assessments have identified the disparity between poverty rates among white and black children, indicating that poverty rates among black children are three times the rate of non-Hispanic whites nationally. These estimates have not changed significantly over the past four years.

Each year the federal government measures regional poverty using the Federal Poverty Level -- a metric based upon a dollar amount for single person and family income. In 2023 the

FPL for a single person household was $14,580, up $2,090 from $12,490 in 2019. For a family of four the FPL was $30,000 in 2023. Reported in the figure below are the Mobile and Baldwin County, Alabama, and United States estimates for the percentage of residents living at or below 100% of the FPL for the years 2014 to 2023.

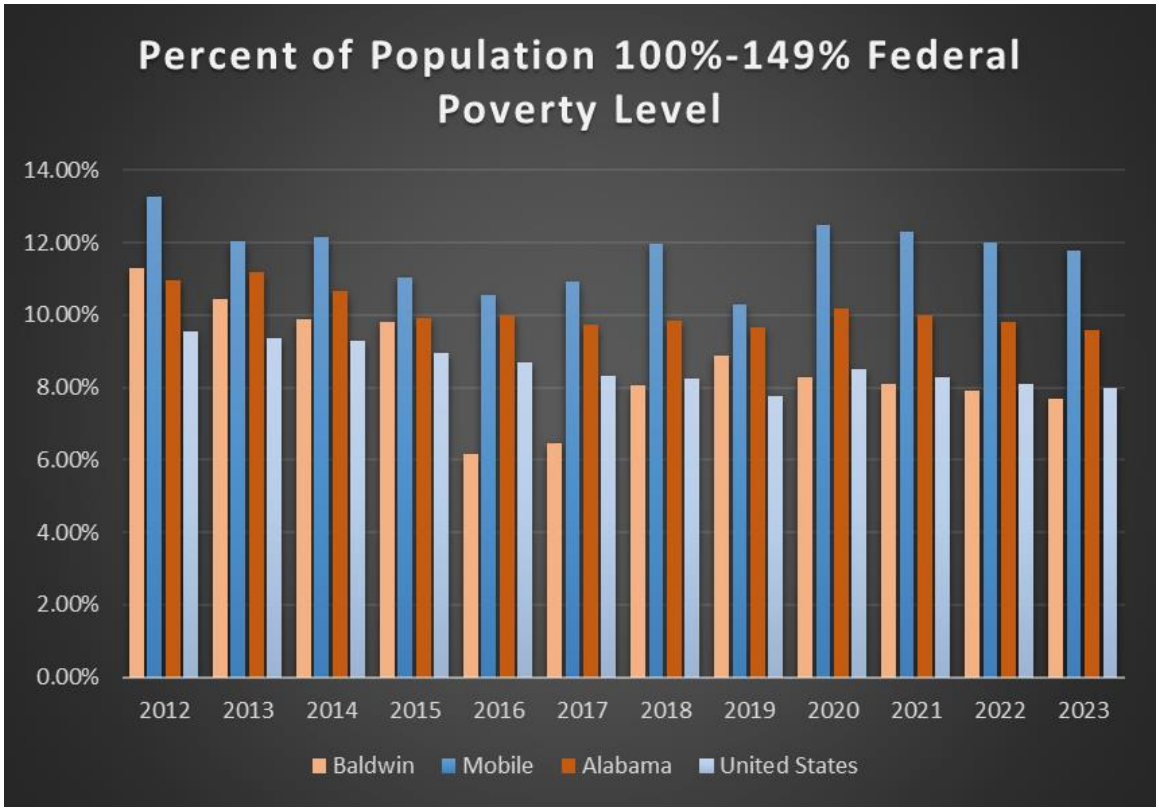


As can be observed, Mobile County consistently exhibits the highest poverty rates, surpassing both the state of Alabama and the national average, reflecting significant economic challenges in the area. In contrast, Baldwin County maintains the lowest poverty rates throughout the time series, consistently falling below both the state and national averages, indicating relatively stronger economic conditions. The state of Alabama's poverty rates remain higher than the national average but generally below Mobile County's, while the United States shows the most stable and consistently lower poverty levels compared to the other regions.

While the gap between Mobile County and Alabama appears to diminish in 2014 and 2023, this is not due to shrinking numbers of residents in Mobile County under the FPL, but rather a worsened state for the entirety of Alabama. Oftentimes, it has been shown that individuals up to 150% and even 200% FPL have difficulty meeting basic needs related to health care, such as food, housing, and transportation. As such, the profile for percent population between 100 - 149% FPL has also been provided below.

From 2020 to 2023, Mobile County consistently had the highest percentage of individuals in the 100-149% FPL category compared to Baldwin County, Alabama, and the United States, despite a gradual decline in this percentage. Baldwin County maintained the lowest levels in

this category, reflecting relatively better economic conditions. Alabama's state-level rates were higher than the national average but consistently below Mobile County's rates. The United States exhibited the most stable and lowest percentages in this income bracket, highlighting the persistent economic challenges within the state and region. For reference, individuals qualify for the Supplemental Nutrition Assistance Program (SNAP) at 130% of the FPL or lower, emphasizing the importance of this income threshold in determining access to basic needs."



Education

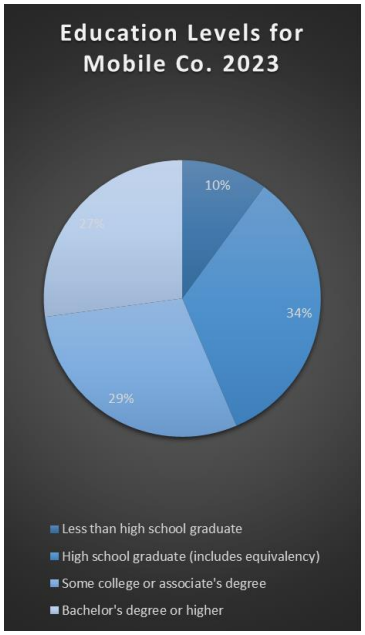
While education is known to increase the likelihood of higher income, and thus influence health in an indirect manner, education also has been tied directly to health benefits in communities. Research has shown that those with higher educational attainment are more likely to have longer lives and healthier lifestyles. For instance, the Robert Wood Johnson Foundation found that the average lifespan for females is increased by approximately 5 years (78.4 years for less than high school degree and 83.5 years for college graduates) and by nearly 7 years for males (72.9 years for less than high school degree and 79.7 years for college graduates) on average. Additionally, education has been tied to reduced health risk in a range of areas:

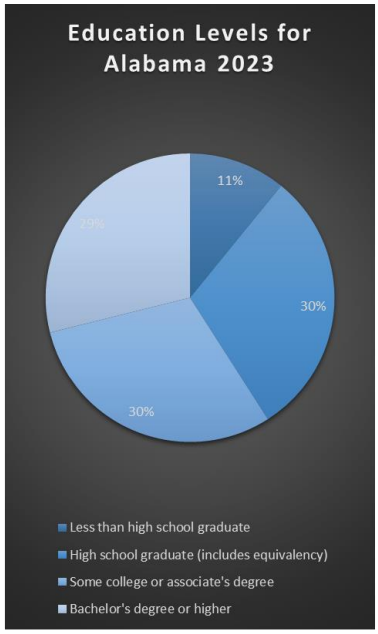
An additional four years of education lead to on average:

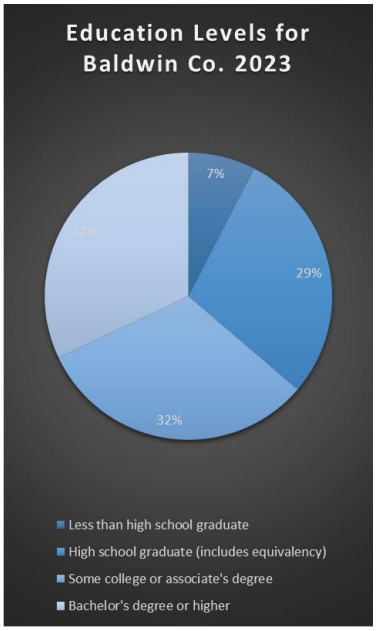
- 1.3% reduction in diabetes
- 2.2% reduction in heart disease
- 5% reduction in being overweight
- 12% reduction in smoking

The impact of education often extends to a child's health as well. For instance, a mother with 0-11 years of education is nearly twice as likely than mothers with 16 or more years of education to experience infant mortality (8.1 versus 4.2 mortality rate in 2010). Additionally, studies have shown that healthier children tend to perform better in school and other collegiate activities.

Below are 2023 pie charts of Mobile County, Baldwin County, and Alabama education levels as a whole for adults 25 and older. Mobile County and Alabama are comparative across all education levels.





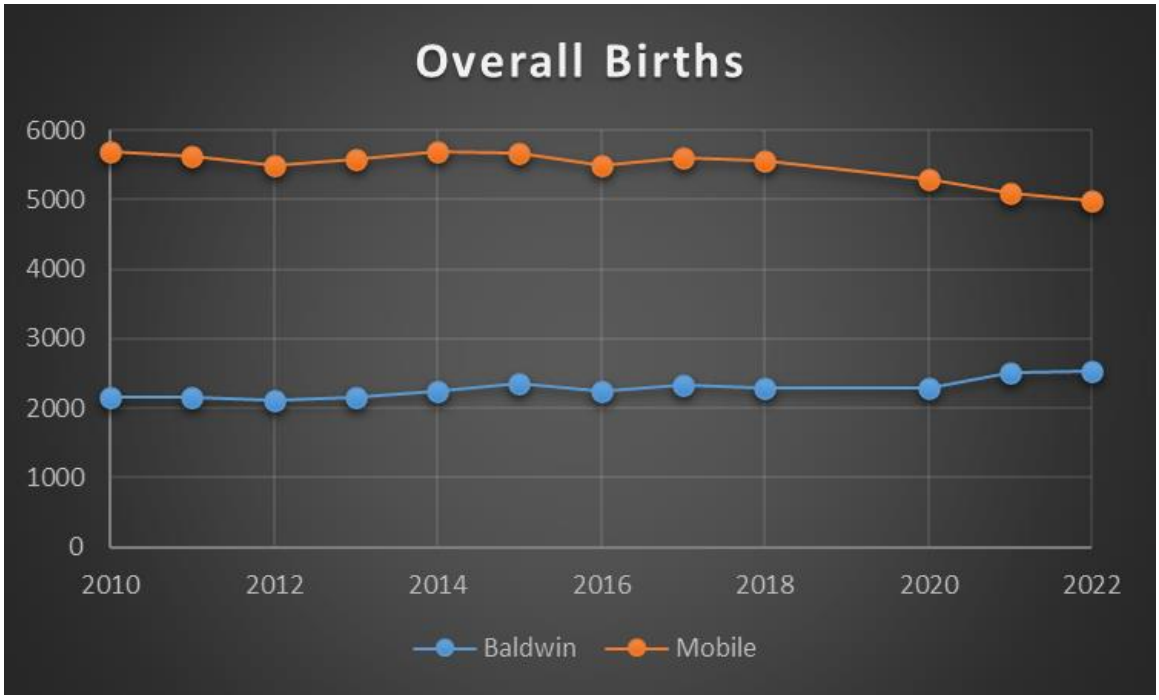


One of the most striking gaps, for both Mobile County and the state of Alabama compared to the nation, is post high school education. While Mobile County and the state have increased the proportion of high school graduates in recent decades, they continue to fall behind in those obtaining bachelors and graduate or professional degrees. In 2023 the resident breakdown was 94,382 high school graduates, 82,308 with some college (associate's degree or no degree) followed by 76,295 with a bachelor's degree or higher and 28,257 residents with less than a high school degree in Mobile County. For Baldwin County, in 2023, 53,077 residents had a high school diploma or equivalent, 58,577 had some college experience (associate's degree or no degree), 59,243 had a bachelor's degree or higher, and 13,975 had less than a high school diploma.

Births

Previous community health needs assessments have identified the decline in both crude birth rates and fertility rates within Alabama since the 1950s. This decline extended to Mobile County, with data from 2007 to 2011 showing a significant decrease (645 fewer births between the two comparative years). Data collected from 2010 to 2022 further indicates a consistent decline in births in Mobile County. For example, in 2018, there were 5,548 births in Mobile County, but this number dropped to 4,995 in 2022.

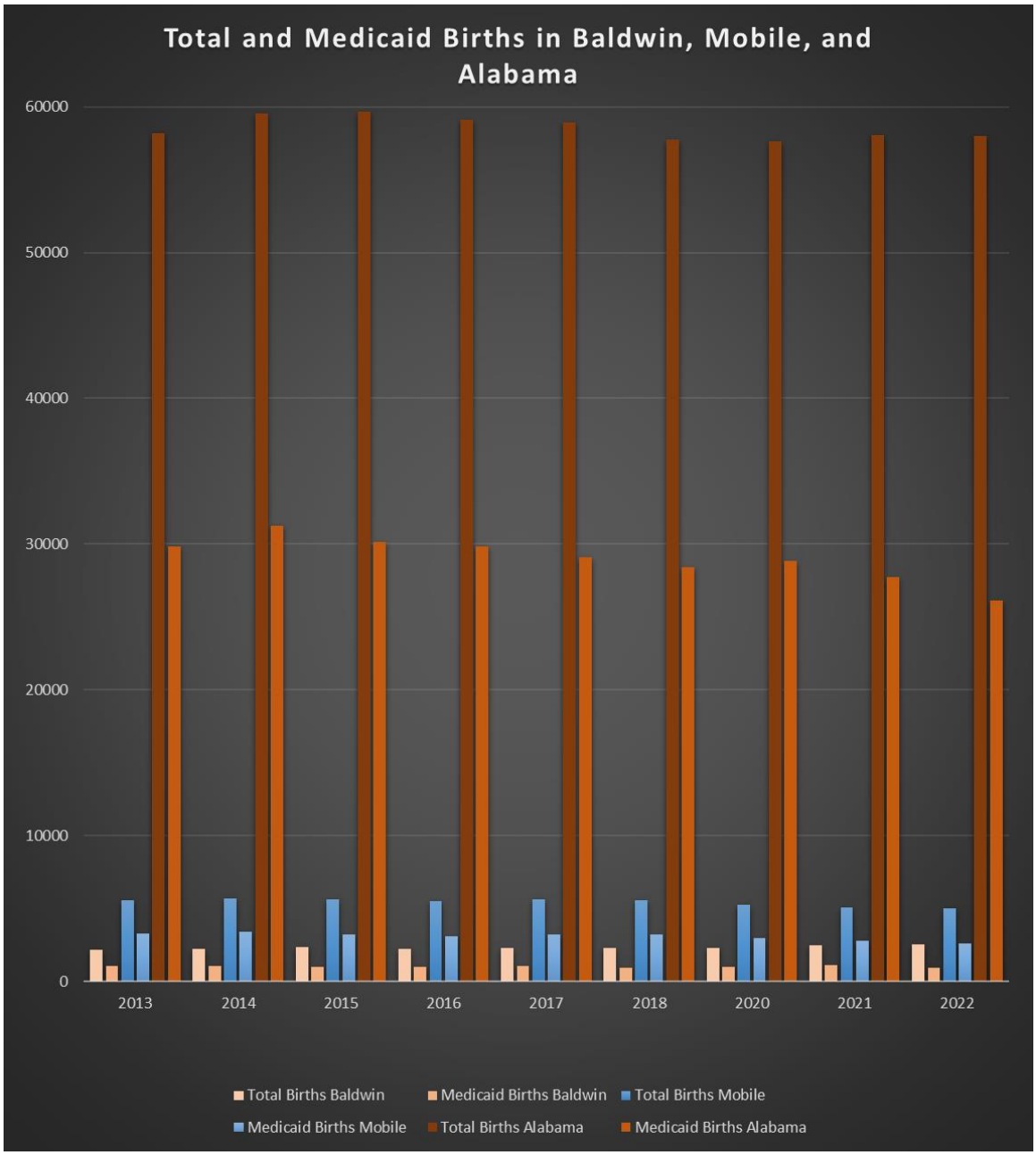
In contrast, Baldwin County has shown an upward trend in the number of births over the same period. Births in Baldwin County increased from 2,290 in 2018 to 2,525 in 2022, indicating a growing population in the area. This divergence highlights differing demographic and population dynamics between the two counties, with Mobile County facing a steady decline in births while Baldwin County experiences growth.



The State of Alabama has experienced a rather steady level of annual births, with 57,754 births in 2018 and 58,033 births in 2022, with the total number of births fluctuating in either direction between those years.

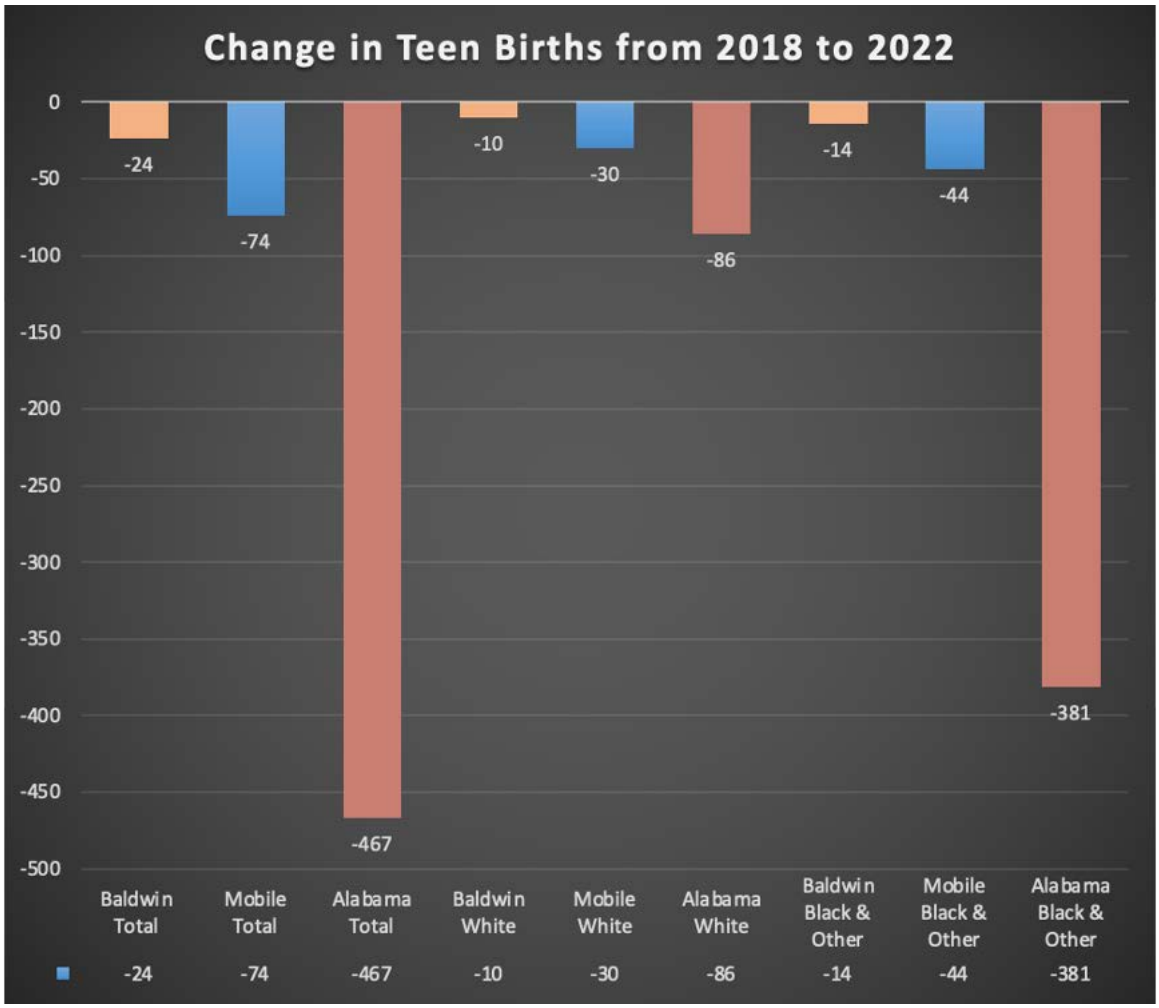
Another useful trend to observe for health outcomes is Medicaid supported births. The data presented below demonstrate the essential role Medicaid plays in supporting maternal care across Alabama, particularly in Mobile County, where reliance on public assistance is higher. The diverging trends between Baldwin and Mobile counties highlight disparities in economic conditions and population growth within the region. Baldwin County's growth in total births and its lower dependence on Medicaid suggest a more stable and affluent demographic,

while Mobile County continues to face economic challenges reflected in its higher proportion of Medicaid-supported births and declining total births. These trends emphasize the need for targeted public health policies and interventions to address disparities in maternal care and support across the state.



Births to Select Groups: Teens and Unwed Mothers

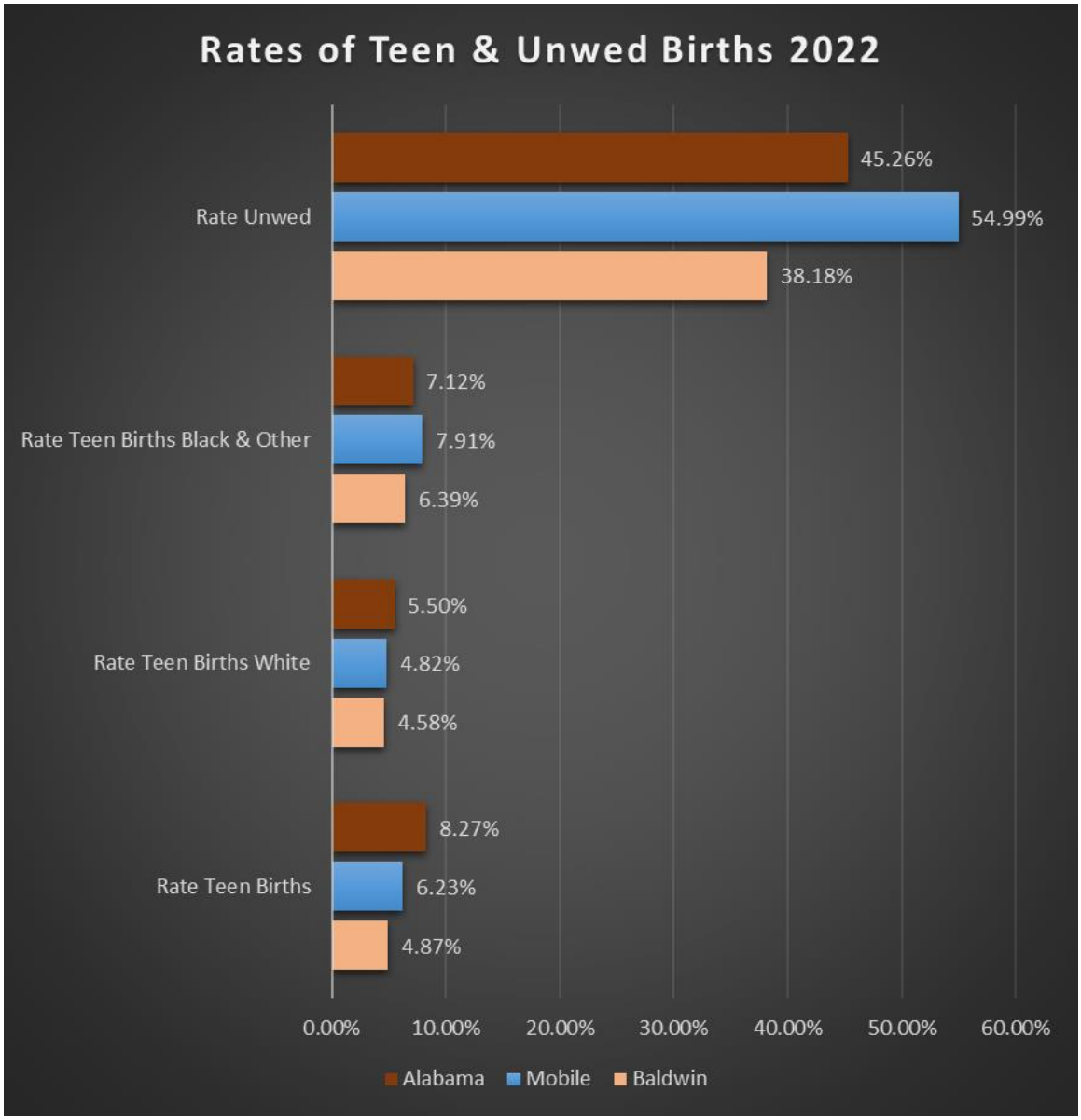
Teenage pregnancy has been a social concern since the 1960s due to the long-term negative effects for both mother and child. Research indicates that teenage pregnancy rates rose significantly between the 1950s and the 1970s, peaking at nearly 19% of births in 1975. However, teenage birth rates have been on a consistent decline over the past several decades. According to the Centers for Disease Control and Prevention (CDC), the national teenage birth rate was 15.4 per 1,000 females aged 15–19 in 2022, marking a continued decline from previous years. This pattern of decline is reflected in Mobile and Baldwin counties, as well as the State of Alabama, though Alabama's overall rates remain higher than the national average. The figure below illustrates the decline in teenage births across Alabama, Mobile County, and Baldwin County over a five-year period (2018 to 2022).



While teenage birth rates have declined significantly over the past few decades, Alabama continues to have higher rates compared to the national average. As of 2022, Alabama's teen birth rate was 20.9 births per 1,000 females aged 15–19, ranking it seventh among states with the highest teen birth rates.

This trend is consistent across much of the south-central region of the United States, where several states report elevated teenage birth rates compared to other regions. Factors contributing to these higher rates in Alabama and neighboring states may include limited access to comprehensive sex education, socioeconomic challenges, and cultural influences. Despite the overall decline in teen births, the persistent regional disparities highlight the need for targeted public health interventions to address the specific needs of adolescents in these areas.

Unsurprisingly, data also shows that most teenage pregnancies are unwed births. According to the Department of Health and Human Services, 89% of teen births in 2014 occurred outside of marriage, a trend that persists a decade later. There also appears to be racial and ethnic differences in birth rates. Nationally, birth rates are highest among Hispanic or black teens. The figure below compares Mobile County to Alabama as a whole for birth rates to teens and unwed mothers for the year 2022.



As shown in the data, both Mobile and Baldwin counties have teen birth rates below the state average of 8.27%. Mobile County's teen birth rate stands at 6.23%, while Baldwin County's rate is even lower at 4.87%. Among racial groups, both counties exhibit higher rates of teen births in the Black & Other population compared to the White population. For example, Mobile County reports a teen birth rate of 7.91% for Black & Other teens, compared to 4.82% for White teens. Similarly, Baldwin County's rates are 6.39% for Black & Other teens and 4.58% for White teens.

When examining births to unwed mothers, Mobile County is significantly above both Baldwin County and the state average. In Mobile County, 54.99% of all births (across all age groups) are to unwed mothers, surpassing the state average of 45.26%. Baldwin County, in contrast, has a significantly lower rate of unwed births at 38.18%, reflecting differing socioeconomic and demographic dynamics between the counties and the state as a whole.

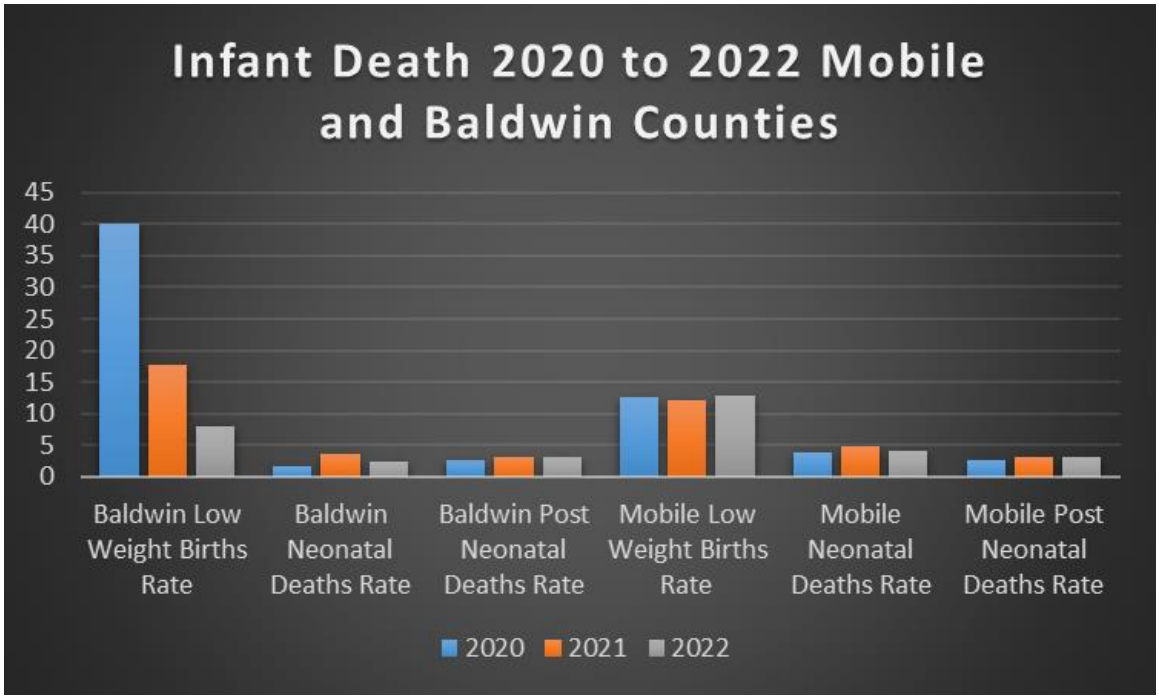
Birth Complications and Infant Mortality

Given Mobile County's declining population in the 0-19 age bracket and the reduction in birth rates following the recession and COVID-19 pandemic, it remains critical to explore the community health needs of pregnant mothers and infants. The updated data from 2020 to 2022 highlights several important trends in infant health for Mobile and Baldwin counties.

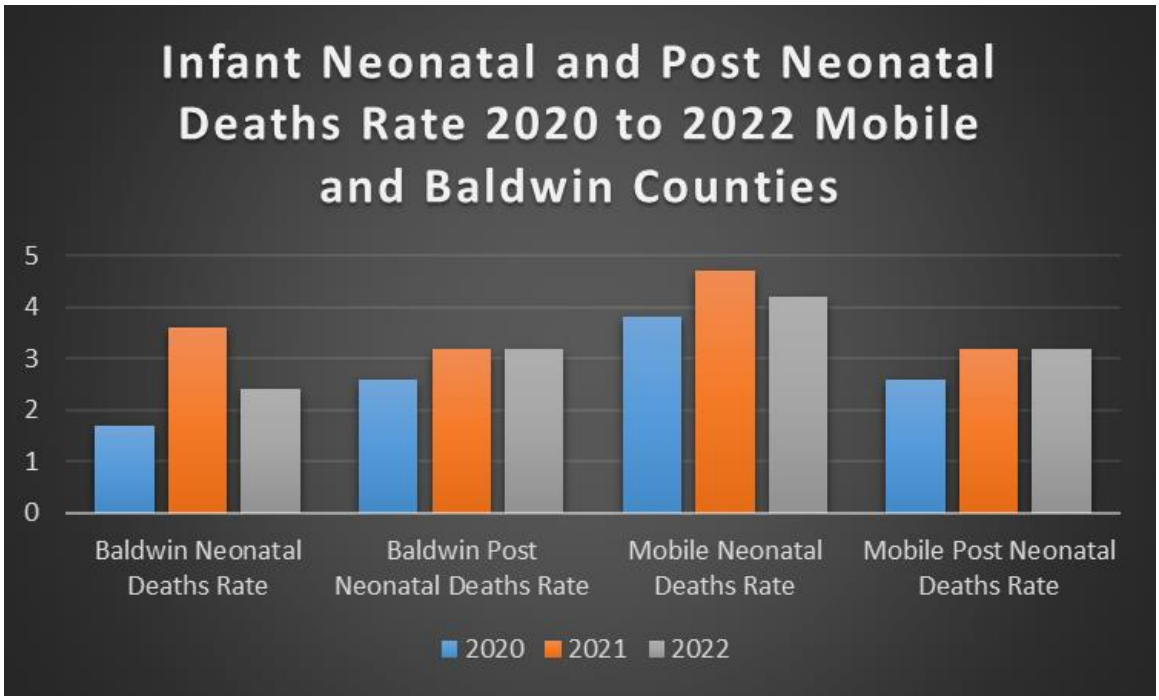
Low birth weight continues to be a consistent challenge for Mobile County, with rates remaining relatively stable over the past three years (2020-2022). In 2022, the low-birth-weight rate in Mobile County remained high compared to Baldwin County, which experienced a notable decline from its peak in 2020. These trends align with Alabama's historically high rates of low birth weight, with the state ranking third nationally in 2019 at 10.5%. Within Alabama it is seen that white infants contribute 69.8% in births and only reflect 44.5% in deaths. Black infants on the other hand account for a mere 28% in births yet a larger 51.4% in deaths.

Neonatal death rates in Mobile County have shown some fluctuation but have remained a significant concern. While Baldwin County's neonatal death rates have stayed consistently lower, Mobile County experienced a slight decline from 2020 to 2022. Post-neonatal death rates in both counties have remained low and relatively stable during the same period, reflecting improvements in postnatal care.

This updated data underscores the importance of addressing low birth weight and neonatal mortality in Mobile County, where rates remain higher than Baldwin County and reflect broader state and national challenges. Focused interventions to support maternal and infant health, especially among vulnerable populations, are necessary to improve outcomes and reduce disparities.



Unfortunately, the problems facing mothers and births in the community go beyond pregnancy complications. Mobile County has had inconsistent infant death rates over the past eight years. In 2010, the infant death rate for Mobile County was 7.5; by 2018, that rate rose to 9.0, with sudden shifts in between. For blacks, that rate is even higher, moving from 11.5 in 2010 to 12.1 in 2018. These trends are presented below.



These disparities remain when examining neonatal and post-neonatal death rates in Mobile and Baldwin counties from 2020 to 2022. Neonatal death rates in Mobile County remained consistently higher than those in Baldwin County, with a peak in 2021 followed by a slight decline in 2022. In contrast, Baldwin County saw an increase in neonatal death rates in 2021 before returning to lower levels in 2022. Post-neonatal death rates in both counties remained relatively stable during this period, though Mobile County consistently reported slightly higher rates compared to Baldwin County.

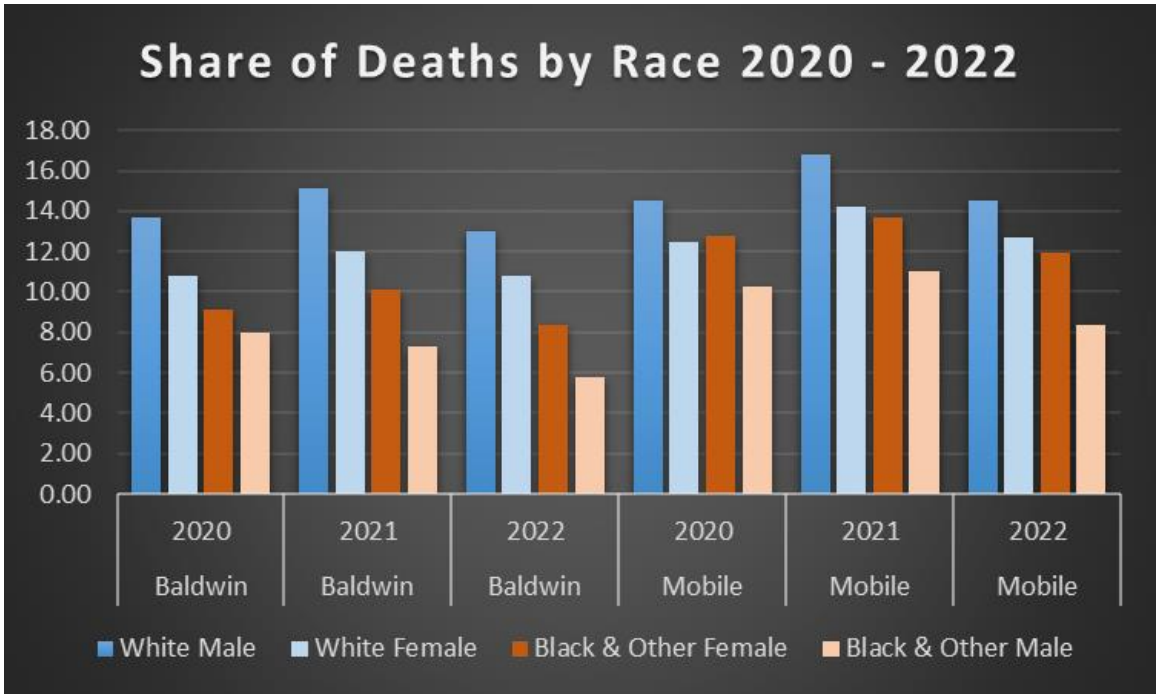
Deaths

Death rates within Mobile County have remained relatively consistent over the past three years, though there has been a slight increase since the last community health needs assessment. Rates differ significantly across sex and race, with White males consistently having the highest rates in both Mobile and Baldwin counties. In 2022, the death rate for White males was 14.5 in Mobile County and 13 in Baldwin County. Conversely, Black females had the lowest death rates, with 8 in Baldwin County and 8.4 in Mobile County in 2022.

These patterns have remained consistent over the three-year period from 2020 to 2022, though trends vary across specific groups. For example, the death rates for Black & Other

females fluctuated over the years, rising in 2020 and then decreasing in both counties in subsequent years. Black & Other males exhibited a more complex trend, with rates rising in Mobile County in 2021 before falling in 2022, while Baldwin County experienced a consistent decline in this group over the three years.

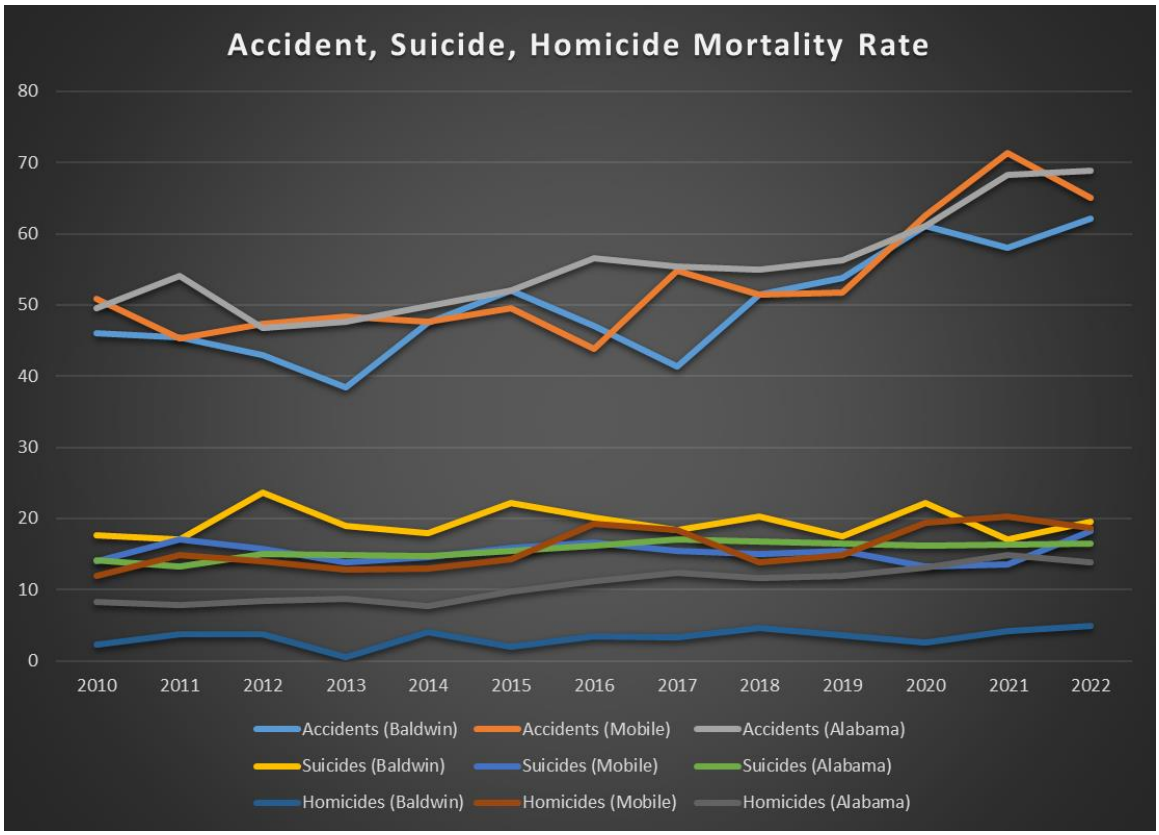
These data underscore the importance of considering both racial and gender differences in addressing health disparities and mortality trends within the region.



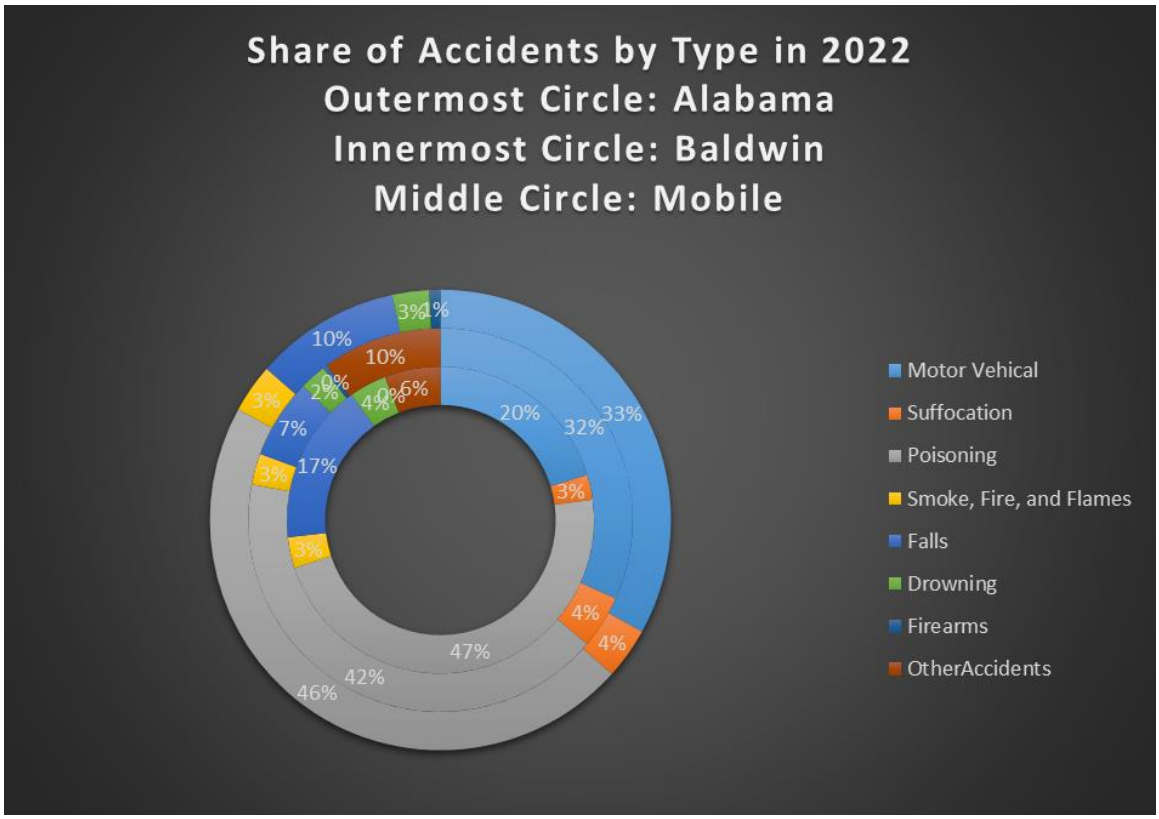
The state of Alabama consistently tracks deaths by type, categorizing them as accidents, suicides, and homicides. Among these, accidents are consistently the leading cause of death across all locations, reflecting a persistent statewide issue. This trend holds true for Mobile and Baldwin counties, though Baldwin County generally records lower rates of accidental deaths compared to Mobile County and the state as a whole. At the state level, accidents rank as the most frequent cause of death, followed by suicides, with homicides showing the lowest frequency among the three categories. This statewide pattern highlights the need for focused interventions to address preventable deaths, particularly in accidents, which remain the leading cause.

In Mobile and Baldwin County, the homicide rate and that of suicides have increased. Over a three-year depicted table (2020-2022), Mobile County's homicide rate was, on average, 18.0 deaths per 100,000 higher than the state average. Meanwhile, the suicide rate was only 13.0 deaths per 100,000. For Baldwin County, the Homicide rate averaged around 4.0 deaths per 100,000 while the suicide average sat much higher at 18.0 deaths per 100,000. This suggests that both Baldwin County as well as Mobile County face unique challenges related to violence and public safety, requiring targeted resources and interventions. By contrast, Baldwin County shows a much lower frequency of homicides compared to suicides and

accidents, reflecting differing socioeconomic and demographic dynamics that influence the prevalence of these causes of death.



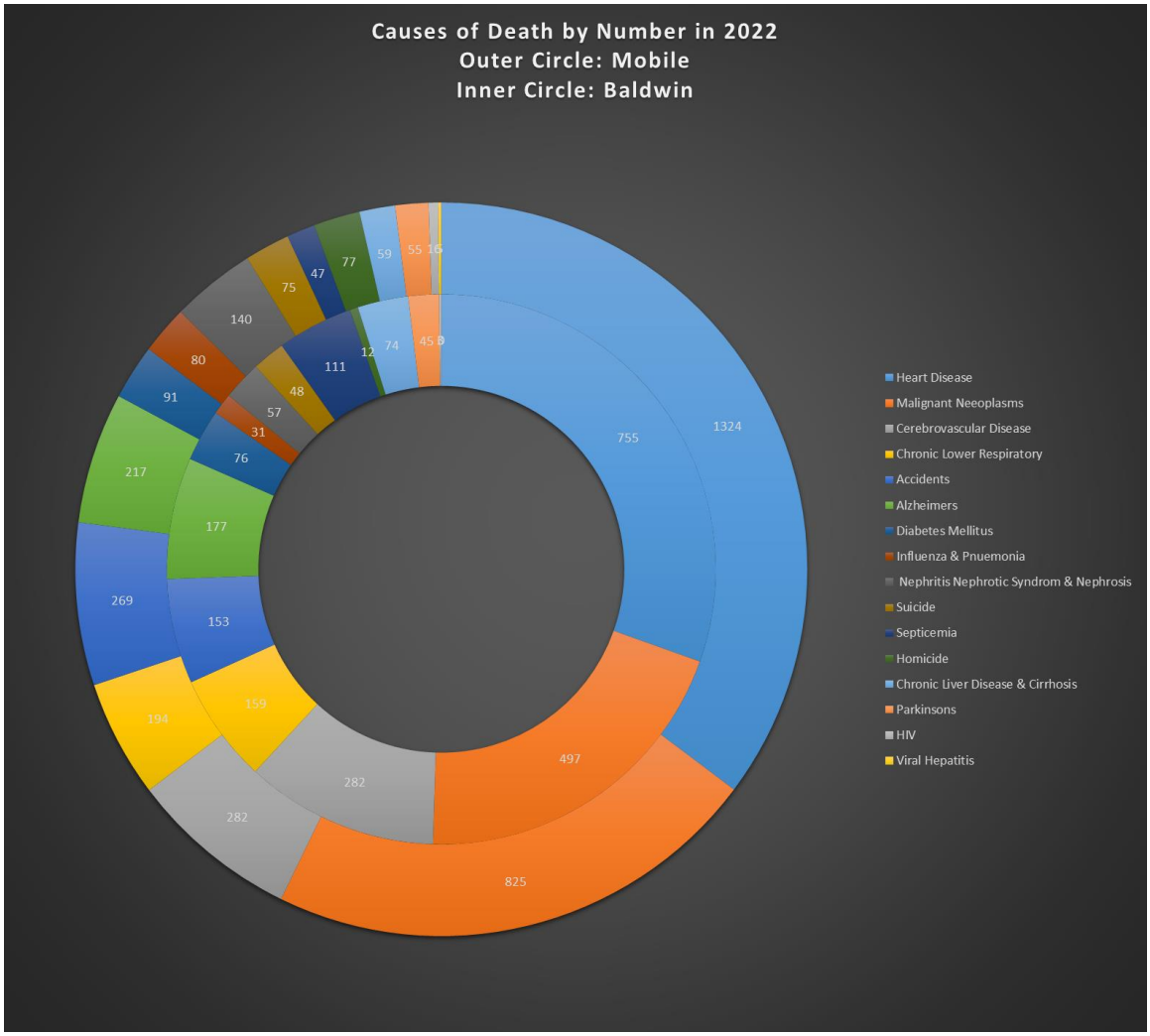
Since accidents are consistently the highest cause of death for both Mobile County, Baldwin County and the State of Alabama, it is important to note these types of accidents that increase mortality.



In 2022, the top three specific causes of accidental death in both Mobile County and Alabama were motor vehicle accidents, poisoning, and falls. Motor vehicle accidents accounted for the largest share of accidental deaths, representing 33% in Mobile County, 32% in Baldwin County, and 46% statewide. Poisoning ranked second, accounting for 20% of accidental deaths in Mobile County, 17% in Baldwin County, and 10% across Alabama. Falls were the third leading cause, making up 10% of accidental deaths in Mobile County, 7% in Baldwin County, and 10% statewide.

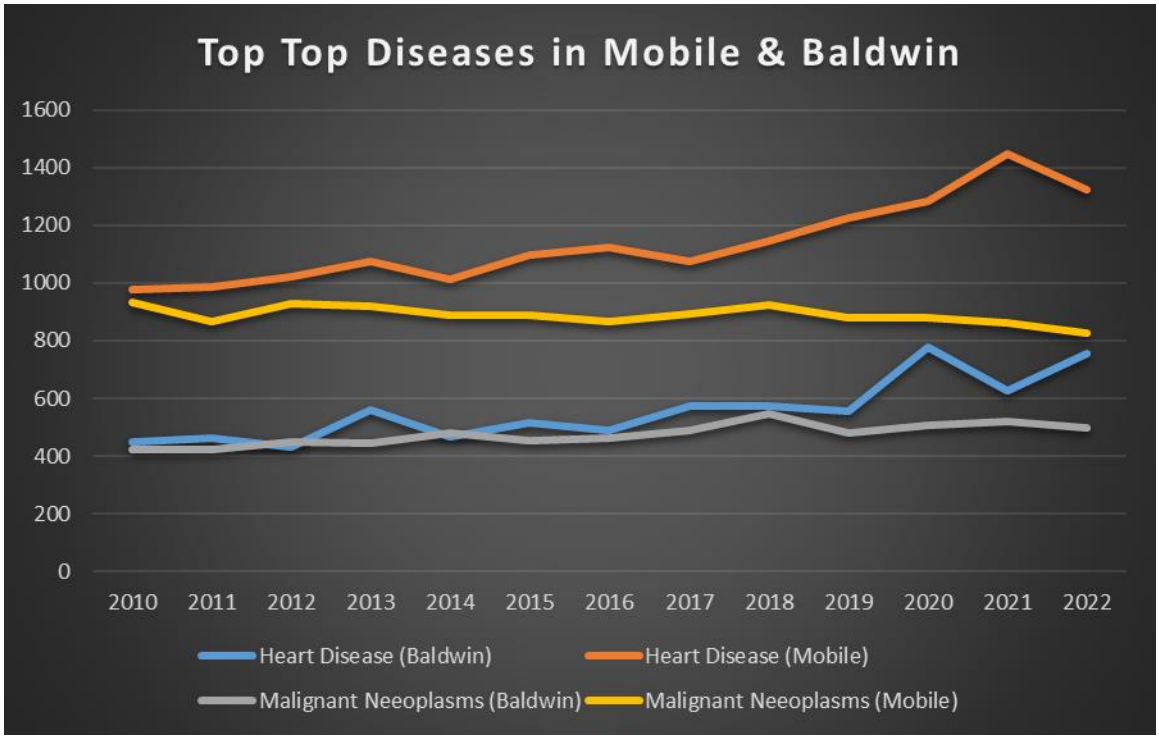
Fire-related deaths, suffocation, and drowning followed, each contributing about 3-4% of deaths in Mobile and Baldwin counties and Alabama. On average, the causes of accidental deaths in Mobile County align closely with the state's overall pattern. However, as reported in previous CHNAs, Mobile County continues to have a higher rate of poisoning-related deaths than the state average, reflecting an ongoing area of concern. Overall, this highlights the need for continued efforts in traffic safety, poison control programs, and fall prevention strategies to address these leading causes of accidental deaths in the region.

Provided below is a 2020-2022 snapshot of all causes of death, by number, in Mobile County, Baldwin County, and Alabama. A detailed discussion of diseases and cancer trends can be found in the following section.



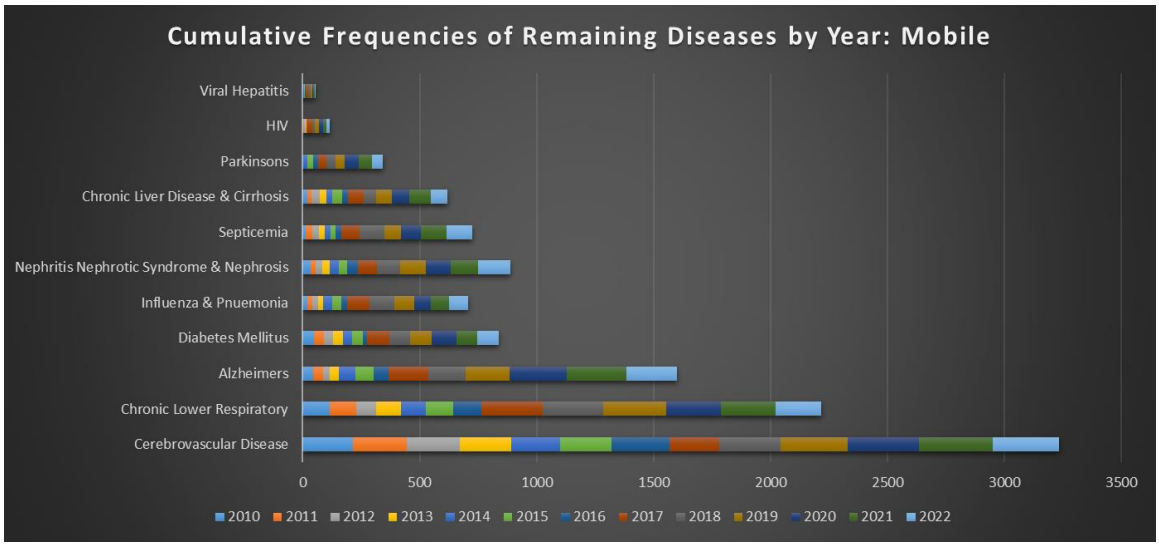
Deaths: Diseases and Cancers

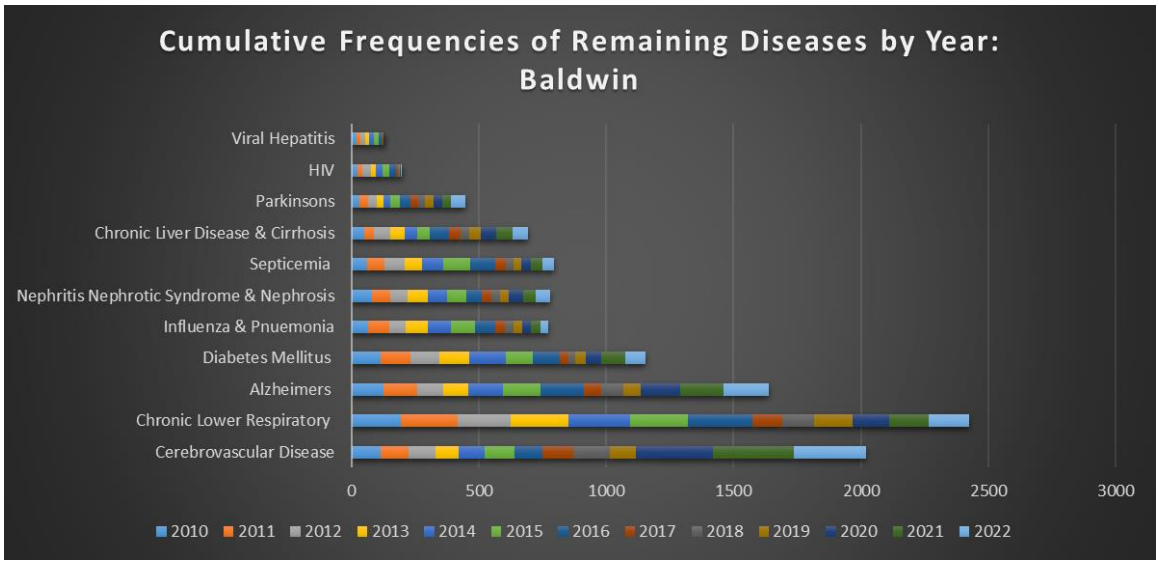
Heart disease, Cancer, Unintentional injuries, COVID-19, Stroke, Chronic lower respiratory diseases, Alzheimer's disease, Diabetes, Kidney disease, Chronic liver disease, and cirrhosis constituted for the top 10 leading causes for death in the United States in 2022. The leading causes for Mobile and Baldwin County are largely the same, with few exceptions. Provided below are the trends for the top causes of death in Baldwin County as well as Mobile County ranging from 2010 to 2022.



Heart disease consistently ranks as the leading cause of death in both counties, with Mobile County showing significantly higher rates than Baldwin County throughout the period. In Mobile County, heart disease mortality rates increased steadily after 2015, peaking in 2021, before experiencing a slight decline in 2022. Baldwin County's heart disease mortality rates remain lower and show a more stable trend, with a gradual increase beginning in 2019.

Malignant neoplasms are the second leading cause of death in both counties, with relatively stable rates across the years. In Mobile County, cancer-related mortality rates are consistently higher than in Baldwin County but exhibit less fluctuation compared to heart disease. Baldwin County's cancer mortality rates remain steady, showing minimal variation over time.





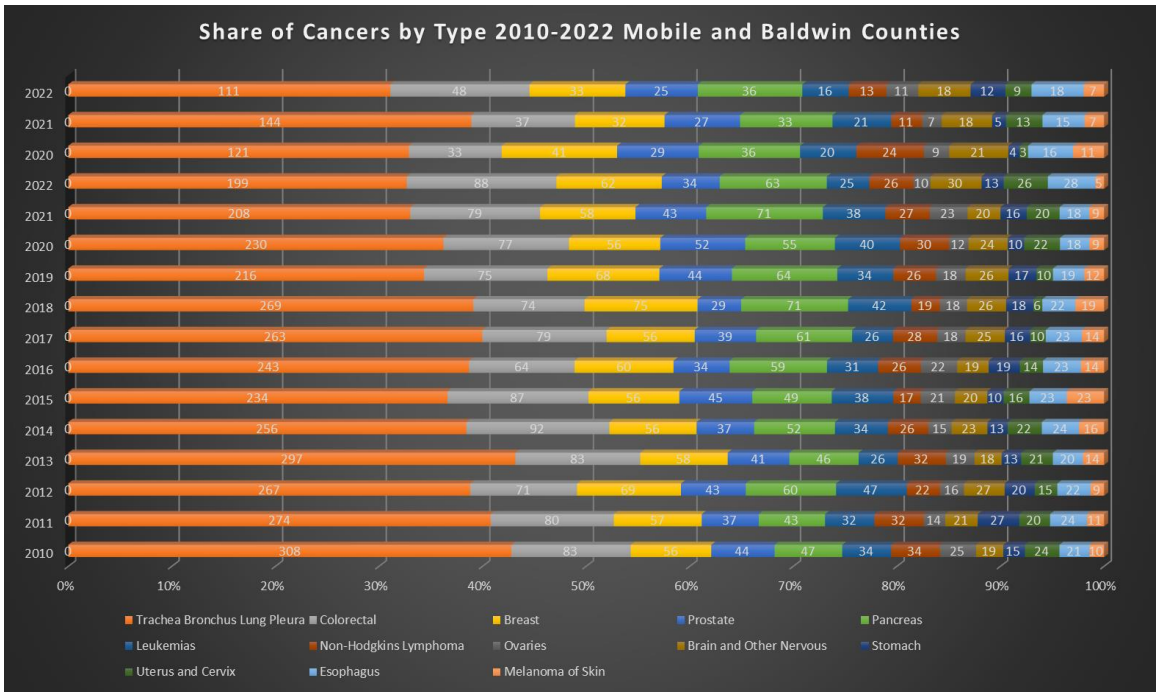
In Mobile County, the number of deaths caused by chronic lower respiratory diseases, diabetes, Alzheimer's disease, and influenza/pneumonia has continued to rise over the 2010 to 2022 period. This trend aligns with the aging population demographics discussed earlier, as these conditions are strongly associated with older age. Alzheimer's disease, in particular, has shown a steady increase, highlighting the growing burden of age-related neurological disorders. The rise in influenza and pneumonia-related deaths may also be partially explained by the relationship between Alzheimer's, dysphagia, and aspiration pneumonia, which are common complications in elderly patients.

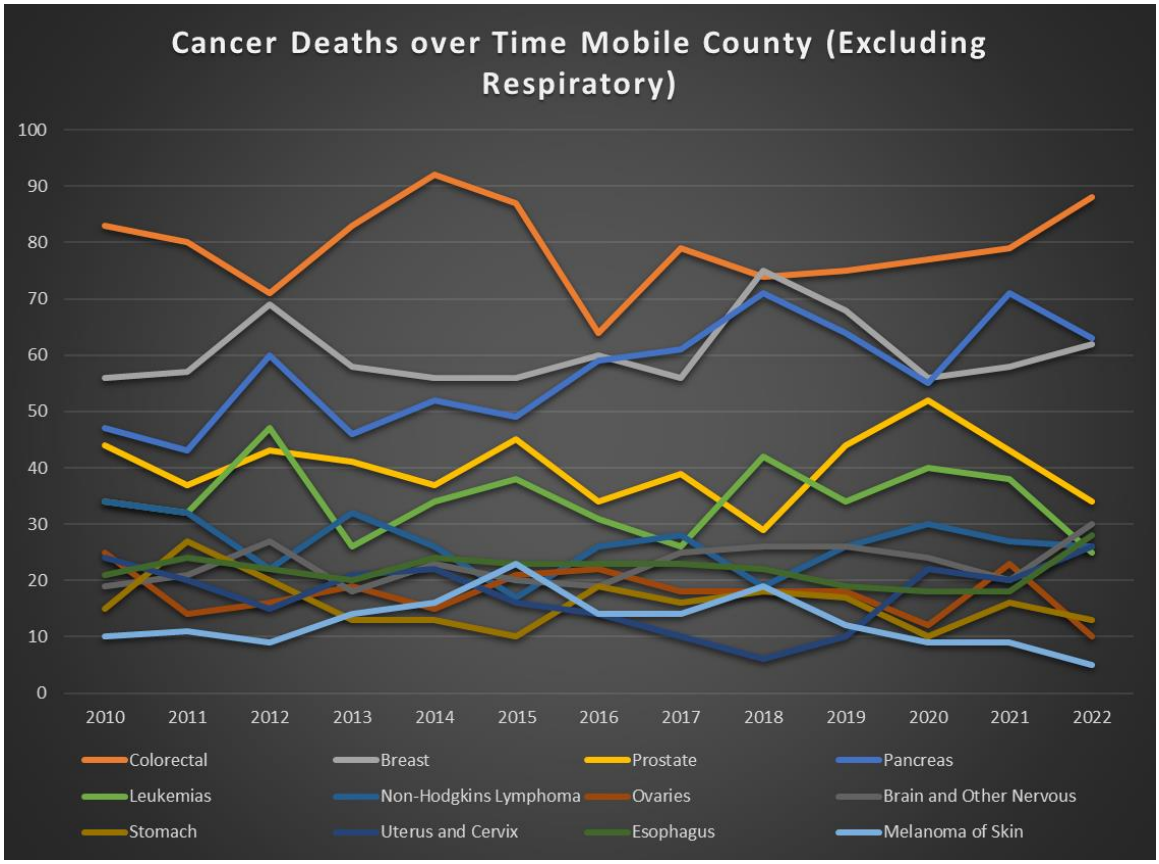
Baldwin County mirrors similar trends, with notable increases in deaths related to Alzheimer's disease, chronic lower respiratory conditions, and influenza/pneumonia. The pronounced growth in Alzheimer's-related mortality reflects the county's aging population, a demographic trend further supported by steady increases in chronic conditions often linked to age. These rising mortality rates in both counties emphasize the need for comprehensive healthcare strategies targeting older adults, focusing on prevention, early intervention, and management of chronic diseases to mitigate their impact on overall mortality.

Cancer remains the second leading cause of death in Mobile County, claiming the lives of approximately 898 residents annually over the past decade. Among the various types of cancers, those of the respiratory system, including trachea, bronchus, lung, and pleura, continue to account for the largest proportion of cancer-related deaths. In 2022, these cancers constituted 25% of all cancer deaths in Mobile County, a trend consistent with previous years. From 2010 to 2022, these respiratory cancers represented a significant share of cancer mortality, reflecting the ongoing burden of smoking and environmental factors in the region. Baldwin County exhibits a similar pattern, with respiratory cancers remaining the leading contributor to cancer-related deaths.

Colorectal and breast cancers are also among the most frequent cancer types in both Mobile County and the state of Alabama. Colorectal cancer accounts for 8% of cancer deaths in Alabama and 7% in Mobile County, figures that align closely with national trends (9% across both sexes). Breast cancer, however, accounts for a smaller proportion of cancer deaths in Mobile County (6%) and Alabama compared to the national average of 14% for women.

Similarly, prostate cancer mortality is also lower in Mobile County and Alabama, representing around 7% of male cancer deaths, compared to the national average of 10%. These figures highlight the importance of continued efforts in early detection and prevention strategies for these cancers to reduce mortality rates further.





Colorectal and breast cancer remain two of the most significant contributors to cancer mortality in Mobile County and the state of Alabama, and both have shown an upward trend since 2020. The recent increase in colorectal cancer deaths could reflect delayed screenings or diagnoses during the COVID-19 pandemic, as well as the continued influence of an aging population, a known risk factor for colorectal cancer. Breast cancer deaths have also risen in the same period, highlighting the ongoing burden of this disease and the need for sustained efforts in early detection and effective treatment.

The increasing age demographics of Mobile County likely contribute to the rising frequency of these cancers, as both colorectal and breast cancer are more common in older adults. Additionally, colorectal cancer mortality rates remain highest among Black populations, a significant demographic in Mobile County, further amplifying its local impact. Factors such as the prevalence of diabetes, which increases colorectal cancer risk and is also rising in Mobile County and Alabama, may be compounding these trends. Addressing these challenges will require targeted public health interventions, including enhanced cancer screening programs, improved access to care, and tailored outreach to vulnerable populations.

COMMUNITY SURVEY – 3

Community Survey Methodology

The Community Health Needs Assessment survey focused on residents living in Mobile County. The community survey was a standard random digit dialed (RDD) survey that also included cell phone respondents.[2] A total of 443 respondents were collected from Mobile County in the general community survey for a margin of error of +/- 4.7%.

For these surveys a computer-assisted telephone interviewing (CATI) system was used to conduct the interviews and collect data. The CATI system recorded information related to the call histories and call dispositions used by interviewers to document the outcome of each call attempt, as well as the survey questions and their responses. The USA Polling Group uses WinCATI/CI3, developed by Sawtooth Technologies in Evanston, Illinois, to program and field its surveys. WinCATI/CI3 is widely used by major academic, public, and private survey organizations. With CATI systems, data are entered directly into the computer by the interviewer, so that interviewing and data entry become a single, seamless step. The benefit is twofold: accuracy of data transmission is enhanced and time otherwise spent re-entering data is saved. Further, CATI capabilities allow skip patterns and range checks within the interview to reduce back-end data cleaning. In addition to questionnaire programming, the USA Polling Group also utilizes WinCATI/CI3's call scheduling capabilities to maximize the probability of contacting potential respondents. A central file server arranges call scheduling for interviewer administration. The system enables calls to be scheduled so that different times of the day and week are represented.

The survey questionnaire was based on Infirmary Health's community health leaders survey deployed during their 2016-2018 CHNA to allow for comparisons with the health leader's responses. The full text of the survey can be found in Appendix F.

Table 3.1: Survey Details

Area	*Date Started*	*Date Completed*	*N*	*Margin of Error*	*Cell Phone %*	*Median Length (minutes)*	*Response Rate w/ No Answers*[1]	*Response Rate w/ out No Answers*[2]
Overall	9/18/2024	12/17/2024	443	+/-4.7	50.1%	17.0	4.7%	8.3%

[1] Calculated by dividing the number of completions by all numbers attempted except those that were out of scope
[2] Calculated the same as [1] but numbers that were categorized as no answers were also excluded from the numerator

Key Survey Findings

[2] Cell phone respondents were screened for the following items: 1) were they in a safe location to be able to speak by phone, 2) were they 18 years of age or older, and 3) were they still residents of Mobile County.

This section details the key elements of the survey findings and in particular identifies some of the most highly rated areas of community need. To see all of the findings regarding the survey data please refer to the tables in Appendix B.

Most respondents feel that Mobile County residents are somewhat healthy (59%); respondents suggest that they think only four percent of residents are very healthy and two percent are very unhealthy.

Respondents are somewhat more positive about the quality of healthcare services. Twelve percent feel services are excellent, 28 percent feel they are very good and 35 percent say they are good. Only four percent say services are poor.

Medicare is the most frequently mentioned form of health insurance. This is not surprising given the older age of many of the respondents. Nineteen percent have employer based private insurance, 14 percent have private insurance they purchased themselves, and three percent do not have insurance. Twelve percent of respondents report not having a personal doctor or healthcare provider. Ninety-two percent say they have seen a doctor for a wellness exam or routine checkup in the past year while 74 percent say the same for a dental exam or cleaning.

Twenty-one percent of respondents reported having used telehealth services in the past year, this is down from over 30% in the previous CHNA. Fifty-three percent of those having used telehealth in the past year rated their experience as either excellent or very good. Six percent reported the experience as poor. Of those not having had a telehealth experience in the past year, eleven percent were very interested in receiving telehealth services while 45 percent were not at all interested in such services.

On a scale of 1 to 7, where 1 is the worse and 7 is the best, 23% of respondents thought that the City of Mobile's COVID response was the best it could be. Two percent thought it was the worst. On the same scale, 32% of respondents thought that healthcare providers response to COVID was the best it could be and less than two percent thought it was the worst it could be.

Respondents were asked about a series of items and how important they felt each item would be in improving the overall health in their community. The top six items rated as most important include: 1) a clean environment, 2) lower crime and safe neighborhoods, 3) cancer care, 4) good schools, 5) Support services to help people with natural disasters: flooding, hurricanes, tornadoes, and 6) Good places to raise children The rankings for Mobile County can be seen in Table 3.2 while the full list of all items can be found in Tables B.13 and B.14 in Appendix B.

Table 3.2: Top 6 items respondent thinks would be important for improving the overall health in your community – Ranked according to overall saying "Very Important"

	Very Important	*Somewhat Important*	*Neither*	*Somewhat Unimportant*	*Very Unimportant*	*Total*	*N*
Q8e. A clean environment including water, air, etc.	94.6	5.0	0.0	0.2	0.2	100.0%	441
Q8n. Lower crime and safe neighborhoods.	94.1	4.8	0.5	0.2	0.5	100.1%	440
Q8x. Cancer Care.	93.2	6.4	0.0	0.5	0.0	100.1%	439
Q8j. Good schools.	91.6	7.3	0.2	0.7	0.2	100.0%	440
Q8ac. Support services to help people with natural disasters: flooding, hurricanes, tornadoes.	90.5	9.1	0.2	0.0	0.2	100.0%	440
Q8h. Good places to raise children.	90.4	8.7	0.7	0.0	0.2	100.0%	436

Respondents were asked how they felt about a number of health issues. Table 3.3 shows the top six issues respondents felt were a problem for Mobile County: 1) child abuse and neglect, 2) cancers, 3) domestic violence, 4) mental health problems, 5) rape and sexual assault, and 6) heart disease and stroke. The full list of health issues is located in Appendix B in Table B.15.

Table 3.3: Top 6 health issues respondent feels are a problem for Mobile County – ranked according to overall saying "Very Important"

	Very Important	*Somewhat Important*	*Naither*	*Somewhat Unimportant*	*Very Unimportant*	*Total*	*N*
Q9d. Child abuse and neglect.	96.1	3.2	0.0	0.5	0.2	100.0%	436
Q9c. Cancers.	91.1	8.0	0.9	0.0	0.0	100.0%	439
Q9g. Domestic violence.	89.3	9.1	0.7	0.7	0.2	100.0%	440
Q9p. Mental health problems.	89.3	8.9	1.4	0.5	0.0	100.1%	440
Q9s. Rape and sexual assault.	88.6	8.4	1.6	0.9	0.5	100.0%	429
Q9j. Heart-disease and stroke.	88.0	10.9	0.7	0.5	0.0	100.1%	441

Determining the prevalence of different health conditions is vital in determining community need. Respondents were asked to identify whether a doctor or other health professional had ever told them if they had any number of a series of twelve major health issues. The top six health conditions identified by respondents in Mobile County were: 1) high blood pressure, 2) high cholesterol, 3) diabetes, 4) depression, 5) obesity, and 6) heart-disease. Table 3.4 shows these rankings and Table B.16 in Appendix B shows the responses to all of the health issues.

Table 3.4: Top 6 health conditions among Mobile County Residents – Ranked according to overall saying "Yes" a doctor or other health professional told them they have the condition

	Yes	*No*	*Total*	*N*
Q10h. High blood pressure.	60.7	39.3	100.0%	440
Q10g. High Cholesterol.	50.7	49.3	100.0%	440
Q10e. Diabetes.	26.1	73.9	100.0%	440
Q10d. Depression.	22.3	77.7	100.0%	440
Q10j. Obesity.	22.1	78.0	100.1%	440
Q10f. Heart-Disease.	19.7	80.3	100.0%	441

Health related services that are difficult to access are a clear problem and point to community needs. Respondents were asked to identify healthcare services that they felt were difficult to obtain in Mobile County. These responses were unprompted, that is respondents had to identify them on their own, and respondents could select as many as they felt were problems. Not counting those saying some "other" issue, Table 3.5 identifies the six healthcare services respondents feel are most difficult to access in Mobile County: 1) mental health services, 2) services for the elderly, 3) specialty medical care (specialist doctors), 4) dental care / dentures, 5) emergency medical care, and 6) preventative healthcare (routine or wellness checkups). The full list of services can be found in Table B.17 in Appendix B. The "other" responses are presented in Appendix C.

Table 3.5: Top 6 healthcare services respondent feels are difficult to get in Mobile County – Ranked according to overall and not counting "other" in Top 6

	Mobile County
Mental health services	26.41
Services for the elderly	13.32
Specialty medical care (specialist doctors)	12.87
Dental care / dentures	9.03
Emergency medical care	8.35
Preventative healthcare (routine or wellness checkups)	7.22

Sixteen percent of Mobile County respondents indicated that they had delayed in getting needed medical care at some point in the past 12 months. Delays in seeking healthcare can lead to more severe, complicated, and costly problems. Factors contributing to such delays are again clear signals of community needs. Table 3.6 lists the top three reasons, not counting those saying "other", identified by respondents for why they delayed in getting needed medical care: 1) could not afford medical care, 2) Could not get an appointment soon enough, and 3) Insurance problems / lack of insurance. The full list of reasons for delaying needed medical care can be found in Table B.19 in Appendix B. The "other" responses are presented in Appendix C.

Table 3.6: Top 3 reasons respondent delayed getting needed medical care – ranked according to overall and not counting "other" in Top 3

	Mobile County
Could not afford medical care	25.7
Could not get an appointment soon enough	15.7
Insurance problems / lack of insurance	12.9

When seeking medical care for someone who is sick, respondents overall were first likely to go to their family doctor (61.4%), then an Urgent care clinic (21.7%), and third to an Emergency Room (12%). This continues to reflect a shift with Urgent care clinics ranking above ERs as a place to go for healthcare.

Respondents have a great deal of confidence that they can make and maintain lifestyle changes. Thirty-six percent are extremely confident in their ability to do so and 42 percent are very confident.

Ten percent of respondents indicate that they are currently using tobacco products such as cigarettes and cigars. A modest two percent report using chewing tobacco or snuff and an other four percent say they use e-cigarettes or vaporizing pens. Eighty percent report never having used tobacco products.

The modal category for how long someone would be willing to wait for a well visit to see their preferred provider is up to 7 days or 1 week with 44% selecting this option. The next most selected category was 17 percent for up to 2 weeks.

A majority of respondents (63.2%) said they would be "Very Likely" to accept an appointment with a Physician's Assistant (PA) if they could see them sooner than their preferred provider.

Again, a majority of respondents (65.5%) said they would "Very Likely" to accept an appointment with a Nurse Practitioner (NP) if they could see them sooner than their preferred provider.

While some respondents were willing to travel more, a great number of respondents were only willing to travel up to 5 miles (27.7%), 10 miles (29.1%) or 20 miles (23.5%).

Most respondents for the survey were older. Twenty percent were between the ages of 46 and 65 and 66 percent were over 65. However, given that the survey's goal is to identify healthcare needs, this upward age bias is less concerning.

Whites constituted 66 percent of those responding overall and African-American's 30 percent.

Twenty-seven percent of respondents possess a high school degree or GED. Twenty-seven percent have some college coursework; 25 percent have a Bachelor's or four-year degree, and 11 percent have a graduate or professional degree.

Given the older age of the respondents it is not surprising that 59 percent say they are retired. Twenty-three percent are working full-time, six percent are disabled, and three percent are unemployed.

Looking at income, seven percent earned less than $15,000 and 17 percent earned more than $100,000.

The majority of survey respondents (69%) were female.

COMMUNITY HEALTH LEADERS SURVEY – 4

Community Health Leaders Survey Methodology

The Community Health Leaders (CHL) survey employed an Internet/E-mail based survey sent to health leaders throughout Mobile County. A total of 57 responses were collected.

The CHL survey was deployed using the Qualtrics Internet survey system. Qualtrics is widely used in the academic and business community. Although the information collected in this survey did not rise to the level of protected health information, the Qualtrics system meets all HIPAA privacy standards. All collected survey information is anonymous.

The USA Polling Group constructed a list of potential health leaders that included a wide diversity of organizations and individuals including healthcare providers, clinics, public health clinics, key hospital personnel, numerous local non-profit groups and charitable organizations, business leaders, local state legislators, and local city officials. The goal was to cast a wide net and to include people in a variety of areas both in healthcare and in related areas such as Feeding the Gulf Coast, Habitat for Humanity, the United Way, etc. Given that a health community is more than just the healthcare resources in an area but includes aspects such as a clean environment, education, safety, etc., we felt this wide net was appropriate.

Overall, a total of 290 e-mails were initially distributed on November 12, 2024. Reminder surveys were sent on November 18, November 25, and December 3, 2024. Of the 290, two e-mails were duplicates, three e-mails failed to send, and 40 e-mails bounced for 245 unique and working e-mails. Thus, with 57 responses, the CHL had a completion rate of 23.3%.

The CHL survey questionnaire duplicated Infirmary Health's community health leaders survey deployed for their 2016-2018 CHNA. The full text of the survey can be found in Appendix G.

Table 4.1: Survey Details

Date Started	*1st Reminder*	*2nd Reminder*	*Date Completed*	*N*	*Estimated Response Time*	*Completion Rate*
11/12/2024	11/18/2024	11/25/2024	12/11/2024	57	7.9 minutes	23.3%

Key Survey Findings

This section details the key elements of the Community Health Leaders (CHL) survey findings and identifies what those leaders see as the highly rated areas of community need. To see all of the findings regarding the CHL survey data please refer to the tables in Appendix D.

The community health leaders were first asked what they think are the most important features of a healthy community. Respondents were presented with a list of 23 possible features of a healthy community and were asked to select up to three items from the list. Respondents were also given three "other" options so that they were not restricted to the items in the pre-defined list but could identify any features that they felt were important. The top six features of a healthy community as identified by community health leaders were: 1) access to health services including family doctors and hospitals, 2) Low crime / safe neighborhoods, 3) Affordable housing, 4) Mental health services, 5) Good employment opportunities, and 6) Quality education. The rankings are presented in Table 4.2 while the full list of all items can be found in Table D.1 in Appendix D.

Table 4.2: Top 6 items community health leader's think are the most important features of a "healthy community"? Check only three[1]

	Frequency	*Percent*
1a. Access to health services (e.g., family doctor, hospitals)	39	68.4
1n. Low crime / safe neighborhoods	17	29.8
1c. Affordable housing	14	24.6
1r. Mental health services	13	22.8
1g. Good employment opportunities	12	21.1
1s. Quality education	12	21.1
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

Health leaders were then asked what they felt were the most important health issues in Mobile County. They were again presented with a pre-defined list of 24 health issues of which they were asked to pick three. Again, they were given three "other" options so that they could identify items not on the pre-defined list. Table 4.3 lists the top six health issues identified by community health leaders: 1) mental health problems, 2) Drug use / abuse, 3) Obesity / excess weight, 4) Heart disease and stroke, 5) Cancers, and 6) Homelessness. The full list of health issues is located in Appendix D in Table D.2.

Table 4.3: What do you think are the most important health issues in Mobile County? Check only three[1]

	Frequency	*Percent*
2p. Mental health problems	39	68.4
2h. Drug use / abuse	19	33.3
2r. Obesity / excess weight	15	26.3
2j. Heart disease and stroke	14	24.6
2c. Cancers	12	21.1
2l. Homelessness	12	21.1
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

Next, health leaders identified their top six unhealthy behaviors in Mobile County. Again, they had the option to select up to three from a pre-defined list of 12 behaviors or could select three "other" options. The top six unhealthy behaviors included: 1) drug abuse, 2) Poor eating habits / poor nutrition, 3) Homelessness, 4) Excess weight, 5) Not seeing a doctor or dentist, and 6) Alcohol abuse. Table 4.4 shows these rankings and Table D.3 in Appendix D shows the responses to all of the health issues.

Table 4.4: Which of the following unhealthy behaviors in Mobile County concern you the most? Check only three[1]

	Frequency	*Percent*
3b. Drug abuse	33	57.9
3f. Poor eating habits / poor nutrition	32	56.1
3d. Homelessness	22	38.6
3c. Excess weight	18	31.6
3i. Not seeing a doctor or dentist	18	31.6
3a. Alcohol abuse	16	28.1
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

Health leaders were also asked to identify which healthcare services are difficult to get in Mobile County. For this question, leaders were allowed to select all that they felt applied. Table 4.5 shows the six healthcare services health leaders felt are the most difficult to access: 1) mental health services, 2) alcohol or drug abuse treatment, 3) Preventative healthcare (routine or wellness check-ups, etc.), 4) services for the elderly, 5) Alternative therapies

(acupuncture, herbals, etc.), and 6a) Dental care including dentures, 6b) Primary medical care (a primary doctor / clinic), and 6c) Specialty medical care (specialist doctors). The full list of services can be found in Table D.4 in Appendix D.

Table 4.5: Which healthcare services are difficult to get in Mobile County? Check all that apply[1]

	Frequency	*Percent*
4f. Mental health services	47	82.5
4m. Alcohol or drug abuse treatment	18	31.6
4h. Preventative healthcare (routine or wellness check-ups, etc.)	16	28.1
4k. Services for the elderly	15	26.3
4a. Alternative therapies (acupuncture, herbals, etc.)	10	17.5
4b. Dental care including dentures	10	17.5
4j. Primary medical care (a primary doctor / clinic)	10	17.5
4l. Specialty medical care (specialist doctors)	10	17.5
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

It is notable that the health leaders do not rate anyone in Mobile County as very healthy. The majority of health leaders suggest that people are either somewhat healthy (61%) or unhealthy (25%).

Four percent of health leaders rate the quality of healthcare services available in Mobile County as excellent, 18 percent say very good, 47 percent say good, another 25 percent say fair, and five percent say the healthcare services are poor.

Many of the health leaders responding were from educational organizations (20%), other healthcare organizations (18%), another 11 percent were in housing or temporary shelter, and five percent were in public service. Finally, another 20 percent indicated some other type of service. Follow-up responses as to the type of other services were quite varied and can be seen in Appendix E.

In looking at the types of clients served, 35 percent of health leaders said their organization served families; 35 percent said their organization served individuals, and 15 percent said some other type of client. Among those saying other, many indicated children or adolescents, or that they served all of the different types of clients.

Most health leaders (76%) said that they provide the client information on where to obtain assistance if their organization cannot provide all the services a client needs. Eight percent said they will phone, e-mail, or fax another organization to help the client obtain those services they cannot provide.

Fifty-one percent of health leaders said their organizations served adults under 65; 42 percent said they served children, and 19 percent served seniors (65 and over).

Most health leaders (79%) indicated that it would be helpful to them and their ability to provide services to know what other services the client has received from other organizations.

Fifty-one percent of health leaders felt that they served 1,000 of fewer clients (that is unique individuals not visits) on an annual basis. Twenty-nine percent said they served 20,000 or more annually.

While some health leaders said their organizations required clients to meet eligibility requirements, most (60%) said that they do not have requirements but serve everyone.

Twenty-three percent of health leaders do not have any volunteers on their staff. Another 50 percent said that between 1 – 25% of their staff was composed of volunteers. Very few health leaders had more than 25% or more of their staff composed of volunteers.

Many health leaders (37%) rely on either electronic medical records (EMR) or electronic health records (HER) for storing client records electronically. Another 43 percent rely on other systems including HMIS, EPIC, Oasis Insight, and others (see Appendix E for a full list), and 14 percent do not know if they store client records electronically or not.

Comparing the Community and the Community Health Leaders

This section compares the results of the 443 community members with the results of the 57 community health leaders from Mobile County. These comparisons should demonstrate where the community and health leaders converge and diverge in terms of what constitutes a healthy community, what the most important health issues are, how each group views the health of the community, the quality of health services available, and what services are perceived to be difficult to obtain. Many of these survey questions were essentially the same; however, the mode of delivery necessitated some differences in their delivery depending on if the questions were being presented over the telephone versus electronically.

In looking at the features of a healthy community, the comparison between the Community Health Leaders Survey and the Community Survey reveals both convergence and divergence in perceptions of what constitutes a healthy community. Both groups clearly agree on the importance of safety and education, as evidenced by their shared emphasis on "low crime / safe neighborhoods" and the value of schooling, albeit framed slightly differently—Community Health Leaders prioritize "quality education," while the Community Survey highlights "good schools" and "good places to raise children." This suggests a mutual recognition that foundational social structures like safety and education are essential for community well-being, though community members may see education more through the lens of child-rearing.

However, differences in emphasis reveal notable distinctions in perspective. Community Health Leaders tend to focus on systemic and institutional elements such as "access to health services," "affordable housing," "mental health services," and "good employment opportunities," which reflect their professional orientation toward structural determinants of

health. In contrast, the Community Survey participants include more situational or environmental concerns such as "a clean environment," "cancer care," and "support during natural disasters." This points to a more immediate, lived-experience perspective from community members who may prioritize tangible, everyday impacts of health and environment over broader institutional structures. These divergences underscore the value of including both professional and public voices in health planning, as each highlights different facets of community health needs.

Table 4.6: Comparison of Features of a Healthy Community

Community Health Leaders Survey	*Community Survey*
1. 1a. Access to health services (e.g., family doctor, hospitals)	1. Q8e. A clean environment including water, air, etc.
2. 1n. Low crime / safe neighborhoods	2. Q8n. Lower crime and safe neighborhoods.
3. 1c. Affordable housing	3. Q8x. Cancer Care.
4. 1r. Mental health services	4. Q8j. Good schools.
5. 1g. Good employment opportunities	5. Q8ac. Support services to help people with natural disasters: flooding, hurricanes, tornadoes.
6. 1s. Quality education	6. Q8h. Good places to raise children.

When examining the most important health issues, table 4.7 highlights several points of alignment between Community Health Leaders and Community Survey respondents regarding the most important health issues. Both groups agree on the significance of mental health problems, cancers, and heart disease and stroke, indicating shared concern over both physical and mental health challenges. These overlaps suggest a consensus on the pervasive impact of chronic conditions and psychological well-being across professional and lived experience perspectives. Additionally, while drug use/abuse and obesity/excess weight are priorities for health leaders, these issues may be embedded within broader concerns voiced by the community, such as domestic violence or child neglect, where substance use may be a contributing factor.

Despite this alignment, some important divergences stand out. Community members place high importance on social and interpersonal trauma, such as child abuse and neglect, domestic violence, and rape and sexual assault—none of which explicitly appear in the top health issues listed by Community Health Leaders. Conversely, homelessness, a pressing issue identified by health leaders, does not appear in the community's top six. These differences reflect varying frames of reference: health leaders may focus on systemic and clinical indicators, while residents emphasize personal safety, trauma, and immediate vulnerabilities. Together, these perspectives underscore the necessity of integrating both institutional expertise and lived community experiences into health prioritization and policy development.

Table 4.7: Comparison of Most Important Health Issues

Community Health Leaders Survey	*Community Survey*
1. 2p. Mental health problems	1. Q9d. Child abuse and neglect.
2. 2h. Drug use / abuse	2. Q9c. Cancers.
3. 2r. Obesity / excess weight	3. Q9g. Domestic violence.
4. 2j. Heart disease and stroke	4. Q9p. Mental health problems.
5. 2c. Cancers	5. Q9s. Rape and sexual assault.
6. 2l. Homelessness	6. Q9j. Heart disease and stroke.

The modal category for both groups for evaluating the health of community members was "somewhat healthy". For the quality of healthcare services available, the modal category was "good" for both leaders and community members. In both cases, this represents the middle category of the scales and is somewhat unsurprising as it is the cognitively easiest answer for both questions.

Table 4.8: Comparison of Community Health and Health Services

	Community Health Leaders Survey	*Community Survey*
The health of my community:	Somewhat Healthy	Somewhat Healthy
Quality of health services:	Good	Good

Table 4.9 reveals notable areas of agreement between Community Health Leaders and Community Survey participants regarding healthcare services that are difficult to obtain. Both groups rank mental health services as the most difficult to access, suggesting a shared recognition of persistent gaps in behavioral health infrastructure. Additionally, both identify challenges related to services for the elderly, specialty care, preventative healthcare, and dental services, though their rankings differ. This general overlap points to widespread concern about the accessibility of core and specialized health services, reinforcing that both system insiders and everyday community members perceive barriers to comprehensive care.

However, the table also shows divergences in emphasis. Community Health Leaders include alcohol or drug abuse treatment, alternative therapies, and primary medical care as significant access issues, while these are not top concerns for community members. Instead, the public gives higher priority to emergency medical care, which is notably absent from the leaders' list. This contrast suggests that professionals may focus more on structural service gaps and long-term care access, whereas residents are also sensitive to urgent care availability and immediate service needs. Such differences underscore the importance of incorporating diverse perspectives into health planning—balancing expert assessments with the community's direct experiences to ensure that service improvements address both strategic and acute access challenges.

Table 4.9: Comparison of Healthcare Services That Are Difficult to Obtain

Community Health Leaders Survey	*Community Survey*
1. 4f. Mental health services	1. Mental health services
2. 4m. Alcohol or drug abuse treatment	2. Services for the elderly
3. 4h. Preventative healthcare (routine or wellness check-ups, etc.)	3. Specialty medical care (specialist doctors)
4. 4k. Services for the elderly	4. Dental care / dentures
5. 4a. Alternative therapies (acupuncture, herbals, etc.)	5. Emergency medical care
6(a). 4b. Dental care including dentures	6. Preventative healthcare (routine or wellness checkups)
6(b). 4j. Primary medical care (a primary doctor / clinic)	
6(c). 4l. Specialty medical care (specialist doctors)	

These findings reveal key points of convergence between Community Health Leaders and community members, including shared concerns about mental health, safe neighborhoods, education, cancers, and access to services for the elderly and specialty care. These alignments reflect common ground on foundational health needs and service gaps.

However, divergences emerge in focus and framing. Health Leaders emphasize systemic and institutional issues such as homelessness, employment, and primary care access, while community members highlight personal safety, trauma (e.g., abuse, violence), and environmental concerns like clean air and emergency care. This underscores the need to integrate professional insights with lived experiences for more responsive health planning.

COMMUNITY RESOURCES – 5

Summary

Along with the eight acute care hospitals, two specialty hospitals, and over nine federally qualified health clinics, there are numerous other community resources dedicated to providing access to healthcare services or provide services that directly impact health. This includes nursing homes, hospice care, and in-home health care for those that need assistance. There are currently 26 nursing homes, 22 hospice care providers, and 18 home care providers. Beyond direct health care, there are a variety of agencies that assist with access to prescriptions, food, housing, childcare, counseling, and more.

A list of major providers of health and social services is provided in the Community Resource List Tables 4.1 thru 4.7. This list however is not exhaustive. To find specific services or further providers, residents can call 211 where operators can direct callers to the appropriate service providers.

Community Resource List

Table 5.1 : Acute Care Hospitals

Facility	*Phone*
Mobile Infirmary	(251) 435-2400
North Baldwin Infirmary	(251) 937-5521
Providence Hospital	(251) 633-1000
South Baldwin Regional Medical Center	(251) 949-3400
Springhill Medical Center	(251) 344-9630
Thomas Hospital	(251) 928-2375
USA University Hospital	(251) 471-7110
USA Children's and Women's Hospital	(251) 415-1000

Table 5.2: Specialty Hospitals

Facility	*Phone*
BayPointe Children's Hospital	(251) 661-0153
Infirmary Long Term Acute Care Hospital	(251) 435-5822

Table 5.3: Federally Qualified Health Clinics

Facility	*Phone*
Aeillo/Buskey Women and Children Center	(251) 452-1442
Family Oriented Primary Health Care Clinic	(251) 690-8115
Franklin Primary Health Centers	(251) 432-4117
La Clinica De Baldwin	(251) 947-1083
Loxley Family Medical Center	(251) 964-4011
Maysville Medical Center	(251) 471-3747
Mostellar Medical Center	(251) 824-2174

South Baldwin Family Health Center	(251) 943-7237
The Hadley Medical Center	(251) 450-8055

Table 5.4: Nursing Homes

Facility	*Phone*
Allen Memorial Home	(251) 433-2642
Ashland Place Health & Rehabilitation	(251) 471-5431
Azalea Gardens of Mobile	(251) 479-0551
Blue Ridge Healthcare Montrose Bay	(251) 928-2177
Citronelle Health & Rehabilitation Center	(251) 866-5509
Crowne Health Care of Mobile	(251) 473-8684
Crowne Health Care of Springhill	(251) 304-3013
Diversicare of Foley	(251) 943-2781
Eastern Shore Rehabilitation and Health Center	(251) 621-4200
Fairhope Health and Rehab	(205) 783-8444
Gordon Oaks Health & Rehab	(251) 661-7608
Grand Bay Convalescent Home, Inc.	(251) 865-6443
Gulf Coast Health & Rehabilitation	(251) 634-8002
Kindred Transitional Care and Rehab	(251) 316-0917
Little Sisters of the Poor Sacred Heart Residence	(251) 476-6335
Lynwood Nursing Home	(251) 661-5404
Mobile Nursing & Rehabilitation Center	(251) 639-1588
North Mobile Nursing & Rehabilitation Center	(251) 452-0996
Crowne Health Care of North Baldwin	(251) 937-3501
Palm Gardens Health & Rehabilitation	(251) 450-2800
Sea Breeze Healthcare Center	(251) 433-5471
Springhill Manor Nursing Home	(251) 342-5623
Springhill Senior Residence	(251) 343-0909
Twin Oaks Rehabilitation & Healthcare Center	(251) 476-3420
William F. Green State Veterans Home	(251) 937-9881
WillowBrooke Court Skilled Care Center at Westminster Village	(251) 626-7007

Table 5.5: Hospice Services

Facility	*Phone*
Alabama Hospice Care of Mobile	(251) 345-1023
AseraCare Hospice-Mobile	(251) 343-0989
Coastal Caregivers Home Care	(251) 721-1297
Comfort Care Coastal Hospice - Baldwin	(251) 621-4229
Comfort Care Coastal Hospice - Mobile	(251) 304-3135
Comfort Keepers Home Care	(251) 202-4860
Community Hospice of Baldwin County	(251) 943-5015
Covenant Hospice, Inc. Mobile	(251) 478-6931
Covenant Hospice, Inc.-Daphne	(251) 626-5255
Encompass Health	(251) 661-5313
Gentiva Hospice	(251) 340-6387
Hospice South	(251) 473-3892
Infirmary Home Care	(251) 450-3300
Kindred Hospice - Daphne	(251) 621-2500
Kindred Hospice - Mobile	(251) 478-9900
Mercy Medical Home Care & Hospice – Mobile	(251) 304-3135
Mercy Medical Home Care & Hospice - Baldwin	(251) 621-4228
Saad's Hospice Services	(251) 343-9600
SouthernCare Daphne	(251) 621-2844
SouthernCare Mobile	(251) 666-2113
Springhill Home Health and Hospice	(251) 725-1268
Springhill Hospice - Baldwin County	(251) 626-5895
St. Joseph Hospice of South Alabama, LLC	(251) 675-7555
Veterans Affairs Outpatient Clinic	(251) 219-3900

Table 5.6: Home Health Agencies

Facility	*Phone*
Addus Healthcare	(251) 414-5855
Alacare Home Health & Hospice - Mobile	(251) 341-0707
Amedisys Home Health of Foley	(800) 763-6382
Amedisys Home Health of Mobile	(251) 380-0492
BrightStar Care North Mobile/Baldwin Co.	(251) 405-6451
Carestaff	(251) 380-2070
Comfort Care Coastal Home Health	(251) 621-4431
Home Instead Senior Care	(251) 342-6655
Infirmary HomeCare of Mobile	(866) 541-0239
Kindred at Home	(251) 316-0917
Maxim Healthcare	(251) 470-0223
Mercy Life of Alabama	(251) 287-8427
Oxford HealthCare Services	(800) 404-3191
ProHealth-Gulf Coast, LLC	(866) 330-0609
Saad Healthcare	(251) 343-9600
South Baldwin Regional Home Health	(251) 424-1045
Springhill Home Health & Hospice	(251) 433-8172
Thomas Home Health	(251) 990-9200

Table 5.7a: Social Service Agencies

Facility	*Phone*
Social Service Organizations	
Community Action Agency of Mobile	(251) 457-7143
Community Action Agency of South Alabama	(251) 626-2646
Community Foundation of South Alabama	(251) 438-5591
Dumas Wesley Community Center	(251) 479-0649
Goodwill Easter Seals of the Gulf Coast	(251) 471-1581
Mobile United	(251) 432-1638
Salvation Army of Coastal Alabama	(251) 438-1625
The Foley Community Service Center	(251) 380.3057
The Light of the Village	(251) 680-4613
United Way of Baldwin County	(251) 943-2110
United Way of Southwest Alabama	(251) 433-3624
Volunteers of America Southeast	(251) 300-3500
Waterfront Rescue Mission	(251) 433-1847
YMCA Dearborn	(251) 432-4768
YMCA North Mobile	(251) 679-8877
YMCA Bounds Branch	(251) 626-0888
Aging and Gerontology	
AARP Mobile	(251) 470-5235
Area Agency on Aging	(251) 433-6541
Independent Living Center	(251) 460-0301
Via! Senior Citizens Services	(251) 470-5226
Alcohol, Tobacco, and Other Drugs	
Drug Education Council	(251) 478-7855
Home of Grace for Women	(251) 456-7807
Mission of Hope	(251) 649-0830
Serenity Care	(251) 478-1917
Wings of Life	(251) 432-5245
Church Groups and Organizations	
Catholic Social Services	(251) 434-1500
Christ United Methodist Church	(251) 342-0462
Dauphin United Way Methodist Church	(251) 471-1511
Ecumenical Ministries, Inc. - Eastern Shore	(251) 928-3430
Ecumenical Ministries, Inc. - South Baldwin	(251) 943-3445
First Baptist of Church of Robertsdale	(251) 947-4362
Little Sisters of the Poor	(251) 476-6335
Mount Hebron	(251) 457-9900
Ramsom Ministries	(251) 751-0044
Revelation Missionary Baptist Church	(251) 473-2555
Trinity Lutheran Church	(251) 456-7929
Trinity Family Church	(251) 423-8238

Table 5.7b: Social Service Agencies

Facility	*Phone*
Developmental Disabilities	
Mobile Arc	(251) 479-7409
Mulherin Custodial Home	(251) 471-1998
The Learning Tree	(251) 649-4420
Education and Youth Development	
Big Brothers Big Sisters of South Alabama	(251) 344-0536
Boys & Girls Club of South Alabama	(251) 432-1235
Child Day Care Association	(251) 441-0840
Fuse Project	(251) 265-3873
Girl Scouts of Southern Alabama	(800) 239-6636
GRMCA Early Childhood Directions	(251) 473-1060
Junior League of Mobile	(251) 471-3348
Mobile Area Education Foundation	(251) 476-0002
Preschool for the Sensory Impaired	(251) 433-1234
South Baldwin Literacy Council	(251) 943-7323
Family and Child Welfare	
Child Advocacy Center	(251) 432-1101
Court Appointed Special Advocates (CASA) Mobile	(251) 574-5277
Crittendon Youth Services	(251) 639-0004
Penelope House Family Violence Center	(251) 342-8994
St. Mary's Home	(251) 344-7733
Wilmer Hall Children's Home	(251) 342-4931
Food Pantries	
Emma's Harvest Home	(251) 478-8768
Feeding the Gulf Coast	(251) 653-1617
Prodisee Pantry (Baldwin)	(251) 626-1720
Health Care	
AIDS South Alabama	(251) 471-5277
Alabama Free Clinic - Baldwin County	(251) 937-8096
Alabama Rehabilitation Services	(251) 479-8611
American Cancer Society	(251) 344-9856
American Heart Association - Mobile	(800) 257-6941 Ext. 5397
American Red Cross	(251) 544-6100
Epilepsy Foundation of Alabama	(251) 341-0170
Franklin H.E. Savage Healthcare for the Homeless	(251) 694-0070
Lifesouth Community Blood Center	(888) 795-2707
March of Dimes – Mobile	(251) 438-1360
Oznam Charitable Pharmacy	(251) 432-4111
Ronald McDonald House Charities of Mobile	(251) 694-6873
Sickle Cell Disease Association of America (Mobile)	(251) 432-0301
United Cerebral Palsy of Mobile	(251) 479-4900
Us Too!	(251) 591-8557
Victory Health Partners	(251) 460-0999

Table 5.7c: Social Service Agencies

Facility	*Phone*
Housing and Homelessness	
Family Promise of Coastal Alabama	(251) 441-1991
Habitat for Humanities of Baldwin County	(251) 943-7268
Habitat for Humanities of Southwest Alabama	(251) 476-7171
Housing First	(251) 450-3345
McKemie Place	(251) 432-1122
South Alabama Center for Fair Housing	(251) 479-1532
Justice and Corrections	
South Alabama Volunteer Lawyers Program	(251) 438-1102
Mental Health and Clinical	
AltaPointe Health Systems	(251) 450-2211
Lifelines Counseling Services	(251) 602-0909
Survivors of Mental Illness	(251) 342-0261
Sustainability Organizations	
Alabama Coastal Foundation	(251) 990-6002
Dauphin Island Sea Lab	(251) 861-2141
Dog River Clearwater Revival	(251) 377-4485
Mobile Bay Keepers	(251) 433-4229
Mobile Waterways	

IMPLEMENTATION STRATEGIES – 6

Toward a More Integrated Approach to Community Health

As USA Health looks ahead to the 2025–2027 implementation cycle, one of the strategic priorities will be the development of a more integrated and coordinated system for documenting, monitoring, and evaluating community-facing activities. This work will be anchored in the Center for Healthy Communities, which will serve as a hub for the collection, organization, and analysis of information related to community health engagement across the health system.

Rather than offer a strict schedule, we envision this initiative evolving over time and guided by the following objectives:

- Enhanced Documentation: Establish consistent, system-wide processes for recording community engagement activities, outreach efforts, and preventive health initiatives.
- Improved Reporting: Develop streamlined mechanisms for aggregating and reporting data on community health activities, enabling greater transparency and responsiveness.
- Stronger Evaluation Capacity: Use improved documentation and reporting to assess the reach, effectiveness, and equity impact of programs, allowing for more evidence-based decision-making.
- Impact on Community Health Outcomes: Ultimately, these improvements will position USA Health to better adapt, refine, and expand programs in response to community needs—that is, advancing its mission to promote health equity and reduce disparities.

This integrated approach will not only support the implementation of the current CHNA priorities but also build institutional infrastructure for sustained, long-term community health improvement. It will also provide a foundation for aligning oversight and evaluation activities with the broader implementation strategy described in this report.

Chronic Disease Management

Chronic conditions such as heart disease, diabetes, hypertension, and obesity remain among the most pressing health challenges in Mobile County. As highlighted herein, these diseases contribute significantly to preventable hospitalizations, reduced quality of life, and premature death—especially among medically underserved populations. In response, USA Health will expand existing efforts and adopt new evidence-based strategies aimed at early detection, risk reduction, care coordination, and patient empowerment.

Building on Existing Initiatives

USA Health has made considerable progress in addressing chronic disease over the past CHNA cycle. The establishment of the Center for Comprehensive Weight Loss represents a significant investment in multidisciplinary care, bringing together medical weight management, bariatric surgery, nutrition counseling, and behavioral support. This program has directly served patients struggling with obesity and its related conditions, including diabetes and cardiovascular disease.

Complementing these clinical services, USA Health has introduced community-based initiatives such as Walk with a Doc, a monthly event that pairs guided physical activity with accessible health education led by physicians. Additionally, USA Health has expanded its participation in community health fairs—offering screenings for hypertension, diabetes, and cholesterol—and has strengthened linkages between outreach staff and clinical services to facilitate follow-up care.

In the 2025–2027 cycle, USA Health will:

- Increase the frequency and geographic reach of community-based screening events, prioritizing ZIP codes with elevated rates of uncontrolled chronic disease.
- Enhance collaboration with the Community Health Worker (CHW) program to provide patient education, care navigation, and follow-up support.
- Expand referrals into the Center for Comprehensive Weight Loss and integrate chronic disease management into its services more broadly.

Enhancing Education and Prevention

To improve prevention and long-term disease management, USA Health will also broaden its efforts in community education and self-management support. Planned activities include:

- Deployment of CHWs in targeted neighborhoods to assist with lifestyle counseling, appointment adherence, and transportation navigation.
- Strengthening of existing partnerships to offer evidence-based chronic disease self-management workshops, including programming for diabetes and hypertension.
- Continued implementation of Walk with a Doc with a focus on underserved communities and consistent messaging around physical activity and nutrition.

Adopting Best Practices from Peer Institutions

Informed by national trends and successful hospital-based interventions, USA Health will investigate potential new strategies that align with proven models in chronic disease care including but not limited to:

- Group Medical Visits: Pilot group-based appointments for patients with diabetes or hypertension, combining individual check-ins with shared education and peer support—an approach used effectively at Cleveland Clinic and Stanford Health.
- Produce Prescription Programs: Explore collaborations with local food banks and farmers markets to provide patients with fresh fruits and vegetables as part of chronic disease treatment plans.

- Digital Engagement Tools: Use SMS messaging, automated reminders, and patient portal outreach to promote medication adherence, routine screenings, and participation in educational programs.
- EMR-Driven Referral Pathways: Embed chronic disease screening prompts and referral options into USA Health's electronic health record (EHR) system to standardize provider workflows and improve early intervention.

Monitoring and Evaluation

Qualitative feedback from patients and community partners will also be gathered to ensure services remain culturally responsive and aligned with community priorities.
Through the continuation and strategic expansion of these initiatives, USA Health will deepen its commitment to reducing the burden of chronic disease in Mobile County—helping patients live longer, healthier, and more empowered lives.

Cancer Screening and Prevention

Cancer remains one of the leading causes of death in Mobile County, with significant disparities in screening rates, early detection, and access to specialty care—particularly among medically underserved populations. In aligning with the priorities identified in this report, USA Health will expand upon its existing efforts through the Mitchell Cancer Institute (MCI) and community outreach teams to improve early detection, education, and linkage to timely treatment.

Building on Existing Initiatives

USA Health's Cancer Control and Prevention (CCP) team has established a strong foundation of community-based cancer screening and education. Over the previous CHNA cycle, MCI's outreach program has used events, campaigns, and media to conduct numerous prostate cancer screenings for men across six counties. Signature events such as the Think Pink Tea, Go Teal & White Campaign, and GORUN have increased public awareness of breast and gynecologic cancers and provided targeted opportunities for HPV education and screening.

During the 2025–2027 cycle, USA Health will:

- Expand the reach of prostate, breast, cervical, and colorectal cancer screenings, prioritizing underserved ZIP codes and populations with elevated risk.
- Scale up mobile outreach by deploying screening services at community health fairs, town halls, and workplaces. These services will build upon USA Health's established community health fair infrastructure and existing outreach partnerships.
- Integrate navigation support through community health workers (CHWs) and clinical staff to ensure individuals with abnormal screening results receive timely follow-up and access to care.

Enhancing Education and Prevention

In addition to direct screening services, USA Health will broaden its public health education efforts with a focus on cancer prevention, including:

- HPV vaccination campaigns in partnership with schools, pharmacies, and pediatric practices.
- Media campaigns and provider-led presentations on modifiable cancer risk factors, such as tobacco use, diet, and occupational exposures.
- Environmental health education through youth programs, including the STEMM Scholars for Environmental Justice Program, emphasizing links between environmental exposures and long-term cancer risk.

Adopting Best Practices from Peer Institutions

To complement these efforts, USA Health will explore implementing additional evidence-based strategies successfully employed by other health systems:

- "Screen and Refer" Protocols in Primary Care: Encourage routine integration of cancer screening checklists into primary care visits using EMR prompts and standing orders—an approach that has improved screening compliance in systems like Kaiser Permanente.
- Workplace Screening Partnerships: Offer on-site cancer screenings (e.g., mobile mammography, skin cancer checks) to employers through Industrial Medicine contracts or as part of employee wellness initiatives. This model has been used effectively by Cleveland Clinic and other large systems.
- Cancer Survivor Peer Navigators: Train cancer survivors to serve as peer navigators, providing education and emotional support to individuals undergoing screening or recently diagnosed. This approach reduces fear and stigma, especially in minority and rural populations.
- Use of Digital Outreach: Deploy targeted messaging via SMS, social media, and patient portals to remind eligible patients of recommended screenings. Hospitals like NYC Health + Hospitals have improved colorectal screening rates through such digital nudges.

Monitoring and Evaluation

USA Health will track progress using screening volume metrics, geographic coverage, demographic reach, and referral-to-follow-up rates. Annual reports will be shared with internal stakeholders and used to refine outreach strategies. Data on patient engagement, satisfaction, and barriers to care will also be gathered to inform program improvements.

Through these combined efforts, USA Health aims to reduce disparities in cancer outcomes, promote earlier detection, and empower individuals with the knowledge and resources needed to prevent and manage cancer. By leveraging its clinical expertise, community partnerships, and institutional reach, USA Health will continue to lead regional efforts to reduce the burden of cancer in a sustainable and equitable manner.

Behavioral Health and Violence Prevention

The current CHNA identifies behavioral health and community violence as persistent and urgent concerns across Mobile County. Community survey participants and health leaders alike emphasized the need for expanded access to mental health services, trauma-informed care, and violence prevention initiatives—particularly for youth and those working through the criminal justice system. In response, USA Health will build upon its current programming while advancing new partnerships and intervention models to reduce behavioral health disparities and promote community well-being.

Building on Existing Initiatives

Over the past CHNA cycle, USA Health has implemented a multifaceted approach to behavioral health and violence prevention. The health system continues to support a hospital-based violence intervention program (HVIP), which connects patients experiencing violence-related injuries to counseling, support services, and case management at the point of care. This program serves as a critical early intervention model and helps to disrupt cycles of violence through trauma-informed outreach.

In parallel, USA Health has developed and expanded a Community Health Worker (CHW) program focused on justice-involved youth, providing navigation support, mentorship, and linkage to health and social services. These efforts are reinforced by Project Inspire, a youth empowerment and leadership development initiative that promotes positive peer engagement, skill-building, and violence prevention.

Additionally, Medical Town Halls hosted by USA Health provide accessible forums for discussing mental health topics, stigma reduction, and local service options. These events serve as a vital entry point for connecting individuals and families with available behavioral health resources.

In the 2025–2027 cycle, USA Health will:

- Expand the reach and staffing of the hospital-based violence intervention program to additional clinical sites, including emergency departments and urgent care facilities.
- Increase recruitment, training, and deployment of CHWs serving youth impacted by trauma, housing instability, or incarceration.
- Formalize referral pathways between CHWs, behavioral health providers, and community organizations offering crisis support and counseling.

Enhancing Education and Prevention

To advance community-based prevention and reduce stigma surrounding mental illness and trauma, USA Health will:

- Develop school- and neighborhood-based mental health education initiatives in partnership with local schools, faith-based institutions, and nonprofits.
- Enhance provider training in trauma-informed care, cultural competence, and suicide prevention.
- Support expanded access to tele-behavioral health services, particularly in rural or underserved ZIP codes, through integration with USA Health's telemedicine platforms.

Adopting Best Practices from Peer Institutions

USA Health will explore several promising practices currently used by peer institutions to deepen impact and sustainability:

- Peer Support Specialists and Recovery Coaches: Integrate individuals with lived experience into behavioral health teams to support recovery from substance use, trauma, and mental illness—a model shown to increase engagement and retention in care.
- Violence Risk Assessments and Screening Tools: Adopt evidence-based screening tools (e.g., the SaFETy or VIP-RS tools) in emergency and primary care settings to identify individuals at high risk of violence involvement or behavioral health crises.
- Youth-Focused Resilience Programs: Implement curricula such as *Handle With Care*, *Youth ALIVE!*, or *Cure Violence* in collaboration with community partners to equip at-risk youth with tools for emotional regulation, conflict de-escalation, and goal setting.
- Behavioral Health Resource Navigation Apps: Pilot digital tools that allow patients, CHWs, and providers to locate and refer to vetted mental health services by zip code, service type, and payment option.

Monitoring and Evaluation

USA Health will monitor behavioral health and violence prevention initiatives through metrics such as program enrollment, referral completion rates, patient-reported outcomes, and geographic reach. Special attention will be paid to tracking youth engagement, reduction in repeat system involvement among program participants, and improved access to mental health services in priority populations. Evaluation findings will guide continuous improvement and inform future investment in behavioral health infrastructure.

Through the continued expansion of behavioral health services and targeted violence prevention strategies, USA Health is committed to advancing mental wellness, resilience, and safety across the community—especially among those historically underserved or at greatest risk.

Community Outreach and Health Education

Effective community outreach and health education are essential components of improving health outcomes, building trust, and advancing health equity. The 2025–2027 CHNA

underscores the importance of sustained, culturally relevant engagement with community members—particularly in addressing chronic disease, preventive health, and social determinants of health. In response, USA Health will continue to strengthen its existing community presence while expanding partnerships and adopting strategies to meet people where they are with timely, actionable health information.

Building on Existing Initiatives

USA Health has demonstrated a strong commitment to community-centered outreach and education through a range of ongoing programs. Its Medical Town Hall series, held in collaboration with community-based organizations, provides opportunities for residents to engage directly with physicians and healthcare professionals in a welcoming and conversational setting. These forums offer space to discuss common health concerns, dispel misinformation, and connect individuals with services and resources.

USA Health's outreach team actively participates in community health fairs and public events, offering blood pressure, glucose, and cancer screenings, along with health education materials tailored to the needs of diverse audiences. These events are conducted in collaboration with local schools, churches, and nonprofits to maximize reach and effectiveness.

Further, the Community Health Worker (CHW) Certification Course has helped to build a cadre of trusted, community-rooted public health workers who serve as a bridge between residents and healthcare services. CHWs are instrumental in providing health education, facilitating navigation of healthcare and insurance systems, and addressing access barriers related to transportation, housing, and food security.

During the 2025–2027 cycle, USA Health will:

- Expand its presence at community-based health events, with particular emphasis on high-need ZIP codes and underserved populations.
- Strengthen the deployment of certified CHWs in clinical, community, and school-based settings to provide one-on-one and group education on disease prevention and management.
- Develop targeted outreach strategies for non-English-speaking residents and immigrant populations.

Enhancing Education and Prevention

To ensure health information is accessible, engaging, and responsive to community needs, USA Health will:

- Launch a mobile health education initiative, delivering pop-up wellness booths and interactive learning experiences in neighborhoods, workplaces, and schools.
- Continue using multi-platform media strategies (social media, local radio, print, and in-person events) to disseminate information on preventive care, healthy lifestyles, and early warning signs of chronic disease.

- Collaborate with community partners to offer health literacy workshops focused on navigating health systems, reading medication labels, managing appointments, and understanding medical terminology.

Adopting Best Practices from Peer Institutions

USA Health will explore and consider adopting best practices from peer institutions to deepen the reach and impact of its outreach and education efforts. Such efforts may include but are not restricted to the following:

- Health Promoter (Promotores) Programs: Recruit and train trusted community members from diverse cultural and linguistic backgrounds to deliver peer education and outreach, as used successfully by hospitals in Texas and California.
- Barbershop and Salon Health Programs: Establish partnerships with barbershops and salons to provide blood pressure checks, health materials, and referrals—a model that has shown success in reducing hypertension among Black men.
- Faith-Based Health Ambassadors: Partner with churches and mosques to train congregation members as health ambassadors, offering education and basic screenings during religious gatherings.
- Digital Storytelling Campaigns: Use short videos and patient testimonials to share health journeys and encourage preventive care in relatable, community-voiced formats.

Monitoring and Evaluation

USA Health will evaluate its outreach and education efforts using both quantitative and qualitative indicators. Key metrics will include the number of outreach events, CHW encounters, community screenings conducted, and educational materials distributed. Feedback from participants will be collected through post-event surveys and community listening sessions to guide improvements and ensure programming remains culturally relevant and responsive to emerging health concerns. These efforts will also be supported by improved data coordination through the Center for Healthy Communities, enhancing USA Health's ability to assess program reach and impact.

Through sustained community presence, collaborative partnerships, and culturally tailored education, USA Health will continue to build a foundation of trust, awareness, and empowerment that supports long-term community health and resilience.

Implementation Oversight and Performance Monitoring

The successful execution of the 2025–2027 Implementation Strategy will be overseen by the **Center for Healthy Communities**, which will serve as the lead entity responsible for coordinating implementation activities, documenting progress, and evaluating outcomes across USA Health's community-facing initiatives. This integrated approach is intended to promote consistency, accountability, and data-informed decision-making system-wide.

The Center for Healthy Communities will, over the course of the 2025-2027 CHNA cycle, begin developing mechanisms for the following:

- Monitoring progress on strategic priority areas;
- Tracking key performance indicators and community impact measures;
- Identifying implementation barriers and/or resource needs;
- Facilitating cross-departmental collaboration;
- Making timely, evidence-based adjustments to programming and outreach efforts.

Each strategic priority—such as chronic disease management, cancer prevention, behavioral health, and access to care—will have designated leads or operational partners who will work in close coordination with the Center to ensure alignment with CHNA objectives and effective documentation of outcomes.

Program evaluation will rely on a combination of **quantitative metrics** (e.g., number of screenings, referrals, encounters, or educational sessions) and **qualitative feedback** (e.g., participant surveys, listening sessions, and partner feedback). These findings will inform ongoing strategy refinement and future CHNA planning.

By maintaining a structured framework for oversight and evaluation, USA Health affirms its commitment to delivering high-quality, community-responsive health improvement initiatives that address both medical and social drivers of health.

APPENDIX A – DEMOGRAPHIC DATA PROFILE

Please note that the charts in the demographic profile have been updated; however, the data tables below reflect the information from the previous CHNA.

Table 1a: County, State, and National Population by Age (2019) – Mobile County
Source: U.S. Census Bureau

	Mobile County	Percent of Total	Male	Female
Under 5 Years	27,444	6.64%	13,469	13,975
5 to 9 years	25,029	6.05%	11,570	13,459
10 to 14 years	27,817	6.73%	15,031	13,161
15 to 19 years	26,380	6.38%	13,732	12,648
20 to 24 years	26,087	6.31%	12,769	13,318
25 to 29 years	30,082	7.28%	15,102	14,980
30 to 34 years	28,433	6.88%	13,180	15,253
35 to 39 years	21,968	5.31%	10,879	11,089
40 to 44 years	27,322	6.61%	12,329	14,993
45 to 49 years	24,074	5.82%	11,593	12,481
50 to 54 years	24,986	6.04%	11,111	13,875
55 to 59 years	27,375	6.62%	12,528	14,793
60 to 64 years	28,204	6.82%	13,260	14,944
65 to 69 years	22,754	5.50%	11,269	11,485
70 to 74 years	17,722	4.28%	7,616	10,106
75 to 79 years	11,516	2.78%	4,985	6,531
80 to 84 years	8,828	2.13%	3,497	5,331
85 years and over	7,189	1.73%	2,336	4,853
Total	413,210	100.00%	196,310	216,900

Table 1b: County, State, and National Population by Age (2019) – Baldwin County
Source: U.S. Census Bureau

	Baldwin County	Percent of Total	Male	Female
Under 5 Years	10,616	4.75%	5,735	4,881
5 to 9 years	12,826	5.74%	5,849	6,977
10 to 14 years	14,373	6.43%	8,901	5,472
15 to 19 years	14,410	6.45%	7,670	6,740
20 to 24 years	11,292	5.05%	5,617	5,675
25 to 29 years	11,807	5.28%	6,008	5,799
30 to 34 years	12,594	5.64%	5,757	6,837
35 to 39 years	16,368	7.33%	8,245	8,123
40 to 44 years	12,109	5.42%	5,845	6,264
45 to 49 years	13,261	5.94%	6,458	6,803
50 to 54 years	14,024	6.28%	6,270	7,754
55 to 59 years	16,425	7.35%	7,620	8,805
60 to 64 years	15,441	6.91%	7,644	7,797
65 to 69 years	14,045	6.29%	6,084	7,961
70 to 74 years	14,873	6.66%	7,170	7,703
75 to 79 years	9,539	4.27%	3,677	6,276
80 to 84 years	4,472	2.00%	2,851	1,621
85 years and over	4,345	1.94%	1,791	2,554
Total	223,234	100.00%	109,192	114,042

Table 1c: County, State, and National Population by Age (2019) - Alabama
Source: U.S. Census Bureau

	Alabama	Percent of Total	Male	Female
Under 5 Years	286,597	5.83%	145,128	141,469
5 to 9 years	294,475	5.99%	148,829	145,646
10 to 14 years	317,645	6.47%	166,244	151,401
15 to 19 years	326,671	6.65%	164,949	161,722
20 to 24 years	317,739	6.47%	158,255	159,484
25 to 29 years	325,338	6.62%	162,250	163,088
30 to 34 years	312,065	6.35%	154,389	157,676
35 to 39 years	307,138	6.25%	156,135	151,003
40 to 44 years	298,601	6.08%	137,487	161,114
45 to 49 years	305,229	6.21%	147,542	157,687
50 to 54 years	304,162	6.19%	145,827	158,335
55 to 59 years	321,296	6.54%	148,502	172,794
60 to 64 years	331,917	6.76%	161,031	170,886
65 to 69 years	274,325	5.58%	126,212	148,113
70 to 74 years	231,232	4.71%	106,285	124,947
75 to 79 years	156,756	3.19%	69,081	87,675
80 to 84 years	107,315	2.18%	43,194	64,121
85 years and over	84,684	1.72%	28,271	56,413
Total	4,907,965	100.00%	2,369,611	2,533,574

Table 1d: County, State, and National Population by Age (2019) – United States
Source: U.S. Census Bureau

	United States	Percent of Total	Male	Female
Under 5 Years	19,404,835	5.91%	9,938,937	9,465,898
5 to 9 years	19,690,437	5.99%	10,033,518	9,656,919
10 to 14 years	21,423,479	6.52%	10,987,313	10,436,166
15 to 19 years	21,353,524	6.50%	10,903,653	10,449,871
20 to 24 years	21,468,680	6.53%	11,014,460	10,454,220
25 to 29 years	23,233,299	7.07%	11,817,829	11,415,470
30 to 34 years	22,345,176	6.80%	11,281,470	11,063,076
35 to 39 years	21,278,259	6.48%	10,892,040	10,836,219
40 to 44 years	20,186,586	6.14%	10,028,675	10,157,911
45 to 49 years	20,398,226	6.21%	10,079,567	10,318,659
50 to 54 years	20,464,881	6.23%	10,075,795	10,389,086
55 to 59 years	21,484,060	6.54%	10,440,265	11,043,795
60 to 64 years	20,984,053	6.39%	10,051,170	10,932,883
65 to 69 years	17,427,013	5.30%	8,191,111	9,235,902
70 to 74 years	14,148,548	4.30%	6,529,918	7,618,630
75 to 79 years	9,759,764	2.97%	4,367,764	5,392,000
80 to 84 years	6,380,474	1.94%	2,671,396	3,709,078
85 years and over	6,358,229	1.93%	2,284,092	4,074,137
Total	328,329,953	100.00%	161,588,973	166,650,550

Table 2: Population Classified by Race and Ethnicity (2019)
Source: U.S. Census Bureau

Race/Ethnicity	Mobile County	Baldwin County	State of Alabama	United States
Total Population	413,210	223,234	4,903,185	4,903,185
White	240,449	190,912	3,326,375	3,326,375
Black	150,159	18,338	1,319,551	1,319,551
Hispanic	12,443	10,534	219,296	219,296
Asian	7779	2,160	66,129	66,129
American Indian or Alaskan	2,915	2,428	23,265	23,265
Hawaiian or Pacific Islander	61	0	1,892	1,892
Other	3,449	4,685	74,451	74,451
Two or More Races	8,398	4,711	91,522	91,522

Table 3a: Population Classified by Race and Ethnicity (2013-2017) – Mobile County
Source: U.S. Census Bureau

Mobile County Race/Ethnicity	2015	2016	2017	2018	2019
Total Population	414,251	414,291	413,955	413,757	413,210
White	248,566	246,794	244,012	233,288	240,449
Black	145,175	146,306	147,234	148,775	150,159
Hispanic	10,917	10,957	11,943	12,648	12,443
Asian	8,148	8,140	7,504	8037	7779
American Indian or Alaskan	2,680	2,568	3,410	5,748	2,915
Hawaiian or Pacific Islander	64	49	79	138	61
Other	2,781	3,207	5,038	6,174	3,449
Two or More Races	6,837	7,227	6,678	7,697	8,398

Table 3b: Population Classified by Race and Ethnicity (2013-2017) – Baldwin County
Source: U.S. Census Bureau

Baldwin County Race/Ethnicity	2015	2016	2017	2018	2019
Total Population	195,121	199,510	212,628	218,022	223,234
White	168,646	172,441	183,893	187,759	190,912
Black	18,735	18,594	20,030	20,554	18,338
Hispanic	8,776	8,712	8,712	10,132	10,534
Asian	1,307	1,338	2,485	2,338	2,160
American Indian or Alaskan	1,166	1,355	2,172	1,209	2,428
Hawaiian or Pacific Islander	0	0	0	45	0
Other	1,766	1,899	2,586	4,685	1,766
Two or More Races	4,016	2,149	3,464	4,711	4,016

Table 3c: Population Classified by Race and Ethnicity (2013-2017) – Alabama
Source: U.S. Census Bureau

Alabama Race/Ethnicity	2015	2016	2017	2018	2019
Total Population	4,830,620	4,841,164	4,874,747	4,887,871	4,903,185
White	3,325,464	3,325,037	3,312,718	3,306,838	3,326,375
Black	1,276,544	1,282,053	1,307,467	1,307,040	1,319,551
Hispanic	193,492	193,503	201,970	211,485	219,296
Asian	59,599	60,744	66,908	65,095	66,129
American Indian or Alaskan	23,850	23,919	25,181	22,063	23,265
Hawaiian or Pacific Islander	2,439	2,008	1,581	1,797	1,892
Other	61,078	61,991	67,308	84,027	74,451
Two or More Races	81,646	85,412	93,584	101,011	91,522

Table 3d: Population Classified by Race and Ethnicity (2013-2017) – United States
Source: U.S. Census Bureau

United States Race/Ethnicity	2015	2016	2017	2018	2019
Total Population	316,515,021	318,558,162	325,719,178	327,167,439	4,903,185
White	232,943,055	233,657,078	235,507,457	236,173,020	3,326,375
Black	39,908,095	40,241,818	41,393,491	41,617,764	1,319,551
Hispanic	54,232,205	55,199,107	58,846,134	59,763,631	219,296
Asian	16,235,305	16,614,625	18,215,328	18,415,198	66,129
American Indian or Alaskan	2,569,170	2,597,817	2,726,278	2,801,587	23,265
Hawaiian or Pacific Islander	546,255	560,021	608,219	626,054	1,892
Other	14,865,258	15,133,856	16,552,940	16,253,785	74,451
Two or More Races	9,447,883	9,752,947	10,715,465	11,280,031	91,522

Table 4: Population by Poverty Level
Source: U.S. Census Bureau

		Population Total	Below 100% FPL	100 to 149% FPL	150% and Over FPL	% at 100 FPL	% at 149 FPL	% at 150 and Over FPL
Mobile	2015	414,251	76,488	45,694	277,073	18.46%	11.03%	66.89%
	2016	414,291	77,180	43,792	277,860	18.63%	10.57%	67.07%
	2017	413,955	77,784	45,243	279,070	18.79%	10.93%	67.42%
	2018	408,921	82,540	49,003	271,060	11.98%	11.98%	66.29%
	2019	408,458	69,254	36,331	296,976	8.89%	8.89%	72.71%
Baldwin	2015	195,121	24,949	19,117	154,274	12.79%	9.80%	79.07%
	2016	199,510	23,011	12,297	168,363	11.53%	6.16%	84.39%
	2017	212,628	19,409	13,701	174,279	9.13%	6.44%	81.96%
	2018	216,612	18,915	17,465	176,950	8.06%	8.06%	81.69%
	2019	221,737	22,043	22,803	173,062	10.28%	10.28%	78.05%
Alabama	2015	4,830,620	857,105	478,990	3,343,710	17.74%	9.92%	69.22%
	2016	4,841,164	794,258	483,084	3,411,191	16.41%	9.98%	70.46%
	2017	4,874,747	786,996	474,099	3,437,640	16.14%	9.73%	70.52%
	2018	4,832,358	784,168	474,825	3,451,639	9.83%	9.83%	71.43%
	2019	4,849,509	728,255	469,002	3,532,845	9.67%	9.67%	72.85%
United States	2015	316,515,021	45,286,625	28,319,483	236,144,610	14.31%	8.95%	74.61%
	2016	318,558,162	43,454,037	27,670,414	240,340,684	13.64%	8.69%	75.45%
	2017	325,719,178	41,824,483	27,131,398	245,151,630	12.84%	8.33%	75.26%
	2018	323,531,965	41,139,731	26,641,678	247,869,700	12.72%	8.23%	76.61%
	2019	324,665,523	38,851,528	25,266,951	252,537,631	11.97%	7.78%	77.78%

Table 5: Population over 25 years by Educational Attainment
Source: U.S. Census Bureau

		Less than High School Graduate	High school Graduate (includes equivalency)	Some College or Associate's Degree	Bachelor's Degree or Higher
Mobile	2015	48243	102778	99654	63299
	2016	46648	102705	100628	64915
	2017	45,018	103,474	100,728	66,241
	2018	44,711	106,443	98,729	66,439
	2019	43,682	107,860	97,335	67,426
Baldwin	2015	16918	44273	49336	40953
	2016	16822	45029	50800	42589
	2017	17,081	44,865	51,063	45,352
	2018	17,095	45,953	51,950	47,432
	2019	16,343	47,497	53,225	49,530
Alabama	2015	587452	1150810	1183615	796769
	2016	570203	1155930	1191896	817946
	2017	551,038	1,163,158	1,196,171	837,722
	2018	535,139	1,172,729	1,201,379	856,640
	2019	518,979	1,175,354	1,205,169	880,372
United States	2015	32,732,542	68,044,371	76,018,103	66,036,180
	2016	32,145,211	68,210,886	76,640,939	67,948,688
	2017	31,606,970	68,573,396	77,076,055	70,146,707
	2018	30,957,810	68,829,720	77,350,369	72,211,891
	2019	30,337,897	69,104,614	77,476,666	74,349,226

Table 6: Medicaid Births
Source: Alabama Public Health

		Total Births	Medicaid Births	Percent Medicaid
Mobile	2015	5,660	3,243	57.30%
	2016	5,502	3,082	56.02%
	2017	5,603	3197	57.06%
	2018	5,548	3244	58.47%
	2019	5,371	3,124	58.16%
Baldwin	2015	2,346	991	42.24%
	2016	2,247	1,024	45.57%
	2017	2,323	1051	45.24%
	2018	2,290	949	41.44%
	2019	2,330	1,048	44.98%
Alabama	2015	59,651	30,149	50.54%
	2016	59,090	29,845	50.51%
	2017	58,936	29116	49.40%
	2018	57,754	28431	49.23%
	2019	58,615	29134	49.70%

Table 7: Births by Race
Source: Alabama Public Health

		Total Births	Births White	% Births White	Births Black and Other	% Births Black and Other
Mobile	2015	5,660	3,036	53.64%	2,624	46.36%
	2016	5,502	2,998	54.49%	2,504	45.51%
	2017	5,603	2,976	53.11%	2,627	46.89%
	2018	5,548	2,912	52.49%	2,636	47.51%
	2019	5,371	2,740	51.01%	2,631	48.99%
Baldwin	2015	2,346	2,040	86.96%	306	13.04%
	2016	2,247	1,929	85.85%	318	14.15%
	2017	2,323	2,015	86.74%	308	13.26%
	2018	2,290	1,950	85.15%	340	14.85%
	2019	2,330	1,984	85.15%	346	14.85%
Alabama	2015	59,651	39,632	66.44%	20,019	33.56%
	2016	59,090	39,241	66.41%	19,849	33.59%
	2017	58,936	38,728	65.71%	20,208	34.29%
	2018	57,754	38,149	66.05%	19,605	33.95%
	2019	58,615	33,394	56.97%	24,181	41.25%

Table 8: Teen and Unwed Births
Source: Alabama Public Health

		Total Births	Births to Teens Total	Birth to Teens White	Birth to Teens Black and Other	Births to Teens Percentage	Unwed Birth Total	Unwed Birth Percentage
Mobile	2015	5,660	466	177	289	8.23%	3,034	53.60%
	2016	5,502	424	174	250	7.71%	2,947	53.56%
	2017	5,603	399	188	211	7.12%	3,215	57.38%
	2018	5,548	385	162	223	6.94%	3,156	56.89%
	2019	5371	373	153	220	6.94%	3,194	59.47%
Baldwin	2015	2,346	175	149	26	7.46%	885	37.72%
	2016	2,247	160	132	28	7.12%	929	41.34%
	2017	2,323	165	138	27	7.10%	896	38.57%
	2018	2,290	147	108	39	6.42%	868	37.90%
	2019	2,330	138	106	32	5.92%	939	40.30%
Alabama	2015	59,651	4,790	2,876	1,914	8.03%	26,150	43.84%
	2016	59,090	4,526	2,642	1,884	7.66%	26,408	44.69%
	2017	58,936	4,285	2,569	1,716	7.27%	27,736	47.06%
	2018	57,754	3,961	2,288	1,673	6.86%	26,991	46.73%
	2019	58,615	4,002	2,253	1,749	6.83%	28,326	48.33%

Table 9: Low Weight Births
Source: Alabama Public Health

		Total Births	Low Weight Births Total	Low Weight Births Percent
Mobile	2014	5,690	643	11.30%
	2015	5,660	683	12.07%
	2016	5,502	654	11.89%
	2017	5,603	605	10.80%
	2018	5,548	722	13%
Baldwin	2014	2,245	221	9.84%
	2015	2,346	199	8.48%
	2016	2,247	174	7.74%
	2017	2,323	178	7.70%
	2018	2,290	198	8.60%
Alabama	2014	59,532	6,024	10.12%
	2015	59,651	6,227	10.44%
	2016	59,090	6,104	10.33%
	2017	57,754	6,052	10.30%
	2018	58,615	6,192	10.70%

Table 10: Infant and Neonatal Death
Source: Alabama Public Health

		Infant Deaths Number	Infant Deaths Rate	Neonatal Deaths Number	Neonatal Deaths Rate	Post Neonatal Deaths Number	Post Neonatal Deaths Rate
Mobile	2014	58	10.2	37	6.5	21	3.7
	2015	43	4.6	24	4.2	19	3.4
	2016	57	10.4	38	6.9	19	3.5
	2017	38	6.8	20	3.6	18	3.2
	2018	50	9	30	5.4	20	3.6
Baldwin	2014	14	6.2	9	4	6	3.1
	2015	12	5.1	8	3.4	4	1.7
	2016	9	4	6	2.7	3	1.3
	2017	15	6.5	6	2.6	6	2.6
	2018	10	4.4	7	3.1	3	1.3
Alabama	2014	517	8.7	307	5.6	210	3.5
	2015	494	8.3	300	5	194	3.3
	2016	537	9.1	324	5.5	213	3.6
	2017	435	7.4	257	4.4	178	3
	2018	405	7	251	4.3	151	2.6

Table 11: Infant Death by Race
Source: Alabama Public Health

		Infant Deaths Number	Infant Deaths Rate	Number White	Rate White	Number Black and Other	Race Black and Other
Mobile	2015	43	4.6	10	3.3	33	12.6
	2016	57	10.4	21	7	36	14.4
	2017	38	6.8	15	5	23	8.8
	2018	50	9	18	6.2	32	12.1
	2019	37	6.9	12	4.4	25	9.5
Baldwin	2015	12	5.1	8	3.9	4	13.1
	2016	9	4	9	4.7	2	6.3
	2017	15	6.5	12	6	3	9.7
	2018	10	4.4	10	5.1	0	0
	2019	12	5.2	9	4.5	3	8.7
Alabama	2015	494	8.3	206	5.2	288	14.4
	2016	537	9.1	255	6.5	282	14.2
	2017	435	7.4	213	5.5	222	11
	2018	405	7	196	5.1	209	10.7
	2019	449	7.7	214	5.6	235	11.4

Table 12: Fetal Deaths and Induced Pregnancy Terminations
Source: Alabama Public Health

		Fetal Deaths Number	Induced Pregnancy Terminations Number	Induced Pregnancy Terminations Rate
Mobile	2015	39	649	7.7
	2016	63	391	4.6
	2017	49	336	4
	2018	45	140	1.7
	2019	48	433	5.2
Baldwin	2015	3	114	3.2
	2016	18	78	2.2
	2017	18	59	1.6
	2018	27	23	0.6
	2019	15	104	2.7
Alabama	2015	500	6848	7.1
	2016	517	5,193	5.4
	2017	569	6,959	7.3
	2018	551	6768	7.1
	2019	498	7381	7.8

Table 13: Deaths by Gender and Race
Source: Alabama Public Health

		Number	Rate	White Male	White Male Rate	White Female	White Female Rate	Black Male	Black Male Rate	Black Female	Black Female Rate
Mobile	2015	4283	10.3	1480	12.2	1361	10.7	784	10.2	659	7.3
	2016	4410	10.6	1478	12.3	1476	11.7	765	9.9	691	7.7
	2017	4302	10.4	1493	12.5	1393	11	771	9.9	645	7.1
	2018	4,494	10.9	1476	12.4	1449	11.5	813	10.4	756	8.3
	2019	4578	11.1	1539	13	1488	11.9	816	10.5	735	8
Baldwin	2015	2092	10.3	1033	11.9	903	9.9	74	5.8	82	6
	2016	1974	9.5	1012	11.4	804	8.6	90	7.1	68	4.8
	2017	2,188	10.3	1,083	12	922	9.7	95	7.3	88	6.2
	2018	2,358	10.8	1169	12.6	1027	10.5	71	5.4	91	6.3
	2019	2,283	10.2	1173	12.4	921	9.2	113	8.4	76	5.2
Alabama	2015	51,896	10.7	20,328	12.3	19,505	11.4	6,266	9	5,797	7.3
	2016	52,452	10.8	20,477	12.4	19,652	11.5	6,364	9.1	5,959	7.5
	2017	53,240	10.9	20,793	12.5	20,009	11.6	6,592	9.3	5,846	7.3
	2018	53,240	11.1	20,793	12.5	20,009	11.7	6,592	9.4	5,846	7.3
	2019	54,109	11	21,187	12.7	19,867	11.5	6,901	9.8	6,154	7.6

Table 14: Deaths
Source: Alabama Public Health

	Mobile 2015	2016	2017	2018	2019	Baldwin 2015	2016	2017	2018	2019
Heart Disease	1,097	1,124	1075	1147	1227	515	491	573	575	555
Rate	264.1	271	259.7	277.2	296.9	252.8	235.4	269.5	263.7	248.6
Malignant Neoplasm	890	867	894	925	881	453	461	489	546	480
Rate	214.3	209	216	223.6	213.2	222.4	221	230	250.4	215
Cerebrovascular Disease	221	248	210	263	289	114	110	121	143	104
Rate	53.2	59.8	50.7	63.6	69.9	56	52.7	56.9	65.6	46.6
Chronic Lower Respiratory	224	256	262	258	271	119	119	115	127	150
Rate	53.9	61.7	63.3	62.4	65.6	58.4	57.1	54.1	58.3	67.2
Accidents	206	182	227	213	214	106	98	88	112	120
Rate	49.6	43.9	54.8	51.5	51.8	52	47	41.4	51.4	53.8
Alzheimer's	146	170	170	159	188	80	63	70	84	70
Rate	35.1	41	41.1	38.4	45.5	39.3	30.2	32.9	38.5	31.4
Diabetes Mellitus	107	106	97	87	94	46	19	34	26	43
Rate	25.8	25.6	23.4	21	22.7	22.6	9.1	16	11.9	19.3
Influenza and Pneumonia	95	81	94	108	84	40	24	35	34	36
Rate	22.9	19.5	22.7	26.1	20.3	19.6	11.5	16.5	15.6	16.1
Nephritis, Nephrotic Syndrome, and Nephrosis	76	63	82	98	111	35	47	35	34	37
Rate	18.3	15.2	19.8	23.7	26.9	17.2	22.5	16.5	15.6	16.6
Suicide	66	69	64	62	64	45	42	39	44	39
Rate	15.9	16.6	15.5	15	15.5	22.1	20.1	18.3	20.2	17.5
Septicemia	104	100	77	108	68	21	26	40	32	31
Rate	25	24.1	18.6	26.1	16.5	10	12	18.8	14.7	9.4
Homicide	59	80	76	57	61	4	7	7	10	8
Rate	14.2	19.3	18.4	13.8	14.8	2	3.4	3.3	4.6	3.6
Chronic Liver Disease and Cirrhosis	52	73	65	54	68	40	27	45	37	43
Rate	12.5	17.6	15.7	13.1	16.5	19.6	12.9	21.2	17	19.3
Parkinson's	36	42	38	36	42	25	21	33	24	36
Rate	8.7	10.1	9.2	8.7	10.2	12.3	10.1	15.5	11	16.1
HIV	27	27	25	10	16	1	0	6	4	5
Rate	6.5	6.5	6	2.4	3.9	0.5	0	2.8	1.8	2.2
Viral Hepatitis	19	12	13	9	8	4	3	1	0	1
Rate	4.6	2.9	3.1	2.4	1.9	2	1	0.5	0	0.4
Other	498	508	455	489	500	274	267	279	341	341
Rate	119.9	122.5	109.9	118.2	121	134.5	128	131.2	156.4	152.8

**Note: Alabama Department of Public Health reports that there exists an error in the causes of death data for Baldwin County in 2010. This error has yet to be corrected and publicly released.

Table 15: Cancers
Source: Alabama Public Health

	Mobile 2015	2016	2017	2018	2019	Baldwin 2015	2016	2017	2018	2019
All Cancer	890	867	894	925	881	453	461	489	546	480
Trachea, Bronchus, Lung, and Pleura	234	243	263	269	216	155	128	132	159	135
Colorectal	87	64	79	74	75	35	37	44	43	39
Breast	56	60	56	75	68	33	31	32	38	26
Prostate	45	34	39	29	44	25	25	28	19	18
Pancreas	49	59	61	71	64	28	45	30	50	36
Leukemias	38	31	26	42	34	8	14	17	23	18
Non-Hodgkin's Lymphoma	17	26	28	19	26	14	3	14	15	15
Stomach	10	19	16	18	17	6	7	3	2	8
Esophagus	23	23	23	22	19	7	11	14	18	29
Brain and Other Nervous	20	19	25	26	26	9	12	13	14	21
Uterus and Cervix	16	14	10	6	10	9	3	3	4	2
Ovaries	21	22	18	18	18	12	7	22	12	13
Melanoma of Skin	23	14	14	19	12	9	8	6	5	11
All Other	251	239	106	97	104	103	130	60	52	44

**Note: Alabama Department of Public Health reports that there exists an error in the causes of death data for Baldwin County in 2010. This error has yet to be corrected and publicly released.

Table 16: Accidental Deaths
Source: Alabama Public Health

		All Accidents	Motor Vehicle	Suffocation	Poisoning	Smoke Fire & Flames	Falls	Drowning	Firearms	Other Accidents
Mobile	2014	198	85	7	52	9	11	7	1	26
	2015	206	69	9	69	5	22	13	1	18
	2016	182	74	5	55	6	15	6	0	21
	2017	227	93	10	48	6	27	8	1	34
	2018	213	86	13	55	8	25	7	0	19
Baldwin	2014	95	35	4	26	2	12	5	0	11
	2015	106	36	3	42	2	9	5	1	8
	2016	98	34	1	25	1	11	7	0	19
	2017	88	31	2	23	1	11	8	0	12
	2018	112	42	2	29	4	9	9	1	19
Alabama	2014	2421	891	122	644	84	221	75	28	356
	2015	2529	958	106	691	86	252	65	20	351
	2016	2747	1157	124	720	94	244	75	21	312
	2017	2700	1032	134	786	66	239	69	21	353
	2018	2682	1062	105	741	82	264	67	25	336

**Note: Alabama Department of Public Health reports that there exists an error in the causes of death data for Baldwin County in 2010. This error has yet to be corrected and publicly released.

APPENDIX B – COMMUNITY HEALTH SURVEY DATA TABLES

Table B.1: q1. Would you say that in general your health is . . . ?

		Mobile County
Excellent		7.7
Very Good		26.6
Good		41.1
Fair		18.1
Poor		6.6
	Total	100.1%
	N	443

Table B.2: q2. Thinking about Mobile County overall, how would you rate the health of people who live in Mobile County . . . ?

		Mobile County
Very Healthy		3.9
Healthy		27.0
Somewhat Healthy		58.6
Unhealthy		8.4
Very Unhealthy		2.1
	Total	100.0%
	N	382

Table B.3: q3. Overall, how would you rate the quality of healthcare services available in Mobile County . . . ?

	Mobile County
Excellent	12.0
Very Good	28.2
Good	34.7
Fair	21.1
Poor	3.9
Total	99.9%
N	432

Table B.4: q4. What type of healthcare insurance do you have?

	Mobile County
Private Insurance – Direct Purchase	14.3
Private Insurance – Employer Based	18.9
Private Insurance – Employer Based Spouse	2.3
Medicare	48.1
Medicaid	6.9
Tricare / Military Insurance	4.4
Other	2.1
No Insurance	3.2
Total	100.2%
N	435

Table B.5: q5. Do you have one person you think of as your personal doctor or health care provider?

	Mobile County
Yes, Only One	79.6
Yes, More than One	8.4
No	12.0
Total	100.0%
N	441

Table B.6: q6. How long has it been since your last visit to a doctor for a wellness exam or routine checkup . . . ?

	Mobile County
Within the past 12 months	91.9
1 to 2 years ago	4.8
2 to 5 years ago	2.3
5 or more years ago	0.7
Have never had one	0.5
Total	100.2%
N	442

Table B.7: q7. How long has it been since your last dental exam or cleaning . . . ?

		Mobile County
Within the past 12 months		74.3
1 to 2 years ago		12.4
2 to 5 years ago		7.6
5 or more years ago		4.8
Have never had one		0.9
	Total	100.0%
	N	436

Table B.8: q7a. In the last 12 months, have you used any telehealth services such as accessing a health provider by phone, Zoom, or text message?

		Mobile County
Yes		20.9
No		79.1
	Total	100.0%
	N	441

Table B.9: q7b. How would you rate the quality of your telehealth experience, would you say it was excellent, very good, good, fair, or poor?

		Mobile County
Excellent		20.0
Very good		33.3
Good		30.0
Fair		11.1
Poor		5.6
	Total	100.0%
	N	90

Table B.10: q7c. How interested would you be in receiving telehealth services from your health care provider . . . very interested, somewhat interested, not very interested, or not at all interested?

		Mobile County
Very interested		10.5
Somewhat interested		21.5
Not very interested		23.6
Not at all interested		44.5
	Total	100.1%
	N	335

Table B.11: q7d. Using a 7-point scale, where 1 is the worst possible and 7 is the best possible, how well do you feel that the City of Mobile has responded to the COVID-19 crisis?

	Mobile County
1 – Worst possible	2.4
2	2.1
3	8.0
4	11.9
5	33.7
6	18.8
7 – Best possible	23.1
Total	99.9%
N	377

Table B.12: q7e. Using the same scale, how well do you feel that local healthcare providers have responded to the COVID-19 crisis?

	Mobile County
1 – Worst possible	1.5
2	2.5
3	4.7
4	8.7
5	30.0
6	20.8
7 – Best possible	31.9
Total	100.1%
N	404

Table B.13: q8a – q8p For each item please tell me how important you think that item would be to improving the overall health in your community.

	Very Important	*Somewhat Important*	*Neither*	*Somewhat Unimportant*	*Very Unimportant*	*Total*	*N*
Q8a. Access to health services such a health clinic or hospital.	87.3	10.6	1.1	0.9	0.0	100.0%	442
Q8b. Active lifestyles including outdoor activities.	70.0	27.5	0.9	1.1	0.5	100.1%	437
Q8c. Affordable housing.	74.4	22.3	1.7	1.0	0.7	100.0%	422
Q8d. Arts and cultural events.	39.6	47.5	5.7	5.0	2.2	100.0%	419
Q8e. A clean environment including water, air, etc.	94.6	5.0	0.0	0.2	0.2	100.0%	441
Q8f. Family doctors and specialists.	89.6	8.8	0.9	0.2	0.5	100.0%	441
Q8g. Good employment opportunities.	84.4	13.7	1.4	0.0	0.5	100.1%	430
Q8h. Good places to raise children.	90.4	8.7	0.7	0.0	0.2	100.0%	436
Q8i. Good race relations.	83.2	13.8	1.6	0.9	0.5	100.0%	435
Q8j. Good schools.	91.6	7.3	0.2	0.7	0.2	100.1%	440
Q8k. Healthy food options.	85.5	13.2	0.9	0.0	0.5	100.0%	441
Q8l. Fewer homeless.	81.2	16.7	1.2	0.2	0.7	100.1%	419
Q8m. Less alcohol and drug abuse.	80.0	16.7	1.2	1.2	0.9	100.0%	430
Q8n. Lower crime and safe neighborhoods.	94.1	4.8	0.5	0.2	0.5	100.1%	440
Q8o. Less obesity.	75.0	22.2	1.6	0.7	0.5	100.1%	432
Q8p. Less sexually transmitted diseases.	86.7	11.0	1.2	0.7	0.5	99.9%	420

Table B.14: q8q – q8ae For each item please tell me how important you think that item would be to improving the overall health in your community.

	Very Important	*Somewhat Important*	*Neither*	*Somewhat Unimportant*	*Very Unimportant*	*Total*	*N*
Q8q. Less tobacco use.	74.1	19.1	3.0	2.1	1.6	100.0%	429
Q8r. Mental health services.	89.8	9.6	0.2	0.2	0.2	100.1%	439
Q8s. More quality education.	87.0	11.4	0.7	0.7	0.2	100.0%	439
Q8t. More quality health care options.	83.3	14.4	1.8	0.2	0.2	100.0%	438
Q8u. Good transportation options.	70.3	25.6	2.8	0.9	0.5	100.0%	437
Q8v. Religious and/or spiritual values.	75.5	17.9	4.4	1.4	0.9	100.0%	437
Q8w. Social support services such as food pantries and charity services.	75.4	21.4	1.4	1.4	0.5	100.1%	439
Q8x. Cancer Care.	93.2	6.4	0.0	0.5	0.0	100.0%	439
Q8y. Access to birth control.	74.6	20.9	2.6	1.0	1.0	100.0%	421
Q8z. Access to HPV, that is human papillomavirus vaccine, that helps prevent cancers.	84.2	12.4	1.7	0.2	1.4	100.1%	418
Q8aa. Regular access to gynecological or GYN examinations.	85.4	13.0	0.9	0.5	0.2	100.0%	439
Q8ab. Support services to assist people with extreme heat and/or cold.	76.6	21.8	0.9	0.5	0.2	100.1%	435
Q8ac. Support services to help people with natural disasters: flooding, hurricanes, tornadoes.	90.5	9.1	0.2	0.0	0.2	100.0%	440
Q8ad. Youth activities and resources, such as playgrounds, parks, and summer programs.	79.3	19.6	0.7	0.2	0.2	100.1%	440
Q8ae. Free health screenings, such as for blood pressure, skin cancer, etc.	79.3	19.6	0.2	0.7	0.2	99.9%	440

Table B.15: q9a – q9l For each health issue please tell me how important of a problem you feel that issue is for Mobile County.

	Very Important	*Somewhat Important*	*Neither*	*Somewhat Unimportant*	*Very Unimportant*	*Total*	*N*
Q9a. Accidental injuries at places like work, home or school.	51.9	39.7	4.4	2.8	1.2	100.0%	428
Q9b. Aging problems like dementia and loss of mobility.	82.8	16.1	0.5	0.7	0.0	100.1%	441
Q9c. Cancers.	91.1	8.0	0.9	0.0	0.0	100.0%	439
Q9d. Child abuse and neglect.	96.1	3.2	0.0	0.5	0.2	100.0%	436
Q9e. Dental problems.	63.5	33.5	1.4	1.4	0.2	100.0%	436
Q9f. Diabetes.	81.9	16.0	1.6	0.2	0.2	99.9%	437
Q9g. Domestic violence.	89.3	9.1	0.7	0.7	0.2	100.0%	440
Q9h. Drug use and abuse.	86.5	10.5	1.4	0.9	0.7	100.0%	438
Q9i. Fire-arm related injuries.	75.9	18.2	3.5	1.2	1.2	100.0%	424
Q9j. Heart-disease and stroke.	88.0	10.9	0.7	0.5	0.0	100.1%	441
Q9k. HIV/AIDS.	76.7	19.7	1.2	1.0	1.4	100.0%	421
Q9l. Homelessness.	78.1	19.4	1.9	0.5	0.2	100.1%	433
Q9m. Homicides.	81.7	14.4	1.8	1.1	0.9	99.9%	437
Q9n. Infant death.	84.0	12.8	1.5	1.2	0.5	100.0%	413
Q9o. Infectious diseases like hepatitis and tuberculosis.	73.0	21.7	2.5	1.2	1.6	100.0%	433
Q9p. Mental health problems.	89.3	8.9	1.4	0.5	0.0	100.1%	440
Q9q. Motor vehicle crash injuries.	70.4	24.8	3.0	1.4	0.5	100.1%	436
Q9r. Obesity or excess weight.	70.9	25.9	2.8	0.5	0.0	100.1%	437
Q9s. Rape and sexual assault.	88.6	8.4	1.6	0.9	0.5	100.0%	429
Q9t. Respiratory problems and lung disease.	80.7	15.7	2.5	0.9	0.2	100.0%	440
Q9u. Sexually transmitted diseases.	77.0	18.4	2.1	2.3	0.2	100.0%	430
Q9v. Suicide.	85.2	12.0	1.4	1.2	0.2	100.0%	432
Q9w. Teenage pregnancy.	79.2	17.6	1.9	1.2	0.2	100.1%	433
Q9x. Tobacco Use.	66.1	27.0	3.9	1.2	1.9	100.1%	433

Table B.16: q10a – q10l For each health condition, please tell me if a doctor or other health care professional has ever told you that you have that condition.

	Yes	*No*	*Total*	*N*
Q10a. Asthma.	15.5	84.5	100.0%	439
Q10b. Chronic obstructive pulmonary disease or COPD.	8.7	91.3	100.0%	439
Q10c. Dementia or Alzheimer's.	1.4	98.6	100.0%	441
Q10d. Depression.	22.3	77.7	100.0%	440
Q10e. Diabetes.	26.1	73.9	100.0%	440
Q10f. Heart Disease.	19.7	80.3	100.0%	441
Q10g. High Cholesterol.	50.7	49.3	100.0%	440
Q10h. High blood pressure.	60.7	39.3	100.0%	440
Q10i. HIV or Aids.	0.9	99.1	100.0%	441
Q10j. Obesity.	22.1	78.0	100.1%	440
Q10k. Tuberculosis.	1.4	98.6	100.0%	439
Q10l. Alcohol or drug addiction.	3.4	96.6	100.0%	440
Q10m. Cancer Care.	18.0	82.0	100.0%	438

Table B.17: q11. Thinking about your experience with healthcare services in Mobile County, please tell me if there are any healthcare services which you feel are difficult to get in Mobile County? Select All That Apply[1]

	Mobile County
Alternative therapies (acupuncture, herbals)	5.64
Dental care / dentures	9.03
Emergency medical care	8.35
Hospital care	5.19
Laboratory services	5.19
Mental health services	26.41
Physical therapy / rehabilitation*	6.32
Preventative healthcare (routine or wellness checkups)	7.22
Prescriptions / pharmacy services	6.32
Primary medical care (primary doctor or clinic)	6.55
Services for the elderly*	13.32
Specialty medical care (specialist doctors)	12.87
Alcohol or drug abuse treatment*	7.22
Vision care / eye exams / glasses	6.55
Women's health	6.55
X-rays	3.39
Mammograms	3.39
Other	9.03
None	53.5
N	443

[1] May add to more than 100% since respondents could select all that apply.

Table B.18: q12. In the past 12 months, have you delayed getting needed medical care for any reason?

	Mobile County
Yes	15.9
No	84.1
Total	100.0%
N	441

Table B.19: q13. (Of those saying YES to Q12) Why did you delay in getting needed medical care? Select All That Apply[1]

	Mobile County
Could not afford medical care	25.7
Insurance problems / lack of insurance	12.9
Lack of transportation	1.4
Language barriers / could not communicate	1.4
Provider did not take my insurance	0.0
Provider was not taking new patients	1.4
Could not get an appointment soon enough	15.7
Could not get a weekend or evening appointment	1.4
Other	1.4
N	70

[1] May add to more than 100% since respondents could select all that apply.

Table B.20: q14. When you or someone in your family is sick, where do you typically go for healthcare?

	Mobile County
Emergency room (hospital)	12.0
Family doctor	61.4
Any doctor	0.2
Urgent care clinic	21.7
Health department	1.4
Community health center	0.5
Free clinic	0.2
VA / Military facility	1.4
Other	1.4
I usually go without receiving healthcare	0.0
Total	100.2%
N	443

Table B.21: q15. Thinking about yourself personally, how confident are you that you can make and maintain lifestyle changes like eating right, exercising, or not smoking . . . ?

	Mobile County
Extremely confident	35.8
Very confident	42.0
Somewhat confident	17.7
Not very confident	3.2
Not at all confident	1.4
Total	100.1%
N	441

Table B.22: q16. Do you currently use any tobacco products such as cigarettes, cigars, chewing tobacco, snuff, vaping or e-cigarettes? Select All That Apply[1]

	Mobile County
Yes, cigarettes or cigars	9.5
Yes, chewing tobacco, snuff	1.8
Yes, vaping or e-cigarettes	3.8
No, quit in the last 12 months	1.4
No, quit more than a year ago*	7.2
No, never used tobacco products	79.7
N	443

[1] May add to more than 100% since respondents could select all that apply.

Table B.23: q17. How long would you be willing to wait to for a well visit to see your preferred provider . . . ?

	Mobile County
Less than a day	12.9
Up to 7 days, 1 week	43.6
Up to 2 weeks	16.5
Up to 3 weeks	5.0
Up to 1 month	8.4
Up to 2 months	3.4
Up to 3 months	3.2
Up to 4 months or longer	7.2
Total	100.2%
N	443

Table B.24: q18. How likely would you be to accept an appointment with a PA or physician's assistant if you could see them sooner than your preferred provider?

	Mobile County
Very Likely	63.2
Somewhat Likely	23.2
Neither Likely nor Unlikely	3.7
Somewhat Unlikely	4.4
Very Unlikely	5.5
Total	100.0%
N	435

Table B.25: q19. How likely would you be to accept an appointment with a NP or nurse practitioner if you could see them sooner than your preferred provider?

	Mobile County
Very Likely	65.5
Somewhat Likely	23.8
Neither Likely nor Unlikely	2.1
Somewhat Unlikely	3.2
Very Unlikely	5.3
Total	99.9%
N	432

Table B.26: q20. How far would you be willing to travel for a well visit to see your preferred provider . . .

	Mobile County
Less than a 10 miles	7.5
Up to 5 miles, Approximately 10 minutes	21.7
Up to 10 miles, Approximately 20 minutes	29.1
Up to 20 miles, Approximately 35 minutes	23.5
Up to 30 miles, Approximately 45 minutes	9.5
Up to 40 miles, Approximately 55 minutes	3.2
Up to or greater than 50 miles, Approximately 1 hour or longer	5.6
Total	100.1%
N	443

Table B.27: q21. How did you select your primary care physician? Select All That Apply[1]

	Mobile County
Recommended by a family member,	24.8
Recommended by a close friend,	17.6
Recommended by a co-worker or acquaintance	5.2
Recommended by another health care provider	20.1
Saw/found them on social media	0.7
Saw/found them in Internet reviews	2.3
Saw/found them on television	0.5
Saw/found them on radio,	0.5
Saw/found them on billboards or other print media like pamphlets	0.2
It was the only provider that I was able to get an appointment with	1.1
It was the only provider that my insurance would cover	2.3
Reputation of the hospital/health system, e.g., hospital/health system rankings	5.9
Other	14.2
None	8.8
N	443

[1] May add to more than 100% since respondents could select all that apply.

Table B.28: D1. Age – Calculated from year respondent was born.

		Mobile County
18 to 30		5.0
31 to 45		8.8
46 to 65		20.4
Over 65		65.8
	Total	100.0%
	N	421

Table B.29: D5. What is your race?

		Mobile County
White / Caucasian		65.7
Black / African-American		30.3
Hispanic or Latino		0.5
Asian		0.2
American Indian / Alaskan Native		0.0
Pacific Islander		0.5
Multi-racial		0.7
Other		2.3
	Total	100.2%
	N	443

Table B.30: D6. What is the highest level of school you have completed or the highest degree you have received?

	Mobile County
Never attended school or only Kindergarten	0.0
Grades 1 through 8	0.9
Some High School (grades 9 through 11)	4.3
High School Degree or GED	26.7
Vocational / Technical School	4.8
Some College	26.9
Bachelors or 4 Year College Degree	25.3
Graduate or Professional Degree (Law Degree)	11.0
Total	99.9%
N	438

Table B.31: D7. What is your current employment status?

	Mobile County
Disabled / Unable to work	5.9
Employed full-time	23.3
Employed part-time	4.6
Homemaker / Housewife or househusband	2.3
Retired	58.7
Seasonal worker	0.0
Student	1.1
Self-employed	1.4
Unemployed	2.7
Total	100.0%
N	438

Table B.32: D8. And finally, what was your total family income last year . . . ?

	Mobile County
Less than $15,000	7.2
$15,000 - $25,000	9.8
$25,000 - $35,000	17.1
$35,000 - $50,000	18.5
$50,000 - $75,000	17.6
$75,000 - $100,000	13.3
More than $100,000	16.5
Total	100.0%
N	346

Table B.33: Sex

		Mobile County
Male		31.2
Female		68.9
	Total	100.1%
	N	443

APPENDIX C – COMMUNITY HEALTH SURVEY OPEN-ENDED RESPONSES

Q11. Thinking about your experience with healthcare services in Mobile County, please tell me if there are any healthcare services which you feel are difficult to get in Mobile County?

- cancer care
- skin care
- waiting
- ONE HOSPITAL HAVE ALOTS OF PEOPLE WHERE THEY BLOCK THE OTHER THE HOSPITAL
- pain managerment and price of over-the-counter medcine are too high
- lymphedema clinic
- cancer treatment centers
- family doctors
- lung screenings
- getting city council to do what is needed
- support for grief
- animal care
- customer service
- holistic
- all of these are difficult without insurance
- good doctor
- getting blood
- AIDS awareness
- mri
- transportation
- treating older people
- #NAME?
- dementia or althimers
- hiv and aids medcine is hard to get
- ER's
- pain medcine
- respondent believes France has a better health care system
- multiplescrollosis center
- courts don't do enough with mental health, more transportation
- finacial help to help a family member
- heart care
- home visits
- more urgent cares stay open late
- ambulance services- not covered under insurance
- pediatrictics rheamotoidologist
- support services for HIV pts

Q13. Why did you delay in getting needed medical care?

- lack of specialist
- caregiver for mother in law
- Fear
- Specialist was booked for several months
- don't trust tne doctors
- death in family
- was not sure he wanted to do it
- wasn't serious enough
- Im overweight and feel doctors write me off.
- took a long time to respond back/conflict of scheduling
- couldn't get time off work
- wanted to wait until after thanksgiving
- son cancer
- finding a good doctor
- finding a new dentist
- out of town
- issiue with doctor
- i am putting off
- was in denial
- scare of doctors
- medcine to strong
- doctor closing to early
- did not like the doctor when he was younger
- diddnt want to go to the hospitol
- too busy
- thought home remedy would work
- Problem with eye
- taking care of daughter with colon cancer
- illness in family
- Terrible doctor who didnot takte my issues
- noone to care for bedridden husband
- Can not find a right doctor

Q21. How did you select your primary care physician - other?

- work with them
- kept the doctors she had
- close by and associated with her hospitol
- not very full with appointments
- Walk in
- where he went to med school
- because of price
- Interviewed certain doctors.
- new doctor took over old PCP's practice
- dont rember
- meeting on ER visit
- traffic
- close to house/ transportation
- hospital reccomendation
- He researched and shopped around for a dr with good bed side manner, etc
- Distance of office was close to house
- no personal dosctor
- close to home
- phone book
- insurance told them
- on insurance list
- can't recall, been 40 years!
- saw them in action
- don't have one
- just looked in the phone book
- knew of them because of previous involement
- took care of him during a heart emergency
- USA army
- worked on providence and picked the doctor
- other healthcare provider left and he picked between two and is happy
- by insurance provider
- just picked themselves
- old doctor retired, selceted from list given by old PCP
- live close by
- pick doctor off list given by office
- searched the internet
- picked them out after primary retired
- proximity
- the insurance changed my provider and who I could see
- proximity
- proximity
- doesnt have a primary care physician
- convenience
- took ovetr prior dr
- researched doctors credentials on internet
- cant rember how selected

- justn picked one
- can not remember
- proximity
- through ther VA
- looked on insurance and seen doctors name
- cant remember
- one of their doctors died and this other doctor took their place.
- through insurance company
- dpesnt remember
- knew from work
- selected by insurance
- prev doctor retired, stated seing NP in same practice
- dont remember
- through the military
- always been the provider
- called the office and they said to come in.

Q21. Thinking again about healthy communities, are there any other items, resources, or services that you feel are needed in your neighborhood to make it a healthier community?

- community center- needs medic for pool/ park
- need more specialists
- no
- Transportation downtown at night, not safe for Uber, help around house, handyman, very little things for children to do in the community, addiction care
- no
- better seniors activity
- no
- no
- dental
- keep a better cleaner yard
- no
- no
- Safer walking areas and sidewalks.
- nothin I can think
- Have more sidewalks so people would be encouraged to walk
- MORE CHOICES MORE PRIVATE CHOICES
- Safer neighborhood
- Easier access to talking to doctors
- dog catcher
- In general air and water improvwement
- no
- no
- more healty food store, farmer market for fresh fruits
- more dedicated walking areas parks
- no
- no
- no
- There not enough facilities for patients with trachea
- making sure water is safe to drink
- no
- Less smoking
- no
- meals on wheel
- needing more YMCA, now 30pounds heavier.
- mental health services
- some type of directory to find different type of doctors
- more access to primary care
- no
- More specialists
- Im surprised that are not more food banks
- Psychiatrists and rehab centers
- Transportation
- no
- people gathering as a community
- no

- no
- none
- movitation education finding people needs
- no
- more general practioner and cancer doctors
- Another doctor
- start training children early to cook
- less fast food more
- More information to victims famileys about services for mental health and mobility.
- more drug treatment center
- better school after care program
- no
- no
- no
- no
- fire hydrant
- more mental health
- lower prices on health so everyone can have it
- no
- no
- no
- Easier dental options for seniors
- We are in need a larger hospital
- Primary Care
- Primary care providers, another hospital.
- none
- no
- none
- gym
- no
- no
- no
- Public transport for people who do not get around well. Primary care is hard to get.
- more transportation besides BRAT
- no
- no
- more affordable inssurance
- None
- noe
- Attitude of health care. Two friend died shortly after being examined.
- no
- Baldwin county}}} more public transportation
- need a recreational director for pool area and more activty
- general doctors
- More Police presence in the communitie
- odor from waste treatment plant -- need help
- more home visits
- clean up garbage and litter on side of road
- More people that support aff ordable sitters and caregivers that come by the house. Hiring caregivers at a cheaper rate.

- better police protection
- My community is really good at providing health care service. Transportation, it is hard to get around when you do not have a car and they charge so much to get from point a to point b. When you live on a fixed income it is hard to find the extra money to put aside for this type of thing.
- remove copper water lines for purer drinking/ bathing water
- There can be improvements in every area need for the community
- Transportation needs attention; and it is too expensive. Less regulations on healthcare insurance and more easy explanations. Better polite officer responding to accident
- none
- no
- affordable housing for low income people,education to maintain life and maintain a healthy lifestyle. Things for the children within the community for kids to do within their home city. City involvment into imporving the childhood lifestyle.
- no not really, living in the same place for over 50 years.
- none
- There is too much wasted time within school on things that are not pertaining to heathcare. Too much overview on sexual orrientation and not about sexual education. Leave the discussion up to the parents, and do not force anything against the parents permission. Abortion within schools and gender care is hurting the school system. Govermental abuse is too prominet in the school system. Schools keeping secrets from the parents regarding the child and the lifestyle choices that the child wants to have. Not pleased with the conversations about gender confusing. There is too much goverment interference. Public schools have had goverment boundary interference. Does not care about pronoun care, cares about wants men out of womens bathrooms and to protect the children. Abuse in medical authority.
- none
- none
- already knew them
- More doctors less people moving here We need to catch up on traffice lights
- no
- no
- more acess to health equipment
- none
- need urgent care clinics and doctors in every community. Need to have long tern Mental Hospitals in stead of Alta Pointe. prisons have become the Mental Health Hospital. Needs to be better medical evaluation of the Drs patients so they can prefer insulin and/or diabetic medication to patients. There are pt who are getting insulin when they should only be getting a diabetic pill and vice versa. Feel different medicines is being pushed on pts . Drs need to focus on what medicine is best for pts overall health. There should be goverment provided locks for weapons to help prevent unneccessary injuries. Local pharmacys need to be able to renew patients perscriptions as perscriptions expire. Need a better perscription renewal between pharmacys and doctors.
- none
- no
- more sidewalks
- none
- more help for the homeless
- more mental health services
- houseing for homeless more mental health care
- everything
- mental health services
- sidewalks
- no
- Communities need more walking trail

- have free classes for mental services eductation on taking care of your body food bank for everybody for people not recieving food stamps
- no
- no
- no
- no
- no
- no
- None come to mind, drug abuse center to help them recover and to help the youth to quit vaping and smoking weed.
- none that comes to mind
- sidewalks, traffic lights.
- screen test and mental services and heart health
- Mobile county
- none
- willing to listen
- a place to go walking/exercise
- none
- funding for after school program
- MOBILE HEALTH CLINIC TO VISIT NEIGHBORHOODS AND PARKS. MORE EDUCATION IN SCHOOL ABOUT HEALTH.
- no
- drug treatment mental health
- more elderley services
- More walking access. More curbs
- Lab services in your area. XRay services.
- none
- better food in school better riding and wakking trails
- Homeless assistance.
- Mental health wise, there is a pretty bad mental health system in alabama. Sister with epilepsy that turns into mental health crisis for the family and the services are difficult to obtain.
- Recreation Parks for kids to have to get activities to become more healthier
- more fruit stands
- support groups for autism /als, need more children physchiatry
- Sidewalk for exercises purposes.
- mor thing to do for kids a rec.
- they need to be quicker in constuction.
- no
- more food assess more stores
- no
- no
- mental facilities
- The only thing is free health care and mental health awareness needs to be dealt with seriously. Poeple suffer in silence and need help available
- dont have a doctor yet
- no
- no
- mental health
- for people of low income should be provide some type of medical help more mental health care
- more food banks- there are not any close by

- people to help elderly in community
- none
- more transportation for Dr appts, better housing for homeless
- updated animal shelter
- Mental Health services
- Mobile County less vandalism
- free clinic /
- clean enviroment
- none
- sidewalks
- more hospitals
- Housing for homeless. More jobs
- no
- no
- better transportation for elder and in home visits and stop closing small hospital
- More mental health and suicide prevention services
- no
- no
- care for people with out insurance
- no
- no
- no
- More informaton about home care
- no
- no
- none
- the cost of medicine for insulin is too high and needs to be more reasonable
- assistance for elderly , custodian care, county transportation for elderly
- something for the homeless
- none
- more health services, home visits
- none
- None
- more things for the elder
- none
- More patroling late at night aka drug exchanges
- no
- mobile cnty
- mental care
- Need a clinic closer to neighborhood
- no
- more wellnesss check
- none
- no
- no
- no
- no
- clinic/free/working people to asist working people
- more parks

- The state should adopt medicaid.
- no
- none
- no
- bike lanes monkey bars in parks
- Can't think of any
- Help people living in overgrown areas
- Education at young age would be more helpful and Mental health help to remove the stigma
- Its a matter of people being able to afford to be healthier. Being able to afford to purchase food to eat health. Make life affordable to grow our own foods. Just make life affordable again. Stop building section 8 housing for people who don't wont to work.Make it harder for people to live on assistance and easier for the working class citizens. Do mor e drug screening for people who get public assistance
- Mental health services
- no
- acess to healthy food
- more health service more health food stores more fresh vegetable
- None that I can think of
- Nearer healthy food option markets in communities so people wont have to travel so far to purchase
- Mental health services
- none
- closer er's more doctors
- bike lane, people would use that for transportation if needed and do not have a car
- less crime
- more police patrols and street lights
- Lives in Mobile. Having to not pay co pays for procedures, medicines
- healthy food option
- /more activities for elders /teens mothers for looking or careing for them as a adult mother or house mother/bug sprayer/keeping gress cut
- none
- have food donation
- Transportation options for people who do not have a car.
- mental health is needed badly
- no
- no
- maintaning and reopening the county parks being back open
- To have Police patrol areas in neighborhoods more frequently to feel more safe because of crime.
- no
- asess to groscie store/
- no
- more parks
- None at this time
- cheaper dentists
- get the drugs and dealers out
- drug clinic
- services for mental
- no
- need more transportation to medical care
- up keep of propertys renter properties kepted up
- no
- gave people what they need can make it a healther community

- no
- community gardens, early reading intervention
- no
- need more specialist
- no
- police , have alot of peple speed in neighborhood
- no It is good now
- good roads
- no
- more health and services for the homeless, transportation assistance
- more options for seniors
- Traffic issues surrounding area, causing wrecks.
- a hospital
- no
- no
- could use an urgent care, doctors office
- no
- none
- no
- none
- better ability to walk in areas, sidewalks
- need more of everthing elderly care more hospital care
- Medicaid expansion, this is their main problem. People do need access to contraceptives. More help towards people with disabilities like autism, mental health assistance. Be mindful of indivisuals with social security as well.
- no
- None
- free healthcare for all
- none
- obesity , what peopl e consume in their daily lives and mental health
- no
- none
- none
- none
- childern more play grounds
- none
- no ne
- no
- Fix the roads.
- none
- no
- no
- Waling trails
- no
- Emergency medical care access that is closer.
- help for the homeless in the neighborhood teen guidance
- obesity
- ER assit
- no
- no

- ascess to gym
- pick herself
- no
- mental health care, affordable health care insurance
- more food pantries, shelters, free health screenings
- no
- more police patrols, power is unstable and needs to go underground
- More playgrounds, and clean up, and safe neighbohood
- mental help help for older people
- affotable health insurance
- Money to fund more access to healthcare services.
- mental health
- Better education of people living in the communities of health care services
- sidewalks
- pain managerment
- none
- no
- none
- more fresh food options
- more medical worker
- no
- more urgent cares
- More Health Fairs to educate communities. Free Community testing
- a gym- family to accomadate all family members
- none
- none
- none
- no
- needs a doctor in area
- None
- no
- Better responsive doctors
- closer ER in neighborhood
- Foster care services, battered women sevices, updating parks with exercise equip, senior programs.
- no
- no
- none
- Mental health facilities
- None
- more walking area
- more health places
- no
- none
- closer eye doctor
- none
- no
- no MRI machine in Creola,Al
- more playgrounds
- None she can think off

- places to walk , closer hopital
- no
- After teaching kids with problems, would like to see more services for mental
- no
- openness to mental health growth Include small businesses and otheres to encourage more interest. Professional sucide wings and addr essing any addition included homeless regarding mental. Encouraging mental health for families to take of children. More care of our professionals who are over worked
- more parks
- Home health services could be improved
- no
- None
- none
- none
- no
- None that can be thought of
- had to travel to Tennessesee for specialty care for 16 yr old
- no
- none
- none
- high population of homeless

APPENDIX D – COMMUNITY HEALTH LEADERS SURVEY DATA TABLES

Table D.1: q1. What do you think are the most important features of a "Healthy Community"? Check only three[1]

	Frequency	*Percent*
1a. Access to health services (e.g., family doctor, hospitals)	39	68.4
1b. Active lifestyles / outdoor activities	8	14.0
1c. Affordable housing	14	24.6
1d. Arts and cultural events	1	1.8
1e. Clean environment (clean water, air, etc.)	11	19.3
1f. Family doctors and specialists	3	5.3
1g. Good employment opportunities	12	21.1
1h. Good place to raise children	3	5.3
1i. Good race relations	0	0.0
1j. Good schools	6	10.5
1k. Healthy food options	4	7.0
1l. Low numbers of homeless	1	1.8
1m. Low alcohol and drug use	2	3.5
1n. Low crime / safe neighborhoods	17	29.8
1o. Low percent of population that are obese	3	5.3
1p. Low numbers of sexually transmitted diseases (STDs)	0	0.0
1q. Low tobacco use	0	0.0
1r. Mental health services	13	22.8
1s. Quality education	12	21.1
1t. Quality hospitals and urgent / emergency services	8	14.0
1u. Good transportation options	2	3.5
1v. Religious or spiritual values	4	7.0
1w. Social support services	5	8.8
1x. Some other feature	3	5.3
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

Table D.2: q2. What do you think are the most important health issues in Mobile County? Check only three[1]

	Frequency	*Percent*
2a. Accidental injuries (at work, home, school, farm)	2	3.5
2b. Aging problems (e.g., dementia, vision / hearing loss, loss of mobility)	10	17.5
2c. Cancers	12	21.1
2d. Child abuse / neglect	11	19.3
2e. Dental problems	3	5.3
2f. Diabetes	7	12.3
2g. Domestic violence	4	7.0
2h. Drug use / abuse	19	33.3
2i. Fire-arm related injuries	6	10.5
2j. Heart disease and stroke	14	24.6
2k. HIV / Aids	0	0.0
2l. Homelessness	12	21.1
2m. Homicide	4	7.0
2n. Infant Death	0	0.0
2o. Infectious diseases (e.g., hepatitis, TB, etc.)	1	1.8
2p. Mental health problems	39	68.4
2q. Motor vehicle crash injuries	2	3.5
2r. Obesity / excess weight	15	26.3
2s. Rape / sexual assault	1	1.8
2t. Respiratory / lung disease	3	5.3
2u. Sexually Transmitted Diseases (STDs)	2	3.5
2v. Suicide	2	3.5
2w. Teenage pregnancy	0	0.0
2x. Tobacco use	0	0.0
2y. Some other health issue	2	3.5
2z. Some other health issue	0	0.0
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

Table D.3: q3. Which of the following unhealthy behaviors in Mobile County concern you the most? Check only three[1]

	Frequency	*Percent*
3a. Alcohol abuse	16	28.1
3b. Drug abuse	33	57.9
3c. Excess weight	18	31.6
3d. Homelessness	22	38.6
3e. Lack of exercise	11	19.3
3f. Poor eating habits / poor nutrition	32	56.1
3g. Not getting shots to prevent disease	5	8.8
3h. Not using seat belts / child safety seats	1	1.8
3i. Not seeing a doctor or dentist	18	31.6
3j. Tobacco use	6	10.5
3k. Unprotected / unsafe sex	2	3.5
3l. Some other unhealthy behavior	7	12.3
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

Table D.4: q4. Which healthcare services are difficult to get in Mobile County? Check all that apply[1]

	Frequency	*Percent*
4a. Alternative therapies (acupuncture, herbals, etc.)	10	17.5
4b. Dental care including dentures	10	17.5
4c. Emergency medical care	2	3.5
4d. Hospital care	6	10.5
4e. Laboratory services	2	3.5
4f. Mental health services	47	82.5
4g. Physical therapy / rehabilitation	2	3.5
4h. Preventative healthcare (routine or wellness check-ups, etc.)	16	28.1
4i. Prescriptions / pharmacy services	7	12.3
4j. Primary medical care (a primary doctor / clinic)	10	17.5
4k. Services for the elderly	15	26.3
4l. Specialty medical care (specialist doctors)	10	17.5
4m. Alcohol or drug abuse treatment	18	31.6
4n. Vision care (eye exams and glasses)	3	5.3
4o. Women's health	4	7.0
4p. X-Rays or mammograms	1	1.8
4q. Cancer Care	4	7.0
4r. Some other healthcare service	1	1.8
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

Table D.5: q5. Overall, how would you rate the health of people who live in Mobile County?

		Frequency	*Percent*
Very healthy		0	0.0
Healthy		5	8.8
Somewhat healthy		35	61.4
Unhealthy		14	24.6
Very unhealthy		3	5.3
Don't Know		0	0.0
	N	57	100.1

Table D.6: q6. Overall, how would you rate the quality of healthcare services available in Mobile County?

		Frequency	*Percent*
Excellent		2	3.5
Very good		10	17.5
Good		27	47.4
Fair		14	24.6
Poor		3	5.3
Don't Know		1	1.8
	N	57	100.1

Table D.7: q7. What is the primary type of service(s) you or your organization provide?

		Frequency	*Percent*
Alcohol / substance abuse treatment		1	1.8
Business		0	0.0
Clothing / thrift store		1	1.8
Disability services		1	1.8
Education		11	19.6
Employment / job training		0	0.0
Faith based counseling		0	0.0
Financial counseling		0	0.0
Food assistance		3	5.4
Government		5	8.9
Healthcare		10	17.9
Housing / temporary shelter		6	10.7
Legal aid		0	0.0
Mental health		1	1.8
Pregnancy or adoption assistance		0	0.0
Public Service		3	5.4
Senior services		1	1.8
Utility payment assistance		2	3.6
Some other services		11	19.6
	N	56	100.1

Table D.8: q8. Which of the following best describes the clients you serve?

		Frequency	*Percent*
Active duty military		0	0.0
Disabled		3	6.5
Families		16	34.8
Homeless		3	6.5
Individuals		16	34.8
Veterans		1	2.2
Other		7	15.2
	N	46	100.0

Table D.9: q9. Which of the following best describes what happens if your organization cannot provide all the services needed by a client?

	Frequency	*Percent*
Give the client information on where to obtain assistance (client is responsible for contacting other organization)	29	76.3
Phone, email, or fax a referral to another organization	3	7.9
Send an electronic referral using a shared software system (such as Bowman Systems or CareScope)	2	5.3
Other	4	10.5
N	38	100.0

Table D.10: q10. What age group do most of your clients fit into? Check all that apply[1]

	Frequency	*Percent*
Children	24	42.1
Adults (under age 65)	29	50.9
Seniors (65 and over)	11	19.3
N	57	

[1] May add to more than 100% since respondents could select up to three responses.

Table D.11: q11. Given the services that your organization provides and the clients you serve; how helpful would it be to know what other services the client has received from other organizations?

	Frequency	*Percent*
Helpful	33	78.6
Somewhat helpful	8	19.1
Not helpful	1	2.4
Don't Know	0	0.0
N	42	100.1

Table D.12: q12. How many clients (unique individuals, not visits) do you serve on an annual basis?

		Frequency	*Percent*
500 or less		7	15.6
501 to 1,000		7	15.6
1,001 to 5,000		9	20.0
5,001 to 10,000		2	4.4
10,001 to 20,000		6	13.3
20,000 or more		13	28.9
Don't Know		1	2.2
	N	45	100.0

Table D.13: q13. Do your clients have to meet income eligibility requirements to obtain services?

		Frequency	*Percent*
Yes, 50% of the federal poverty level or less		3	7.5
Yes, 100% of the federal poverty level or less		3	7.5
Yes, 150% of the federal poverty level or less		2	5.0
Yes, 200% of the federal poverty level or less		2	5.0
Yes, 300% of the federal poverty level or less		2	5.0
No, we serve everyone		24	60.0
Other		2	5.0
Don't Know		2	5.0
	N	40	100.0

Table D.14: q14. What percent of your staff would you say are volunteers?

		Frequency	*Percent*
0%		7	23.3
1 – 25%		15	50.0
26 – 50%		1	3.3
51 – 75%		4	13.3
76 – 100%		3	10.0
	N	30	99.9

Table D.15: q15. Do you use any of the following systems to store client records electronically?

	Frequency	*Percent*
CareScope	0	0.0
Bowman Systems (Service Point or Community Point)	1	2.9
VisionLink (2-1-1 or Community)	0	0.0
Social Solutions (ETO Collaborative)	1	2.9
An electronic medical record (EMR) or electronic health record (EHR)	13	37.1
Some other system	15	42.9
Don't Know	5	14.3
N	35	100.1

APPENDIX E – COMMUNITY HEALTH SURVEY LEADERS OPEN-ENDED RESPONSES

Q1. What is some other feature that you think if most important for a "Healthy Community"?

- Stop building on every inch of grass that is left in Baldwin county, take care of infrastructure first so we don't end up with water shortages
- safe, accessible, affordable childcare
- low rate of child abuse/neglect

Q2. What is some other important health issue in Mobile County?

- Lack of necessary medical equipment (ramps on houses, scooters, wheelchairs, beds, accessible vehicles)
- Hunger

Q3. What is some other unhealthy behavior in Mobile County that concern you the most?

- vaping
- Unrestricted access to smart devices and social media
- Substance Abuse Alcohol/Drugs
- Not seeing mental health professionals
- Lack of two parent families
- Lack of anger management
- Dangerous driving

Q4. What is some other healthcare service in Mobile County that you feel is difficult to get?

No responses

Q7. What other type of service do you or your organization provide?

- Youth development services
- Substance abuse education and prevention
- Primary Healthcare for uninsured, chronically ill
- medication assistance
- Health Promotion, Disease prevention, diagnosis and treatment and Rehallibitation
- Free prescription medications
- Evidence Based Mentoring Programs for youth with wrap around services for families
- Difficult to answer when you ask for just one; we have multiple social service programs
- comprhensive care for child abuse victims
- Advocate for improved water quality

Q8. What other category best describes the clients you serve?

- UNINSURED
- Students with various medical conditions and disabilities
- Students
- children and adolescents
- children
- All of the above plus children and seniors
- All of the above

Q9. What other actions do you or your organization take if you cannot provide all the services needed by a client?

- referral to another hospital
- Our goal is ot provide a warm transfer. We connect the referral and the client.
- Give client information where to obtain assistance (either the client or I contact outside resource)
- combination of providing info to client and/ or assisting with referral

Q15. What other system do you use to store client records electronically?

- Wellsky HMIS
- United Way of Baldwin Co specific program
- Salesforce
- PowerSchool
- Osnium
- Online database
- Oasis insights
- HMIS, AIMS
- Family Registry
- EasyTrac
- ChildPlus
- CAC manager
- Bowman, VisionLink, EHR
- Apricot

APPENDIX F – COMMUNITY HEALTH SURVEY QUESTIONNAIRE

2025-2028 COMMUNITY HEALTH NEEDS ASSESSMENT
INFIRMARY HEALTH/USA HEALTH SYSTEM

SCREENER

I. Introduction

"My name is _____ and I'm calling from the University of South Alabama. We are conducting a survey about healthcare needs and services in (Baldwin/Mobile) County. This survey should take less than 15 minutes. You may refuse to answer any question you wish and you may terminate the survey at any time."

IF LANDLINE SKIPTO II
IF CELL PHONE SKIPTO III

II. Respondent Selection

"I'd like to talk to the person in your household who's 18 or older and who makes most of the household decisions regarding healthcare?"

A. IF RESPONDENT – "Then you're the one I want to talk to." SKIP TO QUESTIONNAIRE

B. IF SOMEONE ELSE – "May I speak to them please?"

IF RESPONDENT IS NOT HOME, ASK – "Could you suggest a convenient time for me to call back when I might be able to reach them?" GIVE SHIFT TIMES IF NECESSARY. GET FIRST NAME OF RESPONDENT IF POSSIBLE.

IF RESPONDENT IS DIFFERENT FROM PERSON WHO ANSWERED PHONE – "My name is _____ and I'm calling from the University Polling Group. We are conducting a survey about healthcare needs and services in (Baldwin/Mobile) County. This survey should take less than 15 minutes. You may refuse to answer any question you wish and you may terminate the survey at any time."

SKIPTO IV

III. Cell Phone

C1. "Is this a safe time to talk with you, or are you driving?"

1 YES, SAFE TIME
2 NO, NOT A SAFE TIME

IF NO: "May I schedule a day and time to call you back?"
PRESSING 2 FOR NO WILL EXIT THE SURVEY AND ALLOW YOU TO DISPOSITION AND SETUP A CALLBACK

C2. "Are you 18 years of age or older?"

1 18 YEARS OF AGE OR OLDER
2 UNDER 18 YEARS OF AGE

IF UNDER 18 YEARS OF AGE: "Thank you, but we are only talking to adults 18 years of age or older for this survey."

EXIT TO DISPOSITION

C3. “And, do you currently live in (Baldwin/Mobile) County?”

1 YES, LIVE IN BALDWIN/MOBILE COUNTY
2 NO, DO NOT LIVE IN BALDWIN/MOBILE COUNTY

IF NO: “Thank you, but we are only talking to residents of (Baldwin/Mobile) County for this survey.”
EXIT TO DISPOSITION

SKIPTO IV

IV. Survey Start

1. (16) “First, would you say that in general your health is . . . excellent, very good, good, fair, or poor?”

1 EXCELLENT
2 VERY GOOD
3 GOOD
4 FAIR
5 POOR

8 DK
9 NA

2. (4) “Thinking about (Baldwin/Mobile) County overall, how would you rate the health of people who live in (Baldwin/Mobile) County . . . very healthy, healthy, somewhat healthy, unhealthy, or very unhealthy?”

1 VERY HEALTHY
2 HEALTHY
3 SOMEWHAT HEALTHY
4 UNHEALTHY
5 VERY UNHEALTHY

8 DK
9 NA

3. (14) “Overall, how would you rate the quality of healthcare services available in (Baldwin/Mobile) County . . . excellent, very good, good, fair, or poor?”

1 EXCELLENT
2 VERY GOOD
3 GOOD
4 FAIR
5 POOR

8 DK
9 NA

4. (6) "What type of healthcare insurance do you have?"

IF RESPONDENT HAS PRIVATE INSURANCE: “Is your private insurance plan one you purchased yourself or is it provided to you through your employer or spouse’s employer?”

1 PRIVATE INSURANCE – DIRECT PURCHASE
2 PRIVATE INSURANCE – EMPLOYER BASED
3 PRIVATE INSURANCE – EMPLOYER BASED SPOUSE
4 MEDICARE
5 MEDICAID
6 OTHER
7 NO INSURANCE
8 TRICARE/MILITARY INSURANCE

98 DON’T KNOW
99 REF/NA

5. “Do you have one person you think of as your personal doctor or health care provider?”

IF “No” ASK: “Is there more than one, or is there no person who you think of as your personal doctor or health care provider?”

1 YES ONLY ONE
2 YES MORE THAN ONE
3 NO

8 DK
9 NA

6. (8) “How long has it been since your last visit to a doctor for a wellness exam or routine checkup . . . was that within the past 12 months, 1 to 2 years ago, 2 to 5 years ago, 5 or more years ago, or have you never had a wellness exam or routine checkup?”

1 WITHIN THE PAST 12 MONTHS
2 1 TO 2 YEARS AGO
3 2 TO 5 YEARS AGO
4 5 OR MORE YEARS AGO
5 NEVER HAD ONE

8 DK
9 NA

7. (7) “How long has it been since your last dental exam or cleaning . . . was that within the past 12 months, 1 to 2 years ago, 2 to 5 years ago, 5 or more years ago, or have you never had a dental exam or cleaning?”

1 WITHIN THE PAST 12 MONTHS
2 1 TO 2 YEARS AGO
3 2 TO 5 YEARS AGO
4 5 OR MORE YEARS AGO
5 NEVER HAD ONE

8 DK
9 NA

7A. “In the last 12 months, have you used any telehealth services such as accessing a health provider by phone, Zoom, or text message?”

1 YES
2 NO

8 DK
9 NA

IF YES SKIPTO 7B
IF NO SKIPTO 7C
SKIPTO 7D

7B. “How would you rate the quality of your telehealth experience, would you say it was excellent, very good, good, fair, or poor?”

1 EXCELLENT
2 VERY GOOD
3 GOOD
4 FAIR
5 POOR

8 DK
9 NA

SKIPTO 7D

7C. “How interested would you be in receiving telehealth services from your health care provider . . . very interested, somewhat interested, not very interested, or not at all interested?”

1 VERY INTERESTED
2 SOMEWHAT INTERESTED
3 NOT VERY INTERESTED
4 NOT AT ALL INTERESTED

8 DK
9 NA

SKIPTO 7D

7D. “Using a 7-point scale, where 1 is the worst possible and 7 is the best possible, how well do you feel that the City of Mobile responded to the COVID-19 crisis?

1 WORST POSSIBLE
2
3
4
5
6
7 BEST POSSIBLE

8 DK
9 NA

7E. “Using the same scale, how well do you feel that local healthcare providers responded to the COVID-19 crisis?

PROMPT IF NEEDED: “A 7-point scale, where 1 is the worst possible and 7 is the best possible.”

1 WORST POSSIBLE
2
3
4
5
6
7 BEST POSSIBLE

8 DK
9 NA

8. (1) Next, I'm going to read a list of things that apply to healthy communities. For each item please tell me how important you think that item would be to improving the overall health in your community.

A. "First, access to health services such a health clinic or hospital . . . would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?"

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

B. "What about, active lifestyles including outdoor activities . . . would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?"

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

C. "Affordable housing?"

PROBE IF NEEDED: "Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?"

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

D. “Arts and cultural events?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

E. “A clean environment including water, air, etc.?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

F. “Family doctors and specialists?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

G. “Good employment opportunities?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

H. “Good places to raise children?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

I. “Good race relations?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

J. “Good schools?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

K. “Healthy food options?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

L. “Fewer homeless?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

M. “Less alcohol and drug abuse?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

N. “Lower crime and safe neighborhoods?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

O. “Less obesity?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

P. “Less sexually transmitted diseases?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

Q. “Less tobacco use?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

R. “Mental health services?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

S. “More quality education?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

T. “More quality health care options?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

U. “Good transportation options?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

V. “Religious and/or spiritual values?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

W. “Social support services such as food pantries and charity services?”

PROBE IF NEEDED: “Would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

X. Cancer Care

Y. Access to birth control

Z. Access to HPV, that is human papillomavirus vaccine, that help prevent cancers

AA. Regular access to gynecological or GYN examinations

AB. “Support services to assist people with extreme heat and/or cold?”

AC. “Support services to help people with natural disasters such as flooding, hurricanes, and tornados?”

AD. “Youth activities and resources, such as playgrounds, parks, and summer programs?

AE. “Free health screenings, such as for blood pressure, skin cancer, etc.”

9. (2) Next, I’m going to read a list of health issues, for each one please tell me how important of a problem you feel that issue is for (Baldwin/Mobile) County.

A. “First, what about accidental injuries at places like work, home or school . . . would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

B. “What about, aging problems like dementia and loss of mobility . . . would say this is very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

C. “Cancers?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

D. “Child abuse and neglect?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

E. “Dental problems?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT

4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

F. “Diabetes?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

G. “Domestic violence?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

H. “Drug use and abuse?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

I. “Fire-arm related injuries?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

J. “Heart disease and stroke?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

K. “HIV/AIDS?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

L. “Homelessness?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

M. “Homicides?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

N. “Infant death?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

O. “Infectious diseases like hepatitis and tuberculosis?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

P. “Mental health problems?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

Q. “Motor vehicle crash injuries?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

R. “Obesity or excess weight?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

S. “Rape and sexual assault?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

T. “Respiratory problems and lung disease?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

U. “Sexually transmitted diseases?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

V. “Suicide?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

W. “Teenage pregnancy?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

X. “Tobacco Use?”

PROBE IF NEEDED: “Would say this issue is a very important, somewhat important, neither important nor unimportant, somewhat unimportant, or very unimportant problem to the overall health in your community?”

1 VERY IMPORTANT
2 SOMEWHAT IMPORTANT
3 NEITHER IMPORTANT NOR UNIMPORTANT
4 SOMEWHAT UNIMPORTANT
5 VERY UNIMPORTANT

8 DK
9 NA

10. (5) “Now I am going to read a list of common health conditions . . . for each one, please tell me if a doctor or other health care professional has ever told you that you have that condition.”

A. “The first condition is asthma, has a doctor or other health professional ever told you that you have asthma?”

1 YES
2 NO

8 DK
9 NA

B. “Has a doctor or other health professional ever told you that you have chronic obstructive pulmonary disease or COPD?”

1 YES
2 NO

8 DK
9 NA

C. “What about dementia or Alzheimer’s (ALS-HI-MERS) disease?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

D. “Depression?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

E. “Diabetes?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

F. “Heart Disease?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

G. “High Cholesterol?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

H “High blood pressure?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

I. “HIV or Aids?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

J. “Obesity?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

K. “Tuberculosis?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

L. “Alcohol or drug addiction?”

PROBE IF NEEDED: “Has a doctor or other health professional ever told you that you have this health condition?”

1 YES
2 NO

8 DK
9 NA

M. Cancer Care

11. (10) “Thinking about your experience with healthcare services in (Baldwin/Mobile) County, please tell me if there are any healthcare services which you feel are difficult to get in (Baldwin/Mobile) County?”

PROBE: “Are there any other healthcare services which you feel are difficult to get?”

SELECT ALL THAT APPLY

1 ALTERNATIVE THERAPIES (ACUPUNCTURE, HERBALS)
2 DENTAL CARE / DENTURES
3 EMERGENCY MEDICAL CARE
4 HOSPITAL CARE
5 LABORATORY SERVICES
6 MENTAL HEALTH SERVICES
7 PHYSICAL THERAPY / REHABILITATION
8 PREVENTATIVE HEALTHCARE (ROUTINE OR WELLNESS CHECKUPS)
9 PRESCRIPTIONS / PHARMACY SERVICES
10 PRIMARY MEDICAL CARE (PRIMARY CARE DOCTOR OR CLINIC)
11 SERVICES FOR THE ELDERLY
12 SPECIALTY MEDICAL CARE (SPECIALIST DOCTORS)
13 ALCOHOL OR DRUG ABUSE TREATMENT
14 VISION CARE / EYE EXAMS / GLASSES
15 WOMEN’S HEALTH
16 X-RAYS
17 MAMMOGRAMS
18 OTHER
19 NO / NO MORE

12. (11) “In the past 12 months, have you delayed getting needed medical care for any reason?”

1 YES
2 NO

8 DK
9 NA

IF YES SKIPTO Q13; ELSE SKIPTO Q14

13. (11) “Why did you delay in getting needed medical care?”

PROBE: “Are there any reasons you delayed getting needed medical care in the past 12 months?”

SELECT ALL THAT APPLY

1 COULD NOT AFFORD MEDICAL CARE
2 INSURANCE PROBLEMS / LACK OF INSURANCE
3 LACK OF TRANSPORTATION
4 LANGUAGE BARRIERS / COULD NOT COMMUNICATE
5 PROVIDER DID NOT TAKE MY INSURANCE
6 PROVIDER WAS NOT TAKING NEW PATIENTS
7 COULD NOT GET AN APPOINTMENT SOON ENOUGH
8 COULD NOT GET A WEEKEND OR EVENING APPOINTMENT
9 OTHER
10 NO MORE REASONS

14. (12) “When you or someone in your family is sick, where do you typically go for healthcare?”

1 EMERGENCY ROOM (HOSPITAL)
2 FAMILY DOCTOR
3 ANY DOCTOR
4 URGENT CARE CLINIC
5 HEALTH DEPARTMENT
6 COMMUNITY HEALTH CENTER
7 FREE CLINIC
8 VA / MILITARY FACILITY
9 OTHER
10 I USUALLY GO WITHOUT RECEIVING HEALTHCARE

98 DK
99 NA

15. (17) “Thinking about yourself personally, how confident are you that you can make and maintain lifestyle changes like eating right, exercising, or not smoking . . . extremely confident, very confident, somewhat confident, not very confident, or not at all confident?”

1 EXTREMELY CONFIDENT
2 VERY CONFIDENT
3 SOMEWHAT CONFIDENT
4 NOT VERY CONFIDENT
5 NOT AT ALL CONFIDENT

8 DK
9 NA

16. (15) “Do you currently use any tobacco products such as cigarettes, cigars, chewing tobacco, snuff, vaping or e-cigarettes?”

IF YES, PROBE: “Anything else?”

IF NO, PROBE: “Have you ever used any of these tobacco products?” IF YES: “Did you stop using them in the last 12 months, or has it been more than a year since you used any of these tobacco products?”

SELECT ALL THAT APPLY

1 YES, CIGARETTES OR CIGARS
2 YES, CHEWING TOBACCO, SNUFF
3 YES, VAPING OR E-CIGARETTES
4 NO, QUIT IN THE LAST 12 MONTHS
5 NO, QUIT MORE THAN A YEAR AGO
6 NO, NEVER USED ANY TOBACCO PRODUCTS / NO MORE PRODUCTS

17. “How long would you be willing to wait to for a well visit to see your preferred provider . . .

1 Up to 7 days, or 1 week,
2 Up to 8 to 14 days, or 2 weeks,
3 Up to 3 weeks,
4 Up to 4 weeks, or 1 month,
5 Up to 2 months,
6 Up to 3 months, or
7 Up to 4 months or longer?”

98 DK
99 NA

18. How likely would you be to accept an appointment with a PA or physician’s assistant if you could see them sooner than your preferred provider?

1 Very likely
2 Somehat likely
3 Neither likely nor unlikely
4 Somewhat unlikely
5 Very unlikely

8 DK
9 NA

19. How likely would you be to accept an appointment with a NP or nurse practitioner if you could see them sooner than your preferred provider?

1 Very likely
2 Somehat likely
3 Neither likely nor unlikely
4 Somewhat unlikely
5 Very unlikely

8 DK
9 NA

20. “How far would you be willing to travel for a well visit to see your preferred provider . . .

1 Up to 5 miles or approximately 10 minutes,
2 Up to 10 miles or approximately 20 minutes,
3 Up to 20 miles or approximately 35 minutes,
4 Up to 30 miles or approximately 45 minutes,
5 Up to 40 miles or approximately 55 minutes, or
6 Up to or greater than 50 miles or 1 hour or longer?”

98 DK
99 NA

21. “How did you select your primary care physician?” (select all that apply)

1 Recommended by a family member,
2 Recommended by a close friend,
3 Recommended by a co-worker or acquaintance,
4 Recommended by another health care provider,
5 Saw them advertised/found them . . . on social media,
6 Saw them advertised/found them . . . in Internet reviews,
7 Saw them advertised/found them . . . on television,
8 Saw them advertised/found them . . . on radio,
9 Saw them advertised/found them . . . on billboards or other print media like pamphlets,
10 It was the only provider that I was able to get an appointment with,
11 It was the only provider that my insurance would cover,
12 Reputation of the hospital/health system, e.g., hospital/health system rankings
13 Other (Please Specify)

22. Thinking again about healthy communities, are there any other items, resources, or services that you feel are needed in your neighborhood to make it a healthier community?

RECORD VERBATIM RESPONSE

PROBE: “Is there anything else?” or “Can you give me an example please?”

DEMOGRAPHICS

D1. (17.) (22) “Finally for statistical purposes, I need to ask a few questions about yourself. In what year were you born?”

RECORD YEAR BORN

D2. (18.) “Have you personally ever served in the United States Armed Forces, military reserves, or National Guard?”

1 YES
2 NO

8 DK
9 NA

IF YES SKIPTO Q18A; ELSE SKIPTO Q19

D3. (19.) “Are you currently serving in the Armed Forces, the military reserves, or the National Guard?”

1 ARMED FORCES
2 MILITARY RESERVES
3 NATIONAL GUARD

8 DK
9 NA

IF ARMED FORCES SKIPTO Q18B; ELSE SKIPTO Q19

D4. (20.) “Are you currently on active-duty service?”

1 YES
2 NO

8 DK
9 NA

IF NO SKIPTO Q18C; ELSE SKIPTO Q19

D5. (40.) (18.) (21) “What is your race?”

1 WHITE / CAUCASION
2 BLACK / AFRICAN-AMERICAN
3 HISPANIC OR LATNIO
4 ASIAN
5 AMERICAN INDIAN / ALASKAN NATIVE
6 PACIFIC ISLANDER
7 MULTI-RACIAL
8 OTHER

98 DK
99 NA

D6. (41.) (19.) (23) “What is the highest level of school you have completed or the highest degree you have received?”

1 GRADES 1 THROUGH 8
2 SOME HIGH SCHOOL (GRADES 9 THROUGH 11)
3 HIGH SCHOOL OR GED
4 VOCATIONAL / TECHNICAL SCHOOL
5 SOME COLLEGE
6 ASSOCIATES DEGREE OR 2 YEAR COLLEGE DEGREE
7 BACHELORS OR 4 YEAR COLLEGE DEGREE
8 GRADUATE OR PROFESSIONAL DEGREE (LAW DEGREE)

98 DK
99 NA

D7. (42.) (20.) (24) “What is your current employment status?”

IF WORKING OR EMPLOYED: “Is that full-time or part-time?”

1 DISABLED / UNABLE TO WORK
2 EMPLOYED FULL-TIME
3 EMPLOYED PART-TIME
4 HOMEMAKER / HOUSEWIFE OR HOUSEHUSBAN
5 RETIRED
6 SEASONAL WORKER
7 STUDENT
8 SELF-EMPLOYED
9 UNEMPLOYED

98 DK
99 NA

D8. (43.) (21.) (25) “And finally, what was your total family income last year . . . was it less than $15,000, $15,001 to $25,000, $25,001 to $35,000, $35,001 to $50,000, $50,001 to $75,000, $75,001 to $100,000 or more than $100,000?”

1 LESS THAN $15,000
2 $15,000 - $25,000
3 $25,000 - $35,000
4 $35,000 - $50,000
5 $50,000 - $75,000
6 $75,000 - $100,000
7 MORE THAN $100,000

8 DK
9 NA

“Thank you very much for your time and taking the survey today!”

END SURVEY

ENTER SEX OF RESPONDENT

1 MALE
2 FEMALE

ENTER YOUR INTERVIEW ID NUMBER

RECORD 4 DIGIT ID

ENTER ANY FINAL COMMENTS

APPENDIX G – COMMUNITY HEALTH LEADERS SURVEY QUESTIONNAIRE

Start of Block: Introduction and informed consent

I1
You have been selected as a community leader from [Baldwin]/[Mobile] County to participate in the Community Health Leaders Survey for the 2025-2027 Community Health Needs Assessment. This needs assessment is being conducted by the USA Polling Group at the University of South Alabama for Infirmary Health including Mobile Infirmary, Thomas Hospital, and North Baldwin Infirmary, and the USA Health System including The USA Medical Center, USA Children's & Women's Hospital, and the Mitchell Cancer Institute (MCI).

The purpose of the survey is to get your opinions about community health issues in [Baldwin]/[Mobile] County. The results of the survey will be used to identify health priorities for community action.

This survey should take less than 10 minutes to complete, and your answers are completely confidential. There are no experimental procedures involved in this research and there should be limited to no risks or discomfort in completing the survey. The benefit of participation is being able to inform policymakers regarding your perspectives on what constitutes a health community. There are no alternative procedures in this research. All responses are completely anonymous and any results will be published in aggregate format thereby preserving anonymity.
You may contact Dr. Thomas Shaw, Director of the USA Polling Group at tshaw@southalabama.edu if you have any questions regarding the survey. Your participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

We very much appreciate you taking the time to complete this survey. By clicking continue you are consenting to participate and will be taken to the survey. If you prefer not to participate please select that option below; it will take you to the end of the survey and remove you from our list to prevent any future reminder emails.

- ○ I'M 18 YEARS OF AGE AND OLDER AND WISH TO CONTINUE TO SURVEY (1)
- ○ PREFER NOT TO PARTICIPATE (2)

Skip To: End of Block If You have been specially selected as a community leader from either Baldwin or Mobile County to pa... = CONTINUE TO SURVEY

Skip To: End of Survey If You have been specially selected as a community leader from either Baldwin or Mobile County to pa... = PREFER NOT TO PARTICIPATE

End of Block: Introduction and informed consent

Start of Block: Community Health 01

Q1 What do you think are the most important features of a "Healthy Community"? *(Those factors that would most improve the quality of life in this community.) Check only three (3).*

- ☐ Access to health services (e.g., family doctor, hospitals) (1)
- ☐ Active lifestyles / outdoor activities (2)
- ☐ Affordable housing (3)
- ☐ Arts and cultural events (4)
- ☐ Clean environment (clean water, air, etc.) (5)
- ☐ Family doctors and specialists (6)
- ☐ Good employment opportunities (7)
- ☐ Good place to raise children (8)
- ☐ Good race relations (9)
- ☐ Good schools (10)
- ☐ Healthy food options (11)
- ☐ Low numbers of homeless (12)
- ☐ Low alcohol & drug use (13)
- ☐ Low crime / safe neighborhoods (14)
- ☐ Low percent of population that are obese (15)
- ☐ Low numbers of sexually transmitted disease (STDs) (16)
- ☐ Low tobacco use (17)

☐ Mental health services (18)

☐ Quality education (19)

☐ Quality hospitals and urgent / emergency services (20)

☐ Good transportation options (21)

☐ Religious or spiritual values (22)

☐ Social support services (such as Salvation Army, food pantries, Catholic charities, Red Cross, etc.) (23)

☐ Some other feature (please specify) (24)
_____

☐ Some other feature (please specify) (25)
_____

☐ Some other feature (please specify) (26)
_____

End of Block: Community Health 01

Start of Block: Community Health 02

*

Q2 What do you think are the most important health issues in [Baldwin]/[Mobile] County (if you work in both, consider the county where you or your agency perform most of your service(s))?

(Those problems that have the greatest impact on overall community health.) Check only three (3).

- ☐ Accidental injuries (at work, home, school, farm) (1)
- ☐ Aging problems (e.g., dementia, vision/hearing loss, loss of mobility) (2)
- ☐ Cancers (3)
- ☐ Child abuse / neglect (4)
- ☐ Dental problems (5)
- ☐ Diabetes (6)
- ☐ Domestic violence (7)
- ☐ Drug use / abuse (8)
- ☐ Fire-arm related injuries (9)
- ☐ Heart disease and stroke (10)
- ☐ HIV / AIDS (11)
- ☐ Homelessness (12)
- ☐ Homicide (13)
- ☐ Infant death (14)
- ☐ Infectious diseases (e.g., hepatitis, TB, etc.) (15)
- ☐ Mental health problems (16)
- ☐ Motor vehicle crash injuries (17)

- ☐ Obesity / excess weight (18)
- ☐ Rape / sexual assault (19)
- ☐ Respiratory / lung disease (20)
- ☐ Sexually Transmitted Diseases (STDs) (21)
- ☐ Suicide (22)
- ☐ Teenage pregnancy (23)
- ☐ Tobacco use (24)
- ☐ Some other health issue (please specify) (25)
  _____
- ☐ Some other health issue (please specify) (26)
  _____
- ☐ Some other health issue (please specify) (27)
  _____

End of Block: Community Health 02

Start of Block: Community Health 03

*

Q3 Which of the following unhealthy behaviors in [Baldwin]/[Mobile] County concern you the most (consider the county where you or your agency perform most of your service(s))?
(Those behaviors that have the greatest impact on overall community health.) Check only thee (3).

- ☐ Alcohol abuse (1)
- ☐ Drug abuse (2)
- ☐ Excess weight (3)
- ☐ Homelessness (4)
- ☐ Lack of exercise (5)
- ☐ Poor eating habits / poor nutrition (6)
- ☐ Not getting shots to prevent disease (7)
- ☐ Not using seat belts / child safety seats (8)
- ☐ Not seeing a doctor or dentist (9)
- ☐ Tobacco use (10)
- ☐ Unprotected / unsafe sex (11)
- ☐ Some other unhealthy behavior (please specify) (12)
_____
- ☐ Some other unhealthy behavior (please specify) (13)
_____
- ☐ Some other unhealthy behavior (please specify) (14)
_____

End of Block: Community Health 03

Start of Block: Community Health 04

Q4 Which healthcare services are difficult to get in [Baldwin]/[Mobile] County (consider the county where you or your agency perform most of your service(s))? *(Check all that apply)*

- ☐ Alternative therapies (acupuncture, herbals, etc.) (1)
- ☐ Dental care including dentures (2)
- ☐ Emergency medical care (3)
- ☐ Hospital care (4)
- ☐ Laboratory services (5)
- ☐ Mental health services (6)
- ☐ Physical therapy / rehabilitation (7)
- ☐ Preventative healthcare (routine or wellness check-ups, etc.) (8)
- ☐ Prescriptions / pharmacy services (9)
- ☐ Primary medical care (a primary doctor / clinic) (10)
- ☐ Services for the elderly (11)
- ☐ Specialty medical care (specialist doctors) (12)
- ☐ Alcohol or drug abuse treatment (13)
- ☐ Vision care (eye exams and glasses) (14)
- ☐ Women's health (15)
- ☐ X-Rays or mammograms (16)
- ☐ Cancer Care

☐ Some other healthcare service (please specify) (17)
_____

End of Block: Community Health 04

Start of Block: Community Health 05

Q5 Overall, how would you rate the health of people who live in [Baldwin]/[Mobile] County (consider the county where you or your agency perform most of your service(s))?

- ○ Very healthy (1)
- ○ Healthy (2)
- ○ Somewhat healthy (3)
- ○ Unhealthy (4)
- ○ Very unhealthy (5)
- ○ Don't know / not sure (6)

Q6 Overall, how would you rate the quality of healthcare services available in [Baldwin]/[Mobile] County (consider the county where you or your agency perform most of your service(s))?

- ○ Excellent (1)
- ○ Very Good (2)
- ○ Good (3)
- ○ Fair (4)
- ○ Poor (5)
- ○ Don't know / not sure (6)

End of Block: Community Health 05

Start of Block: Screener

Q7 What is the primary type of service(s) you or your organization provide?

- ○ Alcohol / substance abuse treatment (1)
- ○ Business (2)
- ○ Clothing / thrift store (3)
- ○ Disability services (4)
- ○ Education (5)
- ○ Employment / job training (6)
- ○ Faith based counseling (7)
- ○ Financial counseling (8)
- ○ Food assistance (9)
- ○ Government (10)
- ○ Healthcare (11)
- ○ Housing / temporary shelter (12)
- ○ Legal aid (13)
- ○ Mental health (14)
- ○ Pregnancy or adoption assistance (15)
- ○ Public service (16)
- ○ Senior services (17)
- ○ Utility payment assistance (18)
- ○ Some other service (please specify) (19)

_____

Skip To: End of Survey If What is the primary type of service(s) you or your organization provide? = Business

Skip To: End of Survey If What is the primary type of service(s) you or your organization provide? = Government

Skip To: End of Survey If What is the primary type of service(s) you or your organization provide? = Public service

End of Block: Screener

Start of Block: Service Information

Q8 Which of the following best describes the clients you serve?

- ○ Active duty military (1)
- ○ Disabled (2)
- ○ Families (3)
- ○ Homeless (4)
- ○ Individuals (5)
- ○ Veterans (6)
- ○ Other (please specify) (7) _____
- ○ Not applicable (8)

Q9 Which of the following best describes what happens if your organization cannot provide all the services needed by a client?

- ○ Give the client information on where to obtain assistance (client is responsible for contacting other organization) (1)
- ○ Phone, email, or fax a referral to another organization (2)
- ○ Send an electronic referral using a shared software system (such as Bowman Systems or CareScope) (3)
- ○ Other (please specify) (4) _____
- ○ Not applicable (5)

Q10 What age group do most of your clients fit into?
(Check all that apply)

- ☐ Children (1)
- ☐ Adults (under the age of 65) (2)
- ☐ Seniors (65+) (3)
- ☐ Not applicable (4)

Q11 Given the services that your organization provides and the clients you serve; how helpful would it be to know what other services the client has received from other organizations?

- ○ Helpful (1)
- ○ Somewhat helpful (2)
- ○ Not helpful (3)
- ○ Don't know / not sure (4)
- ○ Not applicable (5)

Q12 How many clients (unique individuals, not visits) do you serve on an annual basis?

- ○ 500 or less (1)
- ○ 501 to 1,000 (2)
- ○ 1,001 to 5,000 (3)
- ○ 5,001 to 10,000 (4)
- ○ 10,001 to 20,000 (5)
- ○ 20,000 or more (6)
- ○ Don't know / not sure (7)
- ○ Not applicable (8)

Q13 Do your clients have to meet income eligibility requirements to obtain services?

- ○ Yes, 50% of the federal poverty level or less (1)
- ○ Yes, 100% of the federal poverty level or less (2)
- ○ Yes, 150% of the federal poverty level or less (3)
- ○ Yes, 200% of the federal poverty level or less (4)
- ○ Yes, 300% of the federal poverty level or less (5)
- ○ No, we serve everyone (6)
- ○ Other (please specify) (7)
- ○ Don't know / not sure (8)
- ○ Not applicable (9)

Q14 Thinking about your staff . . .

	0 10 20 30 40 50 60 70 80 90 100
What percent of your staff would you say is volunteer? ()	

Q15 Do you use any of the following systems to store client records electronically? *(Check all that apply)*

- ○ CareScope (1)
- ○ Bowman Systems (Service Point or Community Point) (2)
- ○ VisionLink (2-1-1 or Community OS) (3)
- ○ Social Solutions (ETO Collaborative) (4)
- ○ An electronic medical record (EMR) or electronic health record (EHR) (5)
- ○ Some other system (please specify) (6)

_____

- ○ Don't know / not sure (7)
- ○ Not applicable (8)

End of Block: Service Information

Start of Block: Thank You

Q16 Now, thinking again about healthy communities, are there any other items, resources, or services that you feel are needed in [Baldwin]/[Mobile] County to make it a healthier community?

I2 Thank you very much for taking the time to complete the survey.

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

ACADEMIC EXCELLENCE
AND STUDENT SUCCESS COMMITTEE

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

Academic Excellence and Student Success Committee

June 5, 2025
2:25 p.m.

A meeting of the Academic Excellence and Student Success Committee of the University of South Alabama ("USA," "University") Board of Trustees was duly convened by Judge Mike Windom, Chair, on Thursday, June 5, 2025, at 2:25 p.m. in the Board Room of the Frederick P. Whiddon Administration Building. Meeting attendance was open to the public.

Members:	Luis Gonzalez, Ron Graham, Ron Jenkins, Bill Lewis, Lenus Perkins and Mike Windom were present.
Members Absent:	Scott Charlton and Steve Furr.
Other Trustees:	Alexis Atkins, Chandra Brown Stewart, Arlene Mitchell, Jimmy Shumock, Steve Stokes and Jim Yance.
Administration & Guests:	Owen Bailey, Jim Berscheidt, Joél Billingsley, Jo Bonner, Brody Caver, Parker Day, Joel Erdmann, Monica Ezell, Charlie Guest, Connor Holm, Geoffrey Hudson, Shannon Batista Innes, Jerica Johnson, Buck Kelley, Andi Kent, Spence Larche, Nick Lawkis, John Marymont, Mike Mitchell, Allen Parrish, Kristen Roberts, Conner Roden, Michele Schuler, Donna Streeter (Faculty Senate), Margaret Sullivan, Peter Susman, Shayla McShan Thomas and Christina Wassenaar (Faculty Senate).

Following the attendance roll call, **Item 14**, Judge Windom called for consideration of the minutes for a meeting held on March 13, 2025, **Item 15**. On motion by Mr. Graham, seconded by Capt. Jenkins, the Committee voted unanimously to adopt the minutes.

Judge Windom turned to Provost Kent and Dr. Marymont for the presentation of **Item 16**, a resolution granting tenure and/or promotion to faculty from the Division of Academic Affairs and the Whiddon College of Medicine (WCOM). (To view resolutions, policies and other documents authorized, refer to the minutes of the Board of Trustees meeting held on June 6, 2025.) Provost Kent attested that the candidates recommended had been thoroughly vetted through college and administrative approval channels. On motion by Mr. Perkins, seconded by Mr. Graham, the Committee voted unanimously to recommend approval of the resolution by the Board of Trustees.

Judge Windom called for the presentation of **Item 17**, a resolution authorizing adjustments to the academic infrastructure and technology fee ("fee"), WCOM tuition, and housing and dining rates for the 2025-2026 academic year. Provost Kent addressed the proposed fee increase of $15 per credit hour, an approximate three percent increase, to be capped at 12 hours for undergraduates and six hours for graduate students, advising of the significant investments made by the University

for improvements across campus sectors. She projected that, with approval of the fee increase, the University would continue to maintain its competitive position among Alabama's 14 public institutions for the cost of tuition and fees. Judge Windom also pointed out that undergraduate and graduate tuition would remain level with 2024-2025 rates. On motion by Mr. Gonzalez, seconded by Mr. Perkins, the Committee voted unanimously to recommend approval of the fee increase by the Board of Trustees.

Dr. Marymont discussed the recommended three percent increase in WCOM tuition, reminding the Committee that WCOM tuition was not increased in 2024-2025. He added that the proposal aligned with the University of Alabama at Birmingham (UAB) Heersink School of Medicine's tuition increase of three percent, and further stated that the overall cost of earning a degree from the WCOM was less expensive than earning a medical degree from UAB. On motion by Capt. Jenkins, seconded by Mr. Graham, the Committee voted unanimously to recommend approval of the increase in WCOM tuition by the Board of Trustees.

Judge Windom called on Dr. Mitchell to discuss the recommended increase in housing and dining rates. Dr. Mitchell shared details on several renovation projects occurring or scheduled at campus housing and dining facilities. Given the enhancements, he stated that the Administration was recommending an average three percent increase in dining rates and an average 3.8 percent increase in housing rates, asserting that, with approval of the rate increases, the University would continue to be competitive in the state and Gulf Coast region for the cost of campus housing and dining. On motion by Justice Lewis, seconded by Mr. Perkins, the Committee voted unanimously to recommend approval of the increase in housing and dining rates by the Board of Trustees.

Judge Windom asked Provost Kent for a report on the activities of the Division of Academic Affairs, **Item 18**. Provost Kent introduced, Dr. Geoffrey Hudson, Associate Professor from the Department of Health, Kinesiology and Sport and faculty advisor to student who participate in American College of Sports Medicine (ACSM) conferences. Dr. Hudson gave background on the conferences that culminate with Jeopardy-style student quiz competitions and introduced Mr. Parker Day and Mr. Connor Roden, two members of USA's team that competed against 32 teams in the Southeast Regional ACSM Student Bowl in Greenville, South Carolina, in February and won the championship. Also introduced was Mr. Brody Caver, who joined USA's team for the national competition in Atlanta recently. Following remarks by the students, Provost Kent underscored the importance of student engagement beyond the classroom.

Judge Windom called on Dr. Mitchell to present **Item 19**, the annual report to the Alabama Commission on Higher Education that documents infringement of the University's Speech, Expressive Activities and Use of University Space, Facilities and Grounds Policy, as well as the University's response. With reference to the draft report in the meeting materials, Dr. Mitchell advised that infractions had not occurred thus far for the reporting period of August 1, 2024, to July 31, 2025, and welcomed questions and input from the Committee.

Concerning a report on the activities of the Division of Student Affairs, **Item 20**, Dr. Mitchell provided information on the Jaguar Senior Medallion Society program that recognizes seniors who demonstrate a strong commitment to leadership and student engagement. As photos from the recent induction ceremony were shown, he noted that the fourth class included 24 seniors and shared the stories of two inductees, Ms. Mackenzie Kirkman and Ms. Lara Vander Merwe, who received the *Overcomer Award*. He thanked Capt. Jenkins and other donors who support the program.

Dr. Mitchell also presented an update on the *JagPack* program, launched in fall 2024 in partnership with the Barnes & Noble Bookstore, that provides students their course materials on or before the first day of classes for a $22 per credit hour fee. He noted that the results of a recent student survey on *JagPack* demonstrated the program had a positive impact on student outcomes and added that USA students saved a combined total of approximately $3.2 million on the cost of course materials from fall 2024 through spring 2025, an average savings of 46 percent.

Judge Windom called on Provost Kent, who introduced and shared career highlights for Dr. Allen Parrish, Vice President for Research and Economic Development who joined the University in April. Dr. Parrish presented **Item 21**, a report on the activities of the Division of Research and Economic Development, commenting briefly on USA's research enterprise and the opportunities ahead. He introduced Dr. Michele Schuler, WCOM Professor and Director/Attending Veterinarian for the Biological Resources Vivarium, and recognized Ms. Jerica Johnson, animal care technician, for her above-and-beyond efforts in caring for the Vivarium's lab animals when the campus was closed for several days due to the January 21 snowstorm.

Judge Windom called on Dr. Billingsley for a report on the activities of the Division of Community Engagement, **Item 22**. Dr. Billingsley shared details on the *South Serves* virtual platform that connects students, faculty and staff who are interested in volunteer opportunities with community partners. She said the site hosted approximately 3,100 active users over 2024-2025, resulting in more than 45,000 service hours, an increase by 24 percent over the previous year and equating to an economic value of close to $1.3 million for the Mobile community. She stated that USA athletes logged close to 8,000 service hours and noted that eight of USA's women's and men's NCAA Division I sports programs placed in the top ten among all NCAA Division I programs for service hours. Also recognized for their service records were Mr. Connor Holm, Ms. Shannon Batista Innes and Ms. Shayla McShan Thomas, representing the College of Allied Health Professions.

There being no further business, the meeting was adjourned at 2:59 p.m.

Respectfully submitted:

Michael P. Windom, Chair

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

BUDGET AND FINANCE COMMITTEE

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

Budget and Finance Committee

June 5, 2025
2:59 p.m.

A meeting of the Budget and Finance Committee of the University of South Alabama ("USA," "University") Board of Trustees was duly convened by Mr. Lenus Perkins, Chair, on Thursday, June 5, 2025, at 2:59 p.m. in the Board Room of the Frederick P. Whiddon Administration Building. Meeting attendance was open to the public.

Members:	Alexis Atkins, Chandra Brown Stewart, Ron Graham, Lenus Perkins, Jimmy Shumock and Steve Stokes were present.
Member absent:	Meredith Hamilton.
Other Trustees:	Luis Gonzalez, Ron Jenkins, Bill Lewis, Arlene Mitchell, Mike Windom and Jim Yance.
Administration & Guests:	Owen Bailey, Jim Berscheidt, Joél Billingsley, Jo Bonner, Joel Erdmann, Monica Ezell, Charlie Guest, Buck Kelley, Andi Kent, Spence Larche, Nick Lawkis, John Marymont, Mike Mitchell, Allen Parrish, Kristen Roberts, Donna Streeter (Faculty Senate), Margaret Sullivan, Peter Susman and Christina Wassenaar (Faculty Senate).

Following the attendance roll call, **Item 23**, Mr. Perkins called for consideration of the minutes for a meeting held on March 13, 2025, **Item 24**. On motion by Mr. Graham, seconded by Mr. Shumock, the Committee voted unanimously to adopt the minutes.

Mr. Perkins called on Ms. Roberts to discuss the quarterly financial statements for the six months ended March 31, 2025, **Item 25**. Ms. Roberts advised of assets totaling approximately $2.5 billion, a total net position of approximately $690 million and an increase in net position of approximately $4 million to end the second quarter of fiscal year 2025. She credited Mr. Drew Underwood, Executive Director of Treasury Management, for his prudent supervision of the University's endowment despite a challenging market.

Mr. Perkins called on Mr. Kelley for a report on University facilities, **Item 26**. As photos and drone footage were shown, Mr. Kelly shared perspective on the progress of construction projects, as well as on the renovation and repairs taking place at existing facilities. Among the projects discussed were the Whiddon College of Medicine Building, Jaguar Marching Band Complex, Central Energy Plant 3, ROTC obstacle course, Science Laboratory Building, Humanities Building, Archaeology Building, Meisler Hall and Traditions.

There being no further business, the meeting was adjourned at 3:10 p.m.

Respectfully submitted:

Lenus M. Perkins, Chair

UNIVERSITY OF SOUTH ALABAMA

(A Component Unit of the State of Alabama)

Basic Financial Statements

Nine Months Ended June 30, 2025

(Unaudited)

UNIVERSITY OF SOUTH ALABAMA
(A Component Unit of the State of Alabama)
Basic Financial Statements
Nine Months Ended June 30, 2025

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(A Component Unit of the State of Alabama)
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UNIVERSITY OF SOUTH ALABAMA
(A Component Unit of the State of Alabama)
Management's Discussion and Analysis (Unaudited)
Nine Months Ended June 30, 2025

Introduction

The following discussion presents an overview of the financial position and financial activities of University of South Alabama (the University), including the University of South Alabama Health System (USA Health), a division of the University, at June 30, 2025 and 2024, and for the nine months then ended. This discussion has been prepared by University management and should be read in conjunction with the financial statements and notes thereto, which follow.

The basic financial statements of the University consist of the University and its component units. The financial position and results of operations of the component units either are blended with the University's financial position and results of operations or are discretely presented. The treatment of each component unit is governed by pronouncements issued by the Governmental Accounting Standards Board (GASB). As more fully described in note 1 to the basic financial statements, the University of South Alabama Professional Liability Trust Fund, the University of South Alabama General Liability Trust Fund, USA HealthCare Management, LLC, Jaguar Realty, LLC, Providence Medical Network IPA, Jaguar Athletic Fund, University of South Alabama Foundation for Research and Commercialization (FRAC), Providence Medical Network IPA, LLC (Providence IPA), and various billing entities are reported as blended component units. The University of South Alabama Foundation, the USA Research and Technology Corporation, University of South Alabama Health Care Authority, South Alabama Medical Science Foundation, Providence Foundation, and Gulf Coast TotalCare are discretely presented.

Financial Highlights

At June 30, 2025 and 2024, the University had total assets and deferred outflows of approximately $2,653,541,000 and $2,294,052,000, respectively; total liabilities and deferred inflows of approximately $1,902,366,000 and $1,695,478,000, respectively; and net position of approximately $751,177,000 and $598,574,000, respectively.

There was an overall increase in both restricted and unrestricted cash balances between 2024 and 2025 of approximately $10,135,000, or 4%, to $248,948,000. There was an increase in investment balances between 2024 and 2025 of approximately $3,210,000, or 1%, to $435,405,000 at June 30, 2025. The University experienced a decrease in patient service revenues of approximately $4,743,000, or 1%, between 2024 and 2025.

An overview of each statement is presented herein along with financial analysis of the transactions impacting each statement. Where appropriate, comparative financial information is presented to assist in the understanding of this analysis.

Analysis of Financial Position and Results of Operations

Statement of Net Position

The statement of net position presents the assets, deferred outflows, liabilities, deferred inflows, and net position of the University at June 30, 2025. Net position is displayed in three parts: net investment in capital assets, restricted, and unrestricted. Restricted net position may be either expendable or nonexpendable and is the net position that is restricted by law or external donors. Unrestricted net position is generally designated by management for specific purposes and is available for use by the University to meet current expenses for any

purpose. The statement of net position, along with all of the University's basic financial statements, is prepared under the economic resources measurement focus and the accrual basis of accounting, whereby revenues are recognized when earned and expenses are recognized when incurred by the University, regardless of when cash is exchanged.

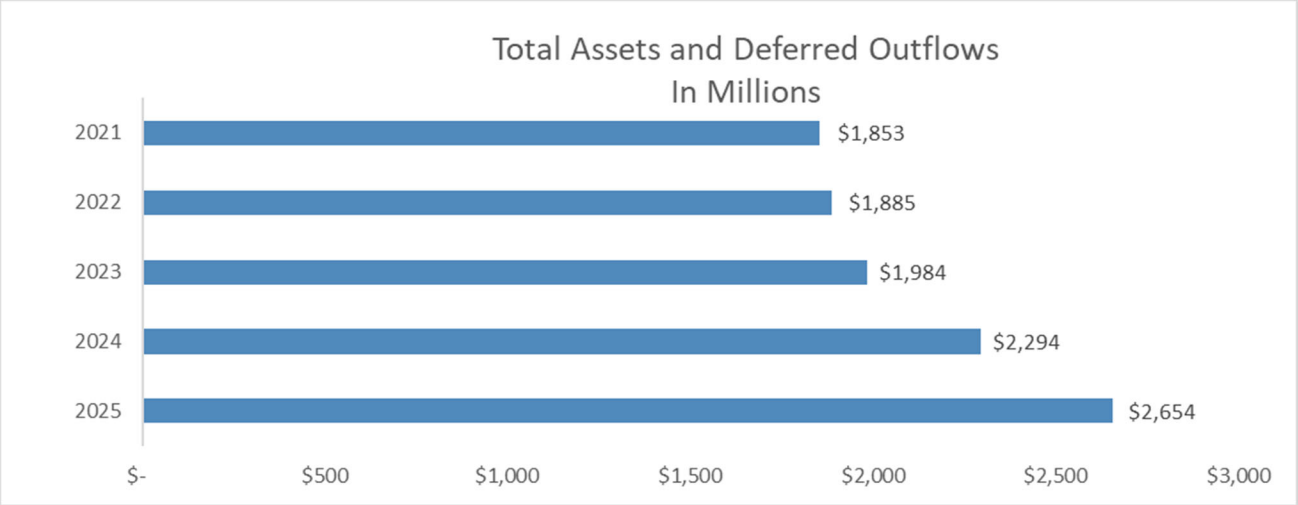
The condensed schedules of net position at June 30, 2025 and 2024 follow (in thousands):

Condensed Schedules of Net Position

		2025	2024
Assets:			
Current	$	562,922	499,490
Capital assets, net		1,134,065	1,026,914
Other noncurrent		494,537	507,059
Total assets		2,191,524	2,033,463
Deferred outflows		462,017	260,589
Total assets and deferred outflows	$	2,653,541	2,294,052
Liabilities:			
Current	$	264,033	344,536
Noncurrent		1,277,347	940,445
Total liabilities		1,541,380	1,284,981
Deferred inflows		360,984	410,497
Total liabilities and deferred inflows	$	1,902,364	1,695,478
Net position:			
Net investment in capital assets	$	578,169	461,133
Restricted, nonexpendable		85,038	81,929
Restricted, expendable		124,050	113,394
Unrestricted (deficit)		(36,080)	(57,882)
Total net position	$	751,177	598,574

Assets included in the statement of net position are classified as current or noncurrent. Current assets consist primarily of cash and cash equivalents, investments, patient receivables, and accounts receivable, other. Of these amounts, restricted and unrestricted cash and cash equivalents, accounts receivable, other, patient receivables, and investments comprise approximately 44%, 22%, 16%, and 13% respectively, of current assets at June 30, 2025. Noncurrent assets consist primarily of restricted investments, lease receivables, and capital assets, net. The increase in total assets and deferred outflows is attributed to an increase in capital assets and lease receivables.

Total assets and deferred outflows of the University as of June 30 is as follows:



Net position represents the residual interest in the University's assets and deferred outflows after liabilities and deferred inflows are deducted. Net position is classified into one of four categories:

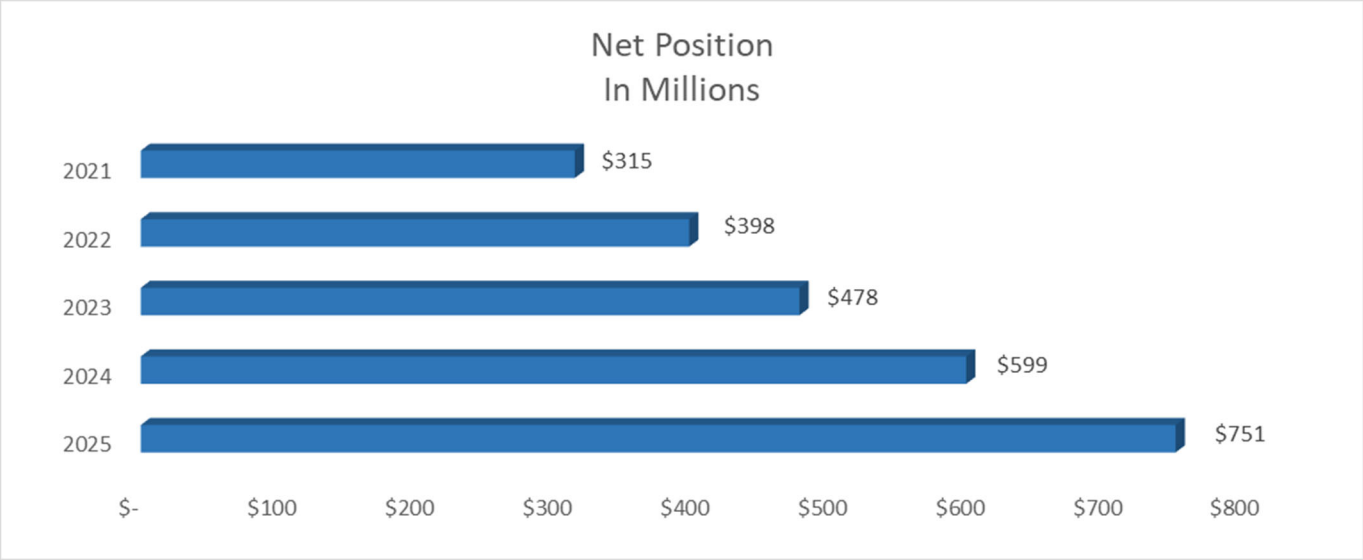
Net investment in capital assets represents the University's capital assets less accumulated depreciation and outstanding principal balances of the debt attributable to the acquisition, construction, or improvement of those assets.

Restricted nonexpendable net position consists primarily of the University's permanent endowment funds. In accordance with the policies of the University and donor agreements, the earnings from these funds may be expended, but the corpus may not be expended and must remain intact with the University in perpetuity.

Restricted expendable net position is subject to externally imposed restrictions governing their use. The funds are restricted primarily for debt service, capital projects, student loans, and scholarship purposes.

Unrestricted net position represents amounts not invested in capital assets or not subject to externally imposed stipulations. Even though these funds are not legally restricted, the majority of the University's unrestricted net position has been internally designated for various projects, all supporting the mission of the University. Unrestricted net position includes funds for various academic and research programs, auxiliary operations (including student housing and dining services), student programs, capital projects, and general operations. Also included in unrestricted net position at June 30, 2025 is the impact of the net pension liability recorded pursuant to the requirements of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions--an amendment of GASB Statement No. 27*, and the impact of the net OPEB liability recorded pursuant to the requirements of GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*.

Net position of the University as of June 30 is as follows:



Restricted net position increased by approximately $13,765,000 between June 30, 2024 and 2025, primarily due to market increases on endowment investments and gifts to the University. Unrestricted net position deficit decreased from approximately $(57,882,000) to $(36,080,000) between June 30, 2024 and 2025. A summary of unrestricted net position (deficit) at June 30, 2025 and 2024 is summarized as follows (in thousands):

		2025	2024
Unrestricted deficit related to net pension liability	$	(279,777)	(349,710)
Unrestricted deficit related to net OPEB liability		(396,009)	(78,808)
Unrestricted net position related to other activity		639,706	370,636
Unrestricted net position (deficit)	$	(36,080)	(57,882)

Statement of Revenues, Expenses, and Changes in Net Position

Changes in total University net position are based on the activity presented in the statement of revenues, expenses, and changes in net position. The purpose of this statement is to present the changes in net position resulting from operating and nonoperating revenues earned by the University, and operating and nonoperating expenses incurred by the University, as well as any other revenues, expenses, gains, and losses earned or incurred by the University.

Generally, operating revenues have the characteristics of exchange transactions and are received or accrued for providing goods and services to the various customers and constituencies of the University. These include tuition and fees (net of scholarship allowances), patient service revenues (net of provision for bad debts), most

noncapital grants and contracts, revenues from auxiliary enterprises, and sales and services of educational activities. Operating expenses are those expenses paid or incurred to acquire or produce the goods and services provided in return for the operating revenues and to carry out the mission of the University.

Nonoperating revenues have the characteristics of nonexchange transactions because, generally, no goods or services are provided. Such transactions include state appropriations, net investment income, gifts, and other contributions. State appropriations are required by GASB to be classified as nonoperating revenues. Nonoperating expenses are those expenses required in the operation and administration of the University, but not directly incurred to acquire or produce the goods and services provided in return for operating revenues. Such nonoperating expenses include interest on the University's indebtedness, losses related to the disposition of capital assets, and transfers to affiliates to fund operations.

The condensed schedules of revenues, expenses, and changes in net position for the nine months ended June 30, 2025 and 2024 follow (in thousands):

	2025	2024
Operating revenues:		
Tuition and fees, net	$ 117,048	109,057
Patient service revenues, net	674,699	679,442
Federal, state, and private grants and contracts	44,770	44,816
Auxiiliary, net and other	101,702	73,414
	938,219	906,729
Operating expenses:		
Salaries and benefits	616,775	549,776
Supplies and other services	376,956	349,667
Other	98,926	101,634
	1,092,657	1,001,077
Operating loss	(154,438)	(94,348)

(continued on next page)

Condensed Schedules of Revenues, Expenses, and Changes in Net Position (continued)

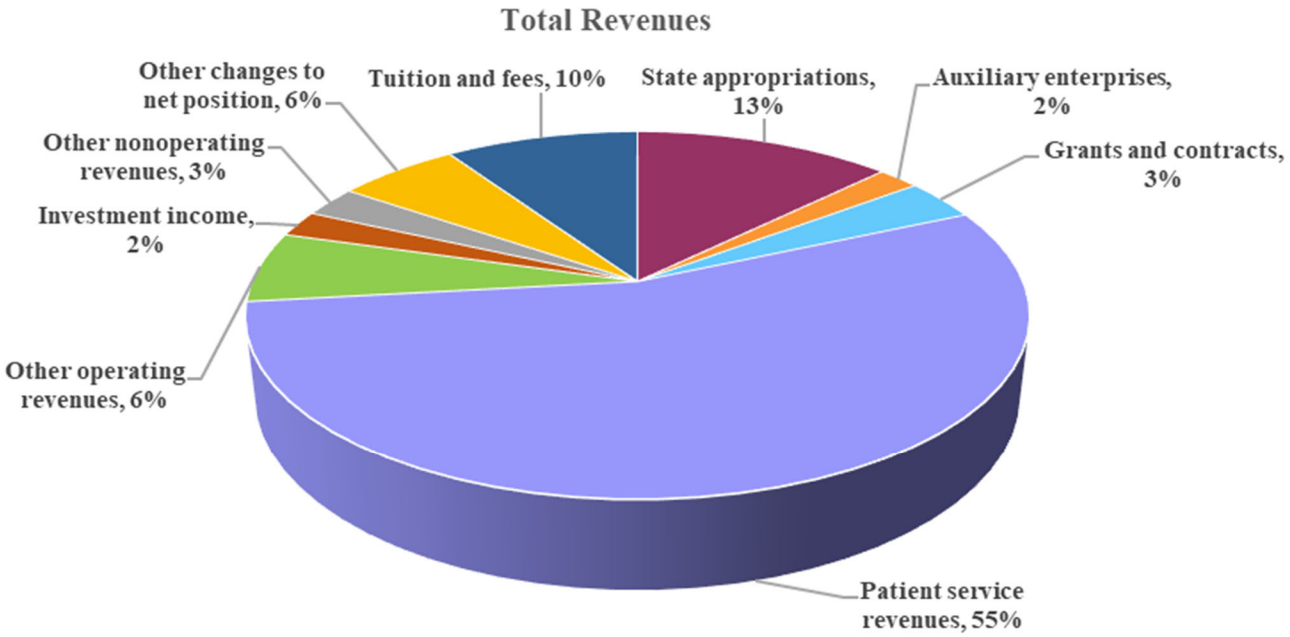
	2025	2024
Nonoperating revenues and expenses:		
State appropriations	$ 156,472	150,065
Net investment income	28,508	57,871
Other, net	(14,955)	(38,610)
Net nonoperating revenues	170,025	169,326
Income before capital appropriations, contributions and grants, and additions to endowment	15,587	74,978
Capital appropriations, contributions and grants, and additions to endowment	73,697	30,357
Increase in net position	89,284	105,335
Beginning net position	684,661	493,239
Cumulative effect of change in accounting principle and change to or within the financial reporting entity	(22,768)	—
Beginning balance, as adjusted	661,893	493,239
Ending net position	$ 751,177	598,574

In 2025, the University adopted the provisions of GASB Statement No. 101, *Compensated Absences*, which requires the University to recognize a liability for leave that has not been used if it is attributable to services already rendered, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means, as well as any leave that has been used but not yet paid or settled through noncash means. The adoption of the provisions of GASB Statement No. 101 resulted in an increase to current portion of other long-term liabilities of approximately $3,145,000 and other long-term liabilities, less current portion of approximately $21,046,000. In accordance with GASB Statement No. 100, *Accounting Changes and Error Corrections-an amendment of GASB Statement No. 62,* beginning unrestricted net position was restated by approximately ($24,191,000) for the impact related to the adoption of GASB Statement No. 101. See note 13 for further discussion.

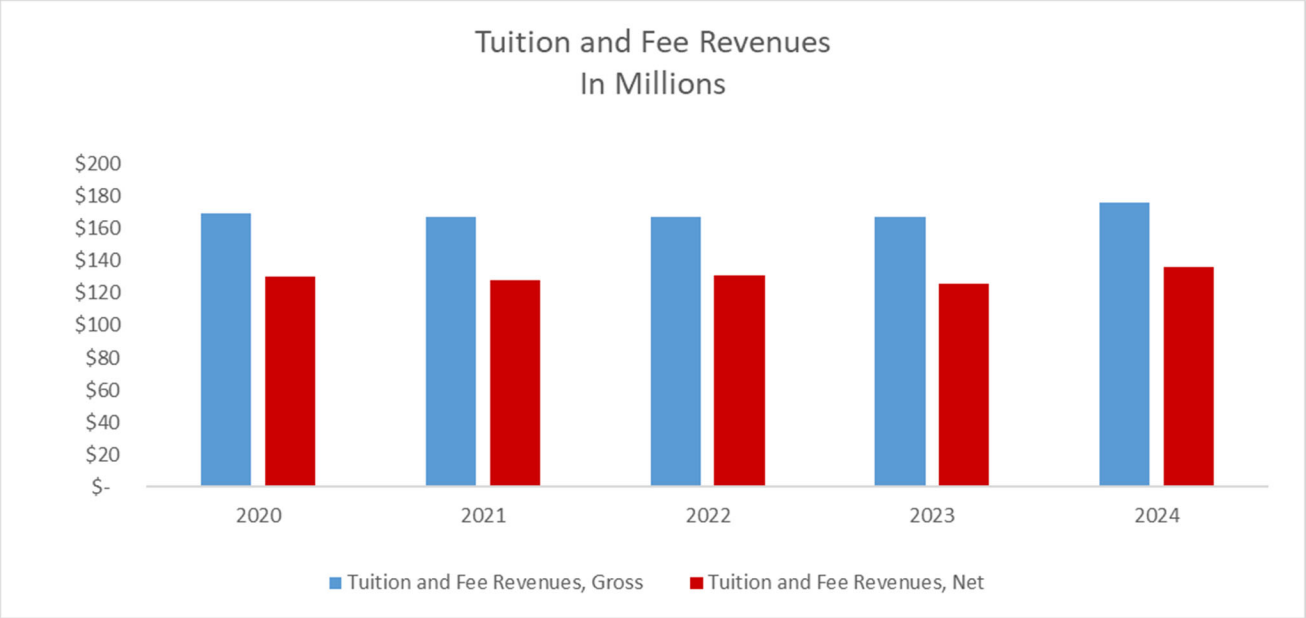
Prior to 2025, the Jaguar Athletic Fund (JAF) and the USA Foundation for Research and Commercialization (FRAC) were not presented in the University's financial statements because they were not considered significant enough to warrant inclusion in the University's reporting entity. In 2025, the University determined both JAF and FRAC would be included in the University's reporting entity going forward resulting in the University recognizing a change to or within the financial reporting entity by restating beginning unrestricted net position by approximately $1,423,000 in accordance with GASB Statement No. 100, *Accounting Changes and Error Corrections-an amendment of GASB Statement No. 62*.

For the nine months ended June 30, 2025, approximately 55% of total revenues of the University were patient service revenues, net. Excluding patient service revenues, tuition and fees charged to students and state appropriations represent the largest component of total University revenues, approximately 10% and 13% of total revenues in 2025, respectively.

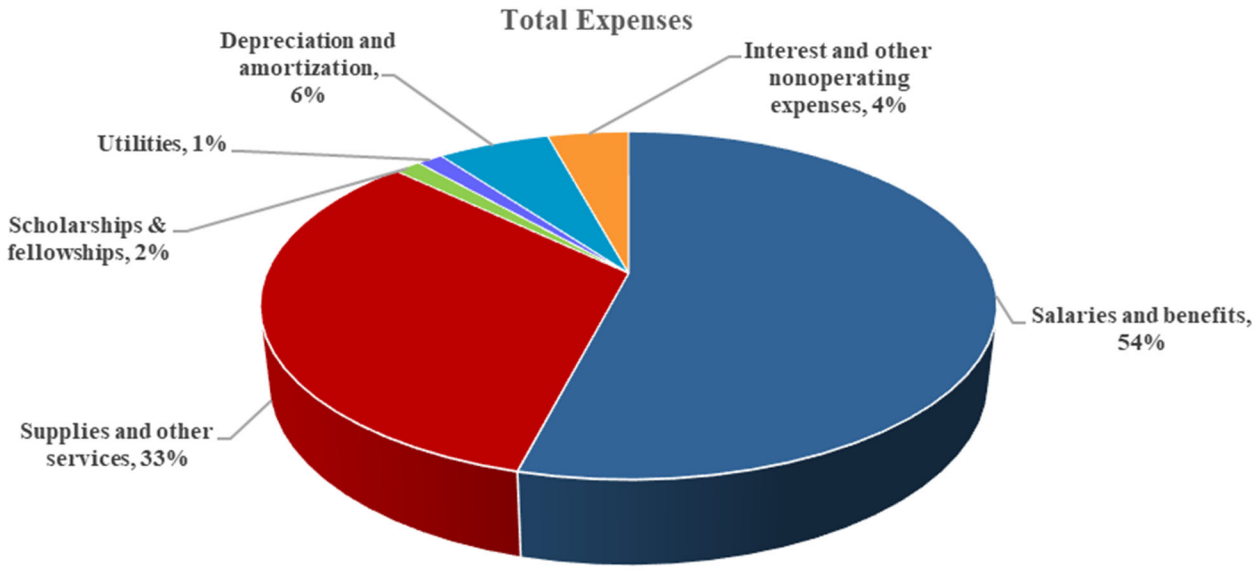
A summary of University revenues for the nine months ended June 30, 2025 is presented as follows:



Tuition revenues have generally remained steady in recent years. Although tuition rates did not increase from 2023 to 2024, there was a slight increase in tuition revenues due to an increase in enrollment. Tuition and fees, gross and net of scholarship allowances, for the past five fiscal years are as follows:

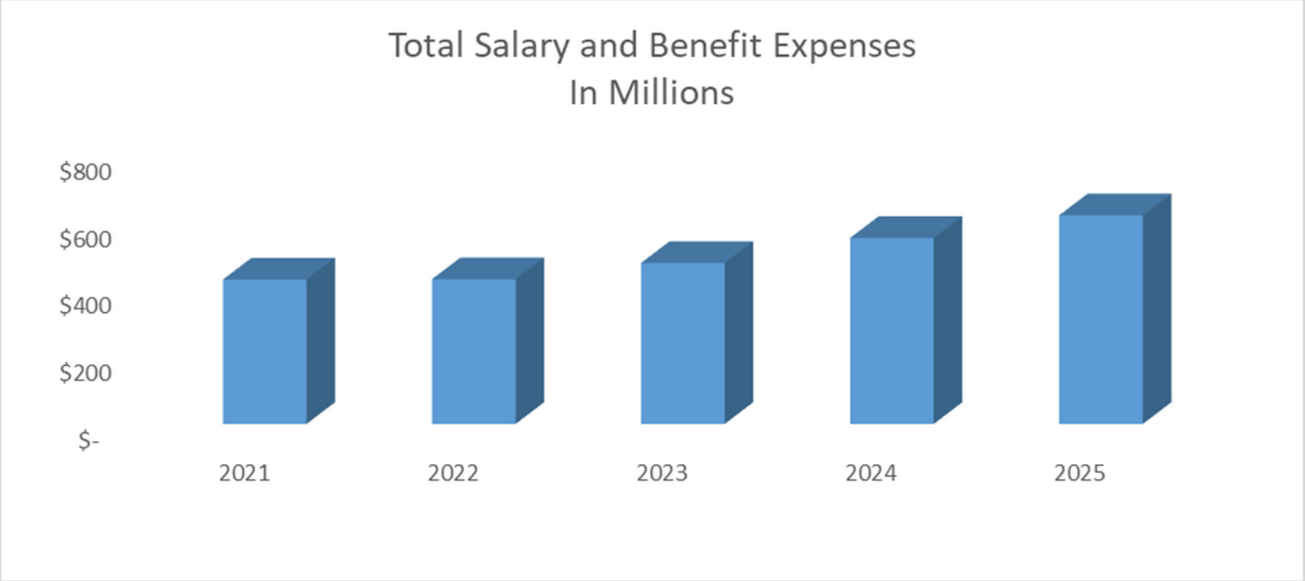


University expenses are presented using their natural expense classifications. A summary of University expenses for the nine months ended June 30, 2025 is presented as follows:



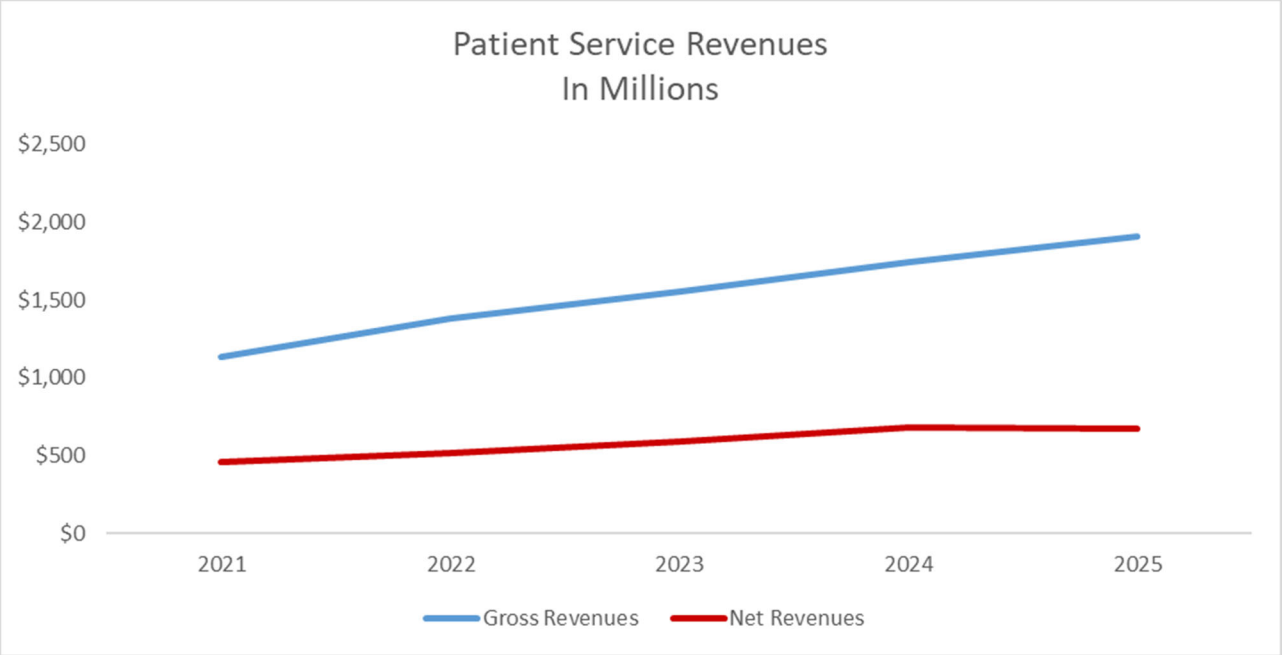
Functional classifications represent expenses categorized based on the function within the University. Such University functions include instruction, research, public service, academic support, student services, institutional support, operation and maintenance of plant, and scholarships. Expenses related to auxiliary enterprise activities, USA Health, and depreciation and amortization are presented separately. Functional expense information is presented in note 18 to the basic financial statements.

For the nine months ended June 30, 2025, approximately 54% of the University's total expenses were salaries and benefits.



For the nine months ended June 30, 2025 and 2024, the University reported an operating loss of approximately $154,438,000 and $94,348,000. The operating loss is offset by state appropriations, which, as mentioned earlier, are reported as nonoperating revenues. After considering all nonoperating revenues and expenses, including capital appropriations, capital contributions and grants, and additions to the endowment, the total increase in net position was approximately $89,284,000 and $105,335,000 for the nine months ended June 30, 2025 and 2024, respectively.

USA Health represents a significant portion of total University revenues. Operating patient service revenues, gross and net, for the nine months ended June 30, 2025 for the last five fiscal years are presented as follows:



Statement of Cash Flows

The statement of cash flows presents information related to cash flows of the University. The statement presents cash flows by category: operating activities, noncapital financing activities, capital and related financing activities, and investing activities. The net cash provided to, or used in, the University is presented by category.

Capital Assets and Debt Administration

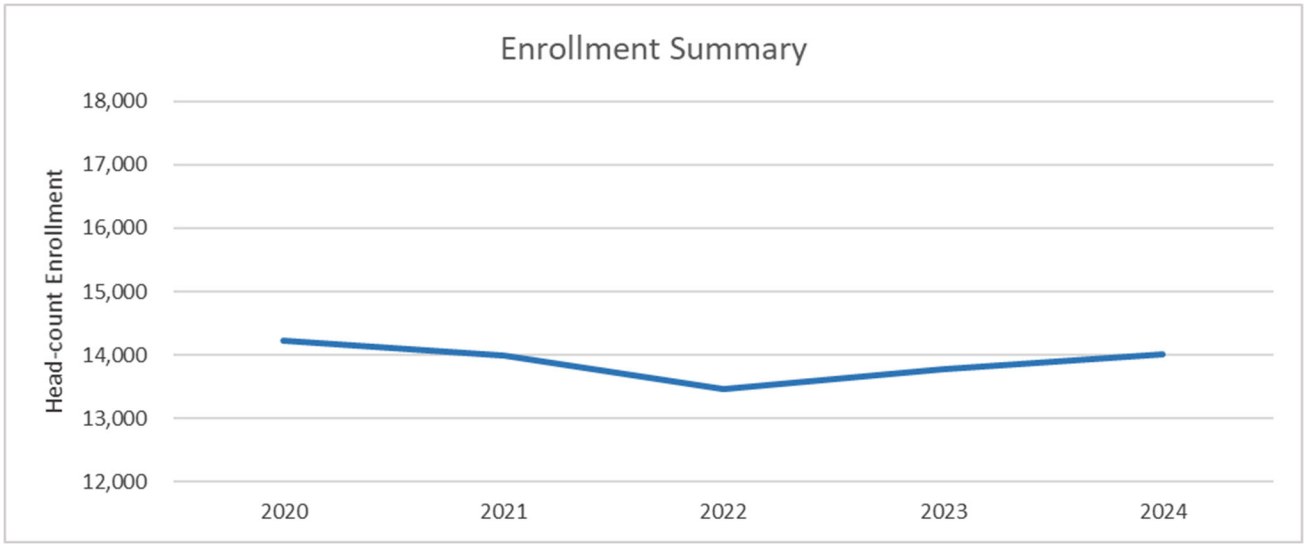
Total capital asset additions for the University were approximately $143,904,000 for the nine months ended June 30, 2025. Significant construction projects that remain in progress as of June 30, 2025 include the new Whiddon College of Medicine Building and related utility improvements, demolition of Alpha Hall South and East, Pediatric Emergency Department expansion, University Hospital Hybrid Operating Room renovation, Science Laboratory Building renovation, Traditions, Jaguar Marching Band Building, and Stanky Field Turf Replacement. Major projects completed and placed into service in fiscal year 2024 include: the Physician's Office Building, North Drive utility and Central Energy Plant improvements; renovations of ROTC building, Simulation Lab, and Dining Hall; and construction of a Campus Storm Shelter and 3D Printing Lab. At June 30, 2025, the University had outstanding commitments of approximately $149,765,000 for various capital projects. Additional information regarding the University's capital assets is included in note 5.

The University's credit rating is A1 (Stable) as rated by Moody's Investors Service and A+ (Stable) as rated by Standard and Poor's Global Ratings. Moody's Investors Services revised the University's outlook from negative to stable and affirmed its A1 issuer and revenue bond ratings in June 2024. Standard and Poor's Global Ratings affirmed the University's current rating in June 2024. Additional information regarding the University's debt is included in note 8.

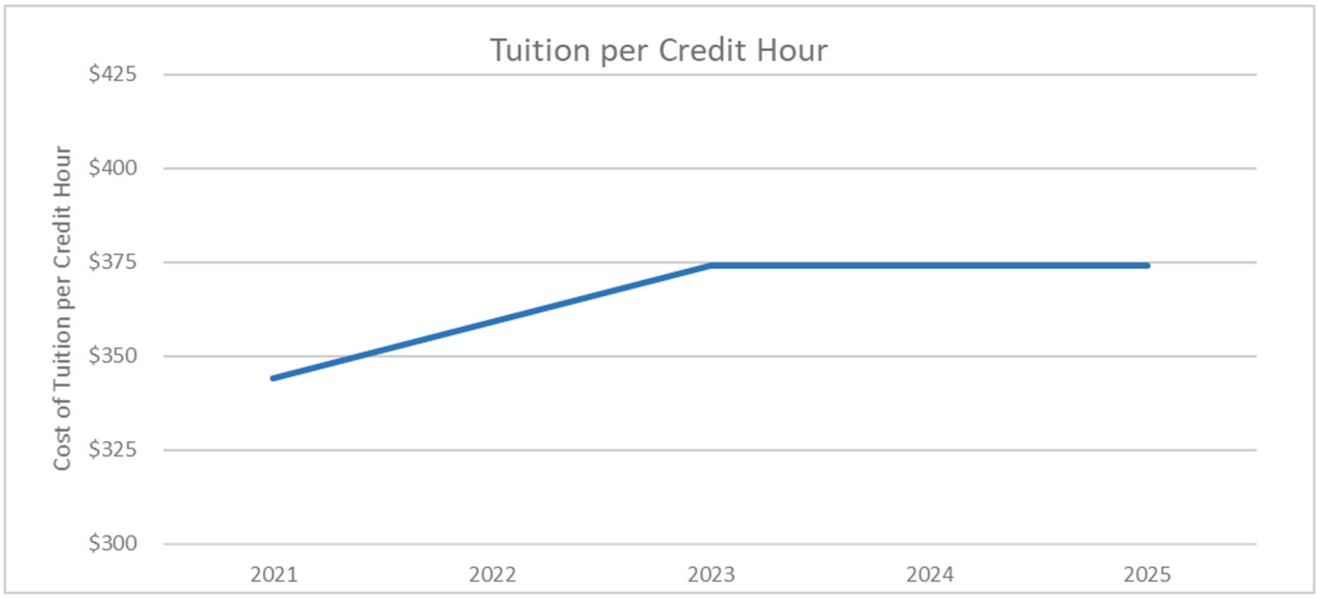
Economic Outlook

While tuition and fee rates per credit hour have increased over the past five years, there were declines in enrollment from 2020 to 2022. The University experienced an increase in enrollment of approximately 2% between Fall 2022 and Fall 2023 and an increase of 2% between Fall 2023 and Fall 2024. The rise in enrollment for Fall 2024 is due mainly to increased freshman enrollment.

The enrollment trend for the University between 2020 and 2024 is as follows:

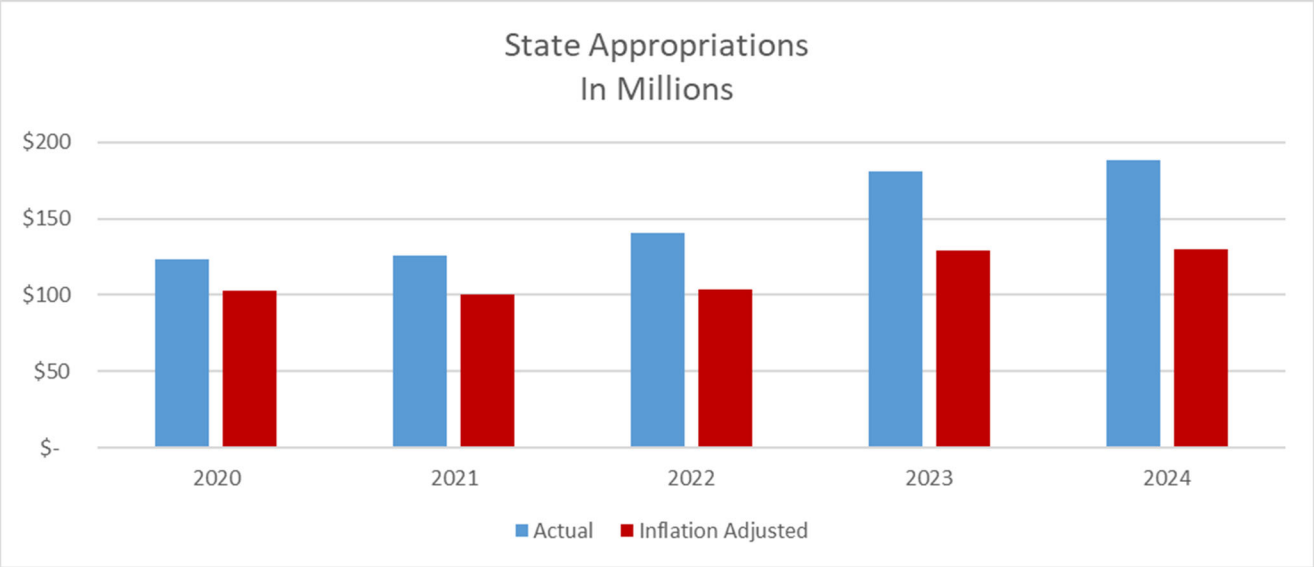


From 2021 to 2025, in-state tuition per credit hour for in-person classes has increased by approximately 9%, with no increase from 2023 to 2025. Similar increases have been experienced in out-of-state tuition and College of Medicine tuition. Web tuition has decreased slightly during that period. The trend of in-state tuition per credit hour between 2021 and 2025 is as follows:



A state appropriation in the amount of approximately $150,375,000 and $140,714,000 was authorized for the years ended September 30, 2024 and 2023, respectively. Additional supplemental appropriations of approximately $37,533,000 and $40,463,000 were received in 2024 and 2023 for advancement and technology, capital project improvements, certain academic and healthcare initiatives, and equipment. A state appropriation in the amount of approximately $161,458,000, representing an increase of approximately 7%, has been authorized for the year ending September 30, 2025. While no announcement has been made, the University is aware that reductions in the 2025 appropriation are possible.

The five-year trend of state appropriations for the University is as follows:



In addition to state appropriations, the University is subject to declines in general economic and political conditions in the United States and, specifically, the State of Alabama. Weakening of the economy, as well as changes in federal and state funding policies, could potentially have a negative impact on the University's enrollment, extramural funding, endowment performance, and healthcare operations.

Requests for Information

These basic financial statements are designed to provide a general overview of the University of South Alabama and its component units' financial activities and to demonstrate the University's accountability. Questions concerning any of the information provided in this report or requests for additional information should be addressed to Kristen Roberts; Chief Financial Officer; University of South Alabama Administration Building Suite 353, Mobile, Alabama 36688. These basic financial statements can be obtained from our website at https:// www.southalabama.edu/departments/financialaffairs/businessoffice/statements.html.

UNIVERSITY OF SOUTH ALABAMA
(A Component Unit of the State of Alabama)

Statement of Net Position

June 30, 2025

(In thousands)

Current assets:	
Cash and cash equivalents	$ 225,546
Restricted cash and cash equivalents	23,402
Investments	71,451
Patient receivables (net of allowance for doubtful accounts of $80,027)	89,265
Accounts receivable, other	124,583
Notes receivable, net	1,185
Prepaid expenses, inventories, and other	20,451
Lease receivable, current portion	7,038
Total current assets	562,921
Noncurrent assets:	
Restricted investments	282,555
Investments	81,399
Other noncurrent assets and accounts receivable	37,427
Lease receivable, less current portion	93,157
Capital assets, net	1,134,065
Total noncurrent assets	1,628,603
Total assets	2,191,524
Deferred outflows	462,017
Total assets and deferred outflows	2,653,541
Current liabilities:	
Accounts payable and accrued liabilities	94,009
Unrecognized revenues	106,912
Deposits	1,566
Current portion of other long-term liabilities	6,568
Current portion lease and subscription obligations	28,573
Current portion of long-term debt	26,405
Total current liabilities	264,033
Noncurrent liabilities:	
Long-term debt, less current portion	460,481
Lease and subscription obligations, less current portion	54,260
Other long-term liabilities, less current portion	279,777
Net pension liability	396,009
Net other postemployment benefits liability	86,820
Total noncurrent liabilities	1,277,347
Total liabilities	1,541,380
Deferred inflows	360,984
Total liabilities and deferred inflows	1,902,364
Net position:	
Net investment in capital assets	578,169
Restricted, nonexpendable:	
Scholarships	50,703
Other	34,335
Restricted, expendable:	
Scholarships	43,490
Other	80,560
Unrestricted	(36,080)
Total net position	$ 751,177

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA

(A Component Unit of the State of Alabama)

Statement of Revenues, Expenses, and Changes in Net Position

Nine Months Ended June 30, 2025

(In thousands)

Operating revenues:		
Tuition and fees (net of scholarship allowances of $23,456)	$	117,048
Patient service revenues (net of provision for bad debts of $70,309)		674,699
Federal grants and contracts		23,364
State grants and contracts		9,931
Private grants and contracts		11,475
Auxiliary enterprises (net of scholarship allowances of $725)		25,114
Other operating revenues		76,588
Total operating revenues		938,219
Operating expenses:		
Salaries and benefits		616,775
Supplies and other services		376,956
Scholarships and fellowships		16,161
Utilities		15,538
Depreciation and amortization		67,227
Total operating expenses		1,092,657
Operating loss		(154,438)
Nonoperating revenues (expenses):		
State appropriations		156,472
Net investment income		28,508
Interest expense		(15,366)
Other nonoperating revenues		33,529
Other nonoperating expenses		(33,118)
Net nonoperating revenues		170,025
Income before capital appropriations, capital contributions and grants, and additions to endowment		15,587
Other changes in net position		
Capital appropriations		21,047
Capital contributions and grants		48,169
Additions to endowment		4,481
Total other changes in net position		73,697
Increase in net position		89,284
Net position:		
Beginning of year		684,661
Cumulative effect of change in accounting principle and change to or within the financial reporting entity (note 1 section (kk))		(22,768)
Beginning balance, as adjusted		661,893
End of period	$	751,177

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA
(A Component Unit of the State of Alabama)

Statement of Cash Flows

Nine Months Ended June 30, 2025

(In thousands)

Cash flows from operating activities:		
Receipts related to tuition and fees	$	82,857
Receipts from and on behalf of patients and third-party payers		677,915
Receipts from grants and contracts		34,066
Receipts related to auxiliary enterprises		18,067
Payments to suppliers and vendors		(391,049)
Payments to employees and related benefits		(610,102)
Payments for scholarships and fellowships		(16,161)
Other operating receipts		99,340
Net cash used in operating activities		(105,067)
Cash flows from noncapital financing activities:		
State appropriations		156,492
Endowment gifts		4,481
Agency funds received		680
Agency funds disbursed		(495)
Student loan program disbursements		(81,132)
Student loan program receipts		81,417
Other nonoperating revenues		39,568
Other nonoperating expenses		(36,099)
Net cash provided by noncapital financing activities		164,912
Cash flows from capital and related financing activities:		
Capital contributions and grants		48,169
Purchases of capital assets		(104,798)
Proceeds from sales of capital assets		103
Principal payments on capital debt		(37,948)
Interest payments on capital debt		(19,023)
Net cash used in capital and related financing activities		(113,497)
Cash flows from investing activities:		
Interest and dividends on investments		19,116
Purchases of investments		(86,895)
Proceeds from sales of investments		100,185
Net cash provided by investing activities		32,406
Net decrease in cash and cash equivalents		(21,246)
Cash and cash equivalents (unrestricted and restricted):		
Beginning of year		270,194
End of period	$	248,948

(Continued)

UNIVERSITY OF SOUTH ALABAMA
(A Component Unit of the State of Alabama)

Statement of Cash Flows

Nine Months Ended June 30, 2025

(In thousands)

Reconciliation of operating loss to net cash used in operating activities:		
Operating loss	$	(154,438)
Adjustments to reconcile operating loss to net cash used in operating activities:		
Depreciation and amortization		67,227
Changes in assets and liabilities, net:		
Student receivables		(59,952)
Net patient receivables		2,837
Grants and contracts receivables		(5,946)
Other receivables		(187,296)
Prepaid expenses, inventories, and other		421
Accounts payable and accrued liabilities		202,510
Unrecognized revenues		29,570
Net cash used in operating activities	$	(105,067)
Reconciliation of cash and cash equivalents to the statement of net position:		
Cash and cash equivalents classified as current assets	$	225,546
Restricted cash and cash equivalents classified as current assets		23,402
Total cash and cash equivalents	$	248,948
Noncash investing, noncapital financing, and capital and related financing transactions:		
Net increase in fair value of investments recognized as a component of investment gains	$	5,690
Payments on behalf of the University by the Alabama Public School and College Authority reducing purchases of capital assets		21,047
Net increase in lease and subscription obligations		18,424
Decrease in accounts payable related to capital projects		(2,693)
Loss on disposals of capital assets		(125)

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA FOUNDATION

(Discretely Presented Component Unit of the University of South Alabama)

Consolidated Statement of Financial Position

March 31, 2025

(In thousands)

Assets		
Cash and cash equivalents	$	768
Investments:		
Equity securities		252,150
Timber and mineral properties		179,818
Real estate		6,361
Other		5,815
Other assets		547
Total assets	$	445,459
Liabilities and Net Assets		
Liabilities:		
Other liabilities	$	502
Total liabilities		502
Net assets:		
Without donor restrictions		60,393
With donor restrictions		384,564
Total net assets		444,957
Total liabilities and net assets	$	445,459

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA FOUNDATION

(Discretely Presented Component Unit of the University of South Alabama)

Consolidated Statement of Activities and Changes in Net Assets

Nine Months Ended March 31, 2025

(In thousands)

	Without donor restrictions	With donor restrictions	Total
Revenues, gains, losses, and other support:			
Net realized and unrealized gains on investments	$ 1,824	444	2,268
Rents, royalties, and timber sales	2,534	147	2,681
Interest and dividends	1,194	1,226	2,420
Gifts	—	112	112
Interfund interest	(636)	636	—
Other income	26	—	26
Net assets released from program restrictions	10,711	(10,711)	—
Total revenues, gains, losses, and other support	15,653	(8,146)	7,507
Expenditures:			
Program services:			
Faculty support	1,877	—	1,877
Scholarships	831	—	831
Other academic programs	8,925	—	8,925
Total program service expenditures	11,633	—	11,633
Management and general	2,390	—	2,390
Other investment expense	932	—	932
Depreciation and depletion expense	2,138	—	2,138
Total expenditures	17,093	—	17,093
Change in net assets	(1,440)	(8,146)	(9,586)
Net assets – beginning of year	61,833	392,710	454,543
Net assets – end of period	$ 60,393	384,564	444,957

See accompanying notes to basic financial statements.

USA RESEARCH AND TECHNOLOGY CORPORATION

(Discretely Presented Component Unit of the University of South Alabama)

Statement of Net Position

June 30, 2025

(In thousands)

Assets:		
Current assets:		
Cash and cash equivalents	$	2,114
Lease receivable, current portion		2,200
Prepaid expenses and other current assets		90
Accrued interest receivable		54
Total current assets		4,458
Noncurrent assets:		
Capital assets, net		16,612
Lease receivable, less current portion		11,024
Total noncurrent assets		27,636
Deferred outflows		356
Total assets and deferred outflows		32,450
Liabilities:		
Current liabilities:		
Deposits, other current liabilities, and accrued expenses		217
Unrecognized rent revenue		265
Notes payable, current portion		1,091
Total current liabilities		1,573
Noncurrent liabilities:		
Notes payable, less current portion		15,084
Total noncurrent liabilities		15,084
Deferred inflows		12,504
Total liabilities and deferred inflows	$	29,161
Net position:		
Net investment in capital assets	$	1,009
Unrestricted		2,280
Total net position	$	3,289

See accompanying notes to basic financial statements.

USA RESEARCH AND TECHNOLOGY CORPORATION

(Discretely Presented Component Unit of the University of South Alabama)

Statement of Revenues, Expenses, and Changes in Net Position

Nine Months Ended June 30, 2025

(In thousands)

Operating revenues	$	2,663
Operating expenses:		
Building management and operating expenses		957
Depreciation and amortization		939
Legal and administrative fees		327
Insurance		67
Total operating expenses		2,290
Operating income		373
Nonoperating revenues (expenses):		
Interest expense		(583)
Interest income		53
Other		315
Net nonoperating expenses		(215)
Increase in net position		158
Net position:		
Beginning of year		3,131
End of period	$	3,289

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA HEALTH CARE AUTHORITY
(A Component Unit of the University of South Alabama)

Statement of Net Position

June 30, 2025

(In thousands)

Current assets:		
Cash and cash equivalents	$	—
Restricted cash and cash equivalents		437
Patient receivables (net of allowance for doubtful accounts of $28,367)		40,158
Accounts receivable, other		8,080
Inventories		2,483
Lease receivable, current portion		895
Other current assets		1,793
Total current assets		53,846
Noncurrent assets:		
Capital assets, net		131,518
Investments		935
Lease receivable, less current portion		2,666
Total noncurrent assets		135,119
Total assets	$	188,965
Current liabilities:		
Accounts payable and accrued liabilities	$	32,514
Accrued salaries and wages		7,106
Lease and subscription obligations, current portion		7,230
Long-term debt, current portion		225
Deferred revenue		3,623
Other current liabilities		346
Cash overdraft		1,140
Total current liabilities		52,184
Noncurrent liabilities:		
Lease and subscription obligations, less current portion		93,588
Long-term debt, less current portion		21,303
Other noncurrent liabilities		3,107
Total noncurrent liabilities		117,998
Deferred inflows		3,148
Total liabilities and deferred inflows	$	173,330
Net position:		
Net investment in capital assets	$	253,860
Restricted		437
Unrestricted		(238,662)
Total net position	$	15,635

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA HEALTH CARE AUTHORITY

(A Component Unit of the University of South Alabama)

Statement of Revenues, Expenses, and Changes in Net Position

Nine Months Ended June 30, 2025

(In thousands)

Operating revenues:		
Patient service revenues (net of provision for bad debts of $18,520)	$	205,268
Other operating revenues		25,992
Total operating revenues		231,260
Operating expenses:		
Salaries and benefits		121,733
Building and equipment expenses		13,561
Medical and surgical supplies		69,766
Other expenses		59,035
Depreciation and amortization		7,443
Total operating expenses		271,538
Operating loss		(40,278)
Nonoperating revenues (expenses):		
Investment income		152
Support from University of South Alabama		32,481
Interest expense		(4,268)
Other nonoperating revenues		40
Other nonoperating expenses		(11)
Total nonoperating revenues, net		28,394
Increase in net position		(11,884)
Net position at beginning of period		28,878
Cumulative effect of change in accounting principle and change to or within the financial reporting entity (note 1 section (m))		(1,359)
Beginning balance, as adjusted		27,519
Net position at end of period	$	15,635

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA MEDICAL SCIENCE FOUNDATION

(Discretely Presented Component Unit of the University of South Alabama)

Consolidated Statement of Financial Position

June 30, 2025

(In thousands)

Assets

Assets:		
Cash and cash equivalents	$	882
Restricted cash		229
Investments		12,434
Accounts receivable, other		61
Prepaid expenses, inventories, and other		6
Total assets	$	13,612

Liabilities and Net Assets

Liabilities:		
Total liabilities		—
Net assets:		
Unallocated		8,119
Basic Science Departments		51
Grants & Contracts		5,213
Endowment		229
Total net assets		13,612
Total liabilities and net assets	$	13,612

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA MEDICAL SCIENCE FOUNDATION

(Discretely Presented Component Unit of the University of South Alabama)

Consolidated Statement of Activities and Changes in Net Assets

Nine Months Ended June 30, 2025

(In thousands)

Revenue:		
Grants and Contracts	$	550
Sales & Registration		451
Interest Income		305
Total Revenue		1,306
Expenditures:		
Contributions to USA		42
Legal & Audit Fees		43
Travel & Entertainment		398
Recruiting & Advertising		11
Contract Services		379
Equipment		15
Other Operating Expenses		439
Total Expenditures		1,327
Revenue Over Expenditures		(21)
Transfers & Other Changes:		
Change in Value of Investments		464
Net Increase	$	443

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA PROVIDENCE FOUNDATION

(Discretely Presented Component Unit of the University of South Alabama)

Consolidated Statement of Financial Position

March 31, 2025

(In thousands)

Assets		
Cash and cash equivalents	$	4,769
Investments:		
Equity securities		4,911
Fixed income		832
Other assets		
Capital assets, net		98
Total assets	$	10,610
Liabilities and Net Assets		
Liabilities:		
Other liabilities	$	82
Total liabilities		82
Net assets:		
Without donor restrictions		8,521
With donor restrictions		2,007
Total net assets		10,528
Total liabilities and net assets	$	10,610

See accompanying notes to basic financial statements.

UNIVERSITY OF SOUTH ALABAMA PROVIDENCE FOUNDATION

(Discretely Presented Component Unit of the University of South Alabama)

Consolidated Statement of Activities and Changes in Net Assets

Nine Months Ended March 31, 2025

(In thousands)

	Without donor restrictions	With donor restrictions	Total
Revenues, gains, losses, and other support:			
Net realized and unrealized gains on investments	$ 490	—	490
Gifts	—	126	126
Interest and dividends	210	1	211
Other income	2	—	2
Net assets released from program restrictions	152	(152)	—
Total revenues, gains, losses, and other support	854	(25)	829
Expenditures:			
Supplies and other services	24	—	24
Foundation grant disbursements	152	—	152
Utilities	8	—	8
Total program service expenditures	184	—	184
Other investment expense	15	—	15
Total expenditures	199	—	199
Change in net assets	655	(25)	630
Net assets – beginning of year	7,875	2,032	9,907
Net assets – beginning balance adjustment	(9)	—	(9)
Net assets – end of period	$ 8,521	2,007	10,528

See accompanying notes to basic financial statements.

GULF COAST TOTALCARE
(Discretely Presented Component Unit of the University of South Alabama)

Statement of Net Position

June 30, 2025

(In thousands)

Current assets:		
Cash and cash equivalents	$	562
Accounts receivable, other		632
Prepaid expenses, inventories, and other		5
Total current assets		1,199
Total assets	$	1,199
Current liabilities:		
Accounts payable and accrued liabilities		572
Total current liabilities	$	572
Unrestricted net assets:		
Unreserved		377
Reserved		250
Total unrestricted net assets		627
Total liabilities and net assets	$	1,199

See accompanying notes to basic financial statements.

GULF COAST TOTALCARE

(Discretely Presented Component Unit of the University of South Alabama)

Statement of Revenues, Expenses, and Changes in Net Position

Nine Months Ended June 30, 2025

(In thousands)

Operating revenues:		
Patient service revenues	$	6,184
Interest income		2
Total operating revenues		6,186
Operating expenses:		
Supplies and other services		6,191
Total operating expenses		6,191
Operating loss		(5)
Net position:		
Beginning of year		632
End of period	$	627

See accompanying notes to basic financial statements.

(1) Summary of Significant Accounting Policies

(a) Reporting Entity

On May 3, 1963, the Governor of Alabama signed enabling legislation creating the University of South Alabama (the University). The accompanying basic financial statements present the financial position and activities of the University, which is a component unit of the State of Alabama.

The financial reporting entity, as defined by Governmental Accounting Standards Board (GASB) Statement No. 14, *The Financial Reporting Entity*, and amended by GASB Statement No. 39, *Determining Whether Certain Organizations Are Component Units*, GASB Statement No. 61, *The Financial Reporting Entity: Omnibus*, and GASB Statement No. 80, *Blending Requirements for Certain Component Units*, consists of the primary government and all of its component units. Component units are legally separate organizations for which the primary government is financially accountable. In addition, the primary government may determine, through exercise of management's professional judgment, that the inclusion of an organization that does not meet the financial accountability criteria is necessary in order to prevent the reporting entity's financial statements from being misleading. In such instances, that organization is included as a component unit. Accordingly, the basic financial statements include the accounts of the University, as the primary government, and the accounts of the entities discussed below as component units.

GASB Statement No. 61 amended GASB Statements No. 14 and No. 39 and provides criteria for determining whether certain organizations should be reported as component units based on the nature and significance of their relationship with the primary government. Such criteria include the appointment of a voting majority of the board of the organization, the ability to impose the will of the primary government on the organization, and the financial benefits/burden between the primary government and the potential component unit. The statement also clarifies reporting and disclosure requirements for those organizations. Based on these criteria as of June 30, 2025, the University reports University of South Alabama Foundation (USA Foundation), USA Research and Technology Corporation (the Corporation), the University of South Alabama Health Care Authority (HCA), the South Alabama Medical Science Foundation (SAMSF), Providence Foundation, and Gulf Coast TotalCare (Gulf Coast) as discretely presented component units. Both SAMSF and Gulf Coast were disclosed as related parties prior to 2025, however, beginning with 2025, these two entities are discretely presented as component units due to meeting the criteria of GASB Statement No. 61, which amended GASB Statements No. 14 and No. 39. The University became the sole corporate member of the Providence Foundation in December 2024, and as a result, the Providence Foundation is discretely presented as a component unit due to meeting the criteria of GASB Statement No. 61, which amended GASB Statements No. 14 and No. 39. Each of these entities issue separate audited financial statements, which can be obtained by contacting Kristen Roberts, Chief Financial Officer, University of South Alabama Administration Building, Suite 353, Mobile, Alabama 36688.

GASB requires the University, as the primary government, to include in its basic financial statements, as a blended component unit, organizations that, even though they are legally separate entities, meet certain requirements. Based on these requirements, the University reports the Professional Liability Trust Fund (PLTF); General Liability Trust Fund (GLTF); USA HealthCare Management, LLC; USA

Jaguar Realty, LLC (Jaguar Realty); Jaguar Athletic Fund (JAF); USA Foundation for Research and Commercialization (FRAC); USA Health Physician Billing Services, LLC; USA Health Hospital Billing Services, LLC; USA Health Anesthesia Billing Services, LLC; USA Health Reference Lab Billing Services, LLC; USA Health MCI Business Services, LLC; USA Health Children's and Women's Provider Based Clinics, LLC; Providence Medical Network IPA, LLC (Providence IPA); USA Health Rehabilitation Services, LLC; and USA Health Community Providers, LLC as blended component units.

Prior to 2025, the Jaguar Athletic Fund (JAF) and the USA Foundation for Research and Commercialization (FRAC) were not presented in the University's financial statements because they were not considered significant enough to warrant inclusion in the University's reporting entity. In 2025, the University determined both JAF and FRAC would be included in the University's reporting entity as a blended component unit going forward resulting in the University recognizing a change to or within the financial reporting entity by restating beginning unrestricted net position by approximately $1,423,000 in accordance with GASB Statement No. 100, *Accounting Changes and Error Corrections-an amendment of GASB Statement No. 62*.

All significant transactions between the University and its blended component units have been eliminated.

The University is also affiliated with the USA Presidential 1963 Fund. This entity is considered a component unit of the University under the provisions of GASB Statement Nos. 14, 39, 61, and 80. However, this entity is not presented in the accompanying basic financial statements as the University does not consider them significant enough to warrant inclusion in the University's reporting entity.

In October 2023, through the acquisition of Ascension Providence, the University obtained joint ownership of HighProv, LLC, and Providence Home Medical Services, LLC. HighProv, LLC and Providence Home Medical Services, LLC are currently included in investments on the statement of net position in accordance with GASB Statement No.14.

(b) Professional Liability and General Liability Trust Funds

The medical malpractice liability of the University is maintained and managed in its separate PLTF in which the University, HCM, SAMSF, and HCA are the only participants. In accordance with the bylaws of the PLTF, the president of the University is responsible for appointing members of the PLTF policy committee. Additionally, the general liability of the University, HCM, SAMSF, the Corporation, and HCA is maintained and managed in its GLTF for which the University is responsible. The PLTF and GLTF are separate legal entities, which are governed by the University Board of Trustees through the University president. As such, PLTF and GLTF are reported as blended component units.

(c) USA HealthCare Management, LLC

In June 2010, the University's Board of Trustees approved the formation of USA HealthCare Management, LLC (HCM). HCM was organized for the purpose of managing and operating on behalf of, and as agent for, payroll activities related to the healthcare clinical enterprise of the University. The University is the sole member of HCM. HCM commenced operations in October 2010 and is reported as a blended component unit.

(d) Jaguar Athletic Fund

Jaguar Athletic Fund (JAF) is a not-for-profit corporation that was organized for the purpose of providing support for the athletic programs and student-athletes at the University. JAF is a legally separate entity whose officers and directors are approved by the University's Board of Trustees. JAF is reported as a blended component unit.

(e) USA Jaguar Realty, LLC

Jaguar Realty, LLC (Jaguar Realty) was formed in July 2020 for the purpose of providing students a unique professional opportunity to complete their pre-real estate license education at the University and gain real estate sales experience. The University's Board of Trustees functions as the governing board of Jaguar Realty. As of June 30, 2025, Jaguar Realty has had no financial activity.

(f) Providence Medical Network IPA, LLC

Through the Ascension Providence acquisition in October 2023, the University became the sole member of the Providence Medical Network IPA, LLC (Providence IPA). The Providence IPA is a legally separate entity reported as a blended component unit and operates as an independent physician association. Revenues of approximately $6,866,000, excluding significant transactions between the University and the IPA, are included within other operating revenues on the statement of revenues, expenses, and changes in net position. Expenses of approximately $6,866,000, excluding significant transactions between the University and the IPA, are included within supplies and other services on the statement of revenues, expenses, and changes in net position. The Providence IPA has a calendar year-end, which differs from the University's September 30 year-end. In accordance with GASB Statement No. 14 and Statement No. 61, the University has included the Providence IPA's financial statements for the period January 1, 2024 through December 31, 2024 in the University's financial statements as of June 30, 2025. For the nine months ended June 30, 2025, the Providence IPA has paid approximately $0 in claims to the University.

(g) USA Foundation for Research and Commercialization

USA Foundation for Research and Commercialization (FRAC) is a not-for-profit corporation that was organized for the purpose of providing support to the University to foster research and educational initiatives for both students and faculty. FRAC is a legally separate entity whose officers and directors are approved by the University's Board of Trustees. FRAC has one wholly owned subsidiary, NovALtech, LLC. FRAC is reported as a blended component unit.

(h) USA Health Billing Limited Liability Companies

Over the last few years, the University formed the USA Health Physician Billing Services, LLC; USA Health Hospital Billing Services, LLC; USA Health Anesthesia Billing Services, LLC; USA Health Reference Lab Billing Services, LLC; USA Health MCI Business Services, LLC; USA Health Children's and Women's Provider Based Clinics, LLC; USA Health Community Providers, LLC; and USA Health Rehabilitation Services LLC as limited liability companies, whereby the University is the sole member. These companies were created to assist with the complex patient and insurance billing of USA Health, a division of the University that includes two hospitals, a free-standing emergency department, a

cancer treatment center, and various health clinics. Based on GASB requirements, the University, as the primary government, includes these limited liability companies as blended component units. All significant transactions between the University and its blended component units have been eliminated.

(i) University of South Alabama Health Care Authority

In May 2017, the University's Board of Trustees approved the formation of HCA. HCA is a public corporation created under and pursuant to the provisions of the State of Alabama University Authority Act of 2016. HCA employs physicians and staff of certain physician practice groups as determined appropriate by the University. HCA presents its financial statements in accordance with GASB.

HCA is the sole member of the following companies: Mobile Heart USA, LLC; USA Health HCA Industrial Medicine Clinic, LLC; USA Health IPA, LLC; USA Health Daphne Family Practice, LLC; USA Mobile County ASC; USA Health HCA Providence Hospital, LLC; and USA Health Providence Retail Pharmacy, LLC. These companies were created to assist with the complex patient and insurance billings within HCA. Based on the criteria listed above, GASB requires HCA, as the primary government, to include each of these limited liability companies as blended component units. All significant transactions among HCA and its blended component units have been eliminated.

During fiscal year 2023, HCA obtained a 51% equity interest in USA BC ASC Holdco, LLC (USA BC ASC Holdco). USA BC ASC Holdco's primary purpose is to invest in ambulatory surgery centers (ASCs) and promote health and wellness to the area. Surgery Center Holdings, Inc. owns the remaining 49%. USA BC ASC Holdco owns 51% of USA Baldwin County ASC, LLC (USA BC ASC), which is a limited liability company that was formed to develop, own, and operate the ASC on the USA Health Mapp Family Campus. The remaining 49% of USA BC ASC is owned by individual physician investors. USA BC ASC Holdco has a calendar year-end, which differs from HCA's September 30 year-end. HCA's capital account balance is presented on the June 30, 2025 statement of net position as a noncurrent investment.

In August 2020, HCA formed USA Health IPA, LLC (the IPA), a limited liability company of which HCA is the sole member. The IPA was formed to operate an independent physician association, which began in August 2021. The IPA has a calendar year-end, which differs from HCA's September 30 year-end. In accordance with GASB Statement No. 14 and GASB Statement No. 61, HCA has included the IPA's financial statements for the year ended December 31, 2024 in HCA's financial statements as of June 30, 2025. Exclusive of transactions between HCA and the IPA totaling approximately $737,000, IPA revenues and expenses of approximately $6,110,000 and $6,110,000, respectively, are included within the statement of revenues, expenses, and changes in net position.

During fiscal year 2022, HCA obtained equity interest in a multimember limited liability company, USA Fairhope Physician Investors, LLC (FPI). FPI was initially considered as a component unit under the provisions of GASB Statement Nos. 14 and 61. Amendment 1 to the initial agreement was executed during fiscal year 2023, removing HCA's control of the entity and ability to impose its will on the entity. The change resulted in HCA's relationship with FPI shifting from a component unit to an investment in a joint venture. FPI has a calendar year-end, which differs from HCA's September 30 year-end. HCA's

capital account balance is presented on the June 30, 2025 statement of net position as a noncurrent investment.

Since inception, HCA's operations have been partially funded by the University, with total support amounting to approximately $32,481,000 for the nine months ended June 30, 2025. This support is reported in nonoperating expenses on the University's statement of revenues, expenses, and changes in net position. Due to the significance of the relationship between the University and HCA, HCA is considered a component unit of the University. The accompanying statement of net position and statement of revenues, expenses, and changes in net position for HCA as of and for the nine months ended June 30, 2025 are discretely presented.

(j) University of South Alabama Foundation

USA Foundation is a not-for-profit corporation that was organized for the purpose of promoting education, scientific research, and charitable purposes, and to assist in developing and advancing the University in furthering, improving, and expanding its properties, services, facilities, and activities. The USA Foundation has two wholly owned subsidiaries, Knollwood Development, Inc. and Shubuta Timber Services, Inc. Because of the significance of the relationship between the University and USA Foundation, USA Foundation is considered a component unit of the University. The Board of Directors of USA Foundation is not appointed or controlled by the University. The University receives distributions from USA Foundation primarily for scholarship, faculty, and other support. Total distributions received or accrued by the University for the nine months ended June 30, 2025 were approximately $7,634,000 and are included primarily in other nonoperating revenues and capital contributions and grants in the University's statement of revenues, expenses, and changes in net position. USA Foundation presents its financial statements in accordance with standards issued by the Financial Accounting Standards Board (FASB). USA Foundation is reported in separate financial statements because of the difference in the financial reporting framework since USA Foundation follows FASB rather than GASB. USA Foundation has a June 30 fiscal year-end, which differs from the University's September 30 fiscal year-end. In accordance with GASB Statement No. 14 and GASB Statement No. 61, the University has included USA Foundation's statements for the nine months ended March 31, 2025 in the University's financial statements as of June 30, 2025. The accompanying consolidated statement of financial position and consolidated statement of activities and changes in net assets for USA Foundation as of and for the nine months ended March 31, 2025 are discretely presented.

(k) USA Research and Technology Corporation

In June 2002, the University's Board of Trustees approved the formation of the Corporation. The Corporation is a not-for-profit corporation that exists for the purpose of furthering the educational and scientific mission of the University by developing, attracting, and retaining technology and research industries in Alabama that will provide professional and career opportunities to the University's students and faculty. Due to the significance of the relationship between the University and the Corporation, the Corporation is considered a component unit of the University. The Corporation presents its financial statements in accordance with GASB. The accompanying statement of net position and statement of

revenues, expenses, and changes in net position for the Corporation as of and for the nine months ended June 30, 2025 are discretely presented.

(l) Providence Foundation

The University became the sole corporate member of the Providence Foundation in December 2024. The Providence Foundation is a not-for-profit corporation whose purpose is to further promote, support and engage in any charitable, scientific, and educational activities established by the University. Providence Foundation presents its financial statements in accordance with standards issued by the Financial Accounting Standards Board (FASB). Providence Foundation is reported in separate financial statements because of the difference in the financial reporting framework since Providence Foundation follows FASB rather than GASB. Providence Foundation has a June 30 fiscal year end, which differs from the University's September 30 fiscal year end. In accordance with GASB Statement No. 14, GASB Statement No. 61 and GASB Statement No. 100, the University has included Providence Foundation's statements for the nine months ended March 31, 2025 in the University's financial statements as of June 30, 2025. The accompanying consolidated statement of financial position and consolidated statement of activities and changes in net assets for USA Foundation as of and for the nine months ended March 31, 2025 are discretely presented.

(m) South Alabama Medical Science Foundation

In August 1981, the South Alabama Medical Science Foundation (SAMSF) was formed as a not-for-profit corporation whose purpose is to support the University's College of Medicine by investing in research and educational activities. The Board of Directors of SAMSF is not appointed or controlled by the University. Due to the significance of the relationship between the University and SAMSF, the SAMSF is considered a component unit of the University. The University receives distributions from SAMSF primarily to support clinical trials and research at the University. Total distributions received or accrued by the University for the nine months ended June 30, 2025 were approximately $145,000 and are included primarily in other nonoperating revenues and capital contributions and grants in the University's statement of revenues, expenses, and changes in net position. SAMSF presents its financial statements in accordance with standards issued by the Financial Accounting Standards Board (FASB). SAMSF is reported in separate financial statements because of the difference in the financial reporting framework since SAMSF follows FASB rather than GASB. The accompanying statement of net position and statement of revenues, expenses, and changes in net position for SAMSF as of and for the nine months ended June 30, 2025 are discretely presented.

(n) Gulf Coast TotalCare

Gulf Coast TotalCare (Gulf Coast) is an Alabama not-for-profit corporation created for the purpose of operating a community-led network to coordinate the healthcare of Medicaid patients in Southwest Alabama. HCM is the sole corporate member of Gulf Coast and appoints the Board of Directors. Based on GASB Statement No. 14, as amended by Statement No. 39, Gulf Coast is a discretely presented component unit of HCM, which is a component unit of the University. Gulf Coast presents its financial statements in accordance with GASB. The accompanying statement of net position and statement of revenues, expenses, and changes in net position for Gulf Coast as of and for the nine months ended June 30, 2025 are discretely presented.

(o) Measurement Focus and Basis of Accounting

For financial reporting purposes, the University is considered a special purpose governmental agency engaged only in business-type activities, as defined by GASB Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis for State and Local Governments*, as amended by GASB Statement No. 35, *Basic Financial Statements and Management's Discussion and Analysis for Public Colleges and Universities*. Accordingly, the University's basic financial statements have been presented using the economic resources measurement focus and the accrual basis of accounting. Under the accrual basis, revenues are recognized when earned, and expenses are recorded when an obligation has been incurred.

(p) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires that management make estimates and assumptions affecting the reported amounts of assets and liabilities, revenues, and expenses, as well as disclosure of contingent assets and liabilities. Actual results could differ from those estimates.

In particular, laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates related to these programs could change by a material amount in the near term.

(q) Cash and Cash Equivalents (including restricted amounts)

Cash and cash equivalents are defined as petty cash, demand accounts, certificates of deposit, and any short-term investments that take on the character of cash. These investments have maturities of less than three months at the time of purchase and include repurchase agreements and money market accounts. Restricted cash and cash equivalents share the same definitions and maturities of unrestricted cash and cash equivalents but are designated by external parties for specified purposes such as collateral requirements, designated gifts, or bond proceeds.

(r) Investments and Investment Income

The University reports the fair value of investments using the three-level hierarchy established under GASB Statement No. 72, *Fair Value Measurement and Application*. The fair value of alternative investments (low-volatility, multistrategy funds of funds) and certain private equity partnerships do not have readily ascertainable market values and the University values these investments in accordance with valuations provided by the general partners or fund managers of the underlying partnerships or companies, typically based on net asset value (NAV) of the partnership or commingled vehicle. Because some of these investments are not readily marketable, the estimated fair value is subject to uncertainty and, therefore, may differ from the fair value that would have been used had a ready market for the investment existed. Investments received by gift are recorded at fair value at the date of receipt. Changes in the fair value of investments are reported in net investment income.

(s) Derivatives

The University has adopted the provisions of GASB Statement No. 53, *Accounting and Financial Reporting for Derivative Instruments* and GASB Statement No. 99, *Omnibus 2022*. GASB Statement No. 53 establishes a framework for accounting and financial reporting related to derivative instruments, requiring the fair value of derivatives to be recognized in the basic financial statements. GASB Statement No. 99 establishes requirements for the presentation of deferred outflows or inflows related to changes in fair value of hedging instruments when hedge accounting is terminated. As of and for the nine months ended June 30, 2025, the University did not hold any derivative instruments.

(t) Deferred Outflows and Inflows of Resources

Deferred outflows of resources consist of employer contributions to the Teacher's Retirement System of Alabama and the Public Education Employees Health Insurance Plan subsequent to the plan's measurement dates, changes in proportion and differences between employer contributions and proportionate share of contributions related to the OPEB plan, changes in actuarial and other assumptions related to the pension plan, the difference between the consideration provided and the net position acquired for South Coast in the Ascension Providence acquisition, and the loss on the defeasement of certain bond series.

Deferred inflows of resources consist of the proportionate share of the differences between expected and actual experience related to the pension plan, net difference between projected and actual earnings on pension and OPEB plan investments, changes of assumptions in the OPEB plan, changes in proportion and differences between employer contributions and proportionate share of contributions in pension and OPEB plans, gain on the refunding of certain bond series, and the value of contractual rights to lease revenue in future reporting periods.

(u) Bond Premiums, Discounts, and Loss on Extinguishment Costs

Bond premiums, discounts, and loss on extinguishment costs associated with the issuance of certain bond series are capitalized and amortized over the life of the respective bond series on a straight-line basis.

(v) Accounts Receivable

Patient receivables primarily result from hospital and ambulatory patient service revenues. Accounts receivable, other includes amounts due from students, the federal government, state and local governments, or private sources in connection with reimbursement of allowable expenditures made pursuant to the University's grants and contracts. Accounts and patient receivables are recorded net of estimated uncollectible amounts.

(w) Lease Receivable

Lease receivable and current portion thereof on the statement of net position represents the University's contractual right to receive cash in exchange for the right to use an asset for a specific amount of time. Lease receivables are recognized at the commencement date based on the present value of lease payments to be received over the lease term discounted using an appropriate

incremental borrowing rate. The commencement date is either when the lessee takes possession of the asset or, in the case of real estate leases, when the landlord makes the building or office space available for use. The value of an option to extend or terminate a lease is reflected to the extent it is reasonably certain the lessee will exercise that option. Interest revenue is recognized as a component of the lease payments received and is included in other nonoperating revenues on the statement of revenues, expenses, and changes in net position.

(x) Inventories

The University's inventories primarily consist of medical supplies and pharmaceuticals. Medical supplies and pharmaceuticals are stated at the lower of cost (first-in, first-out method) or market.

(y) Capital Assets

Capital expenditures with a cost of $5,000 or more are capitalized at cost, if purchased, or, if donated, at fair value at the date of donation. Depreciation is provided over the estimated useful life of each class of depreciable assets using the straight-line method. Major aggregate capital asset purchases, including renewals and renovations, are capitalized. Purchases for multiple items of minor equipment are evaluated to see if they are part of a single overall transaction, have a single objective, and meet or exceed the established aggregate threshold of $75,000. If a purchase of minor equipment meets the aggregate guidelines and has a useful life of two or more years, it is capitalized at cost once all items are received and placed into use. Costs for repairs and maintenance are expensed when incurred. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts and the gain or loss, if any, is included in nonoperating revenues (expenses) in the statement of revenues, expenses, and changes in net position.

All capital assets other than land are depreciated using the following asset lives:

Buildings, infrastructure, and certain building components	10 to 100 years
Fixed equipment	10 to 20 years
Land improvements	8 to 20 years
Library materials	10 years
Other equipment	3 to 15 years

Certain buildings are componentized for depreciation purposes.

Lease and subscriptions are included in capital assets as right-of-use assets on the statement of net position. Right-of-use assets represent the University's right to use an underlying asset for the specified term and are comprised of leased equipment, buildings, office space, and subscription-based information technology arrangements. Lease and subscription right-of-use assets are recognized at the commencement date based on the present value of the payments over the agreement term discounted using the lessor interest rate or an appropriate incremental borrowing rate. The commencement date is either when the University takes possession of the asset or when the asset becomes available for use.

Amortization of right-of-use assets is recognized on a straight-line basis over the agreement term or useful life of the asset, whichever is shorter.

The University evaluates impairment in accordance with GASB Statement No. 42, *Accounting and Financial Reporting for Impairment of Capital Assets and for Insurance Recoveries*. For the nine months ended June 30, 2025, no impairments were identified.

(z) Unrecognized Revenues

Student tuition, fees, and dormitory rentals are billed in advance and initially recorded as a component of unrecognized revenues in the statement of net position and, then recognized in revenue over the applicable portion of each school term.

(aa) Cost Sharing Multiple-Employer Pension Plan

Employees of the University are covered by a cost sharing multiple-employer defined benefit pension plan (the Plan) administered by the Teachers' Retirement System of Alabama (TRS). The TRS financial statements are prepared using the economic resources measurement focus and accrual basis of accounting. Contributions are recognized as revenues when earned, pursuant to Plan requirements. Benefits and refunds are recognized as expenses when due and payable in accordance with the terms of the Plan. Expenses are recognized when the corresponding liability is incurred, regardless of when the payment is made. Investments are reported at fair value. Financial statements are prepared in accordance with requirements of the GASB. Under these requirements, the Plan is considered a component unit of the State of Alabama and is included in the State's Annual Comprehensive Financial Report.

(bb) Postemployment Benefits Other Than Pensions (OPEB)

Employees of the University are covered by a cost sharing multiple-employer other postemployment benefit plan administered by the Alabama Retired Education Employees Health Care Trust (Trust). The Trust's financial statements are prepared using the economic resources measurement focus and accrual basis of accounting. This includes for purposes of measuring the net OPEB liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position of the Trust, and additions to/deductions from the Trust's fiduciary net position. Plan member contributions are recognized in the period in which the contributions are due. Employer contributions are recognized when due pursuant to plan requirements. Benefits are recognized when due and payable in accordance with the terms of the Plan. In accordance with GASB, the Trust is considered a component unit of the State of Alabama and is included in the State's Annual Comprehensive Financial Report.

(cc) Classification of Net Position

The University's net position is classified as follows:

Net investment in capital assets reflects the University's total investment in capital assets, net of outstanding debt obligations related to those capital assets. To the extent debt has been incurred but

not yet expended for capital assets, such debt is excluded from the calculation of net investment in capital assets.

Restricted, nonexpendable net position consists of endowment and similar type funds for which donors or other outside sources have stipulated, as a condition of the gift instrument, that the principal is to be maintained inviolate and in perpetuity, and invested for the purpose of producing present and future income, which may either be expended or added to principal.

Restricted, expendable net position includes resources that the University is legally or contractually obligated to spend in accordance with restrictions imposed by external parties.

Unrestricted net position represents resources derived from student tuition and fees, state appropriations, patient service revenues, sales and services of educational activities, and auxiliary enterprises. Auxiliary enterprises are substantially self-supporting activities that provide services for students, faculty, and staff. While unrestricted net position may be designated for specific purposes by action of management or the Board of Trustees, they are available for use at the discretion of the governing board to meet current expenses for any purpose.

When an expense is incurred that can be paid using either restricted or unrestricted resources, the University addresses each situation on a case-by-case basis prior to determining the resources to be used to satisfy the obligation.

(dd) Scholarship Allowances and Student Financial Aid

Student tuition and fees, and certain other revenues from students, are reported net of scholarship discounts and allowances in the statement of revenues, expenses, and changes in net position. Scholarship discounts and allowances are the difference between the stated charge for goods and services provided by the University and the amount paid by students and/or third parties making payments on the students' behalf. Certain governmental grants, such as Pell grants, and other federal, state, or nongovernmental programs are recorded as either operating or nonoperating revenues in the University's basic financial statements based on their classification as either an exchange or a nonexchange transaction. To the extent that revenues from such programs satisfy tuition and fees and certain other student charges, the University has recorded a scholarship discount and allowance.

(ee) Donor-Restricted Endowments

The University is subject to the "Uniform Prudent Management of Institutional Funds Act" (UPMIFA) of the Code of Alabama. This law allows the University, unless otherwise restricted by the donor, to spend net appreciation, realized and unrealized, of the endowment assets. The law also allows the University to appropriate for expenditure or accumulate to an endowment fund such amounts as the University determines to be prudent for the purposes for which the endowment fund was established. The University's endowment spending policy provides that 4.5% of the five-year invested net asset moving average value (inclusive of net realized and unrealized gains and losses), as measured at September 30, is available annually for spending. The University's policy is to retain the endowment net interest and dividend income and net realized and unrealized appreciation with the endowment

after distributions allowed by the spending policy have been made. These amounts, unless otherwise directed by the donor, are included in restricted expendable net position.

(ff) Classification of Revenues

The University has classified its revenues as either operating or nonoperating revenues.

Operating revenues include activities that have the characteristics of exchange transactions such as student tuition and fees, net of scholarship discounts and allowances; patient service revenues, net of provision for bad debts; most federal, state, and local grants and contracts; sales and services of auxiliary enterprises, net of scholarship allowances; and lease revenue.

Nonoperating revenues include activities that have the characteristics of nonexchange transactions, such as state appropriations, investment income, and gifts and contributions.

(gg) Gifts and Pledges

Pledges of financial support from organizations and individuals representing an unconditional promise to give are recognized in the basic financial statements once all eligibility requirements, including time requirements, have been met. In the absence of such a promise, revenue is recognized when the gift is received. Endowment pledges generally do not meet eligibility requirements, as defined by GASB Statement No. 33, *Accounting and Financial Reporting for Nonexchange Transactions*, and are not recorded as assets until the related gift has been received. Unconditional promises that are expected to be collected in future years are recorded at the present value of the estimated future cash flows.

(hh) Grants and Contracts

The University has been awarded grants and contracts for which funds have not been received or expenditures made for the purpose specified in the award. These awards have not been reflected in the basic financial statements but represent commitments of sponsors to provide funds for specific research or training projects. For grants that have allowable cost provisions, the revenue will be recognized as the related expenditures are made. For grants with work completion requirements, the revenue is recognized as the work is completed. For grants without either of the above requirements, the revenue is recognized as it is received.

(ii) Patient Service Revenues

Patient service revenues are reported at estimated net realizable amounts due from patients, third-party payers, and others for healthcare services rendered, including estimated retroactive revenue adjustments due to future audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such amounts are adjusted in future periods, as adjustments become known or as years are no longer subject to such audits, reviews, and investigations.

(jj) Compensated Absences

The University accrues leave for employees that has not been used if it is attributable to services already rendered, the leave accumulates, and the leave is more likely than not to be used for time off or

otherwise paid in cash or settled through noncash means, as well as any leave that has been used but not yet paid or settled through noncash means. The accrual is based on historical leave usage, is inclusive of salary-related payments that are a function of the salary to be paid, and is measured using employee pay rates as of the date of the financial statements.

(kk) Recently Adopted Accounting Pronouncements

In 2025, the University adopted the provisions of GASB Statement No. 101, *Compensated Absences*, which requires the University to recognize a liability for leave that has not been used if it is attributable to services already rendered, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means, as well as any leave that has been used but not yet paid or settled through noncash means. The adoption of the provisions of GASB Statement No. 101 resulted in an increase to current portion of other long-term liabilities of approximately $3,145,000 and other long-term liabilities, less current portion of approximately $21,046,000. In accordance with GASB Statement No. 100, *Accounting Changes and Error Corrections-an amendment of GASB Statement No. 62,* beginning unrestricted net position was restated by approximately ($24,191,000) for the impact related to the adoption of GASB Statement No. 101. See note 6 and 13 for further discussion. See note 13 for further discussion.

In addition, the University adopted the provisions of GASB Statement No. 102, *Certain Risk Disclosures*. The objective of this statement is to establish reporting requirements for certain concentrations and constraints that may negatively impact operations or the ability to meet outstanding obligations. There was no significant impact to the University's basic financial statements in the adoption of this pronouncement.

A summary of the adjustments to beginning net position related to the adoption of GASB Statement No. 101 and changes to or within the financial reporting entity as of June 30, 2025 are as follows (in thousands):

		09/30/2024 As Previously Reported	Effect of Adoption of GASB 101	Change to or within the Financial Reporting Entity	09/30/2024 As Adjusted and Restated
Net position	$	684,661	(24,191)	1,423	661,893
Discretely Presented Component Units					
South Alabama Medical Science Foundation		-	-	13,168	13,168
Gulf Coast TotalCare		-	-	632	632
Providence Foundation		-	-	9,898	9,898
Total Discretely Presented Component Units	$	-	-	23,698	23,698

(2) Income Taxes

The University is classified as both a governmental entity under the laws of the State of Alabama and as a tax-exempt entity under Section 501(a) of the Internal Revenue Code as an organization described in Section 501(c)(3). Consistent with these designations, no provision for income taxes has been made in the accompanying basic financial statements.

In addition, the University's discretely presented component units, except for HCA, are tax-exempt entities under Section 501(a) of the Internal Revenue Code as organizations described in Section 501(c)(3). The income of HCA is excluded from federal and state income taxation pursuant to the provisions of Section 115(1) of the Internal Revenue Code. Consistent with these designations, no provision for income taxes has been made in the accompanying discretely presented component unit financial statements.

(3) Cash and Cash Equivalents

Pursuant to the Security for Alabama Funds Enhancement Act, funds on deposit may be placed in an institution designated as a qualified public depository (QPD) by the State of Alabama. QPD institutions pledge securities to a statewide collateral pool administered by the State Treasurer's office. Such financial institutions contribute to this collateral pool in amounts proportionate to the total amount of public fund deposits at their respective institutions. The securities are held at the Federal Reserve Bank and are designated for the State of Alabama. Additional collateral was not required for University funds on deposit with QPD institutions. At September 30, 2024, the net public deposits subject to collateral requirements for all institutions participating in the pool totaled approximately $18.7 billion. The University had cash and cash equivalents, including restricted cash and cash equivalents, in the pool of approximately $236,361,000 at September 30, 2024.

At June 30, 2025, restricted cash and cash equivalents consist of approximately $12,671,000 related to unspent bond cash, $1,590,000 related to cash included in the PLTF and GLTF to pay insurance liability claims, $8,630,000 related to restricted donations related to certain capital projects, $243,000 related to endowment funds, $248,000 related to the Providence IPA, and $20,000 related to security deposits.

(4) Investments

(a) University of South Alabama

The investments of the University are invested pursuant to the University of South Alabama "Non-Endowment Investment Policies" and the "Endowment Fund Investment Policy" (collectively referred to as the University Investment Policies) as adopted by the Board of Trustees. The purpose of the Non-Endowment Investment Policy is to provide outlines the goals and guidelines for the accumulated non-endowed investment funds of the University of South Alabama for long-term investment. The Investment Committee oversees the investments of the University's Non-Endowed long-term investment portfolio (the "Long-Term Fund"). The purpose of the Investment Policy Statement (IPS) is to delegate responsibilities among the parties involved in the oversight and management of the Long-Term Fund and to describe the investment objectives, constraints, risk guidelines, policies, and procedures that apply. The goal of the Long-Term Fund is to protect and grow assets that are not needed for daily operational cash flows by earning a total return appropriate for the portfolio's time

horizon, spending requirements, and risk tolerance. The returns generated will be used to support the University while maintaining sufficient liquidity to accommodate fluctuations in revenues and expenses. The Endowment Fund investment policy outlines the goals and guidelines for the accumulated investment funds of the University of South Alabama Endowment. The Investment Committee oversees the investments of the University Endowment's long-term investment portfolio (the "Endowment Fund"). The purpose of this IPS is to delegate responsibilities among the parties involved in the oversight and management of the Endowment Fund and to describe the investment objectives, constraints, risk guidelines, policies, and procedures that apply. In addition, this IPS will guide the investment managers in achieving desired results. The goal of the Endowment Fund is to protect and grow the assets by earning a total return appropriate for the portfolio's time horizon, distribution requirements, and risk tolerance to support projects endowed for specific purposes.

The investments of the blended component units of the University are invested pursuant to the separate investment policy shared by the PLTF and GLTF (the Trust Fund Investment Policy). The objectives of the Trust Fund Investment Policy are to provide a source of funds to pay general and professional liability claims and to achieve long-term capital growth to help defray future funding requirements. Additionally, certain investments of the University's component units, both blended and discretely presented, are subject to UPMIFA as well as any requirements placed on them by contract or donor agreements.

Certain investments, primarily related to the University's endowment assets, are pooled. The University uses this pool to manage its investments and distribute investment income to individual endowment funds.

The University holds a 50% equity interest in Providence Home Medical Services (Home Medical), a multimember limited liability company that was formed to own and operate a durable medical equipment provider. The University's capital account balance in Home Medical is considered an investment in a joint venture, pursuant to GASB Statements Nos. 14 and 61. The University's capital account balance is approximately $115,000 for the nine months ended June 30, 2025 and is presented on the statement of net position as an investment.

The University holds a 35% equity interest in HighProv, LLC (HighProv), a multimember limited liability company formed to construct, own, and operate a hotel facility. For the nine months ended June 30, 2025, the University's capital account balance is approximately $888,000 and is presented on the statement of net position as an investment.

Investments and restricted investments of the University, by type, at fair value at June 30, 2025 (in thousands) are as follows:

Commingled equity funds	$	120,159
Commingled fixed income funds		57,386
Joint ventures		1,003
Managed income alternative investments (low-volatility, multistrategy funds of funds)		41,488
Marketable debt securities		11,999
Marketable equity securities		74,420
Private credit alternative fixed income investments		15,395
Private equity alternative investments		17,667
Private REIT alternative real estate investments		5,126
Publicly traded REIT		77
Real estate		8,479
U.S. federal agency notes		60,776
U.S. treasury securities		21,430
	$	435,405

At June 30, 2025, restricted investments consist of endowment funds and funds held in the PLTF and GLTF to pay insurance liability claims.

At June 30, 2025, $57,577,000 of cumulative increase in fair value of investments of donor-restricted endowments was recognized and is included in restricted expendable net position in the accompanying statement of net position.

The University invests in several private equity and private credit funds. At June 30, 2025, the University had outstanding capital commitments to those funds of approximately $19,712,000.

(i) Credit Risk and Concentration of Credit Risk

Non-Endowment Cash Pool Investment Policy

The University Endowment Fund investment policy require that:

1. No more than 10% of the Endowment Fund's assets will be allocated to any single actively managed fund.
2. No more than 35% of the Endowment Fund's assets will be allocated to a single "Fund of Funds" or multi-manager fund.
3. No more than 45% of the Endowment Fund's assets will be allocated to a single investment firm.

Endowment Fund Investment Policy

The University's exposure to credit risk and concentration of credit risk at June 30, 2025 is as follows:

	Credit rating	Percentage of total investments
Commingled fixed income funds	Various	13.2 %
Marketable debt securities	Various	2.8
U. S. federal agency notes	AAA	14.0
U. S. treasury securities	AAA	4.9

(ii) Interest Rate Risk

At June 30, 2025, the maturity dates of the University's fixed income investments are as follows (in thousands):

		Years to maturity			
	Fair value	Less than 1	1–5	6–10	More than 10
Commingled fixed income funds	$ 57,386	—	32,211	25,175	—
Marketable debt securities	11,999	4,372	5,843	1,092	692
U. S. federal agency notes	60,776	2,968	49,878	174	7,756
U. S. treasury securities	21,430	3,971	11,286	6,173	—
	$ 151,591	11,311	99,218	32,614	8,448

Commingled fixed income funds are classified based on the weighted average maturity of the individual investment instruments within each fund.

The University's Investment Policies do not specifically address the length to maturity or credit rating on investments; however, they do require that the maturity and credit rating range of investments be consistent with the liquidity requirements of the University.

(iii) Custodial Credit Risk

Custodial credit risk is the risk that, in the event of a failure of the counterparty to a transaction, an organization will not be able to recover the value of investment or collateral securities that are in the possession of an outside party. The University's investments are held by third-party institutions in the name of the University. The University's Investment Policies do not specifically address custodial credit risk.

(iv) Mortgage-Backed Securities

The University, from time to time, invests in mortgage-backed securities such as the Federal Home Loan Mortgage Corporation (FHLMC), the Federal National Mortgage Association (FNMA), and other government sponsored enterprises of the United States government. The University invests in these securities to increase the yield and return on its investment portfolio given the available alternative investment opportunities.

(v) Fair Value Measurement

Fair value measurements represent the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The University measures and records its investments using fair value measurement guidelines established by GASB Statement No. 72. These guidelines prioritize the inputs of valuation techniques used to measure fair value as shown below. Certain investments are measured at net asset value (NAV) as a practical expedient, which represents the University's proportionate share of the net assets of the investment fund, and are excluded from the fair value hierarchy.

- Level 1: Quoted prices for identical investments in active markets
- Level 2: Observable inputs other than quoted market prices
- Level 3: Unobservable inputs.

The level in the fair value hierarchy that determines the classification of an asset or liability depends on the lowest-level input that is significant to the fair value measurement. Observable inputs are derived from quoted market prices for assets or liabilities traded on an active market where there is sufficient activity to determine a readily determinable market price. Investments that are not traded on an active exchange and do not have a quoted market price are classified as unobservable inputs. The University may own assets that have unobservable inputs, with fair value based on an independent third-party appraisal performed by qualified appraisers specializing in real estate investments, hedge fund investments, and of investments in private capital, with fair

value determined by the investment managers and primarily utilizes management assumptions and best estimates after considering internal and external factors. Other assets included in the University's investment portfolio with unobservable inputs are the shares or units in certain partnerships or other commingled funds that do not have readily determinable fair values. For these funds, fair value is estimated using the NAV reported by the investment managers as a practical expedient to fair value.

The following tables summarize the fair value measurements for all investment assets and liabilities carried at fair value at June 30, 2025 (in thousands):

Description	Asset fair value measurements			
	Level 1	Level 2	Level 3	Total
Commingled equity funds	$ 93,994	—	—	93,994
Joint ventures	—	—	1,003	1,003
Marketable debt securities	3,670	8,329	—	11,999
Marketable equity securities	32,529	—	—	32,529
Private credit alternative fixed income investments	—	—	454	454
Private equity alternative investments	1,375	—	3,701	5,076
Publicly traded REIT	77	—	—	77
Real estate	—	—	8,479	8,479
U.S. federal agency notes	—	60,776	—	60,776
U.S. treasury securities	21,430	—	—	21,430
Total investments at fair value	$ 153,075	69,105	13,637	235,817
Investments measured at NAV:				
Comingled equity funds				26,165
Comingled fixed income funds				57,386
Managed income alternative investments (low-volatility, multistrategy funds of funds)				41,488
Marketable equities				41,891
Private credit alternative fixed income investments				14,941
Private equity alternative investments				12,591
Private REIT				5,126
Total investments				$ 435,405

A roll-forward schedule for Level 3 financial instruments for the nine months ended June 30, 2025 is as follows (in thousands):

Beginning balance	$	12,212
Purchases		913
Net realized/unrealized gains		512
Sales		—
Ending balance	$	13,637

(b) Health Care Authority

HCA holds a 2.5% equity interest in USA Fairhope Physician Investors LLC (FPI), a multimember limited liability company that was formed to invest in the entity that developed and is now leasing an ambulatory surgical center. HCA's capital account balance is approximately ($8,000) for the nine months ended June 30, 2025 and is presented on the statement of net position as an investment. As a whole, there is positive monthly cash flow and no expectation for HCA to be required to contribute additional capital.

HCA holds a 51% equity interest in USA BC ASC Holdco, LLC (USA BC ASC Holdco), a multimember limited liability company formed to invest in USA Baldwin County ASC, LLC (USA BC ASC), a limited liability company formed to develop, own, and operate the Ambulatory Surgery Center on the USA Health Mapp Family Campus. For the nine months ended June 30, 2025, HCA's capital account balance is approximately $943,000 and is presented on the statement of net position as an investment.

(5) Capital Assets

(a) University of South Alabama

A summary of the University's capital asset activity for the nine months ended June 30, 2025 is as follows (in thousands):

	Beginning balance	Additions	Transfers	Reductions	Ending balance
Capital assets not being depreciated or amortized:					
Land and other	$ 45,270	3,419	—	(83)	48,606
Certificate of Need	225	—	—	—	225
Intagible assets	1,207	57	—	—	1,264
Construction in progress	102,282	91,974	(16,987)	—	177,269
	148,984	95,450	(16,987)	(83)	227,364
Capital assets being depreciated or amortized:					
Land improvements	84,049	—	162	—	84,211
Buildings, fixed equipment, and infrastructure	1,156,274	17,813	9,312	(59)	1,183,340
Other equipment	260,611	11,061	7,513	(1,725)	277,460
Library materials	101,608	—	—	—	101,608
Right-of-use assets	125,953	19,580	—	(5,692)	139,841
	1,728,495	48,454	16,987	(7,476)	1,786,460
Less accumulated depreciation and amortization for:					
Land improvements	(41,369)	(3,044)	—	—	(44,413)
Buildings, fixed equipment, and infrastructure	(452,874)	(25,897)	—	56	(478,715)
Other equipment	(204,114)	(10,442)	—	1,604	(212,952)
Library materials	(79,719)	(3,302)	—	—	(83,021)
Right-of-use assets	(40,979)	(24,500)	—	4,821	(60,658)
	(819,055)	(67,185)	—	6,481	(879,759)
Capital assets being depreciated, net	909,440	(18,731)	16,987	(995)	906,701
Capital assets, net	$ 1,058,424	76,719	—	(1,078)	1,134,065

A summary of the University's net right-of-use assets, which are included in capital assets on the statement of net position, activity categorized by classification for the nine months ended June 30, 2025 are as follows (in thousands):

	Ending balance
Right-of-use assets:	
Buildings	$ 8,968
Equipment	41,028
Office space	12,070
Software	77,775
	139,841
Less accumulated amortization for right-of-use assets:	
Buildings	(4,321)
Equipment	(13,283)
Office space	(6,489)
Software	(36,565)
	(60,658)
Right-of-use assets, net	$ 79,183

Depreciation and amortization of capital assets for the nine months ended June 30, 2025 was approximately $67,185,000 for the University. In addition, the University amortizes bond costs of issuance that is included in other noncurrent assets and accounts receivable on the statement of net position. For the nine months ended June 30, 2025, amortization of bond costs of issuance was approximately $42,000 resulting in total depreciation and amortization of approximately $67,227,000. See note 8 for additional details regarding bonds.

At June 30, 2025, the University had commitments of approximately $149,765,000 related to various capital projects.

For the nine months ended June 30, 2025, the University received approximately $21,047,000 in capital grants from the Alabama Public School and College Authority for the site preparation and construction of the new College of Medicine facility, and this amount is included in capital appropriations on the statement of revenues, expenses, and changes in net position.

(b) USA Research and Technology Corporation

Changes in capital assets for the nine months ended June 30, 2025 are as follows (in thousands):

	Beginning balance	Additions	Transfers	Reductions	Ending balance
Capital assets not being depreciated or amortized:					
Land	$ 223	—	—	—	223
Construction in progress	—	60	—	—	60
	223	60	—	—	283
Capital assets being depreciated or amortized:					
Land improvements	1,985	—	—	—	1,985
Buildings	28,872	81	—	—	28,953
Tenant improvements	3,233	43	—	—	3,276
Other equipment	421	—	—	—	421
Computer software	56	—	—	—	56
Lease commissions	456	—	—	—	456
Right-of-use assets	3	—	—	—	3
	35,026	124	—	—	35,150
Less accumulated depreciation or amortization for:					
Land improvements	(1,810)	(16)	—	—	(1,826)
Buildings	(13,304)	(600)	—	—	(13,904)
Tenant improvements	(2,017)	(269)	—	—	(2,286)
Other equipment	(373)	(8)	—	—	(381)
Computer software	(40)	(12)	—	—	(52)
Lease commissions	(336)	(34)	—	—	(370)
Right-of-use assets	(2)	—	—	—	(2)
	(17,882)	(939)	—	—	(18,821)
Capital assets being depreciated or amortized, net	17,144	(815)	—	—	16,329
Capital assets, net	$ 17,367	(755)	—	—	16,612

Depreciation and amortization expense totaled approximately $939,000 for the nine months ended June 30, 2025.

At June 30, 2025, the Corporation had outstanding commitments of approximately $82,000.

The Corporation's net right-of-use assets categorized by classification for the nine months ended June 30, 2025 are as follows (in thousands):

		Ending balance
Right-of-use assets:		
Software subscriptions	$	3
		3
Less accumulated amortization for right-of-use assets:		
Software subscriptions		(2)
		(2)
Right-of-use assets, net	$	1

(c) Health Care Authority

A summary of HCA's capital assets activity for the nine months ended June 30, 2025 is as follows (in thousands):

	Beginning balance	Additions	Transfers	Reductions	Ending balance
Capital assets not being depreciated or amortized:					
Construction in progress	$ 57	36	—	—	93
Works of art	1	—	—	—	1
	58	36	—	—	94
Capital assets being depreciated or amortized:					
Buildings	33,049	—	—	—	33,049
Leasehold improvements	5,388	—	—	—	5,388
Equipment	4,171	13	—	(41)	4,143
Computer software	139	—	—	—	139
Right-of-use assets	124,491	700	—	(13,129)	112,062
	167,238	713	—	(13,170)	154,781
Less accumulated depreciation or amoritzation for:					
Buildings	(2,293)	(936)	—	—	(3,229)
Leasehold improvements	(1,134)	(406)	—	—	(1,540)
Equipment	(2,664)	(304)	—	30	(2,938)
Computer software	(98)	(7)	—	—	(105)
Right-of-use assets	(10,818)	(5,790)	—	1,063	(15,545)
	(17,007)	(7,443)	—	1,093	(23,357)
Capital assets being depreciated or amortized, net	150,231	(6,730)	—	(12,077)	131,424
Capital assets, net	$ 150,289	(6,694)	—	(12,077)	131,518

Construction in progress totaled approximately $93,000 as of June 30 2025 and relates to installation of HVAC at USA Health Family Practice, exam room chairs at USA Mobile Diagnostic Center, a probe at Coastal OBGYN, and renovation projects at USA Mobile Diagnostic Center, USA Health Family Practice Associates, and the USA Health West Mobile Endocrine & Diabetes Clinic.

Depreciation and amortization totaled approximately $7,443,000 for the nine months ended June 30, 2025.

A summary of HCA's net right-of-use assets categorized by classification for the nine months ended June 30, 2025 is as follows (in thousands):

		Ending balance
Right-of-use assets:		
Buildings	$	104,305
Equipment		7,170
Software subscriptions		587
		112,062
Less accumulated amortization for right of use:		
Buildings		(12,875)
Equipment		(2,477)
Software subscriptions		(193)
		(15,545)
Right-of-use assets, net	$	96,517

During fiscal year 2024, HCA entered into a lease agreement with the University for the hospital facilities and related equipment acquired in the Ascension Providence acquisition. The lease is for 31 years with semi-annual rental payments equal to the ratable portion of principal and interest incurred on the debt service related to the acquisition. This lease is accounted for in accordance with GASB 87, *Leases*, and is reflected in net capital assets and current and noncurrent lease obligations on the statement of net position.

(6) Noncurrent Liabilities

(a) University of South Alabama

A summary of the University's noncurrent liability activity for the nine months ended June 30, 2025 is as follows (in thousands):

	Adjusted Beginning balance	Additions	Reductions	Adjustments	Ending balance	Less amounts due within one year	Noncurrent liabilities
Long-term debt:							
Bonds payable	$ 509,406	—	(20,905)	(2,282)	486,219	26,206	460,013
Notes payable	737	64	(134)	—	667	199	468
Lease and subscription obligations	82,911	18,424	(16,909)	(1,593)	82,833	28,573	54,260
Total long-term debt	593,054	18,488	(37,948)	(3,875)	569,719	54,978	514,741
Other noncurrent liabilities:							
Net pension liability	349,710	—	(69,933)	—	279,777	—	279,777
Net OPEB liability	78,808	317,201	—	—	396,009	—	396,009
Other long-term liabilities	93,888	17,228	(17,728)	—	93,388	6,568	86,820
Total other noncurrent liabilities	522,406	334,429	(87,661)	—	769,174	6,568	762,606
Total noncurrent liabilities	$ 1,115,460	352,917	(125,609)	(3,875)	1,338,893	61,546	1,277,347

Other long-term liabilities primarily consist of self-insurance liabilities and liabilities related to compensated absences. Amounts due within one year are included in current portion of other long-term liabilities. In fiscal year 2025, the University adopted Statement No. 101, *Compensated Absences*, which resulted in a beginning balance adjustment of approximately $24,191,000 to the compensated absence liability. This adjustment is reflected in the beginning balance for compensated absences below.

A detail of the University's other long-term liabilities activity for the nine months ended June 30, 2025 is as follows (in thousands):

	Adjusted beginning balance	Additions	Reductions	Ending balance	Less amounts due within one year	Noncurrent liabilities
Other long-term liabilities:						
Compensated absences*	$ 34,689	-	-	34,689	4,510	30,179
Government advances	3,635	167	-	3,802	-	3,802
Professional Liability Trust Fund	44,819	11,357	(15,453)	40,723	2,009	38,714
General Liability Trust Fund	10,745	5,704	(2,275)	14,174	49	14,125
Total other long-term liabilities	$ 93,888	17,228	(17,728)	93,388	6,568	86,820

*The change in the compensated absences liability is presented as a net change.

Lease and Subscription Obligations

The University determines whether an arrangement is a lease at inception by evaluating whether the contract conveys the right to use an identified asset and whether the University obtains substantially all of the economic benefits from and has the right to control the asset. Any lease or software subscription identified is recorded as a right-of-use asset under capital assets and lease and subscription obligations. Lease and subscription right-of-use assets and related obligations are recognized at the commencement date based on the present value of the payments over the agreement term discounted using an appropriate incremental borrowing rate. Amortization of right-of-use assets is recognized on a straight-line basis over the specified term or useful life of the asset, whichever is shorter. Interest expense is recognized as a component of the lease or subscription payment and recorded as such in the statement of revenues, expenses, and changes in net position. The difference in methodology between the amortization of the right-of-use asset and the reduction in liability balance related to principal payments will result in a difference between the net right-of-use asset and related lease and subscription obligations.

The University leases various automobiles, buildings, equipment, office space, and software subscriptions under leases expiring at various dates through 2039. Aggregate future minimum lease and subscription payments under noncancelable agreements as of June 30, 2025, by fiscal year, are as follows (in thousands):

		Principal	Interest	Total
2025	$	14,172	5,594	19,766
2026		21,048	7,471	28,519
2027		16,688	6,502	23,190
2028		14,278	5,700	19,978
2029		8,421	5,037	13,458
2030 – 2034		8,207	4,799	13,006
2035 – 2039		19	4,407	4,426
Lease and subscription obligations	$	82,833	39,510	122,343

These amounts are included in lease and subscription obligations and the current portion thereof in the accompanying statement of net position.

The University has commitments under leases and subscriptions for which the lease term has not commenced of approximately $11,138,000 as of June 30, 2025.

The University leases space from the Corporation and HCA. As of June 30, 2025, the University had lease and subscription obligations of approximately $6,094,000 related to leases between the University and component units.

(b) USA Research and Technology Corporation

Changes in noncurrent liabilities for the nine months ended June 30, 2025 are as follows (in thousands):

	Beginning balance	Additions	Reductions	Ending balance	Less amounts due within one year	Noncurrent liabilities
Notes payable	$ 16,967	—	(792)	16,175	1,091	15,084

(i) Notes Payable

Notes payable from direct borrowings consisted of the following as of June 30, 2025 (in thousands):

PNC Bank promissory note, 4.38%, payable through 2028	$ 9,795
Hancock Whitney Bank promissory note, 3.08%, payable through 2031	6,380
	$ 16,175

The promissory note payable to PNC Bank has a 10-year term and amortization is based on a 10-year term. The promissory note payable is secured by an interest in tenant leases for Buildings II and III, and an interest in income received from rental of Buildings II and III. The Corporation agreed to not transfer or encumber the buildings or its leasehold interest in the real estate on which the buildings stand.

The promissory note payable to Hancock Whitney Bank has a 10-year term and is secured by an interest in rental leases and an interest in income received from rental of Building I. The Corporation agreed to not transfer or encumber the buildings or its leasehold interest in the real estate on which the buildings stand.

In connection with the PNC note and the Hancock Whitney note, the University entered into an agreement with both lenders providing that for any year in which the Corporation's debt service coverage ratio is less than 1 to 1, the University will pay the Corporation rent equal to the amount necessary to bring the ratio to 1 to 1. The debt service coverage ratio is calculated by dividing the sum of unrestricted cash and cash equivalents at the beginning of the year (reduced by current year capital asset additions) and current year change in net position (determined without depreciation, amortization, and interest expenses) by current year debt service. As of September 30, 2024, the Corporation's debt service coverage ratio was 2.41 to 1.

The Corporation's outstanding notes from direct borrowings with PNC Bank and Hancock Whitney Bank contain a provision that, in the event of default, PNC Bank or Hancock Whitney Bank may take any or all of the following actions: (a) declare the loan due and payable, (b) declare the note in default, and (c) exercise any other remedies or rights, which it has under any instrument executed

in connection with the loan. Prior to any of these actions, however, PNC Bank and Hancock Whitney Bank will give the Corporation 31 days to cure the default.

(ii) Debt Service on Long-Term Obligations

As of June 30, 2025, total future debt service by fiscal year is as follows (in thousands):

	Debt service on notes payable		
	Principal	**Interest**	**Total**
2025	$ 268	156	424
2026	1,101	597	1,698
2027	1,144	554	1,698
2028	9,028	424	9,452
2029	574	135	709
2030–2032	4,060	151	4,211
Total	$ 16,175	2,017	18,192

(iii) Derivative Transaction

The Corporation was a party to a derivative with Wells Fargo Bank, N.A., the counterparty (successor to Wachovia Bank, N.A. the original counterparty). The derivative was a "receive-variable, pay-fixed" interest rate swap entered into in connection with the promissory note to Wells Fargo Bank, N.A.

The swap was terminated on June 20, 2018 as part of a transaction refunding the Wells Fargo loan with the proceeds of a loan from PNC Bank. The fee paid by the Corporation to Wells Fargo to terminate the swap was $1,478,000. Pursuant to GASB Statement No. 65, *Items Previously Reported as Assets and Liabilities*, the fee is reported in deferred outflows on the statement of net position and amortized to interest expense according to the percentage of annual interest paid on the loan from PNC Bank to the total interest to be paid on that loan over the 118 months that were remaining on the Wells Fargo loan when the swap was terminated. As of June 30, 2025, the unamortized balance in deferred outflows was approximately $356,000.

(c) Health Care Authority

A summary of HCA's noncurrent liability activity for the nine months ended June 30, 2025 follows (in thousands):

	Beginning balance	Additions	Reductions	Adjustments	Ending balance	Less amounts due within one year	Noncurrent liabilities
Long-term debt	$ 21,673	—	(145)	—	21,528	225	21,303
Lease and subscription obligations	119,015	711	(7,321)	(11,587)	100,818	7,230	93,588
Other long-term liabilities	3,453	—	—	—	3,453	346	3,107
Total noncurrent liabilities	$ 144,141	711	(7,466)	(11,587)	125,799	7,801	117,998

Long-Term Debt

HCA entered into an agreement with Family Medical Investments, LLC to construct a medical office building on the USA Health Mapp Family Campus. Construction began in 2021 and was completed in October 2022. The agreement commenced upon construction completion for an initial 15-year period plus two options to extend for consecutive 5-year terms. HCA began making monthly payments at an interest rate of 4.79% in October 2022 to Family Medical Investments, LLC. The total balance of principal payments outstanding at June 30, 2025 is approximately $21,528,000. Upon conclusion of the agreement term, HCA will obtain ownership of the building.

At June 30, 2025, future debt service for long-term debt by year is as follows (in thousands):

	Debt service on long-term debt		
	Principal	**Interest**	**Total**
2025	$ 50	258	308
2026	236	1,024	1,260
2027	280	1,011	1,291
2028	326	997	1,323
2029	376	980	1,356
2030-2034	2,750	4,559	7,309
2035-2039	4,573	3,697	8,270
2040-2044	7,030	2,327	9,357
2045-2048	5,907	464	6,371
Total	$ 21,528	15,317	36,845

Lease and Subscription Obligations

HCA determines whether an arrangement is a lease at inception by evaluating whether the contract conveys the right to use an identified asset and whether HCA obtains substantially all of the economic benefits from and has the right to control the asset. Any lease or software subscription identified is recorded as a right-of-use asset under capital assets with a related lease and subscription obligation. Right-of-use assets and related obligations are recognized at the commencement date based on the present value of lease payments over the lease term discounted using the lessor interest rate or an appropriate incremental borrowing rate. Amortization of right-of-use assets is recognized on a straight-line basis over the lease term or useful life of the asset, whichever is shorter. Interest expense is recognized as a component of the lease payment and recorded as such in the statement of revenues, expenses, and changes in net position. The difference in methodology between the amortization of the right-of-use asset and the reduction in liability balance related to principal payments will result in a difference between the net right-of-use asset and related lease and subscription liability.

HCA has entered into agreements to lease various buildings and equipment and to utilize various software under lease and subscription obligations expiring at various dates through 2055.

Aggregate future minimum lease payments under noncancelable agreements as of June 30, 2025 by fiscal year, are as follows (in thousands):

	Principal	Interest	Total
2025	$ 2,751	162	2,913
2026	5,535	4,405	9,940
2027	5,607	4,153	9,760
2028	4,575	3,918	8,493
2029	3,065	3,729	6,794
2030–2034	10,537	17,020	27,557
2035–2039	11,987	14,425	26,412
2040–2044	14,948	11,468	26,416
2045–2049	18,617	7,792	26,409
2050–2054	23,196	3,217	26,413
	$ 100,818	70,289	171,107

These amounts are included in lease and subscription obligations and current portion thereof in the accompanying statement of net position.

The University has entered into two equipment lease agreements on behalf of Providence Hospital in the amount of approximately $6,094,000 for which the terms have not yet commenced. HCA will be responsible for making lease payments to the University for use of the equipment once the terms commence and an invoice is received. As of June 30, 2025, there are no other known lease or subscription commitments for which the terms have not yet commenced.

Other Noncurrent Liabilities

Other long-term liabilities primarily consist of self-insurance liabilities and liabilities related to compensated absences. Amounts due within one year are included in current portion of other long-term liabilities. In 2025, the University adopted Statement No. 101, *Compensated Absences*, which resulted in a beginning balance adjustment of approximately $1,358,000 to the compensated absence liability.

(7) Deferred Outflows and Inflows

(a) University of South Alabama

Deferred outflows of resources are consumption of net assets that are applicable to a future reporting period. In 2016, the University issued its Series 2016 Bonds. The proceeds from this series were used to partially defease the Series 2008 Bonds resulting in a loss of the difference between the acquisition price of the new debt and the net carrying amount of the old debt. In accordance with GASB Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position,* and GASB Statement No. 65, this loss was recorded as a deferred outflow and is being amortized over the remaining life of the Series 2016-A Bonds. In 2024, the University acquired an 81% ownership interest in a legally separate entity, South Coast, in the Ascension Providence acquisition.

During 2024, the University acquired the remaining 19% ownership interest in South Coast and formally dissolved the entity. In accordance with GASB Statement No. 69, *Government Combinations and Disposals of Government Operations*, the excess consideration provided over the net position acquired was recognized as a deferred outflow of resources and is being amortized over 338 months, the remaining service life of the capital assets acquired. Additionally, in accordance with GASB Statement No. 68, *Accounting and Financial Reporting for Pensions--an amendment of GASB Statement No. 27*, and Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*, changes in assumptions, changes in the proportion of total net liabilities relative to other plan participants, differences between employer contributions and the proportionate share of contributions, and employer contribution subsequent to the measurement date of the net pension liability but prior to the end of the fiscal year are presented as a deferred outflow of resources.

The components of deferred outflows of resources as of June 30, 2025 are summarized below (in thousands):

Loss on refunding of 2016-A bonds	$	4,431
South Coast acquisition		125
Pension		54,419
OPEB		403,042
	$	462,017

Deferred inflows of resources are net asset acquisitions that are applicable to a future reporting period. In 2016, the University issued its 2016-B, C, and D Bonds. In accordance with GASB Statement Nos. 63 and 65, the proceeds from these series refunded the remaining outstanding 2006 Bonds and the resulting gain was recognized as a deferred inflow of resources and was being amortized over the remaining life of the Series 2016-B, C, and D Bonds. In August 2024, the University refunded the Series 2016-B, C, and D with the Series 2024-C Bonds. In accordance with GASB Statement No. 23, *Accounting and Financial Reporting for Refundings of Debt Reported by Proprietary Activities*, Statement No. 63, and Statement No. 65, the difference between the reacquisition price and the net carrying amount of the old debt is reported as a deferred inflow and is being amortized over the remaining life of the Series 2024-C Bonds.

Additionally, in accordance with GASB Statement Nos. 68 and 75, the difference between the expected and actual experience and the net difference between projected and actual earnings on investments are presented as a deferred inflow of resources. Finally, in accordance with GASB Statement No. 87, the

deferred inflow of resources attributable to leases is recognized on a straight-line basis over the respective lease terms.

The components of deferred inflows of resources as of June 30, 2025 are summarized below (in thousands):

Gain on refunding of 2016 Series B, C and D Bonds	$	2,591
Pension		72,549
OPEB		189,838
Leases		96,006
	$	360,984

(b) Health Care Authority

Deferred inflows of resources represent HCA's right to receive lease revenue in future reporting periods. In accordance with GASB Statement No. 87, Leases, the deferred inflow of resources attributable to leases is recognized on a straight-line basis over the respective lease terms. Deferred inflows for the nine months ended June 30, 2025 totaled approximately $3,148,000.

(8) Bonds Payable

Bonds payable consisted of the following at June 30, 2025 (in thousands):

University Facilities Revenue Capital Improvement Bonds, Series 2013-A, 2.83% payable through August 2033	$	16,617
University Facilities Revenue Capital Improvement Bonds, Series 2013-B, 2.83% payable through August 2033		4,154
University Facilities Revenue Capital Improvement Bonds, Series 2013-C, 2.78% payable through August 2028		3,080
University Facilities Revenue Capital Improvement Bonds, Series 2015, 2.47% payable through August 2030		2,250
University Facilities Revenue Refunding Bonds, Series 2016-A, 3.00% to 5.00% payable through November 2037		64,500
University Facilities Revenue Bonds, Series 2017, 2.00% to 5.00%, payable through October 2037		27,775
University Facilities Revenue Bonds, Series 2019-A, 5.00%, payable through April 2049		47,750
University Facilities Revenue Bonds, Series 2019-B, 3.09% to 4.10%, payable through April 2033		11,855
University Facilities Revenue Bonds, Series 2019-C, 1.87%, payable through April 1, 2030		9,350
University Facilities Revenue Bonds, Series 2020, 4%, payable through April 1, 2040		31,515
University Facilities Revenue Bonds, Series 2021, 4%, payable through April 1, 2041		35,210
University Facilities Revenue Bonds, Series 2021-B 1.398%, payable through August 1, 2032		11,492
University Facilities Revenue Bonds, Series 2024-A, 5.0% through 2053 and 5.25% for 2054, payable through April 1, 2054		72,810
University Facilities Taxable Revenue Bonds, Series 2024-B, 4.753% to 5.233%, payable through April 1, 2035		17,165
University Facilities Revenue Bonds, Series 2024-C, 5%, payable through October 1, 2036		83,845
		439,368
Plus unamortized premium		47,979
Less unamortized debt extinguishment costs		(1,128)
	$	486,219

Substantially all student tuition and fee and auxiliary revenues secure University bonds. Additionally, security for all bonds includes USA Health Children's and Women's Hospital revenues in an amount not exceeding $10,000,000. The Series 2013-A, 2013-B, and 2013-C Bonds began maturing in August 2014 and were redeemable beginning in June 2023. The Series 2015 Bonds began maturing in August 2015 and were redeemable beginning in June 2020. The Series 2016-A Bonds began maturing in November 2018 and are redeemable beginning in November 2026. The Series 2016-B, C, and D Bonds were refunded in August 2024 with the proceeds from Series 2024-C Bonds. The Series 2017 Bonds began maturing in October 2017 and are redeemable beginning in October 2027. The Series 2019-A Bonds will begin

maturing in April 2033. The Series 2019-B Bonds began maturing in April 2021. Both Series 2019-A and 2019-B are both redeemable beginning in April 2029. The Series 2019-C Bonds began maturing in April 2020 and are not subject to redemption at the option of the University. Series 2020 Bonds began maturing in April 2021 and are redeemable beginning April 2030. Series 2021 Bonds began maturing in April 2022 and are redeemable beginning April 2031. The Series 2021-B Bonds began maturing in August 2022 and are subject to redemption beginning August 2024. The Series 2023-A and 2023-B Bonds were amended and restated in April 2024, extending their final maturities to April 2025. The Series 2023-A and 2023-B Amended and Restated Bonds were refunded in July 2024 with proceeds from Series 2024-A and 2024-B Bonds. The Series 2024-A Bonds begin maturing in April 2035 and are redeemable beginning April 1, 2034. The Series 2024-B Bonds begin maturing in April 2025 and are redeemable at the option of the University beginning April 1, 2034. The Series 2024-C Bonds begin maturing in April 2025 and are redeemable at the option of the University beginning April 1, 2034.

In September 2016, the University issued its University Facilities Revenue Refunding Bonds, Series 2016- A, with a face value of $85,605,000. The proceeds from the Series 2016-A Bonds were used to partially defease the Series 2008 Bonds. The funds were deposited into escrow trust funds to provide for the subsequent repayment of the Series 2008 Bonds when they were called in December 2018. Neither the assets of the escrow trust account nor the defeased indebtedness is included in the accompanying statement of net position. The loss on the defeasement of the Series 2008 Bonds of $7,859,000 was recorded as a deferred outflow and is being amortized over the remaining life of the Series 2016-A Bonds. The balance of the related deferred outflow totaled $4,431,000 at June 30, 2025. The principal outstanding on all defeased bonds is $64,500,000 at June 30, 2025.

In December 2016, the University issued its University Facilities Revenue Refunding Bonds, Series 2016-B, C, and D, with a face value totaling $100,000,000. The proceeds refunded the remaining outstanding Series 2006 Bonds. The gain on the refunding of the Series 2006 Bonds of $4,539,000 was recorded as a deferred inflow and was being amortized over the remaining life of the Series 2016-B, C, and Bonds. In August of 2024, the University refunded the Series 2016-B, C, and D with the Series 2024-C Bonds. In accordance with GASB Statement No. 23, *Accounting and Financial Reporting for Refundings of Debt Reported by Propietary Activities*, the difference between the reacquisition price and the net carrying amount of the old debt is reported as a deferred inflow and is being amortized over the remaining life of the Series 2024-C Bonds. The balance of the related net deferred inflow at June 30, 2025 totaled $2,591,000.

In September 2021, the terms for the outstanding bonds of the University designated “Series 2016-B,” “Series 2016-C,” and “Series 2016-D” (together, the Original 2016 Bonds), each of which bore interest at a variable rate based on a one-month LIBOR base index, were revised to address, among other things, the cessation of LIBOR. Specifically, the University issued bonds designated “Amended and Restated Series 2016-B,” “Amended and Restated Series 2016-C,” and “Amended and Restated Series 2016-D” (together, the Amended and Restated 2016 Bonds) in exchange for the Original 2016 Bonds. Each of the Amended and Restated 2016 Bonds provide that, upon the cessation of LIBOR as a base index for purposes of ISDA-based defined rates, the base index for such bond (the Replacement Index) would equal a benchmark replacement and any applicable spread adjustment that would apply for derivatives transactions referencing the ISDA Definitions. In addition, for each Amended and Restated 2016 Bond, the earliest date (the Put Date) on which the holder could elect to cause all scheduled principal thereunder to

become due and payable was extended by approximately five years as compared to the first Put Date for the Original 2016 Bond exchanged therefor.

On March 5, 2021, the Financial Conduct Authority (FCA) announced the final publication date for US LIBOR was June 30, 2023. The Alternative Reference Rates Committee (ARRC) has recommended the Secured Overnight Financing Rate (SOFR) as an alternative to replace LIBOR.

In April 2023, the University issued University Facilities Revenue Bond (Draw-Down Loan) 2023-A, which could be drawn up to $80,000,000, and University Facilities Revenue Bond (Draw-Down Loan) 2023-B, which could be drawn upon up to $20,000,000. An initial draw of $485,000 was made on 2023-A at the inception of the bond. On September 27, 2023, an additional draw was made from 2023-A and 2023-B in the amounts of $66,535,000 and $16,635,000, respectively. In April 2024, the final draw was made from 2023-A and 2023-B in the amounts of $12,980,000 and $1,875,000, respectively.

In October 2023, the University entered into a Revolving Line of Credit Agreement with Hancock Whitney Bank for up to $50,000,000, with a term of up to thirty months, to provide funds for covering the operating expenses of USA HCA in managing and operating USA Health Providence Hospital. On September 30, 2024, the University terminated this line of credit without making any draws.

In July 2024, the University issued University Facilities Revenue Bonds Series 2024-A $72,810,000 and Taxable Series 2024-B $19,925,000. Proceeds of the Series 2024-A and 2024-B Bonds were used to refund the University Facilities Revenue Bonds (Draw-Down Loan) 2023-A and the University Facilities Revenue Bonds (Draw-Down Loan) 2023-B, the proceeds of which were used by the University to purchase and improve the healthcare facilities located at 6801 Airport Blvd., Mobile, AL, known as “Providence Hospital.”

In August 2024, the University issued University Facilities Revenue Bonds Series 2024-C $90,850,000. Proceeds of the Series 2024-C Bonds were used to refund the Amended and Restated University Facilities Revenue Refunding Bond Series 2016-B, 2016-C and 2016-D. The related interest rate swap agreement with Wells Fargo Bank was terminated using $14,745,000 of University funds to pay swap termination fees, accrued interest and other related costs.

All bond funds are restricted for capital purposes as outlined in the bond indentures. The University is subject to arbitrage restrictions on its bonded indebtedness prescribed by the U.S. Internal Revenue Service. As such, amounts are accrued as needed in the University’s basic financial statements for any expected arbitrage liabilities. At June 30, 2025, no amounts were due or recorded in the financial statements.

Debt Service on Long-Term Obligations

Total debt service (which includes bonds and notes payable) by fiscal year is as follows at June 30, 2025 (in thousands):

	Debt service on notes and bonds				
	Bonds		Notes payable from direct borrowing		
	Principal	Interest	Principal	Interest	Total
2025	$ 4,549	446	28	5	5,028
2026	23,285	19,892	199	26	43,402
2027	24,190	18,980	196	17	43,383
2028	25,200	17,994	190	8	43,392
2029	25,431	16,944	54	1	42,430
2030–2034	126,083	67,941	—	—	194,024
2035–2039	109,670	37,882	—	—	147,552
2040–2044	39,160	21,039	—	—	60,199
2045–2049	35,990	12,227	—	—	48,217
2050–2054	25,810	4,204	—	—	30,014
Subtotal	439,368	$ 217,549	667	57	657,641
Plus (less):					
Unamortized bond premium	47,979		—		
Unamortized debt extinguishment costs	(1,128)		—		
Total	$ 486,219		667		

(9) Lease Receivables

(a) University of South Alabama

The University leases land, buildings, and suites to various lessees expiring at various dates through 2069. For the nine months ended June 30, 2025, the University recognized a total of approximately $9,129,000 of inflows of resources from leases, of which $5,644,000 was recognized as lease revenue which is included in other operating revenues and interest approximately of $3,485,000 which was recognized as a component of net investment income in the statement of revenues, expenses, and changes in net position.

The following table provides future minimum lease revenue by year that is included in the measurement of the lease receivable (in thousands):

		Principal	Interest	Total
2025	$	2,927	160	3,087
2026		4,931	4,400	9,331
2027		4,714	4,178	8,892
2028		4,611	3,961	8,572
2029		3,301	3,761	7,062
2030–2034		10,947	17,069	28,016
2035–2039		11,988	14,429	26,417
2040–2044		14,949	11,471	26,420
2045–2049		18,619	7,796	26,415
2050–2054		23,198	3,220	26,418
2055–2059		3	2	5
2060–2064		3	2	5
2065–2069		4	1	5
Lease receivable	$	100,195	70,450	170,645

Of the $100,195,000 lease receivable, approximately $93,665,000 is related to leases between the University and its component units.

(b) USA Research and Technology Corporation

The Corporation leases land, buildings, and suites to various lessees under financing leases and short-term leases expiring at various dates through 2057. In Building I, space is leased under four lease agreements. The first lease had a 5-year initial term that expired in October 2023, which was renewed in November 2023 for a 5-year term expiring October 2028. The first lease has one 5-year renewal option remaining. The second lease had a 1-year initial term, which was amended to include an additional 2-year term expiring in December 2025 with no renewal options. The third lease had a 5-year initial term that expired August 2024 with one 5-year renewal option. The fourth lease had a 5-year initial term that expired April 2024, which was amended in January 2024 for a 5-year term expiring April 2029.

Space in Buildings II and III is leased to the University and various other tenants. The leases have remaining terms varying from month to month to seven years.

Under leases for Buildings I, II, and III, the Corporation must pay all operating expenses of the buildings, including utilities, janitorial, maintenance, and insurance. Tenants will reimburse the Corporation for such expenses only as the total expenses for a year increase over the total expenses for the base year of the lease (which generally is the first calendar year of the lease term). For the nine

months ended June 30, 2025, the Corporation recognized no operating expense reimbursement income.

Space under lease to the University was 78,123 square feet at June 30, 2025.

The Corporation owns a building located on the premises of USA Health, which is leased to a single tenant. The Corporation paid for construction of the building shell and land improvements while the tenant paid for the cost of finishing the building's interior. The lease had a 10-year initial term, which was set to expire in March 2020, with three 5-year renewal options. The initial lease was terminated in December 2022 and replaced with a new lease with an initial term of 10 years, expiring in March 2030, with three 5 year renewal options. Under the lease, the tenant must also pay for utilities, taxes, insurance, and interior repairs and maintenance. The Corporation is responsible for repairs and maintenance to the exterior and HVAC system.

The Corporation, as lessor, had three ground leases in place at June 30, 2025. One lease is for a 40 year initial term expiring in October 2046 with two renewal options, the first for 20 years and the second for 15 years. The second lease is for a 31 year initial term expiring in October 2036 with four 5 year renewal options. The third lease has a 38.5 year initial term expiring in September 2046 with two renewal options, the first for 20 years and the second for 15 years.

The terms and conditions of each lease agreement vary by tenant with some including early termination options. Of the existing lease agreements, two tenants in Building II have options to terminate their lease agreement early if notice is given within the stated timeframe and all, if any, monetary obligations have been met.

For the nine months ended June 30, 2025, the Corporation recognized approximately $322,000 in revenues related to short-term leases and a total of approximately $2,652,000 of inflows of resources from financing leases, of which approximately $2,337,000 was recognized as lease revenue and approximately $315,000 was recognized as interest income in other nonoperating revenues.

The following table provides future minimum lease revenue by fiscal year that is included in the measurement of the lease receivable (in thousands):

		Principal	Interest	Total
2025	$	759	100	859
2026		1,874	358	2,232
2027		1,721	303	2,024
2028		1,662	250	1,912
2029		1,436	200	1,636
2030–2034		1,902	703	2,605
2035–2039		1,240	511	1,751
2040–2044		1,567	296	1,863
2045–2049		819	72	891
2050–2054		143	27	170
2055–2059		101	5	106
Lease receivable	$	13,224	2,825	16,049

(c) Health Care Authority

Leases as a lessor are included in the lease receivable and current portion thereof on the statement of net position.

Lease receivables represent HCA's contractual right to receive cash in exchange for the right to use an asset for a specific amount of time. HCA subleases buildings, suites, and land under leases expiring at various dates through 2073. For the nine months ended June 30, 2025, HCA recognized a total of approximately $654,000 of inflows of resources from leases, of which approximately $532,000 was recognized as lease revenue and approximately $122,000 was recognized as interest income. 98% of total lease revenue recognized was attributable to subleases to the University. The other 2% of total lease revenue is attributable to a ground lease with Family Medical Investments and a ground lease with HHRE USA Fairhope ASC, LLC; both of which lease land from HCA at the USA Health Mapp Family Campus. Lease revenue is included within other operating revenues and interest income is included within investment income on the statement of revenues, expenses, and changes in net position.

Future minimum lease revenue under noncancelable agreements as of June 30, 2025, by fiscal year, are as follows (in thousands):

	Principal	Interest	Total
2025	$ 387	46	433
2026	682	132	814
2027	727	98	825
2028	777	63	840
2029	237	36	273
2030-2034	250	130	380
2035-2039	28	111	139
2040-2044	35	104	139
2045-2049	44	95	139
2050-2054	55	84	139
2055-2059	69	71	140
2060-2064	86	54	140
2065-2069	107	32	139
2070-2073	77	7	84
	$ 3,561	1,063	4,624

As of June 30, 2025, 85% of the total lease receivable balance amount reflected on the accompanying statement of net position is related to subleases to the University.

(10) Patient Service Revenues

The University of South Alabama Health System (USA Health) has agreements with governmental and other third-party payers that provide for reimbursement at amounts different from their established rates. Contractual adjustments under third party reimbursement programs represent the difference between USA Health's billings at established rates for services and amounts reimbursed by third party payers.

A summary of the basis of reimbursement with major third-party payers follows:

Medicare – Substantially all acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. Additionally, USA Health is reimbursed for both direct and indirect medical education costs (as defined), principally based on per resident prospective payment amounts and certain adjustments to prospective rate per discharge operating reimbursement payments. USA Health is

generally paid for certain retroactively determined items at tentative rates, with final settlements determined after submission of annual cost reports by USA Health and audits by the Medicare fiscal intermediary.

USA Health University Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through September 30, 2021. USA Health Children's & Women's Hospital's Medicare cost reports have been audited by the Medicare fiscal intermediary through September 30, 2020.

Revenues from the Medicare program accounted for approximately 13% of USA Health's net patient service revenues for the nine months ended June 30, 2025.

Blue Cross Blue Shield – Inpatient services rendered to Blue Cross subscribers are paid at a contractually determined per diem rate based upon Medicare Severity Diagnosis Related Groups. Outpatient services are reimbursed under a contractually determined reimbursement methodology based on Blue Cross Enhanced Ambulatory Patient Groups.

Revenues from the Blue Cross program accounted for approximately 28% of USA Health's net patient service revenues for the nine months ended June 30, 2025.

Medicaid – Inpatient services rendered to Medicaid program beneficiaries are reimbursed at all-inclusive prospectively determined per diem rates. Outpatient services are reimbursed based on an established fee schedule.

USA Health qualifies as a Medicaid essential provider and, therefore, also receives supplemental payments based on formulas established by the Alabama Medicaid Agency. There can be no certainty that USA Health will continue to qualify for future participation in this program or that the program will not ultimately be discontinued or materially modified. For the nine months ended June 30, 2025, the University received net supplemental payments from this program of approximately $62,507,000, which is included in patient service revenues on the statement of revenues, expenses, and changes in net position.

Revenues from the Medicaid program accounted for approximately 17% of USA Health's net patient service revenues for the nine months ended June 30, 2025.

Other – USA Health has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payments to USA

Health under these agreements includes discounts from established charges and prospectively determined daily and case rates.

The composition of net patient service revenues for the nine months ended June 30, 2025 follows (in thousands):

Gross patient service revenues	$	1,911,419
Less:		
Provision for contractual and other adjustments		(1,166,411)
Provision for bad debts		(70,309)
	$	674,699

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance which vary in amount. USA Health also provides services to uninsured patients and offers those uninsured patients a discount, either by policy or law, from standard charges. USA Health estimates the provision for bad debts for patients with deductibles and coinsurance and for those who are uninsured based on historical experience and current market conditions. Subsequent changes to the estimate of the provision for bad debts are generally recorded as adjustments to net patient service revenues in the period of the change. For the nine months ended June 30, 2025, a reduction in revenue of approximately $2,263,000 was recognized due to changes in estimates of the provision for bad debts.

The composition of gross patient service revenues before the provision for contractual and other adjustments and the provision for bad debts by major payor source is as follows for the nine months ended June 30, 2025 (in thousands):

		Gross patient service revenues	**Percentage**
Blue Cross	$	424,136	22
Medicaid		405,957	21
Medicare Advantage		390,721	21
Medicare		218,699	11
Commercial		223,392	12
Other		150,702	8
Self pay		97,812	5
	$	1,911,419	100 %

The University provides charity care to patients who meet specific financial need criteria, as outlined in its USA Health Financial Assistance Policy. Charity care is defined as services provided to patients who are unable to pay for all or part of their care and for whom no expectation of payment exists. For the nine months ended June 30, 2025, charity care costs were calculated based on the cost-to-charge ratio, which was applied to the amounts of services provided to qualifying patients. The total charity care provided during the period was approximately $17,446,000 which represents 0.01% of total hospital charges.

(11) Business and Credit Concentrations

The University grants credit to patients, substantially all of whom reside in the University's service area. The University generally does not require collateral or other security in extending credit to patients; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans, or policies (e.g., Medicare, Medicaid, Blue Cross, preferred provider arrangements, and commercial insurance policies).

The mix of receivables from patients and third-party payors as of June 30, 2025 is as follows:

Medicare	26 %
Self Pay	23
Blue Cross	18
Medicaid	12
Commercial	12
Other	9
	100 %

(12) Defined-Benefit Cost-Sharing Pension Plan

Employees of the University are covered by a cost-sharing, multiple-employer defined-benefit pension plan administered by the TRS.

(a) Plan Description

The TRS was established in September 1939, under the provisions of Act 419 of the Legislature of 1939 for the purpose of providing retirement allowances and other specified benefits for qualified persons employed by State-supported educational institutions. The responsibility for the general administration and operation of the TRS is vested in its Board of Control. The TRS Board of Control consists of 15 trustees. The Plan is administered by the Retirement Systems of Alabama (RSA). Title 16-Chapter 25 of the Code of Alabama grants the authority to establish and amend the benefit terms to the TRS Board of Control. The Plan issues a publicly available financial report that can be obtained at www.rsa-al.gov.

(b) Benefits Provided

State law establishes retirement benefits as well as death and disability benefits and any ad hoc increase in postretirement benefits for the TRS. Benefits for TRS members vest after ten years of creditable service. Tier 1 TRS members who retire after age 60 with 10 years or more of creditable

service or with twenty-five years of services (regardless of age) are entitled to an annual retirement benefit, payable monthly for life. Service and disability retirement benefits are based on a guaranteed minimum or formula method, with the member receiving payment under the method that yields the higher monthly benefit. Under the formula method, members of the TRS are allowed 2.0125% of their average final compensation (highest three of the last ten years) for each year of service.

Act 377 of the Legislature of 2012 established a new tier of benefits (Tier 2) for members hired on or after January 1, 2013. Act 2022-222 amended benefits for Tier 2 members, and they are now eligible for retirement after 31 years of creditable service and are entitled to an annual retirement benefit, with a 2% reduction for each year under 62, payable monthly for life. Service and disability retirement benefits are based on a guaranteed minimum or formula method, with the member receiving payment under the method that yields the highest monthly benefit. Under the formula method, Tier 2 members of the TRS are allowed 1.65% of their average final compensation (highest five of the last ten years) for each year of service. Members are eligible for disability retirement if they have ten years of credible service, are currently in service, and determined by the RSA Medical Board to be permanently incapacitated from further performance of duty. Preretirement death benefits are calculated and paid to the beneficiary based on the member's age, service credit, employment status, and eligibility for retirement.

(c) Contributions

Covered members of the TRS contributed 5% of earnable compensation to the TRS as required by statute until September 30, 2011. From October 1, 2011 to September 30, 2012, covered members of the TRS were required by statute to contribute 7.25% of earnable compensation. Effective October 1, 2012, covered Tier 1 members of the TRS are required by statute to contribute 7.50% of earnable compensation.

Tier 2 covered members of the TRS contribute 6.2% of earnable compensation to the TRS as required by statute.

Participating employers' contractually required contribution rates are 12.59% of annual pay for Tier 1 members and 11.57% of annual pay for Tier 2 members. These required contribution rates are a percentage of annual payroll, actuarially determined as an amount that, when combined with member contributions, is expected to finance the costs of benefits earned by members during the year, with an additional amount to finance any unfunded accrued liability. Total employer contributions to the pension plan from the University for fiscal year 2025 will be updated when available.

(d) Pension Liabilities, Pension Expenses, Deferred Outflows of Resources, and Deferred Inflows of Resources Related to Pensions

At June 30, 2025, the University reported a liability of approximately $279,777,000 for its proportionate share of the collective net pension liability. At June 30, 2025, the collective net pension liability was measured as of September 30, 2024 and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of September 30, 2023. The University's proportion of the collective net pension liability is based on the employer's shares of contributions to the pension plan relative to the total employer contributions of all participating TRS employers. At the measurement

date of September 30, 2024, the University's proportion of contributions to the pension plan was 2.150783%, which was a decrease of 0.04068% from its proportion measured as of September 30, 2023 of 2.191463%.

For the nine months ended June 30, 2025, the University recognized pension expense of approximately $22,166,000, which is included in salaries and benefits on the statement of revenues, expenses, and changes in net position.

At June 30, 2025, the University reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources (in thousands):

	Deferred outflows of resources	Deferred inflows of resources
Differences between expected and actual experience	$ 27,821	2,017
Changes of assumptions	4,291	—
Net difference between projected and actual earnings on pension plan investments	—	45,881
Changes in proportion and differences between employer contributions and proportionate share of contributions	—	23,534
Employer contributions subsequent to measurement date	*	—
	$ 32,112	71,432

At September 30, 2024, approximately $22,317,000 reported as deferred outflows of resources related to pensions resulting from University contributions subsequent to the measurement date that will be recognized as a reduction of the net pension liability for the year ending September 30, 2025. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows (in thousands):

Year ending September 30:	
2026	$ (9,881)
2027	4,789
2028	(20,168)
2029	(15,177)
	$ (40,437)

(e) Actuarial Assumptions

The total pension liability as of June 30, 2025 was determined by an actuarial valuation as of September 30, 2023, using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.50 %
Investment rate of return*	7.45 %
Projected salary increases**	3.25–5.00%

* Net of pension plan investment expense, including inflation
** Includes inflation

The actuarial assumptions used in the September 30, 2023 valuation were based on the results of an actuarial experience study for the period from October 1, 2015 through September 30, 2020, and a discount rate of 7.45%. Mortality rates for TRS were based on the Pub-2010 Teacher Below Median tables adjusted for males (108% ages < 63, 96% ages > 67; phasing down 63–67) and for females (112% ages < 69, 98% > age 74, phasing down 69–74), projected generationally using scale MP-2020 adjusted by 66-2/3% beginning with year 2019.

The long-term expected rate of return on pension plan investments was determined using a log-normal distribution analysis in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. The target asset allocation and best estimates of geometric real rates of return for each major asset class are as follows:

	Target allocation	Long-term expected rate of return*
Fixed income	15.0 %	2.8 %
U.S. large stocks	32.0	8.0
U.S. mid stocks	9.0	10.0
U.S. small stocks	4.0	11.0
International developed market stocks	12.0	9.5
International emerging market stocks	3.0	11.0
Alternatives	10.0	9.0
Real estate	10.0	6.5
Cash equivalents	5.0	1.5
	100.0 %	

* Includes assumed rate of inflation of 2.00%

(f) Discount Rate

The discount rate used to measure the total pension liability as of June 30, 2025 was 7.45%. The projection of cash flows used to determine the discount rate assumed that plan member contributions will be made at the current contribution rate and that the employer contributions will be made at rates equal to the difference between actuarially determined contribution rates and the member rate. Based on those assumptions, the pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

(g) Sensitivity of the University's Proportionate Share of the Net Pension Liability to Changes in the Discount Rate

The following table presents the University's proportionate share of the net pension liability calculated using the discount rate of 7.45%, as well as what the University's proportionate share of the net pension liability would be if it were calculated using a discount rate that is one percentage point lower (6.45%) or one percentage point higher (8.45%) than the current rate (in thousands):

	1% Decrease (6.45)%	Current rate (7.45)%	1% Increase (8.45)%
University's proportionate share of collective net pension liability	$ 389,007	279,777	187,836

(h) Pension Plan Fiduciary Net Position

Detailed information about the pension plan's fiduciary net position is available in the separately issued RSA Annual Comprehensive Financial Report for the fiscal year ended September 30, 2024 as well as prior-year reports. The supporting actuarial information is included in the GASB Statement No. 68 Report for the TRS prepared as of September 30, 2024. The auditors' report dated February 27, 2025 on the total pension liability, total deferred outflows of resources, total deferred inflows of resources, and total pension expense for the sum of all participating entities as of September 30, 2024 along with supporting schedules is also available. The additional financial and actuarial information is available at www.rsa-al.gov.

(13) Other Employee Benefits

(a) Other Pension Plans

Certain employees of the University also participate in a defined-contribution pension plan. The defined-contribution pension plan covers certain academic and administrative employees, and participation by eligible employees is optional. The plan is administered by the University and the plan assets are held in annuity contracts and custodial accounts. The annuity contracts are with, and the custodial account assets are invested through investment options offered by, Teachers Insurance and Annuity Association – College Retirement Equities Fund (TIAA-CREF). Under this plan, contributions by eligible employees are matched equally by the University up to a maximum of 3% of current annual pay. The University contributed approximately $234,000 representing 124 employees for the nine months ended June 30, 2025.

All employees of HCM working at least half-time are eligible to participate in a defined-contribution pension plan. The plan is administered by HCM and the plan assets are held in annuity contracts and custodial accounts. The annuity contracts are with, and the custodial account assets are invested through investment options offered by TIAA-CREF. Under this plan, contributions by eligible employees are matched equally by HCM up to a maximum of 5% of current annual pay. HCM contributed

approximately $9,402,000 representing 2,921 employees participating in this plan for the nine months ended June 30, 2025. University employees as of September 30, 2010, who later transfer to HCM, are immediately vested in the plan. All other employees do not vest until they have held employment with HCM for 36 months; at which time, they become 100% vested in the plan.

Effective April 1, 2022, HCM adopted a deferred compensation retirement plan. All nonstudent employees are eligible to defer receipt of a portion of their salary until a later date. The plan is administered by HCM and the plan assets are held in annuity contracts and custodial accounts. The annuity contracts are with, and the custodial account assets are invested through investment options offered by, TIAA-CREF. Under this plan, contributions by eligible employees are not matched by HCM. During the nine months ended June 30, 2025, 356 employees participated in this plan. All eligible employees are fully vested in their accounts under this plan immediately upon contributing.

(b) Compensated Absences

In 2025 the University adopted the provisions of Statement No. 101, *Compensated Absences*, which requires the University to recognize a liability for leave that has not been used if it is attributable to services already rendered, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means, as well as leave that has been used but not yet paid or settled through noncash means. Regular University employees accumulate vacation and sick leave and hospital and clinical employees accumulate paid time off. These are subject to maximum limitations, at varying rates depending upon their employee classification and length of service. Upon separation of employment, employees who were hired before January 1, 2012 are paid all unused accrued vacation at their regular rate of pay up to a maximum of two times their annual accumulation rate. Employees hired after January 1, 2012 are not eligible for payment of unused accrued vacation or paid time off (PTO) hours upon separation of employment. Employees acquired through the Providence purchase were able to transfer their current PTO balances to the University. This transferred PTO is eligible for payout. The accompanying statement of net position includes accruals for unused leave of approximately $34,689,000 at June 30, 2025. The accrual is included in other long-term liabilities (and current portion thereof) in the accompanying financial statements.

(14) Other Postemployment Benefit Plans

Retirees of the University are covered by the Public Education Employees Health Insurance Plan (PEEHIP), which is a cost-sharing, multiple-employer defined-benefit OPEB plan administered by the TRS.

(a) Plan Description

The Alabama Retiree Health Care Funding Act of 2007 authorized and directed the Public Education Employees Health Insurance Board (Board) to create an irrevocable trust to fund postemployment healthcare benefits to retirees participating in PEEHIP. Active and retiree health insurance benefits are paid through the PEEHIP. The PEEHIP was established in 1983 pursuant to the provisions of the Code of Alabama 1975, Title 16, Chapter 25A to provide a uniform plan of health insurance for active and retired employees of state and local educational institutions and to fund benefits related to the plan. The responsibility for the general administration and operation of the PEEHIP is vested in its Board,

which consists of 15 trustees. Title 16-Chapter 25 of the Code of Alabama grants the authority to establish and amend the benefit terms to the PEEHIP Board. GASB Statement No. 75, requires the reporting of the participating employers' share of net OPEB liability and the OPEB expense in the financial statements as well as enhanced financial statements note disclosures.

(b) Benefits Provided

PEEHIP offers a basic hospital medical plan to active members and non-Medicare eligible retirees. Active employees and non-Medicare eligible retirees who do not have Medicare eligible dependents can enroll in a health maintenance organization (HMO). In addition to or in lieu of the basic hospital medical plan or HMO, the PEEHIP offers four optional plans: Hospital Indemnity, Cancer, Dental, and Vision. Also, PEEHIP members (only active and non-Medicare eligible) may elect the Supplemental Plan as their hospital medical coverage instead of the PEEHIP Hospital Medical Plan. This Supplemental Plan provides secondary benefits to the member's primary plan provided by another employer.

Effective January 1, 2020, Medicare eligible members and Medicare eligible dependents covered on a retiree contract were enrolled in the Humana Group Medicare Advantage plan for PEEHIP retirees. Effective January 1, 2023, United Health Care (UHC) Group replaced the Humana contract. The Medicare Advantage Prescription Drug Plan (MAPDP) is fully insured by UHC, and members are able to have all of their Medicare Part A, Part B, and Part D (prescription drug coverage) in one convenient plan. With the UHC plan for PEEHIP, retirees can continue to see their same providers with no interruption and see any doctor who accepts Medicare on a national basis. Retirees have the same benefits in and out-of-network, and there is no additional retiree cost share if a retiree uses an out-of-network provider and no balance billing from the provider.

(c) Contributions

The employer contribution to the health insurance premium is set forth by the Board annually.

Total employer contributions to the OPEB plan from the University were approximately $6,172,000 the year ended September 30, 2024 and are included in salaries and benefits on the statement of revenues, expenses, and changes in net position.

(d) OPEB Liabilities, OPEB Expenses, Deferred Outflows of Resources, and Deferred Inflows of Resources Related to OPEB

At June 30, 2025, the University reported a liability of approximately $396,009,000, for its proportionate share of the net OPEB liability. At June 30, 2025, the net OPEB liability was measured as of September 30, 2024, and the total OPEB liability used to calculate the net OPEB liability was determined by an actuarial valuation as of September 30, 2023. The University's proportion of the net OPEB liability was based on a projection of the University's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating employers, actuarially determined. At the measurement date of September 30, 2024, the University's proportion of contributions to the OPEB plan was 4.317503%, which was an increase of 0.207525% from its proportion measured as of September 30, 2023 of 4.099978%.

For nine months ended June 30, 2025, the University recognized OPEB expense of approximately $21,812,000, which is included in salaries and benefits on the statement of revenues, expenses, and changes in net position.

At June 30, 2025, the University reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources (in thousands):

	Deferred outflows of resources	Deferred inflows of resources
Differences between expected and actual experience	$ 184,682	85,470
Changes of assumptions	136,383	56,029
Net difference between projected and actual earnings on OPEB plan investments	—	9,770
Changes in proportion and differences between employer contributions and proportionate share of contributions	75,805	38,569
Employer contributions subsequent to the measurement date	*	—
	$ 396,870	189,838

At September 30, 2024, approximately $6,171,000 reported as deferred outflows of resources related to OPEB resulting from University contributions subsequent to the measurement date will be recognized as a reduction of the net OPEB liability in the year ending September 30, 2025.
*Contributions subsequent to measurement date for fiscal year 2025 will be available later this year.

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB income as follows (in thousands):

Year ending September 30:	
2026	$ 43,809
2027	37,602
2028	18,561
2029	34,143
2030	55,985
Thereafter	16,932
	$ 207,032

(e) Actuarial Assumptions

The total OPEB liability as of June 30, 2025 was determined by an actuarial valuation performed as of September 30, 2023, using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.50 %
Projected salary increases*	3.25-5.00 %
Long-term investment rate of return**	7.00 %
Municipal bond index rate at the measurement date	3.89 %
Municipal bond index rate at prior measurement date	4.53 %
Projected year for fiduciary net position to be depleted	2040
Single equivalent interest rate at the measurement date	4.32 %
Single equivalent interest rate at prior measurement date	7.00 %
Healthcare cost trend rate	
Pre-Medicare eligible	6.75 %
Medicare eligible	***
Ultimate trend rate	
Pre-Medicare eligible	4.50 %
Medicare eligible	4.50 %
Year of ultimate trend rate	
Pre-Medicare eligible	2033
Medicare eligible	2028
Optional plans trend rate	2.00 %

* Includes 2.75% wage inflation

** Compounded annually, net of investment expense, and includes inflation

*** Initial Medicare trend rates are set based on renewal premium rates through calendar year 2025 with an assumed 0% increase for the upcoming 2026-2028 negotation period.

Mortality rates were based on the Pub-2010 Teacher Below Median tables adjusted for males (108% ages < 63, 96% ages > 67; phasing down 63–67) and for females (112% ages < 69, 98% > age 74, phasing down 69–74), projected generationally using scale MP-2020 adjusted by 66–2/3% beginning with year 2019.

The decremental assumptions used in the valuation were selected based on the actuarial experience study prepared as of September 30, 2020, submitted to and adopted by the TRS on September 13, 2021. The remaining actuarial assumptions (e.g., initial per capita costs, healthcare cost trends, rate of plan participation, rates of plan election, etc.) of the total OPEB liability were based on the September 30, 2023 valuation.

The target asset allocation and best estimates of expected geometric real rates of return for each major asset class are summarized in the following table:

	Target allocation	Long-term expected real rate of return*
Fixed income	30 %	4.40 %
U.S. large stocks	38	8.00
U.S. mid stocks	8	10.00
U.S. small stocks	4	11.00
International developed market stocks	15	9.50
Cash	5	1.50
	100 %	

* Geometric mean, includes 2.50% inflation

(f) Discount Rate

The discount rate used to measure the total OPEB liability at June 30, 2025 was 4.32%. The projection of cash flows used to determine the discount rate assumed that plan contributions will be made at the current contribution rates. Each year, the State specifies the monthly employer rate that participating employers must contribute for each active employee, which is currently $800 per non-university active member. 9.751% of the employer contributions were used to assist in funding retiree benefit payments in fiscal year 2024. It is assumed that the 9.751% will increase or decrease at the same rate as expected benefit payments for the closed group until reaching an employer rate of 20.000%, at which point, based on budget projections, the monthly employer rate will increase to $904 in fiscal year 2026, $1,114 in fiscal year 2027, and then will increase with inflation at 2.5% starting in fiscal year 2028. The long-term expected rate of return on OPEB plan investments will be determined based on the allocation of assets by asset class and by the mean and variance of real returns. The discount rate determination will use a municipal bond rate to the extent the trust is projected to run out of money before all benefits are paid. Therefore, the projected future benefit payments for all current plan members were projected through 2122.

(g) Sensitivity of the University's Proportionate Share of the Net OPEB Liability to Changes in the Healthcare Cost Trend Rates and Discount Rates

The following table presents the University's proportionate share of the net OPEB liability calculated using the healthcare cost trend rate of 4.50%, as well as what the net OPEB liability would be if calculated using one percentage point lower 3.50% or one percentage point higher 5.50% than the current rate (in thousands):

	1% Decrease (3.50)%	Current rate (4.50)%	1% Increase (5.50)%
University's proportionate share of collective net OPEB liability	$ 318,556	396,009	495,885

The following table presents the University's proportionate share of the net OPEB liability calculated using the discount rate of 4.32%, as well as what the net OPEB liability would be if calculated using one percentage point lower 3.32% or one percentage point higher 5.32% than the current rate (in thousands):

	1% Decrease (3.32)%	Current rate (4.32)%	1% Increase (5.32)%
University's proportionate share of collective net OPEB liability	$ 481,060	396,009	328,044

(h) OPEB Plan Fiduciary Net Position

Detailed information about the OPEB plan's fiduciary net position is available in the Alabama Retired Education Employees' Health Care Trust's financial statements for the fiscal year ended September 30, 2024. The supporting actuarial information is included in the GASB Statement No. 75 Report for PEEHIP prepared as of September 30, 2024. Additional financial and actuarial information is available at www.rsa-al.gov.

(15) Risk Management

The University, HCM, SAMSF, and HCA participate in the PLTF; and the University, HCM, SAMSF, the Corporation, and HCA participate in the GLTF. An independent trustee administers both funds. These trust funds are revocable and use contributions by the University and HCA, together with earnings thereon, to pay liabilities arising from the performance of its employees, trustees, and other individuals acting on behalf of the University. Any risk related to the payment of claims is the responsibility of the PLTF and GLTF. If the trust funds are ever terminated, appropriate provision for payment of related claims will be made and any remaining balance may be distributed to the participating entities in proportion to contributions made.

As discussed in note 1, the PLTF and GLTF are blended component units of the University and, as such, are included in the financial statements of the University for the nine months ended June 30, 2025. Claims and expenses are reported when it is probable that a loss has occurred and the amount of the loss can be reasonably estimated. Those losses include an estimate of claims that have been incurred but not reported and the future costs of handling claims. These liabilities are generally based on actuarial valuations and are reported at their present value.

The University, HCM, and HCA each participate in a separate self-insured health plan administered by unaffiliated entities. Administrative fees paid by the University for such services were approximately $3,021,000 for the nine months ended June 30, 2025 and are included in accounts payable and accrued liabilities on the statement of net position. Contributions by the University and its employees, together with earnings thereon, are used to pay liabilities arising from healthcare claims. It is the opinion of University administration that plan assets are sufficient to meet future plan obligations.

The changes in the total self-insurance liabilities for the nine months ended June 30, 2025 for the PLTF, GLTF, and health plan are summarized as follows (in thousands):

Balance, beginning of year	$	72,621
Premiums and other additions		96,306
Claims, administrative fees paid, and other reductions		(100,114)
Balance, end of period	$	68,813

These amounts are included in other long-term liabilities and in accounts payable and accrued liabilities in the accompanying statement of net position.

(16) Related Parties

USA Presidential 1963 Fund is an Alabama not-for-profit corporation created for promoting charitable, scientific, literary, or educational initiatives that benefit and support the University. This not-for-profit corporation had no financial activity for the nine months ended June 30, 2025.

(17) Commitments and Contingencies

(a) Grants and Contracts

At June 30, 2025, the University had been awarded approximately $96,018,000 in grants and contracts for which resources had not been received and for which reimbursable expenditures had not been made for the purposes specified. These awards, which represent commitments of sponsors to provide funds for research or training projects, have not been reflected in the accompanying basic financial statements, as the eligibility requirements of the awards have not been met. Advances, if any, are included in unrecognized revenues and include amounts received from grant and contract sponsors that have not been expended under the terms of the agreements and, therefore, have not yet been included in revenues in the accompanying basic financial statements. Federal awards are subject to

audit by federal agencies. The University's management believes any potential adjustment from such audits will not be material.

(b) Litigation

Various claims have been filed against the University alleging discriminatory employment practices and other matters. University administration and legal counsel are of the opinion the resolution of these matters will not have a material effect on the financial position or the statement of revenues, expenses, and changes in net position of the University.

(c) Rent Supplement Agreements

The University has entered into two irrevocable rent supplement agreements with the Corporation and a financial institution. The agreements require that, in the event the Corporation fails to maintain a debt service coverage ratio of one to one with respect to all of its outstanding indebtedness, the University will pay to the Corporation any and all rent amounts necessary to cause the Corporation's net operating income to be equal to the Corporation's annual debt service obligations (see note 6). As of June 30, 2025, no amounts were payable pursuant to these agreements.

(d) USA Research and Technology Corporation Leases

The University has commitments under lease receivables with the Corporation. Space under lease to the University was 78,123 square feet at June 30, 2025. See note 9 for additional details.

(18) Functional Expense Information

Operating expenses by functional classification for the nine months ended June 30, 2025 are as follows (in thousands).

Instruction	$	97,840
Research		25,009
Public service		11,504
Academic support		25,214
Student services		35,428
Institutional support		41,538
Operation and maintenance of plant		12,137
Scholarships		15,179
USA Health		747,015
Auxiliary enterprises		14,566
Depreciation and amortization		67,227
	$	1,092,657

(19) Blended Component Units

As more fully described in note 1, HCM, PLTF, GLTF, Providence IPA, JAF and FRAC are reported as blended component units. Prior to 2025, the Jaguar Athletic Fund (JAF) and the USA Foundation for Research and Commercialization (FRAC) were not presented in the University's financial statements because they were not considered significant enough to warrant inclusion in the University's reporting entity. In 2025, the University determined both JAF and FRAC would be included in the University's reporting entity as a blended component unit going forward resulting in the University recognizing a change to or within the financial reporting entity by restating beginning unrestricted net position by approximately $1,423,000 in accordance with GASB Statement No. 100, Accounting Changes and Error Corrections-an amendment of GASB Statement No. 62.

Required combining financial information of the aggregate blended component units as of and for the nine months ended June 30, 2025 follows (in thousands):

Current assets	$	52,870
Noncurrent assets		43,333
Total assets		96,203
Current liabilities		35,658
Noncurrent liabilities		50,914
Total liabilities		86,572
Net position	$	9,631
Operating revenues	$	416,093
Operating expenses		(418,392)
Operating income		(2,299)
Nonoperating revenues		4,444
Nonoperating expenses		—
Change in net position	$	2,145

(20) Recently Issued Accounting Pronouncements

In April 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements*, which is effective for fiscal years beginning after June 15, 2025. The objective of this statement is to improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government's accountability.

In September 2024, the GASB issued Statement No. 104, *Disclosure of Certain Capital Assets*, which is effective for fiscal years beginning after June 15, 2025. The objective of this Statement is to provide users of

government financial statements with essential information about certain types of capital assets and requires disclosure of certain information regarding capital assets to be presented by major class.

The effect of the implementation of GASB Statement Nos. 103 and 104 on the University has not yet been determined.

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

LONG-RANGE PLANNING COMMITTEE

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

Long-Range Planning Committee

June 5, 2025
3:10 p.m.

A meeting of the Long-Range Planning Committee of the University of South Alabama ("USA," "University") Board of Trustees was duly convened by Ms. Chandra Brown Stewart, Chair, on Thursday, June 5, 2025, at 3:10 p.m. in the Board Room of the Frederick P. Whiddon Administration Building. Meeting attendance was open to the public.

Members:	Chandra Brown Stewart, Ron Jenkins, Bill Lewis, Lenus Perkins, Steve Stokes, Mike Windom and Jim Yance were present.
Other Trustees:	Alexis Atkins, Luis Gonzalez, Ron Graham, Arlene Mitchell and Jimmy Shumock.
Administration & Guests:	Owen Bailey, Jim Berscheidt, Joél Billingsley, Jo Bonner, Joel Erdmann, Julie Estis, Monica Ezell, Charlie Guest, Buck Kelley, Andi Kent, Spence Larche, Nick Lawkis, John Marymont, Mike Mitchell, Allen Parrish, Kristen Roberts, Donna Streeter (Faculty Senate), Margaret Sullivan, Peter Susman and Christina Wassenaar (Faculty Senate).

Following the attendance roll call, **Item 27**, Ms. Brown Stewart called for consideration of the minutes for a meeting held on March 13, 2025, **Item 28**. On motion by Capt. Jenkins, seconded by Mr. Perkins, the Committee voted unanimously to adopt the minutes.

Ms. Brown Stewart called on Dr. Julie Estis, Interim Associate Vice President for Institutional Effectiveness, for a report on institutional planning and assessment, **Item 29**. Dr. Estis provided background on the Institutional Planning and Assessment Committee (IPAC) and talked about the productive work accomplished at its quarterly meeting. She indicated that student success, faculty success and research advancement were the focus points following discussion on each of the strategic priorities. She added that an update on the strategic priorities and a scorecard with metrics would be presented in the coming months.

Dr. Estis advised that the IPAC also monitored the University's Master Plan ("Plan") and asked Mr. Kelley to share insight on development of the next Plan. Mr. Kelley discussed the groundwork for the 2027-2037 Plan and noted that the Plan would align with the strategic priorities.

There being no further business, the meeting was adjourned at 3:17 p.m.

Respectfully submitted:

Chandra Brown Stewart, Chair

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

COMMITTEE OF THE WHOLE

UNIVERSITY OF SOUTH ALABAMA
BOARD OF TRUSTEES

Committee of the Whole

June 5, 2025
3:17 p.m.

A meeting of the Committee of the Whole of the University of South Alabama ("USA," "University") Board of Trustees was duly convened by Ms. Arlene Mitchell, Chair *pro tempore*, on Thursday, June 5, 2025, at 3:17 p.m. in the Board Room of the Frederick P. Whiddon Administration Building. Meeting attendance was open to the public.

Members:	Alexis Atkins, Chandra Brown Stewart, Luis Gonzalez, Ron Graham, Ron Jenkins, Bill Lewis, Arlene Mitchell, Lenus Perkins, Jimmy Shumock, Steve Stokes, Mike Windom and Jim Yance were present.
Members Absent:	Scott Charlton, Steve Furr, Meredith Hamilton and Kay Ivey.
Administration & Guests:	Owen Bailey, Jim Berscheidt, Joél Billingsley, Jo Bonner, Joel Erdmann, Monica Ezell, Charlie Guest, Buck Kelley, Andi Kent, Spence Larche, Nick Lawkis, John Marymont, Mike Mitchell, Allen Parrish, Kristen Roberts, Donna Streeter (Faculty Senate), Margaret Sullivan, Peter Susman and Christina Wassenaar (Faculty Senate).

Following the attendance roll call, **Item 30**, Chair Mitchell called for consideration of the minutes for a meeting held on March 13, 2025, **Item 31**. On motion by Justice Lewis, seconded by Mr. Shumock, the Committee voted unanimously to adopt the minutes.

Chair Mitchell presented **Item 33**, a resolution authorizing the schedule of regular Board of Trustees meetings for the 2025-2026 academic year. (To view resolutions, policies and other documents authorized, refer to the minutes of the Board of Trustees meeting held on June 6, 2025.) On motion by Ms. Atkins, seconded by Mr. Shumock, the Committee voted unanimously to recommend approval of the resolution by the Board of Trustees.

Chair Mitchell called on Mr. Lawkis to address **Item 32**, a resolution authorizing a revised *Bylaws of the Board of Trustees of the University of South Alabama* ("Bylaws"). Mr. Lawkis reminded the Committee of the need to revise the Bylaws to conform with legislation recently signed into law that updated regions represented by Board members, the notice requirement for special meetings and the parameter for holding annual meetings in June. President Bonner recognized Mr. Lawkis for his efforts to advance the legislation. On motion by Mr. Yance, seconded by Mr. Shumock, the Committee voted unanimously to recommend approval of the resolution by the Board of Trustees.

In accordance with the provisions of the Alabama Open Meetings Act, Chair Mitchell made a motion to convene an executive session for an anticipated duration of 20 minutes for the purpose

of discussing pending or threatened litigation, **Item 34**. She stated Mr. Larche had submitted the required written declaration for the minutes and that adjournment of the meeting would be in effect immediately upon the conclusion of the executive session. Ms. Atkins seconded and, at approximately 3:23 p.m., the Committee voted unanimously to convene an executive session, as recorded herein. The executive session began at approximately 3:28 p.m.:

AYES:
- Ms. Atkins
- Ms. Brown Stewart
- Mr. Gonzalez
- Mr. Graham
- Capt. Jenkins
- Justice Lewis
- Chair Mitchell
- Mr. Perkins
- Mr. Shumock
- Dr. Stokes
- Judge Windom
- Mr. Yance

There being no further business, the meeting was adjourned at approximately 3:37 p.m.

Respectfully submitted:

Arlene Mitchell, Chair *pro tempore*

September 5, 2025

RESOLUTION

BOARD OF TRUSTEES EXECUTIVE COMMITTEE

WHEREAS, the *Bylaws of the Board of Trustees of the University of South Alabama* provides for the appointment by the Chair pro tempore of an Executive Committee, subject to the approval of the Board, for terms concurrent with the term of the Chair pro tempore, who shall serve as Chair of the Executive Committee, and

WHEREAS, the Trustees named herein have been appointed to serve on the Executive Committee for three-year terms that are concurrent with the term of the current Chair pro tempore:

- Mrs. Katherine Alexis Atkins
- Mr. Lenus Perkins
- Mr. William Ronald Graham
- Mrs. Chandra Brown Stewart
- Mrs. Arlene Mitchell
- Mr. James H. Shumock
- Hon. Michael P. Windom,

THEREFORE, BE IT RESOLVED, the Board of Trustees of the University of South Alabama hereby authorizes the Executive Committee as presented.