

Community Medical Centers, Inc.

Independent Auditor's Reports and Financial Statements

June 30, 2014 and 2013

Community Medical Centers, Inc.
June 30, 2014 and 2013

Contents

Independent Auditor’s Report.....	1	
 Financial Statements		
Balance Sheets.....	3	
Statements of Operations.....	4	
Statements of Changes in Net Assets	5	
Statements of Cash Flows	6	
Notes to Financial Statements	7	
 Supplementary Information		
Schedule of Expenditures of Federal Awards	21	
 Independent Auditor’s Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with <i>Government Auditing Standards</i>		23
 Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance – Independent Auditor’s Report.....		25
 Schedule of Findings and Questioned Costs.....		28
 Summary Schedule of Prior Audit Findings.....		35

Independent Auditor's Report

Board of Directors
Community Medical Centers, Inc.
Stockton, California

Report on the Financial Statements

We have audited the accompanying financial statements of Community Medical Centers, Inc. (the "Organization"), which comprise the balance sheets as of June 30, 2014 and 2013, and the related statements of operations, changes in net assets and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes 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.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America 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 from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements 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 entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Community Medical Centers, Inc. as of June 30, 2014 and 2013, and the results of its operations, the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying schedule of expenditures of federal awards required by U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, as listed in the table of contents, 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 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 financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated July 7, 2015, on our consideration of the Organization'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* in considering Community Medical Centers, Inc.'s internal control over financial reporting and compliance.

BKD, LLP

Springfield, Missouri
July 7, 2015

Community Medical Centers, Inc.

Balance Sheets

June 30, 2014 and 2013

Assets

	<u>2014</u>	<u>2013</u>
Current Assets		
Cash and cash equivalents	\$ 3,813,887	\$ 4,247,508
Short-term investments	700,000	2,938,000
Assets limited as to use - current	130,193	143,118
Patient accounts receivable, net of allowance; 2014 - \$2,678,384, 2013 - \$2,207,824	2,074,463	2,970,869
Grants and other receivables	3,558,559	1,102,363
Estimated amounts due from third-party payers - current	582,000	1,578,000
Prepaid expenses and other	329,248	510,898
	<u>11,188,350</u>	<u>13,490,756</u>
Assets Limited As To Use	2,655,766	2,486,513
Less amount required to meet current obligations	130,193	143,118
	<u>2,525,573</u>	<u>2,343,395</u>
Estimated Amounts Due From Third-Party Payers	1,150,000	2,408,000
Less current portion	582,000	1,578,000
	<u>568,000</u>	<u>830,000</u>
Property and Equipment, At Cost		
Land and land improvements	591,598	242,272
Buildings and leasehold improvements	4,877,772	4,522,980
Equipment	2,748,972	2,235,114
Construction in progress	380,741	-
	<u>8,599,083</u>	<u>7,000,366</u>
Less accumulated depreciation	3,511,640	2,931,721
	<u>5,087,443</u>	<u>4,068,645</u>
Other Assets		
Deferred financing costs	119,468	115,413
	<u>119,468</u>	<u>115,413</u>
Total assets	<u>\$ 19,488,834</u>	<u>\$ 20,848,209</u>

Liabilities and Net Assets

	<u>2014</u>	<u>2013</u>
Current Liabilities		
Current maturities of long-term debt	\$ 175,000	\$ 170,000
Accounts payable	1,864,404	779,468
Accrued expenses	2,524,607	2,389,024
Estimated amounts due to third-party payers	<u>1,622,000</u>	<u>1,175,000</u>
Total current liabilities	6,186,011	4,513,492
Deferred Compensation	2,095,209	1,807,214
Long-Term Debt	<u>1,775,000</u>	<u>1,950,000</u>
Total liabilities	<u>10,056,220</u>	<u>8,270,706</u>
Net Assets		
Unrestricted	9,422,114	12,557,503
Temporarily restricted	<u>10,500</u>	<u>20,000</u>
Total net assets	<u>9,432,614</u>	<u>12,577,503</u>
Total liabilities and net assets	<u>\$ 19,488,834</u>	<u>\$ 20,848,209</u>

Community Medical Centers, Inc.
Statements of Operations
Years Ended June 30, 2014 and 2013

	2014	2013
Unrestricted Revenues, Gains and Other Support		
Net patient service revenue (net of contractual discounts and allowances)	\$ 17,665,847	\$ 25,611,975
Provision for uncollectible accounts	470,560	996,574
Net patient service revenue less provision for uncollectible accounts	17,195,287	24,615,401
Capitation revenue	10,134,801	6,810,005
Grant revenue	8,180,145	7,170,320
Contribution revenue	40,850	198,181
Other	737,861	777,912
Net assets released from restrictions used for operations	20,000	-
Total unrestricted revenues, gains and other support	36,308,944	39,571,819
Expenses and Losses		
Salaries and wages	22,154,150	21,790,396
Employee benefits	3,693,251	4,090,778
Purchased services and professional fees	5,793,736	4,932,538
Supplies and other	6,071,712	5,881,198
Rent	1,088,800	1,116,034
Depreciation and amortization	575,863	621,094
Interest	100,317	106,570
Total expenses and losses	39,477,829	38,538,608
Operating Income (Loss)	(3,168,885)	1,033,211
Other Income		
Investment return	16,496	22,376
Excess (Deficiency) of Revenues Over Expenses	(3,152,389)	1,055,587
Contributions for acquisition of property and equipment	17,000	-
Increase (Decrease) in Unrestricted Net Assets	\$ (3,135,389)	\$ 1,055,587

Community Medical Centers, Inc.
Statements of Changes in Net Assets
Years Ended June 30, 2014 and 2013

	2014	2013
Unrestricted Net Assets		
Excess (deficiency) of revenues over expenses	\$ (3,152,389)	\$ 1,055,587
Contributions for acquisition of property and equipment	17,000	-
Increase (decrease) in unrestricted net assets	(3,135,389)	1,055,587
Temporarily Restricted Net Assets		
Contributions	10,500	20,000
Net assets released from restriction	(20,000)	-
Increase (decrease) in temporarily restricted net assets	(9,500)	20,000
Change in Net Assets	(3,144,889)	1,075,587
Net Assets, Beginning of Year	12,577,503	11,501,916
Net Assets, End of Year	\$ 9,432,614	\$ 12,577,503

Community Medical Centers, Inc.
Statements of Cash Flows
Years Ended June 30, 2014 and 2013

	<u>2014</u>	<u>2013</u>
Operating Activities		
Change in net assets	\$ (3,144,889)	\$ 1,075,587
Items not requiring (providing) operating cash flows		
Depreciation	575,863	621,094
Contributions for acquisition of property and equipment	(17,000)	-
Changes in		
Patient accounts receivable, net	896,406	(492,929)
Grants and other receivable	(2,456,196)	626,709
Estimated amounts due to and from third-party payers	1,705,000	(433,187)
Prepaid expense and other	181,650	125,437
Accounts payable and accrued expenses	1,133,373	(197,181)
Deferred revenue	-	(98,777)
Deferred compensation	287,995	276,945
	<u>(837,798)</u>	<u>1,503,698</u>
Net cash provided by (used in) operating activities		
Investing Activities		
Acquisition of assets limited as to use	(169,253)	(1,473,776)
Proceeds from disposition of assets limited as to use	-	1,099,663
Purchase of investments	(6,985,275)	(9,922,480)
Proceeds from disposition of investments	9,223,275	9,628,223
Purchase of property and equipment	(1,511,570)	(98,321)
	<u>557,177</u>	<u>(766,691)</u>
Net cash provided by (used in) investing activities		
Financing Activities		
Proceeds from contributions for acquisition of property and equipment	17,000	-
Principal payments on long-term debt	(170,000)	(165,000)
	<u>(153,000)</u>	<u>(165,000)</u>
Net cash used in financing activities		
Increase (Decrease) in Cash and Cash Equivalents	(433,621)	572,007
Cash and Cash Equivalents, Beginning of Year	<u>4,247,508</u>	<u>3,675,501</u>
Cash and Cash Equivalents, End of Year	<u>\$ 3,813,887</u>	<u>\$ 4,247,508</u>
Supplemental Cash Flows Information		
Interest paid	\$ 101,991	\$ 108,096
Property and equipment acquisitions in accounts payable	\$ 87,146	\$ -

Community Medical Centers, Inc.
Notes to Financial Statements
June 30, 2014 and 2013

Note 1: Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations

Community Medical Centers, Inc. (the "Organization") is a federally qualified health center which provides health care and education services to patients. The Organization primarily earns revenues by providing physician and related health care services and dental services through clinics located in San Joaquin County, Solano County and Yolo County, California.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

The Organization considers all liquid investments with original maturities of three months or less to be cash equivalents. At June 30, 2014 and 2013, cash equivalents consisted primarily of certificates of deposits. At June 30, 2014, the Organization's cash accounts exceeded federally insured limits by approximately \$2,883,000.

Investments and Investment Return

Investments in equity securities having a readily determinable fair value and in all debt securities are carried at fair value. Other investments are valued at the lower of cost (or fair value at time of donation, if acquired by contribution) or fair value. Investment return includes dividend, interest and other investment income; realized and unrealized gains and losses on investments carried at fair value; and realized gains and losses on other investments.

Assets Limited As To Use

Assets limited as to use include amounts held by trustee under bond indenture, funds held by trustees for unemployment claims and deferred compensation plan assets. Amounts required to meet current liabilities of the Organization are included in current assets.

Patient Accounts Receivable

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Organization analyzes its past history and identifies trends for each of its major payer sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for uncollectible accounts. Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts.

Community Medical Centers, Inc.

Notes to Financial Statements

June 30, 2014 and 2013

For receivables associated with services provided to patients who have third-party coverage, the Organization analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for uncollectible accounts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payer has not yet paid, or for payers who are known to be having financial difficulties that make the realization of amounts due unlikely).

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Organization records a significant provision for uncollectible accounts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated or provided by sliding fee or other policy) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Organization's allowance for doubtful accounts for self-pay patients increased from 81% of self-pay accounts receivable at June 30, 2013, to 97% of self-pay accounts receivable at June 30, 2014. The Organization's write-offs decreased approximately \$3,749,000 from write-offs of approximately \$3,749,000 for the year ending June 30, 2013, to write-offs of \$0 for the year ended June 30, 2014.

Pharmacy Inventory

The Organization states supply inventories at the lower of cost, determined using the first-in, first-out method, or market.

Property and Equipment

Property and equipment acquisitions are recorded at cost and are depreciated on a straight-line basis over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are depreciated over the shorter of the lease term or their respective estimated useful lives.

The useful lives for each major depreciable classification of property and equipment are as follows:

Buildings and leasehold improvements	3 – 40 years
Equipment	3 – 20 years

Certain property and equipment have been purchased with grant funds received from the U.S. Department of Health and Human Services. Such items or a portion thereof may be reclaimed by the federal government if not used to further the grant's objectives.

Donations of property and equipment are reported at fair value as an increase in unrestricted net assets unless use of the assets is restricted by the donor. Monetary gifts that must be used to acquire property and equipment are reported as restricted support. The expiration of such restrictions is reported as an increase in unrestricted net assets when the donated asset is placed in service.

Community Medical Centers, Inc.
Notes to Financial Statements
June 30, 2014 and 2013

Long-Lived Asset Impairment

The Organization evaluates the recoverability of the carrying value of long-lived assets whenever events or circumstances indicate the carrying amount may not be recoverable. If a long-lived asset is tested for recoverability and the undiscounted estimated future cash flows expected to result from the use and eventual disposition of the asset is less than the carrying amount of the asset, the asset cost is adjusted to fair value and an impairment loss is recognized as the amount by which the carrying amount of a long-lived asset exceeds its fair value. No asset impairment was recognized during the years ended June 30, 2014 and 2013.

Deferred Financing Costs

Deferred financing costs represent costs incurred in connection with the issuance of long-term debt. Such costs are being amortized over the term of the respective debt using the straight-line method.

Temporarily Restricted Net Assets

Temporarily restricted net assets are those whose use by the Organization has been limited by donors to a specific time period or purpose.

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. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payers and others for services rendered and includes estimated retroactive revenue adjustments. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered and such estimated amounts are revised in future periods as adjustments become known.

Capitation Revenue

The Organization has agreements with various Medi-Cal Managed Care Organizations (MCOs) to provide medical services to subscribing participants. Under these agreements, the Organization receives monthly capitation payments based on the number of each MCO's participants, regardless of the services actually performed by the Organization. In addition, the MCOs make fee-for-service payments to the Organization for certain covered services based upon discounted fee schedules.

Pharmacy Revenue

Pharmacy revenue is recognized as pharmaceuticals are dispensed. The Organization has a network of participating pharmacies that dispense the pharmaceuticals to its patients under contract arrangement with the Health Center as well as one in-house pharmacy. The Organization participates in the 340B "Drug Discount Program" which enables qualifying health care providers to purchase drugs from pharmaceutical suppliers at a substantial discount. The 340B Drug Pricing

Community Medical Centers, Inc.

Notes to Financial Statements

June 30, 2014 and 2013

Program is managed by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs. The Organization earns revenue under this program by purchasing pharmaceuticals at a reduced cost to fill prescriptions to qualified patients. 340B revenue consists of the pharmacy reimbursements, net of the initial purchase price of the drugs, administrative and filling fees. The net 340B pharmacy revenue from this program was \$3,802,629 and \$2,707,605 for the years ending June 30, 2014 and 2013, respectively, and is included in net patient service revenue on the statement of operations. The net 340B pharmacy revenue from this program is used in furtherance of the Organization's mission.

Government Grants

Support funded by grants is recognized as the Organization performs the contracted services or incurs outlays eligible for reimbursement under the grant agreements. Grant activities and outlays are subject to audit and acceptance by the granting agency and, as a result of such audit, adjustments could be required.

Contributions

Unconditional gifts expected to be collected within one year are reported at their net realizable value. Unconditional gifts expected to be collected in future years are initially reported at fair value determined using the discounted present value of estimated future cash flows technique. The resulting discount is amortized using the level-yield method and is reported as contribution revenue.

Gifts received with donor stipulations are reported as either temporarily or permanently restricted support. When a donor restriction expires, that is, when a time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified and reported as an increase in unrestricted net assets. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions. Conditional contributions are reported as liabilities until the condition is eliminated or the contributed assets are returned to the donor.

Income Taxes

The Organization has been recognized as exempt from income taxes under Section 501 of the Internal Revenue Code and a similar provision of state law. However, the Organization is subject to federal income tax on any unrelated business taxable income.

Electronic Health Records Incentive Program

The Electronic Health Records Incentive Program, enacted as part of the *American Recovery and Reinvestment Act of 2009*, provides for one-time incentive payments under both the Medicare and Medicaid programs to eligible organizations that demonstrate meaningful use of certified electronic health records technology (EHR). Payments under the Medicare program are generally made for up to four years based on a statutory formula. Payments under the Medicaid program are generally made for up to six years based upon a statutory formula, as determined by the state, which is approved by the Centers for Medicare and Medicaid Services. Payment under both programs are

Community Medical Centers, Inc.

Notes to Financial Statements

June 30, 2014 and 2013

contingent on the Organization continuing to meet escalating meaningful use criteria and any other specific requirements that are applicable for the reporting period. The final amount for any payment year is determined based upon an audit by the state, fiscal intermediary or Medicare Administrative Contractor. Events could occur that would cause the final amounts to differ materially from the initial payments under the program.

The Organization recognizes revenue ratably over the reporting period starting at the point when management is reasonably assured it will meet all of the meaningful use objectives and any other specific grant requirements applicable for the reporting period.

The Organization has recorded revenue of approximately \$535,500 and \$510,000 for the years ended June 30, 2014 and 2013, respectively, which is included in grant revenue in the statements of operations.

Excess (Deficiency) of Revenues Over Expenses

The statements of operations include excess (deficiency) of revenues over expenses. Changes in unrestricted net assets which are excluded from excess (deficiency) of revenues over expenses, consistent with industry practice, include contributions and grants of long-lived assets (including assets acquired using contributions or grants which by donor or granting agency restriction are to be used for the purpose of acquiring such assets).

Subsequent Events

Subsequent events have been evaluated through the date of the Independent Auditor's Report, which is the date the financial statements were available to be issued.

Note 2: Grant Revenue

The Organization is the recipient of a Consolidated Health Centers (CHC) grant from the U.S. Department of Health and Human Services. The general purpose of the grant is to provide expanded health care service delivery for residents of Stockton, California, and surrounding areas. Terms of the grant generally provide for funding of the Organization's operations based on an approved budget. Grant revenue is recognized as qualifying expenditures are incurred over the grant period. During the years ended June 30, 2014 and 2013, the Organization recognized \$5,391,662 and \$4,401,591, respectively, in CHC grant revenue. Funding for the grant budget periods ending November 30, 2014 and December 31, 2015, is approved at \$6,958,079 and \$6,788,098, respectively.

In addition to these grants, the Organization receives additional financial support from other federal, state and private sources. Generally, such support requires compliance with terms and conditions specified in grant agreements and must be renewed on an annual basis.

Community Medical Centers, Inc.

Notes to Financial Statements

June 30, 2014 and 2013

Note 3: Net Patient Service Revenue

The Organization recognizes patient service revenue associated with services provided to patients who have third-party payer coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for the sliding fee program, the Organization recognizes revenue on the basis of its standard rates for services provided. On the basis of historical experience, a significant portion of the Organization's uninsured patients who do not qualify for the sliding fee program will be unable or unwilling to pay for the services provided. Thus, the Organization records a significant provision for uncollectible accounts related to uninsured patients who do not qualify for the sliding fee program in the period the services are provided. This provision for uncollectible accounts is presented on the statement of operations as a component of net patient service revenue.

The Organization is approved as a Federally Qualified Health Center (FQHC) for both Medicare and Medi-Cal reimbursement purposes. The Organization has agreements with third-party payers that provide for payments to the Organization at amounts different from its established rates. These payment arrangements include:

Medicare. Covered FQHC services rendered to Medicare program beneficiaries are paid based on a cost reimbursement methodology. The Organization is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of an annual cost report by the Organization and audit thereof by the Medicare fiscal intermediary. Services not covered under the FQHC benefit are paid based on established fee schedules.

Medi-Cal. Covered FQHC services rendered to Medi-Cal program beneficiaries are paid based on a prospective reimbursement methodology. The Organization is reimbursed a prospectively determined encounter rate for covered services provided.

The Organization is required to submit an annual Medi-Cal Reconciliation Request Form to the California Department of Health Care Services (the "Department") for purposes of determining whether it was paid appropriately for certain Medi-Cal visits. These annual reconciliations result in the determination of any underpayment or overpayment by the Medi-Cal program for the affected visits. The Organization has recorded estimated settlements for the Medi-Cal Reconciliation Request Forms for the years ended June 30, 2008 through 2014. Such amounts are recorded on the balance sheet as estimated amounts due to and from third-party payers. Following submission of the Medi-Cal Reconciliation Request Form, the Organization will generally receive a tentative settlement from the Medi-Cal program with a final settlement made within three years of the date of submission. Due to the timing of the interim and final settlement process, the Organization has allocated a portion of the estimated receivable as a noncurrent asset.

Laws and regulations governing the Medicare and Medi-Cal programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

Community Medical Centers, Inc.
Notes to Financial Statements
June 30, 2014 and 2013

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 and discounts from established charges.

Patient service revenue, net of contractual allowances and discounts (but before the provision for uncollectible accounts), recognized in the years ended June 30, 2014 and 2013, was:

	2014	2013
Medicare	\$ 1,777,184	\$ 2,371,669
Medi-Cal	13,017,963	17,915,577
Other third-party payers	982,221	1,936,265
Self-pay	1,888,479	3,388,464
	<u>17,665,847</u>	<u>35,611,975</u>
Total	<u>\$ 17,665,847</u>	<u>\$ 25,611,975</u>

Note 4: Concentrations of Credit Risk

The Organization grants credit without collateral to its patients, most of whom are area residents and are insured under third-party payer agreements. The mix of net receivables from patients and third-party payers at June 30, 2014 and 2013, was:

	2014	2013
Medicare	5%	6%
Medicaid	79%	70%
Patients and other third-party payers	5%	7%
Self-pay	11%	17%
	<u>100%</u>	<u>100%</u>

Community Medical Centers, Inc.
Notes to Financial Statements
June 30, 2014 and 2013

Note 5: Investments and Investment Return

Assets Limited As To Use

Assets limited to use at June 30, include:

	2014	2013
457b deferred plan assets		
Pooled investments	\$ 2,095,209	\$ 1,807,214
Held by trustee		
Money market funds	448,366	448,794
Self-insured unemployment reserve funds		
Cash	112,191	230,505
	\$ 2,655,766	\$ 2,486,513

Short-Term Investments

Short-term investments at June 30, include:

	2014	2013
Certificate of deposit	\$ 700,000	\$ 2,938,000

Investment return of \$16,496 and \$22,376 for the years ended June 30, 2014 and 2013, respectively, is comprised of interest income and is reflected in the statements of operations as other nonoperating income.

Community Medical Centers, Inc.
Notes to Financial Statements
June 30, 2014 and 2013

Note 6: Long-Term Debt

At June 30, 2014 and 2013, the Organization's long-term debt consisted of:

	2014	2013
Bond payable, bank (A)	\$ 1,950,000	\$ 2,120,000
Less current maturities	175,000	170,000
	\$ 1,775,000	\$ 1,950,000

(A) The Revenue Bonds (Series 2005A) consist of Insured Revenue Bonds in the original amount of \$3,220,000 dated April 1, 2005, which bear interest at 3.5% to 5.0%. The Bonds are payable in annual installments from April 1, 2006, to April 1, 2021, and fluctuate between approximately \$270,000 and \$546,000. The Organization is required to make monthly deposits to the reserve fund of approximately \$23,000. The bonds are secured by the net revenues and accounts receivable of the Organization and the assets restricted under the bond indenture agreement.

The proceeds of the bonds were used to finance capital improvements and to redeem the 1994 Series B bonds. The bond is subject to redemption at the option of the Organization, in whole or in part, at a price equal to 100% of the current outstanding principal amount of the bond.

The indenture agreement requires that certain funds be established with the trustee. Accordingly, these funds are included as assets limited as to use held by trustee in the financial statements. The indenture agreement also requires the Organization to comply with certain restrictive covenants including minimum insurance coverage, restrictions on incurrence of additional debt, submitting audited financial statements within 120 days after the end of each fiscal year, and maintaining a Net Income Available for Debt Service ratio of at least 1.20 times the Maximum Aggregate Annual Debt Service. The Organization was not in compliance with the Net Income Available for Debt Service ratio as well as the requirement to submit audited financial statements within 120 days after year end. Management has reported the noncompliance to the bank and the bank has decided to take no action against the Organization based solely on the default status of the covenant for the year ended June 30, 2014.

Aggregate annual maturities of long-term debt at June 30, 2014, are as follows:

2015	\$ 175,000
2016	185,000
2017	195,000
2018	200,000
2019	215,000
Thereafter	980,000
	\$ 1,950,000

Community Medical Centers, Inc.

Notes to Financial Statements

June 30, 2014 and 2013

Note 7: Medical Malpractice Claims

The U.S. Department of Health and Human Services has deemed the Organization and its practicing physicians covered under the Federal Tort Claims Act (FTCA) for damage and personal injury, including death resulting from the performance of medical, surgical, dental and related functions. FTCA coverage is comparable to an occurrence policy without a monetary cap. The Organization purchases excess umbrella liability coverage, which provides additional coverage above the FTCA coverage up to the amount specified in the umbrella policy.

Claim liabilities are to be determined without consideration of insurance recoveries. Expected recoveries are presented separately. Based upon the Organization's claims experience, no such accrual has been made for medical malpractice costs for the years ended June 30, 2014 and 2013. However, because of the risk of providing health care services, it is possible that an event has occurred which will be the basis of a future material claim.

Note 8: Temporarily Restricted Net Assets

Temporarily restricted net assets are available for the following purposes or periods:

	<u>2014</u>	<u>2013</u>
Health care services	\$ 10,500	\$ 3,333
Chronic disease management	-	16,667
	<u>\$ 10,500</u>	<u>\$ 20,000</u>

Note 9: Functional Expenses

The Organization provides health care services to residents within its service area. Expenses related to providing these services, including depreciation expense, are as follows:

	<u>2014</u>	<u>2013</u>
Health care services	\$ 32,459,840	\$ 32,392,825
General and administrative	7,017,989	6,145,783
	<u>\$ 39,477,829</u>	<u>\$ 38,538,608</u>

Community Medical Centers, Inc.
Notes to Financial Statements
June 30, 2014 and 2013

Note 10: Operating Leases

Noncancellable operating leases for primary care outpatient offices expire in various years through 2020. These leases generally contain renewal options for periods ranging from 5 to 10 years and require the Organization to pay all executory costs (property taxes, maintenance and insurance).

Future minimum lease payments at June 30, 2014, were:

2015	\$ 1,033,854
2016	1,011,078
2017	785,553
2018	698,532
2019	511,785
Thereafter	<u>411,477</u>
Future minimum lease payments	<u><u>\$ 4,452,279</u></u>

Note 11: Retirement Plan

The Organization has a 403(b) defined contribution plan covering substantially all employees. For each eligible participant, the Organization contributes a matching contribution equal to 25% of employee contributions that do not exceed 6% of compensation; however, any employer contributions are discretionary in nature and are subject to reduction or termination. The Organization also has a 457(b) retirement plan that covers select highly compensated employers. Retirement plan expense for the year ended June 30, 2014 and 2013, was \$214,287 and \$221,321, respectively.

Note 12: Disclosures About Fair Value of Assets and Liabilities

Fair value is 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. Fair value measurements must maximize the use of observable inputs and minimize the use of unobservable inputs. There is a hierarchy of three levels of inputs that may be used to measure fair value:

- Level 1** Quoted prices in active markets for identical assets or liabilities
- Level 2** Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities
- Level 3** Unobservable inputs supported by little or no market activity and are significant to the fair value of the assets or liabilities

Community Medical Centers, Inc.
Notes to Financial Statements
June 30, 2014 and 2013

Recurring Measurements

The following table presents the fair value measurements of assets recognized in the accompanying balance sheets measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall at June 30, 2014 and 2013:

	Fair Value	Fair Value Measurements Using		
		Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
June 30, 2014				
Money market funds	\$ 448,366	\$ 448,366	\$ -	\$ -
Pooled investments	\$ 2,095,209	-	2,095,209	-
June 30, 2013				
Money market funds	\$ 448,794	\$ 448,794	\$ -	\$ -
Pooled investments	\$ 1,807,214	-	1,807,214	-

Following is a description of the valuation methodologies and inputs used for assets and liabilities measured at fair value on a recurring basis and recognized in the accompanying balance sheets, as well as the general classification of such assets pursuant to the valuation hierarchy. There have been no significant changes in the valuation techniques during the year ended June 30, 2014.

Cash Equivalents and Investments

Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using quoted prices of securities with similar characteristics or independent asset pricing services and pricing models, the inputs of which are market-based or independently sourced market parameters, including, but not limited to, yield curves, interest rates, volatilities, prepayments, defaults, cumulative loss projections and cash flows. Such securities are classified in Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

The value of certain investments, classified as alternative investments, is determined using net asset value (or its equivalent) as a practical expedient. Investments for which the Organization expects to have the ability to redeem its investments with the investee within 12 months after the reporting date are categorized as Level 2. Investments for which the Organization does not expect to be able to redeem its investments with the investee within 12 months after the reporting date are categorized as Level 3.

Community Medical Centers, Inc.

Notes to Financial Statements

June 30, 2014 and 2013

Note 13: Construction in Progress

In November 2013, the Organization was awarded a federal grant from the U.S. Department of Health and Human Services for 5 years at \$650,000 per year to open a New Access Point (NAP) clinic in Stockton, California. In April 2014, the Organization purchased a property and construction commenced shortly thereafter. In November 2014, a portion of the facility was opened to operate as an interim annex clinic. The construction on the entire facility was completed in March 2015, at a total cost of approximately \$4,700,000 which was funded by internal resources. The NAP site includes 6 dental operatories and 12 exam rooms, plus 3 additional exam rooms in an adjoining annex, which can be used for a range of special services. The NAP site is estimated to generate additional revenues and costs of approximately \$3,000,000 through its first twelve months of operation serving an estimated 8,000 patients. As of June 30, 2014, project costs and equipment totaling approximately \$380,000 had been incurred and are included in construction in progress on the balance sheet.

Note 14: Significant Estimates and Concentrations

Accounting principles generally accepted in the United States of America require disclosure of certain significant estimates and current vulnerability due to certain concentrations. Those matters include the following:

Grant Revenues

Concentration of revenues related to grant awards and other support are described in *Note 2*.

Allowance for Net Patient Service Revenue Adjustments

Estimates of allowances for adjustments included in net patient service revenue are described in *Notes 1* and *3*.

Medical Malpractice Claims

Estimates related to the accrual for professional liability claims are described in *Note 7*.

Litigation

In the normal course of business, the Organization is, from time to time, subject to allegations that may or do result in litigation. Some of these allegations are in areas not covered by commercial insurance; for example, allegations regarding employment practices, performance of contracts or medical malpractice claims not covered under FTCA (*Note 7*). The Organization evaluates such allegations by conducting investigations to determine the validity of each potential claim. Management records an estimate of the amount of ultimate expected loss, if any, for these matters. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

Community Medical Centers, Inc.
Notes to Financial Statements
June 30, 2014 and 2013

Investments

The Organization invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such change could materially affect the amounts reported in the accompanying consolidated balance sheets.

340B Drug Pricing Program

The Organization participates in the 340B Drug Pricing Program (340B Program) enabling the Organization to receive discounted prices from drug manufacturers on outpatient pharmaceutical purchases. This program is overseen by the Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs (OPA). HRSA is currently conducting routine audits of these programs at health care organizations and increasing its compliance monitoring processes. Laws and regulations governing the 340B Program are complex and subject to interpretation and change. As a result, it is reasonably possible that material changes to financial statement amounts related to the 340B Program could occur in the near term.

Current Economic Conditions

The current economic environment presents community health centers with difficult circumstances and challenges. As employers make adjustments to health insurance plans or more patients become unemployed, certain patients may find it difficult to pay for services rendered. The continuing implementation of the Affordable Care Act, including the health insurance exchanges and the decision by the state regarding Medicaid expansion, will directly impact community health centers' net revenues. Further, the effect of economic conditions on federal and state budgets could adversely impact the grant revenues available to community health centers and the programs they administer. Each of these factors could have an adverse impact on the Organization's future operating results.

Supplementary Information

Community Medical Centers, Inc.
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2014

Cluster/Program	Federal Agency/ Pass-Through Entity	CFDA Number	Grant or Identifying Number	Amount Expended
Consolidated Health Centers	U.S. Department of Health and Human Services	93.224	6H80CS00138-13-18	\$ 2,066,744
Affordable Care Act (ACA) Grants for New and Expanded Services under the Health Center Program	U.S. Department of Health and Human Services	93.527	6H80CS00138-13-18	3,324,918
Total Health Centers Cluster				<u>5,391,662</u>
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	U.S. Department of Health and Human Services	93.918	6H76HA00191-18-03	361,066
Special Supplemental Nutrition Program for Women, Infants and Children	Department of Agriculture Food and Nutrition Service / State of California	10.557	11-10445	1,360,422
Scholarships for Health Professions Students from Disadvantaged Background	Department of Health and Human Services Office of the Secretary / State of California / Central Valley Health Network	93.925		54,765
State Administrative Matching Grants for the Supplemental Nutrition Assistance Program	Department of Agriculture Food and Nutrition Service / Central Valley Health Network	10.561	10-10037	30,141
HIV Care Formula Grants	U.S. Department of Health and Human Services / County of Solano	93.917	00189-14	<u>49,950</u>
				<u><u>\$ 7,248,006</u></u>

Community Medical Centers, Inc.
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2014

Notes to Schedule

1. This schedule includes the federal awards activity of Community Medical Centers, Inc. 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.
2. Community Medical Centers, Inc. did not provide a federal award to a subrecipient during the year ended June 30, 2014.

Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

Board of Directors
Community Medical Centers, Inc.
Stockton, California

We have audited, 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, the financial statements of Community Medical Centers, Inc. (the "Organization"), which comprise the balance sheet as of June 30, 2014, and the related statements of operations, changes in net assets and cash flows for the year then ended and the related notes to the basic financial statements, and have issued our report thereon dated July 7, 2015.

Internal Control Over Financial Reporting

Management of the Organization is responsible for establishing and maintaining effective internal control over financial reporting (internal control). In planning and performing our audit, we considered the Organization's internal control to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses and, therefore, there can be no assurance that all material weaknesses have been identified. However, as discussed in the accompanying schedule of findings and questioned costs, we identified certain deficiencies in internal control that we consider to be material weaknesses.

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 significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. 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 Organization's financial statements will not be prevented or detected and corrected on a timely basis. We consider the deficiencies described in the accompanying schedule of findings and questioned costs as items 2014-001 and 2014-002 to be material weaknesses.

Board of Directors
Community Medical Centers, Inc.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Organization's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, 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*.

Community Medical Centers, Inc.'s Response to Findings

The Organization's responses to the findings identified in our audit are described in the accompanying schedule of findings and questioned costs. Community Medical Centers, Inc.'s responses were not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on them.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Organization's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

BKD, LLP

Springfield, Missouri
July 7, 2015

Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance

Independent Auditor's Report

Board of Directors
Community Medical Centers, Inc.
Stockton, California

Report on Compliance for Each Major Federal Program

We have audited the compliance of Community Medical Centers, Inc. (the "Organization") with the types of compliance requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on its major federal program for the year ended June 30, 2014. The Organization's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with the requirements of laws, regulations, contracts and grants applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for Community Medical Centers, Inc.'s major federal program based on our audit of the types of compliance requirements referred to above.

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 Non-Profit 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 occurred. An audit includes examining, on a test basis, evidence about the Organization'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 on compliance for the major federal program. However, our audit does not provide a legal determination on the Organization's compliance.

Board of Directors
Community Medical Centers, Inc.

Basis for Qualified Opinion on the Major Federal Program

As described in item 2014-003 in the accompanying schedule of findings and questioned costs, Community Medical Centers, Inc. did not comply with requirements regarding reporting for its Health Centers Cluster program. Compliance with such requirements is necessary, in our opinion, for Community Medical Centers, Inc. to comply with requirements applicable to that program.

Qualified Opinion on the Major Federal Program

In our opinion, except for the noncompliance described in the Basis for Qualified Opinion paragraph, Community Medical Centers, Inc. complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on the Health Centers Cluster program for the year ended June 30, 2014.

Other Matters

The Organization's response to the finding identified in our audit is described in the accompanying schedule of findings and questioned costs. The Organization's response was not subjected to the auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

Report on Internal Control Over Compliance

Management of Community Medical Centers, Inc. is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Organization's internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing our opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, 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 the Organization'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. A significant deficiency in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Board of Directors
Community Medical Centers, Inc.

Our consideration of internal control over compliance 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 compliance that might be material weaknesses and therefore, material weaknesses may exist that were not identified. We consider the deficiency in internal control over compliance described in the accompanying schedule of findings and questioned costs as item 2014-003 to be a material weakness.

The Organization's response to the finding identified in our audit is described in the accompanying schedule of findings and questioned costs. The Organization's response was not subjected to the auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

BKD, LLP

Springfield, Missouri
July 7, 2015

Community Medical Centers, Inc.
Schedule of Findings and Questioned Costs
Year Ended June 30, 2014

Summary of Auditor's Results

1. The opinion expressed in the independent auditor's report was:
 Unmodified Qualified Adverse Disclaimer

2. The independent auditor's report on internal control over financial reporting disclosed:
 Significant deficiency(ies)? Yes None reported
 Material weakness(es)? Yes No

3. Noncompliance considered material to the financial statements was disclosed by the audit? Yes No

4. The independent auditor's report on internal control over compliance for major federal awards programs disclosed:
 Significant deficiency(ies)? Yes None reported
 Material weakness(es)? Yes No

5. The opinion expressed in the independent auditor's report on compliance for major federal awards was:
 Unmodified Qualified Adverse Disclaimer

6. The audit disclosed findings required to be reported by OMB Circular A-133? Yes No

7. The Organization's major program was:

Cluster/Program	CFDA Number
Health Centers Cluster	93.224 and 93.527

Community Medical Centers, Inc.
Schedule of Findings and Questioned Costs
Year Ended June 30, 2014

8. The threshold used to distinguish between Type A and Type B programs as those terms are defined in OMB Circular A-133 was \$300,000.

9. The Organization qualified as a low-risk auditee as that term is defined in OMB Circular A-133?

Yes

No

Community Medical Centers, Inc.
Schedule of Findings and Questioned Costs
Year Ended June 30, 2014

Findings Required to be Reported by *Government Auditing Standards*

Reference Number	Finding	Questioned Costs
2014-001	<p>Criteria or Specific Requirement – Management is responsible for establishing and maintaining effective internal control over financial reporting.</p> <p>Condition – The Organization’s financial statements required adjustments to be in conformity with accounting principles generally accepted in the United States of America. Areas in which adjustments were proposed, including those which management recorded, include:</p> <ul style="list-style-type: none"> • Grants and other receivables • Prepaid expenses and other • Construction in progress • Accounts payable and accrued expenses • Temporarily restricted net assets • Grant revenue • Contribution revenue • Salaries and wages • Employee benefits • Purchased services and professional fees • Interest expense <p>Context – The Organization’s financial statements should be presented in conformity with accounting principles generally accepted in the United States of America (GAAP). Timely and thorough review of balance sheet accounts, including estimates, is necessary to identify necessary adjustments.</p> <p>Effect – Adjusting journal entries were proposed during the financial statement audit.</p> <p>Cause – The Organization did not identify certain necessary adjustments required to present the financial statements in accordance with GAAP due to the following:</p> <ul style="list-style-type: none"> • There were not necessary accounting policies and procedures in place • All month-end account reconciliations were not prepared and/or reviewed • All journal entries were not reviewed 	None

Community Medical Centers, Inc.
Schedule of Findings and Questioned Costs
Year Ended June 30, 2014

Reference Number	Finding	Questioned Costs
2014-001 (Continued)	<p>Recommendation – Management should modify month-end closing procedures to ensure controls in place are sufficient to assure financial statements are prepared in accordance with accounting principles generally accepted in the United States of America.</p> <p>View of Responsible Officials and Planned Corrective Actions – The financial data for a portion of Fiscal Year 2014 was recorded, compiled and presented by a contracted third-party firm. Many former staff members and department managers were terminated from service when the contractor commenced operations in FY 13. The contractor also changed accounting systems and operating practices during their service period; some of the changes were not consistent with best-practice methods of attaining a high level of internal control or conformity with generally accepted accounting standards.</p> <p>When the contractor relationship was terminated, all key accounting and reporting functions become the direct responsibility of in-house staff, but senior financial management was not seated until mid-way through the year. The in-house staff was re-trained, and many procedural changes were instituted to help assure a return to proper accounting methodologies. The reconstruction of prior period financial data was an on-going process to the time of the fiscal audit. Policies and practices have been added or amended to reflect high professional expectations.</p>	

Community Medical Centers, Inc.
Schedule of Findings and Questioned Costs
Year Ended June 30, 2014

Findings Required to be Reported by Government Auditing Standards

Reference Number	Finding	Questioned Costs
2014-002	<p>Criteria or Specific Requirement – The objectives of internal controls are to provide reasonable rather than absolute assurance that assets are safeguarded and financial statements are reliable. Segregation of incompatible duties is often an effective way of strengthening internal control.</p> <p>Condition – Certain individuals perform or have the ability to perform duties in the cash receipts, cash disbursements and payroll cycles that are incompatible from a control perspective.</p> <p>Context – Generally access, monitoring and recording responsibilities should be assigned to different individuals. In instances where these duties are not segregated, potential internal control weaknesses exist.</p> <p>Effect – Potentially material misstatements in the financial statements or material misappropriations of assets due to error or fraud could occur and not be prevented or detected in a timely manner.</p> <p>Cause – Duties are not adequately segregated and monitoring or other compensating controls are insufficient.</p> <p>Recommendation – Management should periodically review the costs versus benefits of further segregating duties or consider the addition of monitoring or other compensating controls and implement those changes it deems appropriate for which benefits are determined to exceed costs.</p> <p>Views of Responsible Officials and Planned Corrective Actions – In the wake of a departing contracted accounting service firm, some employees were performing multiple tasks to provide back-up in the event of absences, or because of staff shortages in key positions. A new management group undertook an inventory of duty assignments by desk, and of user functions and permission profiles within applications. Where potentially serious control vulnerabilities appeared on duty grids, changes in task assignments were made, or new staff was hired in order to provide a broader base for task and responsibility delegation. Management makes on-going assessments of the relative risks and benefits of multiple task assignments.</p>	None

Community Medical Centers, Inc.
Schedule of Findings and Questioned Costs
Year Ended June 30, 2014

Findings Required to be Reported by OMB Circular A-133

Reference Number	Finding	Questioned Costs
2014-003	Health Centers Cluster CFDA Nos. 93.224 and 93.527 U.S. Department of Health and Human Services Award No. 6 H80CS 00138-13-18 Program Year 2014	None

Criteria or Specific Requirement – Reporting

Condition – The Organization is required to prepare certain reports as a recipient of the Consolidated Health Centers grant funds. These reports are to be prepared using accurate financial information and filed by specific due dates.

Context – During the year ended June 30, 2014, the Organization was required to prepare and submit a total of six reports for the Consolidated Health Centers grant. A sample of three reports submitted during the fiscal year was selected for testing. Of these reports, errors were noted on one of the reports selected for testing and two of the reports were not submitted timely.

Effect – Certain information presented on the 2013 annual Uniform Data System (UDS) report was not consistent with the information recorded on the general ledger and practice management system. In addition, the annual Federal Financial Report for the year ending June 30, 2014, and the UDS report were not filed timely.

Cause – The processes in place for the Organization to reconcile the information on the general ledger and practice management system to information included on the grant reports and to ensure that the reports were filed timely were not sufficient.

Recommendation – Policies and procedures over federal grant reporting should be modified to ensure reports are prepared using accurate information and that the due dates for reports are properly identified so that the reports can be filed timely.

Community Medical Centers, Inc.
Schedule of Findings and Questioned Costs
Year Ended June 30, 2014

Findings Required to be Reported by OMB Circular A-133

Reference Number	Finding	Questioned Costs
2014-003 (Continued)	Views of Responsible Officials and Planned Corrective Actions – This finding addresses the failure to file timely and accurate reports, specifically referencing the annual Inform Data System (UDS) report. The fact that there were inconsistencies in data as between years and programs was quickly evident to new managers. While the data capture event could not be recreated, employees were organized into work groups for the purpose of becoming trained on how to correctly capture, compile and verify data for the reports, and were given the responsibility of drafting reports for management review well in advance of filing deadlines.	

Community Medical Centers, Inc.
Summary Schedule of Prior Audit Findings
Year Ended June 30, 2014

Reference Number	Summary of Finding	Status
2013-003	<p>Health Centers Cluster CFDA Nos. 93.224 and 93.527</p> <p>U.S. Department of Health and Human Services Award No. 6 H80CS 00138-12-11 Program Year 2013</p> <p>Criteria or Specific Requirement – Eligibility</p> <p>Condition – Patients were given inappropriate sliding fee adjustments or were given a sliding fee adjustment without having proper supporting income documentation in accordance with the Organization’s policy.</p> <p>Context – Out of an undetermined number of patients who received sliding fee adjustments, a sample of 40 patients was tested. Proper documentation was not maintained for six patients out of the 40 to support the need for the sliding fee adjustment in accordance with the Organization’s sliding fee scale.</p> <p>Effect – Improper sliding fee adjustments were given.</p> <p>Cause – The Organization’s sliding fee policy was not in line with program requirements. Organization personnel were not appropriately following the sliding fee policy.</p>	No longer valid

Community Medical Centers, Inc.
Summary Schedule of Prior Audit Findings
Year Ended June 30, 2014

Reference Number	Summary of Finding	Status
2013-004	<p>Health Centers Cluster CFDA Nos. 93.224 and 93.527</p> <p>U.S. Department of Health and Human Services Award No. 6 H80CS 00138-12-11 Program Year 2013</p> <p>Criteria or Specific Requirement – Reporting</p> <p>Condition – The Organization is required to prepare certain reports as a recipient of the Consolidated Health Centers grant funds. These reports are to be prepared using accurate financial information and filed by specific due dates.</p> <p>Context – During the year ended June 30, 2013, the Organization was required to prepare and submit a total of six reports for the Consolidated Health Centers grant. A sample of three reports submitted during the fiscal year was selected for testing. Of these reports, errors were noted on two of the reports selected for testing and two of the reports were not submitted timely.</p> <p>Effect – Certain information presented on the 2012 annual Uniform Data System (UDS) report was not consistent with the information recorded on the general ledger and practice management system. In addition, the annual Federal Financial Report for the year ending June 30, 2013, and the UDS report were not filed timely.</p> <p>Cause – The processes in place for the Organization to reconcile the information on the general ledger and practice management system to information included on the grant reports and to ensure that the reports were filed timely were not sufficient.</p>	Unresolved. See Finding 2014-003

Community Medical Centers, Inc.
Summary Schedule of Prior Audit Findings
Year Ended June 30, 2014

Reference Number	Summary of Finding	Status
2013-005	<p>Health Centers Cluster CFDA Nos. 93.224 and 93.527</p> <p>U.S. Department of Health and Human Services Award No. 6 H80CS 00138-12-11 Program Year 2013</p> <p>Criteria or Specific Requirement – Special Test and Provisions</p> <p>Condition – The Organization is required to establish policies and procedures to ensure they are in accordance with governance provisions of the Consolidated Health Centers grant.</p> <p>Context – The Organization’s bylaws do not contain sufficient detail regarding Board authority to ensure the governing Board maintains appropriate authority to oversee the operations of the Organization.</p> <p>Effect – The Organization was not operating in accordance with certain governance provisions of the Consolidated Health Centers grant.</p> <p>Cause – The processes in place for the Organization to ensure they were in compliance with the governance requirements were not sufficient.</p>	Resolved

Community Medical Centers, Inc.
Summary Schedule of Prior Audit Findings
Year Ended June 30, 2014

Reference Number	Summary of Finding	Status
2012-01	<p>Health Centers Cluster CFDA No. 93.224</p> <p>U.S. Department of Health and Human Services Award No. 6 H80CS 00138-11-05 Program Year 2012 Eligibility</p> <p>Criteria or Specific Requirement – Grant compliance provisions require that the Center correctly identify a patient’s ability to pay and that the rates for services be adjusted accordingly based on the sliding fee schedule. The Center is required to follow its sliding fee policy when providing discounts to eligible patients.</p> <p>Condition/Context – Ten cases from the sample of twenty tested, were found to be deficient for either not being able to verify the family size, or the sliding fee assigned in the computer was incorrect, or the monthly income was not supported by actual income backup information, or the computer system did not adjust the sliding fee.</p> <p>Effect – Lack of strict enforcement of the regulation of sliding fee eligibility determination and compliance resulted in Community Medical Centers, Inc. providing discounted services to beneficiaries greater than the appropriate amounts or not at all when a patient qualified.</p> <p>Cause – Policy and procedures are well documented and currently maintained with current poverty guidelines; however, turnover of staff and a new computer system that was not set up to automate the process has led to inaccurate calculations and missed documentation. Staff has experienced a significant amount of change with two different patient registration systems in the last couple years. Training on new system and quality improvement not yet developed to ensure compliance and staff training.</p>	No longer valid

Community Medical Centers, Inc.
Summary Schedule of Prior Audit Findings
Year Ended June 30, 2014

Reference Number	Summary of Finding	Status
2012-02	<p>Health Centers Cluster Grants to Provide Outpatient Early Intervention Services with Respect to HIV Health Care and Other Facilities CFDA Nos.: 93.224, 93.918 and 93.887</p> <p>U.S. Department of Health and Human Services Program Year: 2012 Reporting</p> <p>Criteria or Specific Requirement – Grant compliance provisions require that the Center complete certain reports within a given timeframe. Based on review of the Center's Electronic Hand Book (EHB) system and other correspondence with the granting agency, the Center did not submit numerous required reports when they were due.</p> <p>Condition/Context – Required reporting terms and conditions were not being monitored and reports were not filed on time. These reporting requirements were part of the grant's terms and conditions.</p> <p>Effect – Not complying with the terms and conditions of the grants.</p> <p>Cause – Lack of accountability and no master calendar of due dates being maintained.</p>	Partially resolved. See Finding 2014-003

Community Medical Centers, Inc.
Summary Schedule of Prior Audit Findings
Year Ended June 30, 2014

Reference Number	Summary of Finding	Status
2012-03	<p>Health Centers Cluster CFDA No. 93.224</p> <p>U.S. Department of Health and Human Services Award No. 6 H80CS 00138-11-05 Program Year 2012 Eligibility</p> <p>Criteria or Specific Requirement – In general, the objective of the Consolidated Health Centers Program (CHCP) is to provide to populations that would ordinarily not have access to health care (1) primary and preventive health services, (2) referrals to other services, such as hospital and substance abuse services, and (3) case management and other services designed to assist health center patients in establishing eligibility and gaining access to Federal, State and local programs that provide additional medical, social or educational support or enabling services, such as transportation, translation and outreach services and patient education services. Some health center delivery sites serve vulnerable populations, including homeless individuals, migrant farm workers; however, the center must see these patients at any of their sites.</p> <p>Condition/Context – Currently, the Center has developed a specific site for their homeless patients called Carelinks. Homeless patients that do not go to their Carelinks site specifically are not identified as homeless, and accordingly, the Center is not giving themselves credit for the total number of homeless patients they have seen. The Center is identifying the patients as self-pay and adjusting the charges as bad debt instead of using appropriate sliding fee. The sliding fee policy does not reflect the language of the Carelink’s application; for example, the form has a box marked as “other” that is to be marked if the patient has been homeless in the last 12 months. The policy does not list “other” as a qualification for the Carelinks.</p> <p>Effect – Incorrect determination of appropriate discounts resulted in Community Medical Centers, Inc. under recording the homeless population the Center is serving, not being consistent with the sliding fee policy administration for homeless patients seen at all sites and policies not matching the forms.</p> <p>Cause – Lack of staff understanding and training of the Carelinks (homeless) program by staff not part of the Carelinks location. Policies and forms not being updated.</p>	No longer valid.



Federally Qualified Health Centers Servicing San Joaquin, Yolo, and Solano Counties

**ANNUAL FISCAL AUDIT, YEAR ENDING JUNE 30, 2014
VIEWS OF RESPONSIBLE OFFICERS
AND PLANS OF CORRECTIVE ACTIONS**

FINDINGS REQUIRED TO BE REPORTED BY GOVERNMENT AUDIT STANDARDS

Finding 2014-001:

Views of Responsible Officials and Planned Corrective Actions:

The financial data for a portion of Fiscal Year 2014 was recorded, compiled and presented by a contracted third party firm. Many former staff members and department managers were terminated from service when the contractor commenced operations in FY 13. The contractor also changed accounting systems and operating practices during their service period; some of the changes were not consistent with best-practice methods of attaining a high level of internal control or conformity with generally accepted accounting standards.

When the contractor relationship was terminated, all key accounting and reporting functions become the direct responsibility of in-house staff, but senior financial management was not seated until mid-way through the year. The in-house staff was re-trained, and many procedural changes were instituted to help assure a return to proper accounting methodologies. The reconstruction of prior period financial data was an on-going process to the time of the fiscal audit. Policies and practices have been added or amended to reflect high professional expectations.

Finding 2014-002:

Views of Responsible Officials and Planned Corrective Actions:

In the wake of a departing contracted accounting service firm, some employees were performing multiple tasks to provide back-up in the event of absences, or because of staff shortages in key positions. A new management group undertook an inventory of duty assignments by desk, and of user functions and permission profiles within applications. Where potentially serious control vulnerabilities appeared on duty grids, changes in task assignments were made, or new staff was hired in order to provide a broader base for task and responsibility delegation. Management makes on-going assessments of the relative risks and benefits of multiple task assignments.

FINDINGS REQUIRED TO BE REPORTED BY OMB CIRCULAR A-133

Finding 2014-003:

Views of Responsible Officials and Planned Corrective Actions:

This finding addresses the failure to file timely and accurate reports, specifically referencing the annual Inform Data System (UDS) report. The fact that there were inconsistencies in data as between years and programs was quickly evident to new managers. While the data capture event could not be recreated, employees were organized into work groups for the purpose of becoming trained on how to correctly capture, compile and verify data for the reports, and were given the responsibility of drafting reports for management review well in advance of filing deadlines.



Art Feagles

Chief Financial Officer

afeagles@cmcenters.org