COMMUNITY HEALTH CARE

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEAR ENDED MAY 31, 2012

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INDEPENDENT AUDITORS' REPORT

Board of Directors
Community Health Care
Tacoma, Washington

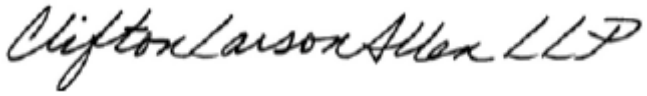
We have audited the accompanying statement of financial position of Community Health Care (the Organization) as of May 31, 2012, and the related statements of activities and changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of the Organization's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and the significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Community Health Care as of May 31, 2012, and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated September 26, 2012, on our consideration of Community Health Care's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Our audit was conducted for the purpose of forming an opinion on the basic financial statements. The supplementary schedule of functional expenses is presented for purposes of additional analysis and is not a required part of the financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements as a whole.



CliftonLarsonAllen LLP

Bellevue, Washington
September 26, 2012

COMMUNITY HEALTH CARE
STATEMENT OF FINANCIAL POSITION
MAY 31, 2012

ASSETS

CURRENT ASSETS	
Cash and Cash Equivalents	$ 894,054
Cash Set Aside for Medicaid Settlement	3,200,000
Restricted Cash	406,184
Patient Receivables, Net	2,619,250
Grants and Other Receivables	401,965
Promises to Give, Current Portion	153,947
Inventory and Other Prepaid Assets	696,719
Total Current Assets	8,372,119
PROPERTY, EQUIPMENT, AND LEASEHOLD IMPROVEMENTS, Net	21,383,372
OTHER ASSETS	
Promises to Give, Net of Current Portion	49,232
Issuance Costs, Net	158,276
Bond Reserve Fund	185,000
Reserves	7,900,000
Total Other Assets	8,292,508
Total Assets	$ 38,047,999

See accompanying Notes to Financial Statements.

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES	
Accounts Payable	$ 513,375
Accrued Wages and Related Payables	1,208,484
Construction Payables	176,827
Other Accrued Expenses	4,191,542
Deferred Revenue	35,498
Current Portion of Debt	115,066
Total Current Liabilities	6,240,792
LONG-TERM DEBT, Net of Current Portion	4,480,437
Total Liabilities	10,721,229
COMMITMENTS AND CONTINGENCIES	
NET ASSETS	
Unrestricted:	
Designated by Board of Directors	11,100,000
Undesignated	15,820,586
Temporarily Restricted	406,184
Total Net Assets	27,326,770
Total Liabilities and Net Assets	$ 38,047,999

COMMUNITY HEALTH CARE
STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS
YEAR ENDED MAY 31, 2012

OPERATING ACTIVITIES	
Revenue and Support:	
Patient Service Revenue, Net of Contractual Discounts	$ 20,682,576
Provision for Bad Debt	(443,924)
Net Patient Service Revenue Less Provision for Bad Debt	20,238,652
Grant Revenue	2,544,721
Contributions	115,435
Donations In-Kind	684,189
Other Income	902,814
Total Revenue and Support	24,485,811
Expenses:	
Clinics and Programs	21,186,538
Management and General	5,626,576
Fundraising	335,970
Total Expenses	27,149,084
CHANGE IN NET ASSETS FROM OPERATING ACTIVITIES	(2,663,273)
NONOPERATING ACTIVITIES	
Managed Care Pooled Savings	21,355
Other	26,881
CHANGE IN NET ASSETS FROM NONOPERATING ACTIVITIES	48,236
DEFICIENCY OF REVENUES AND SUPPORT UNDER EXPENSES	(2,615,037)
Capital Campaign Contributions	184,855
Affordable Care Act Capital Development Grant Revenue	1,054,962
CHANGE IN UNRESTRICTED NET ASSETS	(1,375,220)
CHANGE IN TEMPORARILY RESTRICTED NET ASSETS	
Capital Campaign Contributions	406,184
CHANGE IN NET ASSETS	(969,036)
Net Assets - Beginning of Year	28,295,806
NET ASSETS - END OF THE YEAR	$ 27,326,770

See accompanying Notes to Financial Statements.

COMMUNITY HEALTH CARE
STATEMENT OF CASH FLOWS
YEAR ENDED MAY 31, 2012

CASH FLOWS FROM OPERATING ACTIVITIES	
Cash Received from Patients	$ 22,562,621
Cash Received from Granting Agencies and Others	4,005,527
Cash Paid to Suppliers and Employees	(25,063,121)
Interest Paid	(193,280)
Other Income	48,236
Net Cash Provided by Operating Activities	1,359,983
CASH FLOWS FROM INVESTING ACTIVITIES	
Cash and Cash Equivalents Held as Investments	203,595
Cash Paid for Capital Assets	(1,682,212)
Proceeds from Capital Grant	1,054,962
Capital Campaign	591,039
Net Cash Provided by Investing Activities	167,384
CASH FLOWS FROM FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(113,464)
NET INCREASE IN CASH AND CASH EQUIVALENTS	1,413,903
Cash and Cash Equivalents - Beginning of Year	3,086,335
CASH AND CASH EQUIVALENTS - END OF YEAR	$ 4,500,238
RECONCILIATION OF CHANGE IN NET ASSETS TO NET CASH PROVIDED BY OPERATING ACTIVITIES	
Change in Net Assets	$ (969,036)
Adjustments to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:	
Depreciation and Amortization	1,304,125
Bad Debt Expense	443,924
Capital Grant	(1,054,962)
Capital Campaign	(591,039)
(Increase) Decrease in Assets:	
Patient Receivables	(454,777)
Grants Receivables	(87,979)
Prepaid Expenses	341,258
Promises to Give	(153,653)
Increase in Liabilities:	
Accounts Payable	415,479
Accrued Expenses	2,166,643
Net Cash Provided by Operating Activities	$ 1,359,983
SUPPLEMENTARY DISCLOSURE OF CASH FLOW INFORMATION	
Cash is Comprised as Follows:	
Cash and Cash Equivalents	$ 894,054
Cash Set Aside for Medicaid Settlement	3,200,000
Restricted Cash	406,184
Cash and Cash Equivalents - End of Year	$ 4,500,238

See accompanying Notes to Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Nature of Operations

Community Health Care (the Organization), is a not-for-profit organization that provides affordable comprehensive health care services for uninsured and underserved individuals in the Pierce County, Washington, area. The Organization meets the community's health care needs by maintaining and supporting various clinics and programs.

Use of Estimates

Management uses estimates and assumptions in preparing these financial statements in accordance with accounting principles generally accepted in the United States of America. Those estimates and assumptions affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities, and the reported revenues and expenses. Actual results could vary from the estimates that were used.

The Organization uses the allowance method of accounting for uncollectible accounts and contractual adjustments from third-party payers on accounts receivable. In estimating these allowances, management reviews the individual accounts receivable, payer type, and their collection status.

Basis of Presentation

Net assets and revenues, expenses, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, the net assets of the Organization and changes therein are classified and reported as follows:

Unrestricted – Net assets that are not subject to externally imposed restrictions. Amounts designated by the board of the Organization are included in this classification.

Temporarily Restricted – Net assets subject to donor-imposed stipulations that may or will be met either by actions of the Organization and/or the passage of time.

Permanently Restricted – Net assets subject to donor-imposed restrictions that stipulate the resources be maintained permanently, but permit the Organization to use, or expend, part or all of the income derived from the donated assets for either specified or unspecified purposes. The Organization had no permanently restricted net assets as of May 31, 2012.

Revenues are reported as increases in unrestricted net assets, unless use of the related assets is limited by donor-imposed restrictions. Expenses are reported as decreases in unrestricted net assets. Gains and losses on investments and other assets or liabilities are reported as increases or decreases in unrestricted net assets, unless their use is restricted by explicit donor restriction or by law. Expirations of temporary restrictions on assets are reported as transfers between the applicable classes of net assets. Contributions with externally imposed restrictions that are met in the same year as received are reported as revenues of the unrestricted net asset class.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Basis of Presentation (Continued)

Temporarily restricted net assets at year end consisted of amounts received on behalf of the capital campaign and are restricted for use as part of the Hilltop Regional Health Center project.

Cash and Cash Equivalents

The Organization considers all highly liquid investments purchased with an original maturity of three months or less to be cash equivalents, except for funds held in the investment accounts designated for long-term purposes.

Restricted Cash

The Organization considers cash received on behalf of the capital campaign to be restricted to use.

Credit Risk

Financial instruments that potentially subject the Organization to concentration of credit risk consist principally of cash deposits and receivables. At May 31, 2012, The Organization had cash deposits in excess of the federally insured limit.

Accounts Receivable

Patient accounts receivable are stated at net realizable value. Third-party contractual adjustments are made based on past experience. Receivables are reduced by an allowance for estimated uncollectible amounts and accounts deemed uncollectible are charged against this allowance. The Organization provides care to patients regardless of their ability to pay. A minimum payment is requested for each medical and dental visit and collection is made at the time of the visit, but if the patient is unable to pay, they are subsequently billed. The Organization notifies patients of past-due amounts and a significant number of these accounts are ultimately determined to be uncollectible. The allowance for uncollectible accounts was approximately 91 percent of self-pay accounts receivable at May 31, 2012.

Inventory

Inventory consists mainly of prescription drugs and medical supplies, and is stated at the lower of cost or market. Cost is determined by the first-in, first-out method.

Property, Equipment, and Leasehold Improvements

Property, equipment, and leasehold improvements are recorded at cost or, if donated, at the fair market value at the date of donation. Depreciation is provided on the straight-line method over the estimated useful lives of the assets ranging from two to forty years or, for leasehold improvements, the shorter of the useful life or lease term. The Organization capitalizes all computer equipment and other depreciable assets with a purchase price and/or donated fair market value greater than $2,000. Interest cost incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. Repairs and maintenance are charged to expense as incurred.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Property, Equipment, and Leasehold Improvements (Continued)

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from deficiency of revenue over (under) expenses, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash/or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulation about how long those long-lived assets must be maintained, expiration of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

The Organization reviews its capital assets for impairment whenever events or changes in circumstances indicate that the carrying value of such property may not be recoverable.

Nonoperating Versus Operating

For the purpose of the statement of activities and changes in net assets, the Organization considers support related to the capital campaign, managed care pooled savings, and gains or losses on the disposition of fixed assets to be nonoperating activities.

(Deficiency) Excess of Support and Revenues (Under) Over Expenses

The statement of activities and changes in net assets includes (deficiency) excess of support and revenues (under) over expenses. Changes in unrestricted net assets which are excluded from operations, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, permanent transfers of assets to and from affiliates for other than goods and services, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets and the related releases).

Net Patient Service Revenue

The Organization has agreements with third-party payers that provide for payments to the Organization at amounts different from its established rates. Payment arrangements include prospectively determined rates per encounter, reimbursed costs, case rates, discounted charges, per diem payments, and enhancements. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payers as final settlements are determined. For uninsured patients that do not qualify for a discounted payment schedule, the Organization recognizes revenue on the basis of its standard rates for services provided. A significant portion of the Organization's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Organization records a significant provision for bad debts related to uninsured patients in the period the services are provided. The Organization also records provision for doubtful accounts related to third-party payers for services provided. Net patient service revenue, net of contractual allowances and discounts but before the provision for bad debts and doubtful accounts, recognized in the period from these major payer sources at May 31, 2012 is as follows:

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Net Patient Service Revenue (Continued)

	Third-Party Payers	Self-Insured	Total
Patient Service Revenue (Net of Contractual Allowance and Discounts)	$ 18,868,010	$ 1,814,566	$ 20,682,576

Managed Care Pooled Savings

As a member of the Community Health Plan (CHP), the Organization has agreed to serve as a provider of primary care services for a certain amount per member per month and to provide case management services to these same members related to specialty and hospital services. In return, the Organization will participate in any specialty and hospital pool savings realized by CHP in providing these services, based upon the formula determined by the board of directors of CHP. The plan year for determining these savings follows the calendar year. The Organization recognizes pool savings amounts on a modified cash basis where pool savings amounts are accrued to the extent that notification of pool savings amounts are received subsequent to year end. See further discussion at Note 11.

Contributions

Contributions, which include unconditional promises to give (pledges), are recognized as revenues at fair value in the period received. Promises to give, receivable in more than one year, are discounted to present value at a risk-adjusted rate.

Donations In-Kind

Contributed goods and services are recorded at rates that would have been paid for similar goods and services if purchased. Donations in-kind reported in the statement of activities and changes in net assets consisted of the following for the year ended May 31, 2012:

Donated Pharmaceuticals and Vaccines	$ 666,522
Donated Professional Services	17,667
Total Donations In-Kind	$ 684,189

Discounted Services

The Organization has a policy of providing care to patients, who meet certain criteria under its policy, without charge or at amounts less than its established rates. However, all patients are requested to pay a minimum fee for each visit and no patient is denied services because of inability to pay. Since management does not expect payment for this care, the discounted services are excluded from revenue. During the year ended May 31, 2012, the Organization provided $1,505,792 of discounted services under this policy based upon charges.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Grant Revenue

The Organization receives support from various federal, state, and local government agencies. Grant receipts are subject to restrictions on the use of funds placed by the grantor. The Organization administers these funds in accordance with grantor guidelines. Grant revenue under cost reimbursement arrangements is recognized as expenses are incurred. Amounts incurred but not yet reimbursed are reported as grant receivables. Management believes the amounts to be fully collectible.

Advertising Costs

Advertising costs are expensed as incurred. Advertising costs for the year ended May 31, 2012 totaled $46,518.

Income Taxes

No provision for income taxes is shown in the financial statements because the Organization is a nonprofit organization, exempt from income taxes under 501(c)(3) of the Internal Revenue Code. Management evaluated the Organization's tax positions and concluded that the Organization had taken no uncertain tax positions that require adjustments to the financial statements to comply with the provisions of Topic 740 of the *Accounting Standards Codification* (ASC). The Organization is no longer subject to U.S. federal income tax examinations by tax authorities for the years before 2009.

Fundraising

The Organization began the Tanbara Health Center capital campaign in 2007 and began the Hilltop Regional Health Center capital campaign in 2010, and has separately stated the contributions related to the capital campaign fundraising activities in the statement of activities and changes in net assets.

Collective Bargaining

For the year ended May 31, 2012, approximately 52 percent of the Organization's employees were covered under a collective bargaining agreement with the Service Employees International Union 1199NW. The contract was renegotiated and a new contract was signed December 9, 2011.

Subsequent Events

Subsequent events have been evaluated through September 26, 2012, which is the date the financial statements were available to be issued.

NOTE 2 RESERVES

The Organization invests funds with various banks and investment brokers. These investments consist primarily of certificates of deposit and money market funds, pay interest and dividends at variable rates, and are subject to market fluctuations. Investment income is comprised solely of interest income for the year ended May 31, 2012 and is included in other operating income on the statement of activities and changes in net assets. The investment of these funds is controlled by the investment policies of the Organization as approved by its board of directors.

NOTE 2 RESERVES (CONTINUED)

In accordance with professional standards, fair value is defined as the price that the Organization would receive upon selling an asset in an orderly transaction to an independent buyer in the principal or most advantageous market of the asset. The guidance established a three-tier hierarchy to maximize the use of observable measurements for disclosure purposes. Inputs refer broadly to the assumptions that market participants would use in pricing the asset or liability, including assumptions about risk. Inputs may be observable measurements for disclosure purposes. Inputs refer broadly to the assumptions that market participants would use in pricing the asset or liability, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset or liability developed based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about the assumptions market participants would used in pricing the asset or liability developed based on the best information available. The three-tier hierarchy of inputs is summarized in the three broad levels listed below:

Level 1 – Valuations for assets and liabilities traded in active exchange markets, such as the New York Stock Exchange. Level 1 also includes U.S. Treasury and federal agency securities and federal agency mortgage-backed securities, which are traded by dealers or brokers in active markets. Valuations are obtained from readily available pricing sources for market transactions involving identical assets or liabilities.

Level 2 – Valuations for assets and liabilities traded in less active dealer or broker markets. Valuations are obtained from third-party pricing services for identical or similar assets or liabilities. The Organization has no Level 2 assets or liabilities.

Level 3 – Valuations for assets and liabilities that are derived from other valuation methodologies, including option pricing models, discounted cash flow models, and similar techniques, and not based on market exchange, dealer, or broker traded transactions. The Organization has no Level 3 assets or liabilities.

As required by Financial Accounting Standards Board (FASB) ASC 820, financial assets and liabilities are classified in their entirety based on the lowest level of input that is significant to the fair value measurement. The Organization's assessment of the significance of a particular input to the fair value measurement requires judgment and may affect the valuation of fair value assets and liabilities and their placement within the fair value hierarchy levels. Following is a description of the valuation methodologies used for assets measured at fair value. There have been no changes in the methodologies used at May 31, 2012.

Investments measured on a recurring basis at May 31, 2012 are comprised of money market accounts and certificates of deposit that were valued using Level 1 inputs.

NOTE 2 RESERVES (CONTINUED)

The following table sets forth, within the fair value hierarchy, the Organization's assets at fair value as of May 31, 2012:

	Level 1	Level 2	Level 3	Total
Cash Held for Reserve	$ 4,700,000	$ -	$ -	$ 4,700,000
Money Market Funds	769,921	-	-	769,921
Certificates of Deposit	2,430,079	-	-	2,430,079
Total	$ 7,900,000	$ -	$ -	$ 7,900,000

NOTE 3 NET PATIENT SERVICE REVENUE

Patient Service Revenue

The Organization has agreements with third-party payers that provide for payments to the Organization at amounts different from its established rates. Payment arrangements include prospectively determined rates per encounter, reimbursed costs, case rates, discounted charges, and per diem payments. A summary of the payment arrangements with major third-party payers is as follows:

Medicare - Outpatient services rendered to Medicare program beneficiaries are paid at established federal qualified health center (FQHC) enhancement rates, no matter the level or amount of services provided to the beneficiary. For each visit provided to a Medicare program beneficiary, the Organization is paid 80 percent of the established FQHC rate, with the beneficiary being responsible for the remaining 20 percent representing a co-pay. The Organization is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Organization and audits thereof by the Medicare fiscal intermediary. Retroactive settlements have historically not been material for Medicare.

Medicaid - Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology.

Revenue from the Medicare and Medicaid programs accounted for approximately 7 percent and 76 percent respectively, of the Organization's net patient revenue for the year ended May 31, 2012. 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 will change by a material amount in the near term. As further described in Note 13, the methodology for payment of the Medicaid enhancement for managed care and fee-for-services changed effective January 1, 2009.

The Organization also has agreements with various insurance companies or insurance plans to provide primary care services to subscribing participants on a per member, per month basis, and receives monthly capitation payments based upon the number of participants, regardless of services actually performed by the Organization.

NOTE 3 NET PATIENT SERVICE REVENUE (CONTINUED)

The Organization has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per encounter, case rates, discounted charges, and per diem payments.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including retroactive adjustments under reimbursement agreements with third-party payers as final settlements are determined. As of May 31, 2012, accounts receivable was net of a provision for doubtful accounts and contractual adjustments of $2,688,513.

NOTE 4 DESIGNATED BALANCES

The composition of assets designated by the board of directors at May 31, 2012, is set forth in the following table.

Board Designated for Acquiring Long-Term Assets	$ 5,000,000
Board Designated for Repayment to Medicaid	3,200,000
Board Designated Reserves	2,900,000
Total	$ 11,100,000

The designated cash balances are included in cash and cash equivalents and investments on the statement of financial position as of May 31, 2012.

NOTE 5 PROPERTY, EQUIPMENT, AND LEASEHOLD IMPROVEMENTS

Property, equipment, and leasehold improvements at cost consisted of the following at May 31, 2012:

Land	$ 3,642,530
Building and Building Improvements	16,725,531
Leasehold Improvements	2,297,428
Furniture and Equipment	6,822,755
Automobiles	106,274
Projects in Progress	1,195,887
Total	30,790,405
Less: Accumulated Depreciation and Amortization	(9,407,033)
Total	$ 21,383,372

NOTE 5 PROPERTY, EQUIPMENT, AND LEASEHOLD IMPROVEMENTS (CONTINUED)

The Organization has made a commitment to build a Health Center, Hilltop Regional Health Center, as replacement and expansion of the existing Downtown Family Organization. The majority of the balance in projects in progress is related to this commitment. The Organization has been awarded a $12 million grant by Health Services and Human Resources Agency and $1.5 million from the State toward the project. Total costs are expected to be approximately $26 million.

The Organization is in the process of evaluating financing options and is currently pursuing eligibility under the New Markets Tax Credit Program.

NOTE 6 PROMISES TO GIVE

Unconditional promises to give consisted of the following at May 31, 2012:

Receivable in Less Than One Year	$ 153,947
Receivable in One to Five Years	57,677
Total Unconditional Promises to Give	211,624
Less: Discounts to Net Present Value	(8,445)
Net Unconditional Promises to Give	$ 203,179

Promises to give that are receivable in more than one year are discounted at a risk-adjusted rate of 4 percent for each additional year through the term of the pledge.

NOTE 7 LONG-TERM DEBT

Long-term debt at May 31, 2012, consisted of the following:

Series 2003 Washington Health Care Facilities Authority Weekly Rate Demand Revenue Bonds (passed through the Washington Association of Community and Migrant Health Centers), variable interest rate (0.29% at May 31, 2012, respectively), payable in annual principal payments of $65,000 and monthly interest payments through December 1, 2029. The bonds are publicly placed, and secured by a reducing letter of credit, as well as by land and building at the Downtown and Spanaway clinics.	$ 1,395,000
Mortgage payable to Umpqua Bank, secured by the Tanbara Health Center. Monthly payments of $18,737 including interest at 5.5%, maturing March 2020.	3,200,503
Total Debt	4,595,503
Less: Current Portion	(115,066)
Long-Term Debt, Noncurrent Portion	$ 4,480,437

NOTE 7 LONG-TERM DEBT (CONTINUED)

Interest expense recorded for the year ended May 31, 2012 was $193,280.

Principal maturities of long-term debt for future years are as follows:

Year Ending May 31,	Bond	Mortgage	Total
2013	$ 65,000	$ 50,066	$ 115,066
2014	65,000	52,890	117,890
2015	70,000	55,695	125,695
2016	70,000	57,961	127,961
2017	75,000	61,307	136,307
Thereafter	1,050,000	2,922,584	3,972,584
Total	$ 1,395,000	$ 3,200,503	$ 4,595,503

Bonds

On January 23, 2003, the Organization received $3,320,000 from the proceeds of the sale of weekly rate demand revenue bonds by the Washington Health Care Facilities Authority passed through the Washington Association of Community and Migrant Health Centers. Bond issuance costs of $224,971 are being amortized over the life of the bonds on a straight-line basis.

The 2003 Series bonds bear interest at a variable rate determined on a weekly basis by a remarketing agent based upon a weekly rate index of the average seven-day yield evaluations at par of securities which have been issued. The bond indenture requires the Organization to make deposits to restricted accounts for the periodic payment of bond interest and retirement of bond principal. The amount held for future bond redemption requirements of $21,667 as of May 31, 2012, is in cash and cash equivalents in the statement of financial position. The bonds are secured by land, building, and equipment and certain revenues. The indenture also requires the Organization to maintain a reserve account amounting to $185,000, which is also reported in the statement of financial position.

Covenants

The bond and mortgage agreements contain various covenants which, among other things, place restrictions on the Organization's ability to incur additional indebtedness and require the Organization to maintain certain financial ratios. The Organization is required to maintain a debt service coverage ratio of not less than 1.20 to 1.00 as of the end of each fiscal year. For the year ended May 31, 2012, the Organization was not in compliance with the covenant, which is a breach of the mortgage agreement. The financial institution has provided a forbearance notice for noncompliance with loan covenants through the earlier of August 31, 2013 or receipt of the audited financial statements for the year ended May 31, 2013. As part of the notice the Organization is required to establish a reserve fund equal to 12 monthly payments or approximately $225,000 for future debt payments owed.

NOTE 8 PENSION PLAN

The Organization has a 403(b) Thrift Pension Plan (the Plan) available to all eligible employees. The Plan permits employees to defer a portion of their salary until future years. The Plan also allows for a discretionary match up to one percent and a base contribution of four percent from the employer on the participant's compensation received during the plan year after the participant meets the minimum service requirement. The Plan contains a vesting provision based upon a participant's years of vesting service. During fiscal year 2012, the Organization's combined matching and base contributions to the Plan were $592,150.

NOTE 9 SELF INSURANCE

The Organization is a member of 501(c) Agencies Trust (the Trust). The Trust facilitates the utilization by member agencies of the reimbursement financing method of meeting obligations under state unemployment insurance statutes. As of May 31, 2012, the Organization had deposits on hand with the Trust of $273,772, which is included as prepaid expenses in the statement of financial position. Any potential claims that may exist cannot be estimated at May 31, 2012; therefore, no accrual has been made.

NOTE 10 MALPRACTICE INSURANCE

Effective January 1, 2004, the Organization was covered under the provision of the Federal Tort Claims Act (FTCA) for malpractice. The FTCA is a government funded program which allows community health centers and other qualified providers to be covered for malpractice. The Organization has purchased malpractice insurance, through One Beacon Insurance Company, for activities not covered under the FTCA and is covered on a claims-made basis.

NOTE 11 MANAGED CARE

The Organization is a member of the Community Health Network of Washington (the Plan), a managed care plan network formed by 21 community and migrant health centers throughout the state of Washington to participate in the managed care marketplace. The Plan is a not-for-profit corporation and accepts the full insurance risk of providing health care services to enrollees in the State Medicaid and Basic Health Plan programs. The individual health centers are contingently liable for their proportionate share of any claims should the Plan be unable to meet its financial obligations. The Plan believes that its assets are sufficient to meet its financial obligation.

The Organization is also a member of the Community Health Plan (CHP), an affiliate of Community Health Network of Washington that contracts with the state of Washington for the delivery of managed care health care through community health centers.

NOTE 11 MANAGED CARE (CONTINUED)

As a member of CHP, the Organization has agreed to serve as a provider of primary care services for a certain amount per member per month and to provide case management services to these same members related to specialty and hospital services. In return, the Organization will participate in any specialty and hospital pool savings realized by CHP in providing these services, based upon a formula determined by the board of directors of CHP. Included on the statement of activities and changes in net assets is $21,355 of Hospital and Specialty Pool Revenues for the year ended May 31, 2012.

NOTE 12 ELECTRONIC HEALTH RECORD

The Electronic Health Record (EHR) incentive program was enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. These Acts provided for incentive payments under both the Medicare and Medicaid programs to eligible facilities that demonstrate meaningful use of certified EHR technology. The incentive payments are made based on a statutory formula and are contingent on the Organization continuing to meet the escalating meaningful use criteria. For the first payment year, the Organization must attest, subject to an audit, that it met the meaningful use criteria for a continuous 90-day period. For the subsequent payment year, the Organization must demonstrate meaningful use for the entire year. The incentive payments are generally made over a four-year period.

The Organization recorded incentive payments of $873,021 for the year ended May 31, 2012, which are included in other income from operating activities.

NOTE 13 COMMITMENTS AND CONTINGENCIES

Operating Leases

The Organization is party to a number of operating lease agreements involving buildings and office space. The leases extend for varying periods and generally provide for the payment of taxes, insurance, and maintenance by the Organization. Several of these leases are on a month-to-month basis, and can be terminated by giving the lessor written notice within a specified period, such as 30 to 90 days. Total rental expense for the year ended May 31, 2012, was $407,826.

Future minimum payments required under noncancellable operating leases are as follows:

Year Ending May 31,	Amount
2013	$ 301,468
2014	313,230
2015	325,114
2016	337,123
2017	349,275
Total	$ 1,626,210

NOTE 13 COMMITMENTS AND CONTINGENCIES (CONTINUED)

Grants

The Organization receives federal grants for specific purposes that are subject to review and audit by the grantor agencies. Entitlements to these resources are generally conditional upon compliance with the terms and conditions of grant agreements and applicable federal regulations, including the expenditure of resources for allowable purposes. Any disallowance resulting from a review or audit may become a liability of the Organization.

Litigation

The Organization is also involved in litigation in the normal course of business. After consultation with legal counsel, management estimates that these matters will be resolved without a material adverse effect to the Organization's future financial position or results from operations.

Medicaid Funding

A CMS (Centers for Medicare and Medicaid Services) audit of DSHS found that the current method of paying federally-required Prospective Payment System rates in the state's Healthy Options Managed Medicaid Program was inconsistent with federal requirements. The resolution of this audit finding has been negotiated, with the results finalized in July 2009 and retroactive to January 1, 2009. As part of the resolution, new rates for calculating managed care enhancements were provided to DSHS with two methodology options available to choose from. The new rates were effective January 1, 2009; however, the new rates are being used to pay for services provided on and after July 1, 2009. The difference of payments from January 1 through June 30, 2009, were finalized in September 2011 and have resulted in a settlement due that is included in other accrued expenses on the statement of financial position.

During 2011 the State of Washington informed the Organization of various rate changes that would potentially result in additional amounts owed to the Medicaid program. Management has estimated the impact and included that estimate in other accrued expenses on the statement of financial position. For the period of January 1, 2009 to December 31, 2009, the Organization has recorded an estimated payable to the state of Washington of approximately $1,597,000. For the period of January 1, 2010 through May 31, 2012, the Organization has recorded a payable of approximately $2,580,000. These liabilities were determined based on correspondence received from the state as well as management's estimate based on the number of encounters and the applicable encounter rate. These liabilities and the reduction to revenues are reflected in the statement of financial position. These estimates are subject to material change based on the state's final reconciliations and settlements of the activity to be performed.

COMMUNITY HEALTH CARE
SCHEDULE OF FUNCTIONAL EXPENSES
YEAR ENDED MAY 31, 2012
(SEE INDEPENDENT AUDITORS' REPORT)

	Medical Clinics	Dental Clinics	Pharmacies	Other Programs	Total Clinics and Programs	Management and General	Fundraising	Total Supporting Services	Total Program and Supporting Services
Salaries	$ 7,631,619	$ 2,750,429	$ 1,101,608	$ 535,823	$ 12,019,479	$ 3,094,580	$ 139,215	$ 3,233,795	$ 15,253,274
Payroll Taxes and Employee Benefits	2,157,703	722,145	314,724	137,510	3,332,082	895,973	28,713	924,686	4,256,768
Total Operational Salaries and Benefits	9,789,322	3,472,574	1,416,332	673,333	15,351,561	3,990,553	167,928	4,158,481	19,510,042
Contract Providers	537,007	42,783	14	28	579,832	620	-	620	580,452
Contract Services	326,663	80,592	44,298	11,096	462,649	146,845	73,144	219,989	682,638
Lab Fees	228,771	-	-	-	228,771	-	-	-	228,771
X-Ray Fees	43,374	-	-	-	43,374	144	-	144	43,518
Pharmacy Supplies	276,279	1,000	820,811	-	1,098,090	3,645	-	3,645	1,101,735
Medical and Dental Supplies	633,678	195,293	316	1,197	830,484	2,810	565	3,375	833,859
Linen Supplies	-	48,525	-	-	48,525	-	-	-	48,525
Translation	8,590	156	1	678	9,425	206	104	310	9,735
Insurance	51,975	14,819	1,897	1,450	70,141	32,732	111	32,843	102,984
Occupancy	327,209	58,895	22,184	12,617	420,905	404,643	21,030	425,673	846,578
Telephone	111,055	15,098	8,166	11,626	145,945	121,108	4,432	125,540	271,485
Travel and Training	50,175	27,305	3,078	13,043	93,601	116,866	948	117,814	211,415
Advertising and Recruiting	14,867	1,265	189	229	16,550	115,478	16,422	131,900	148,450
Office Supplies	37,589	7,926	4,265	770	50,550	31,571	1,421	32,992	83,542
Legal and Accounting	23,639	6,862	1,059	1,446	33,006	152,450	704	153,154	186,160
Repairs and Maintenance	102,320	63,534	7,782	3,815	177,451	31,830	911	32,741	210,192
Printing and Postage	18,629	7,977	2,652	2,040	31,298	25,476	20,136	45,612	76,910
Association Dues	67,020	22,670	8,655	1,905	100,250	39,675	2,286	41,961	142,211
Miscellaneous	95,430	23,048	25,277	1,084	144,839	141,986	25,704	167,690	312,529
Interest and Bank Charges	145,577	42,031	10,056	9,907	207,571	5,657	-	5,657	213,228
Depreciation and Amortization	669,491	249,106	74,772	48,351	1,041,720	262,281	124	262,405	1,304,125
Total Expenses	$ 13,558,660	$ 4,381,459	$ 2,451,804	$ 794,615	$ 21,186,538	$ 5,626,576	$ 335,970	$ 5,962,546	$ 27,149,084

COMMUNITY HEALTH CARE

SINGLE AUDIT REPORTS

MAY 31, 2012

COMMUNITY HEALTH CARE
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SINGLE AUDIT REPORTS

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Community Health Care
Tacoma, Washington

We have audited the financial statements of Community Health Care, (a not-for-profit organization), as of and for the year ended May 31, 2012, and have issued our report thereon dated September 26, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control over Financial Reporting

In planning and performing our audit, we considered Community Health Care's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Community Health Care's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Community Health Care's internal control over financial reporting.

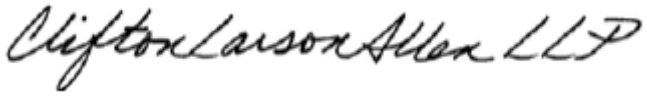
A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Community Health Care's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, grant agreements, and other matters, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

This report is intended solely for the information and use of the board of directors, management, federal awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than those specified parties.



CliftonLarsonAllen LLP

Bellevue, Washington
September 26, 2012

INDEPENDENT AUDITORS' REPORT ON COMPLIANCE WITH REQUIREMENTS THAT COULD HAVE A DIRECT AND MATERIAL EFFECT ON EACH MAJOR PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE IN ACCORDANCE WITH OMB CIRCULAR A-133

Board of Directors
Community Health Care
Tacoma, Washington

Compliance

We have audited the compliance of Community Health Care's (a not-for-profit organization) compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) Circular A-133, *Compliance Supplement* that could have a direct and material effect on each of its major federal programs for the year ended May 31, 2012. Community Health Care's major federal programs are identified in the summary of auditors' results section of the accompanying schedule of audit findings. Compliance with the requirements of laws, regulations, contracts, and grant agreements applicable to its major federal programs is the responsibility of Community Health Care's management. Our responsibility is to express an opinion on Community Health Care's compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Nonprofit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program have occurred. An audit includes examining, on a test basis, evidence about Community Health Care's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination on Community Health Care's compliance with those requirements.

In our opinion, Community Health Care complied, in all material respects, with the requirements referred to above that are applicable to its major federal programs for the year ended May 31, 2012.

Internal Control Over Compliance

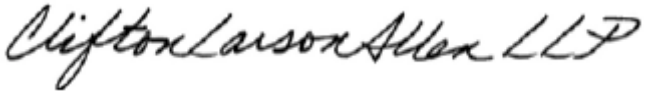
The management of Community Health Care is responsible for establishing and maintaining effective internal control over compliance with requirements of laws, regulations, contracts, and grant agreements applicable to federal programs. In planning and performing our audit, we considered Community Health Care's internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of Community Health Care's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in Community Health Care's internal control that might be significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above.

We have audited the financial statements of Community Health Care as of and for the year ended May 31, 2012, and have issued our report thereon dated September 26, 2012, which contained an unqualified opinion on those financial statements. Our audit was conducted for the purpose of forming an opinion on the basic financial statements. The schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, and is not a required part of the basic financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with the auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the basic financial statements as a whole.

This report is intended solely for the information and use of the board of directors, management, federal awarding agencies, and pass-through entities and is not intended to be and should not be used by anyone other than those specified parties.



CliftonLarsonAllen LLP

Bellevue, Washington
September 26, 2012

COMMUNITY HEALTH CARE
SCHEDULE OF AUDIT FINDINGS AND QUESTIONED COSTS
YEAR ENDED MAY 31, 2012

SECTION 1 – SUMMARY OF AUDITORS' RESULTS

Financial Statements

Type of auditors' report issued: *Unqualified*

Internal control over financial reporting:

- Material weakness(es) identified? _____ yes ___X___ no
- Significant deficiency(ies) identified not considered to be material weakness(es)? _____ yes ___X___ none reported

Noncompliance material to financial statements noted? _____ yes ___X___ no

Federal Awards

Internal control over major programs:

- Material weakness(es) identified? _____ yes ___X___ no
- Significant deficiency(ies) identified not considered to be material weakness(es)? _____ yes ___X___ none reported

Type of auditors' report issued on compliance for major programs: *Unqualified*

Any audit findings disclosed that are required to be reported in accordance with Circular A-133, section .510(a)? _____ yes ___X___ no

Identification of major programs:

CFDA Number(s)	Name of Federal Program or Cluster
93.224	Community Health Centers
93.526	Affordable Care Act (ACA) Grants for Capital Development in Health Centers

Dollar threshold used to distinguish between Type A and Type B programs: $300,000

Auditee qualified as low-risk auditee? _____ yes ____X__ no

SECTION II – FINANCIAL STATEMENT FINDINGS

No matters were reported.

SECTION III – FEDERAL AWARD FINDINGS

No matters were reported.

COMMUNITY HEALTH CARE
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
YEAR ENDED MAY 31, 2012

Federal Grantor/Pass-Through Grantor/Program Title	Federal CFDA Number		Agency/Pass-Through Identifying Number	Disbursements/ Expenditures
Department of Health and Human Services				
Community Health Centers Section 330	93.224	*	H8OCS00481	$ 2,381,172
Affordable Care Act (ACA) Grants for Capital Development in Health Centers	93.526	*	C8ACS21298	1,054,962
Passed Through Pierce County:				
Center for Disease Control and Prevention, Investigations and Technical Assistance				
Breast and Cervical Health	93.283		2011-00000010	
			2012-00000068	8,017
Refugee and Entrant Assistance				
Refugee Health Screening	93.566/93.576		2011-443-1	
			2012-00000013	97,098
Total Federal Expenditures				**$ 3,541,249**

* Major Federal Program

NOTE TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS

This schedule includes the federal grant activity of Community Health Care and is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations.* Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in, the preparation of the basic financial statements.

COMMUNITY HEALTH CARE
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
YEAR ENDED MAY 31, 2012

Finding 2011-01: Corrected in the current year.

Finding 2011-02: Corrected in the current year.