COUNTRY DOCTOR COMMUNITY HEALTH CENTERS

FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2012 AND 2011

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
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CliftonLarsonAllen LLP
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INDEPENDENT AUDITORS' REPORT

Board of Directors
Country Doctor Community Health Centers
Seattle, Washington

Report on the Financial Statements

We have audited the accompanying financial statements of Country Doctor Community Health Centers (a nonprofit organization) which comprise the statements of financial position as of December 31, 2012 and 2011, and the related statements of activities and 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.

Auditors' Responsibility

Our responsibility is to express opinions 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 auditors' 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 opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Country Doctor Community Health Centers as of December 31, 2012 and 2011, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The schedule of functional expenses is presented for purposes of additional analysis and is not a required part of the financial statements. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by OMB Circular A-133 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 schedule of expenditures of federal awards 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 June 19, 2013, on our consideration of Country Doctor Community Health Centers' internal control over financial reporting and on 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 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 Country Doctor Community Health Centers' internal control over financial reporting and compliance.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Bellevue, Washington
June 19, 2013

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
STATEMENTS OF FINANCIAL POSITION
DECEMBER 31, 2012 AND 2011

ASSETS	2012	2011
CURRENT ASSETS		
Cash	$ 284,735	$ 308,879
Patient Receivables, Net	591,395	749,314
Grants Receivable	597,017	734,297
Other Receivables	331,723	28,765
Prepaid Expenses	459,628	440,321
Total Current Assets	2,264,498	2,261,576
PROPERTY AND EQUIPMENT, NET	4,167,307	2,992,864
OTHER ASSETS		
Board Designated Investments	50,000	50,000
Assets Restricted by Donors for Endowments	83,055	83,055
Investments	1,349,057	1,624,914
PTSO Prepaid Costs, Net	9,493	19,849
	1,491,605	1,777,818
Total Assets	$ 7,923,410	$ 7,032,258

See accompanying Notes to Financial Statements.

LIABILITIES AND NET ASSETS	2012	2011
CURRENT LIABILITIES		
Accounts Payable	$ 376,664	$ 121,532
Accrued Wages and Related Payables	829,313	756,977
FQHC Enhancement Settlement	287,133	287,133
Current Portion of Long-Term Debt	69,844	27,605
Current Portion of Obligations Under Capital Leases	10,460	8,138
Total Current Liabilities	1,573,414	1,201,385
LONG-TERM LIABILITIES		
Long-Term Debt, Less Current Portion	2,686,542	1,670,248
Obligations Under Capital Lease, Less Current Portion	5,490	13,516
Other Liabilities	-	13,102
Total Long Term Liabilities	2,692,032	1,696,866
Total Liabilities	4,265,446	2,898,251
COMMITMENTS AND CONTINGENCIES		
NET ASSETS		
Unrestricted:		
Undesignated	2,175,852	2,376,038
Designated by the Board of Directors	1,399,057	1,674,914
Total Unrestricted	3,574,909	4,050,952
Permanently Restricted Net Assets	83,055	83,055
Total Net Assets	3,657,964	4,134,007
Total Liabilities and Net Assets	$ 7,923,410	$ 7,032,258

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
STATEMENTS OF ACTIVITIES AND CHANGES IN NET ASSETS
YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012	2011
REVENUE AND SUPPORT		
Public Sponsored Insurance and Entitlements	$ 1,832,909	$ 2,315,342
Private Insurance	1,143,982	866,409
Capitation Revenues	1,548,845	1,290,200
Patient Paid Fees	1,465,605	859,261
Net Patient Service Revenue	5,991,341	5,331,212
In-Kind Contributions	344,882	375,714
Fees and Grants from Government Agencies	4,196,962	4,023,415
Contributions and Private Grants	396,279	456,053
Interest, Dividends, and Investment Income	37,684	16,364
Other Revenue	150,744	337,249
Total Revenue and Support	11,117,892	10,540,007
EXPENSES		
Program Services	10,210,101	9,746,638
Supporting Services	1,574,891	1,538,385
Total Expenses	11,784,992	11,285,023
OTHER REVENUE		
Realized and Unrealized (Loss) Gain on Investments, Net	(9,388)	9,771
Risk Pool Revenue	141,982	383,760
Rental Income	58,463	41,008
Total Other Revenue	191,057	434,539
DEFICIT OF REVENUE AND SUPPORT OVER EXPENSES	(476,043)	(310,477)
Net Assets - Beginning of the Year	4,134,007	4,444,484
NET ASSETS - END OF THE YEAR	$ 3,657,964	$ 4,134,007

See accompanying Notes to Financial Statements.

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
STATEMENTS OF CASH FLOWS
YEARS ENDED DECEMBER 31, 2012 AND 2011

	2012	2011
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in Net Assets	$ (476,043)	$ (310,477)
Adjustments to Reconcile Change in Net Assets		
to Net Cash Provided (Used) by Operating Activities:		
Depreciation and Amortization	381,428	375,913
PTSO Amortized Costs	31,177	81,087
Realized and Unrealized Loss (Gain) on Investments, Net	9,388	(9,771)
Bad Debt Expense	582,298	209,798
Changes in Assets and Liabilities:		
Grants Receivable	137,280	(22,230)
Patient Receivables	(424,379)	(519,271)
Other Receivables	(302,958)	30,386
Prepaid Expenses	(19,307)	(174,389)
Accounts Payable	255,132	(163,490)
Accrued Expenses	72,336	82,967
Other Liabilities	(13,102)	13,102
Net Cash Provided (Used) by Operating Activities	233,250	(406,375)
CASH FLOWS FROM INVESTING ACTIVITIES		
Proceeds from Sale of Investments	2,623,053	1,447,734
Purchases of Investments	(2,356,584)	(1,203,218)
Payments for PTSO Costs	(20,821)	(23,996)
Purchases of Property and Equipment	(459,771)	(107,535)
Net Cash (Used) Provided by Investing Activities	(214,123)	112,985
CASH FLOWS FROM FINANCING ACTIVITIES		
Principal Repayments of Long-Term Debt	(37,567)	(26,437)
Principal Payments on Obligations Under Capital Leases	(5,704)	(6,361)
Net Cash Used by Financing Activities	(43,271)	(32,798)
DECREASE IN CASH AND CASH EQUIVALENTS	(24,144)	(326,188)
Cash - Beginning of Year	308,879	635,067
CASH - END OF YEAR	$ 284,735	$ 308,879
SUPPLEMENTAL CASH FLOW INFORMATION		
Cash Payments for Interest	$ 76,483	$ 78,339
NONCASH INVESTING AND FINANCING ACTIVITIES		
Acquisition of Capital Assets through the Issuance of Debt	$ 1,096,100	$ -

See accompanying Notes to Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Organization

Country Doctor Community Health Centers (CDCHC) is a nonprofit organization providing comprehensive primary medical care through the operation of health centers in Seattle, Washington. The mission of CDCHC is to improve the health of the community by providing high quality, caring, culturally appropriate primary health care that addresses the needs of the people regardless of their ability to pay. CDCHC historically served primarily the people of the Central Area and Capitol Hill neighborhoods. Patients now come from throughout Seattle, King County, and beyond. Of CDCHC's patient population, the majority of the patients seen are entirely uninsured.

Basis of Presentation

The financial statements are presented in accordance with generally accepted accounting and reporting standards for nonprofit organizations.

Under these standards, 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 CDCHC 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 CDCHC are included in this classification.

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

Permanently Restricted – Net assets subject to donor-imposed restrictions that stipulate the resources be maintained permanently, but permit CDCHC to use or expend part or all of the income derived from the donated assets for either specified or unspecified purposes.

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 net 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.

Deficit of Revenues and Support Over Expenses

The statement of activities includes excess (deficit) of support and revenues 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, restricted contributions 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).

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Expense Allocation

The costs of providing various programs and other activities have been summarized on a functional basis (see schedule of functional expenses). Accordingly, certain costs have been allocated among the program and supporting services benefited, based on rationale specific and attributable to each program (e.g., FTE, square footage, etc.).

Fair Value of Financial Instruments

The carrying amounts of financial instruments, including cash, cash equivalents, accounts receivable, accounts payable, and accrued liabilities, approximate fair value due to the short maturity of these instruments.

Investments

Investments in debt, equity, or other securities that do not meet the criteria for cash and cash equivalents are accounted for as investments. Investments with readily determinable fair values are stated at fair market values in the accompanying financial statements. Investment income, including realized and unrealized gains and losses, is included in the statements of activities and changes in nets assets.

Credit Risk

Financial instruments that potentially subject CDCHC to concentration of credit risk consist principally of cash, short-term investments, and receivables. CDCHC places its cash and investments only in high quality financial institutions. At December 31, 2012 and 2011, CDCHC had cash deposits and investments in excess of the federally insured limit.

Patient Receivables

Patient receivables are stated at the amount management expects to collect from outstanding balances. Management provides for probable uncollectible amounts based on its assessment of the current status of individual accounts. Balances that are still outstanding after management has used reasonable collection efforts are written off.

Over 42 percent and 57 percent of CDCHC's revenues for 2012 and 2011, respectively, were generated from government sponsored health programs. The health programs are dependent upon continued funding from these government agencies and the legislative acts that impact the programs. The fee-for-service and capitated revenues from these programs are subject to periodic audit and review by the governmental agencies.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Patient Receivables (Continued)

CDCHC also grants credit without collateral to its patients, most of whom are local residents who are uninsured. The mix of receivables from patients and third-party payers at December 31 was as follows:

	2012	2011
Medicaid	9%	8%
Medicare	9%	20%
Other Third-Party Payers	7%	15%
Patients	75%	57%
	100%	100%

Assets Restricted for Endowment

At December 31, 2012, assets that were restricted by donors for endowments consisted of investments. See Note 14.

Property and Equipment

Property and equipment are recorded at cost or, if donated, at the fair market value at the date of donation. Repairs and maintenance are charged to expense as incurred. Leasehold improvements are amortized over the shorter of the useful life or lease term. Depreciation is provided using the straight-line method over the following estimated lives:

Building and Improvements	10-40 Years
Furniture and Equipment	3-10 Years

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

Patient Service Revenue

Patient service revenue is recognized at the date of service based on estimated net realizable amounts from patients and third-party payers for services rendered, or is recognized based on a specified dollar amount per month for patients enrolled in a managed care plan.

CDCHC receives reimbursements from several sources including Medicaid, Medicare, and private insurance. Payments include reimbursed costs and fees for services charged at discounted rates. Revenues from third-party payer agreements are subject to audit and retroactive adjustments. Retroactive adjustments are recorded at the time that such amounts can first be reasonably determined, which is normally upon notification by the paying entity.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Charity Care

CDCHC has a policy of providing care to patients who meet certain criteria under its policy, at amounts less than its established rates or without charge. However, all patients are requested to pay a minimum fee for each visit although no patient is denied services because of an inability to pay. Since management does not expect payment for this care, the services that are discounted from the established rates are excluded from revenue. During the years ended December 31, 2012 and 2011, the direct and indirect costs incurred to provide charity care was approximately $2,669,000 and $2,379,000, respectively.

CDCHC has estimated its direct and indirect costs of providing charity care under its policy. In order to estimate the cost of providing such care, management calculated a cost to revenue ratio by comparing the total costs incurred to the gross revenue received as reported on the financial statements. The ratio is applied to the charity care charges foregone to calculate the estimated direct and indirect cost of providing charity care. Using this methodology, CDCHC has estimated the costs foregone for services furnished under CDCHC's policy aggregated approximately $1,957,000 and $1,808,000 for the years ended December 31, 2012 and 2011, respectively.

CDCHC received a grant through Health Resources Service Administration to provide care to individuals, regardless of their ability to pay. The grant revenue which is used to cover costs of CDCHC totaled approximately $1,569,000 and $1,552,000 for the years ended December 31, 2012 and 2011, respectively.

Grant Revenue

CDCHC 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. CDCHC 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 grants receivable.

Contributions

Contributions, which include unconditional promises to give (pledges), are recognized as revenue in the period received. These contributions are given to support the overall mission and are not specifically set aside or earned through operations.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

In-Kind Contributions

CDCHC receives contributed services, supplies, and debt forgiveness from various sources. Certain professional services, supplies, and mortgage interest formally documented and charged to the relevant project are recorded in the accompanying financial statements. These contributions are recorded at market values or the usual customary charge. Summarized below are totals for the years ended December 31.

	2012	2011
Contributed Pharmaceuticals	$ 262,995	$ 234,295
Contributed Mortgage Interest	60,460	60,460
Contributed Goods and Services	21,427	80,959
Total In-Kind Contributions	$ 344,882	$ 375,714

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in 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 reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Federal Income Tax

CDCHC has received a determination letter from the IRS that states it is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. No provision for income taxes is shown in the financial statements because CDCHC is a nonprofit organization, exempt from income taxes. Management evaluated CDCHC's tax positions and concluded that CDCHC 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.* CDCHC is no longer subject to U.S. federal income tax examinations by tax authorities for the years before 2009.

Electronic Health Record Incentive Payments

As discussed in Note 11, CDCHC received funds under the Electronic Health Records (EHR) Incentive Program during 2012 and 2011. CDCHC recognized revenue for payments received during those periods. Going forward, CDCHC will recognize revenue when management is reasonably assured that they will meet all meaningful use objectives and any other specific grant requirements that are applicable, e.g., electronic transmission of quality measures to Centers for Medicare and Medicaid Services (CMS) in the second and subsequent payment years.

Reclassifications

Certain items in the 2011 financial statements have been reclassified for comparability purposes with the 2012 financial statements. The reclassifications had no change on the overall net assets of CDCHC.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Subsequent Events

Subsequent events have been evaluated through June 19, 2013, which is the date the financial statements were available to be issued.

NOTE 2 NET PATIENT SERVICE REVENUE

CDCHC has agreements with third-party payers that provide for payments at amounts different from its established charges. A summary of the payment arrangements with major third-party payers follows:

Medicare Fee for Service

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, CDCHC is paid 80 percent of the established FQHC rate, with the beneficiary being responsible for the remaining 20 percent as co-insurance or, alternatively, the remaining 20 percent is billed to Medicaid for qualifying patients (dual eligible). CDCHC is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by CDCHC and audits thereof by the CMS Medicare fiscal intermediary. Historically, these settlement amounts have not been material.

Medicare Advantage

Private insurance companies administer Medicare Advantage (MA) programs. Payment rates for outpatient services provided to MA enrollees are based on contractual agreements with each MA administrator. FQHC health centers qualify for supplemental wrap-around payment, which is the difference between FQHC approved per-visit rate and the average MA per-visit rate. Wrap-around rate determination and payment is handled by the CMS Medicare fiscal intermediary.

Medicaid

Outpatient services rendered to Medicaid program beneficiaries were reimbursed under a prospective payment system (PPS) cost reimbursement methodology that was established in 2001 based on audited Medicaid cost reports for years 1999 and 2000. The base rate that was established in 2001 includes enhancement and has since increased every calendar year by the Medicare Inflationary Index. During 2009, the State of Washington provided an option for FQHC centers to rebase their cost or accept an Alternative Payment Methodology (APM) which has a higher payment rate than PPS. CDCHC accepted the APM reimbursement. The Medicaid APM rate is paid for each FQHC encounter regardless of the level or amount of services provided to the beneficiary.

NOTE 2 NET PATIENT SERVICE REVENUE (CONTINUED)

Healthy Options

The Medicaid managed-care program administered by private insurance companies is known as Healthy Options. Outpatient services provided to Healthy Options (HO) enrollees are either paid based on a capitated rate or fee-for-service, depending on the contract. FQHC clinics qualify for supplemental enhancement payment; see Note 15 for a description of enhancement payment and settlement.

Revenues from third-party payer agreements are subject to audit and retroactive adjustments. Retroactive adjustments are recorded at the time that such amounts can first be reasonably determined, which is normally upon notification by the paying entity.

CDCHC receives reimbursements from several sources, including Medicaid, Medicare, and private insurance. Payments include reimbursed costs and fees for service charges at discounted rates.

A significant percentage of patient service revenue was for services provided to Medicaid and Medicare participants. Medicaid revenue represented approximately 61 percent and 34 percent of patient medical and pharmacy fees for the years ended December 31, 2012 and 2011, respectively. Medicare revenue represented approximately 13 percent and 14 percent of patient medical and pharmacy fees for the years ended December 31, 2012 and 2011, respectively.

NOTE 3 PROPERTY AND EQUIPMENT

The cost and accumulated depreciation of property and equipment were as follows:

	2012	2011
Land	$ 184,000	$ 184,000
Buildings and Improvements	6,780,574	5,377,881
Leasehold Improvements	182,047	182,047
Furniture and Equipment	2,048,213	1,898,693
Total Depreciable Assets	9,194,834	7,642,621
Less: Accumulated Depreciation	(5,027,527)	(4,649,757)
Total Property and Equipment, Net	$ 4,167,307	$ 2,992,864

During 2012, CDCHC purchased property in Seattle, Washington that was previously leased by CDCHC. The space is utilized to provide patient care and for administrative offices. The increase of approximately $1,375,000 is included in buildings and improvements.

NOTE 4 INVESTMENTS

CDCHC invests funds with TIAA-CREF. These investments pay interest and dividends at variable rates and are subject to market fluctuations. The investment of these funds is controlled by the investment policies of CDCHC as approved by the board of directors.

In accordance with *Accounting Standards Codification Topic 820, Fair Value Measurements and Disclosures* (Topic 820), fair value is defined as the price that CDCHC 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 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 use 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. CDCHC 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. CDCHC has no Level 3 assets or liabilities.

The following is a summary of assets stated at fair value as of December 31, 2012:

	Level 1	Level 2	Level 3	Total
Interest Bearing Cash	$ 95,080	$ -	$ -	$ 95,080
Government Bonds	550,549	-	-	550,549
Fixed Income Mutual Funds	836,483	-	-	836,483
Total	$ 1,482,112	$ -	$ -	$ 1,482,112

NOTE 4 INVESTMENTS (CONTINUED)

The following is a summary of assets stated at fair value as of December 31, 2011:

	Level 1	Level 2	Level 3	Total
Interest Bearing Cash	$ 91,367	$ -	$ -	$ 91,367
Government Bonds	1,666,602	-	-	1,666,602
Total	$ 1,757,969	$ -	$ -	$ 1,757,969

Investment income consisted of the following for the years ended December 31:

	2012	2011
Interest and Dividends	$ 37,684	$ 16,364
Realized Loss	-	(2,154)
Unrealized (Loss) Gain	(9,388)	11,925
Total Investment Income	$ 28,296	$ 26,135

NOTE 5 CENTRAL AREA HEALTH CENTER

The Central Area Health Center is owned by a condominium association whose equal members are CDCHC and Seattle Children's Hospital. Seattle Children's Hospital submitted the land with an existing structure to the condominium for use and ownership. CDCHC acted as the administrative and fiscal agent on the project and obtained the financing to improve and expand the existing structure renamed the Central Area Health Center. Seattle Children's Hospital deeded one half the value of the improved building to CDCHC at the completion of the project. CDCHC's portion of the building has a recorded cost of $2,485,000. CDCHC is solely obligated on all debt related to the building, which was recorded on CDCHC's books, in full, as of December 31, 2012 and 2011. See Note 6.

NOTE 6 LONG-TERM DEBT

Long-term debt consisted of the following at December 31:

	2012	2011
Mortgage note payable to a regional banking institution in the amount of $761,100. Principal and interest payable in monthly installments of $5,171; remaining upaid principal and accrued interest due 2017; the note bears interest at 5.35% per annum; note is secured by properties in Seattle.	$ 754,168	$ -
Note payable in the amount of $335,000. Principal and interest payable monthly based on a 15-year amortization schedule; $2,711 the first year, and increased by 2% each year thereafter; the note bears interest at 5.35% per annum. Note is secured by properties in Seattle.	331,019	-
Mortgage note payable to a regional banking institution, due 2016, payable $6,475 per month, including interest; the note bears interest at 5.4% per annum; note is secured by a Deed of Trust on Country Doctor Community Clinic and the Central Area Health Center and assignment of rents and leases, and contains certain financial covenants.	915,450	942,104
Non-interest bearing note payable to the City of Seattle; note will be forgiven upon maturity in 2013 if no event occurs accelerating the maturity date; the note plus contingent interest may be payable if, before 20 years have passed, the property is sold or ceases to be used as a community clinic intended to serve primarily low to moderate income persons; note is secured by a Deed of Trust on the Country Doctor Community Clinic and assignment of rents and leases.	755,749	755,749
Total Long-Term Debt	2,756,386	1,697,853
Less: Current Portion	(69,844)	(27,605)
Long-Term Debt, Less Current Portion	$ 2,686,542	$ 1,670,248

NOTE 6 LONG-TERM DEBT (CONTINUED)

Scheduled principal repayments of long-term debt are as follows:

Year Ending December 31,	Amount
2013	$ 69,844
2014	71,261
2015	75,869
2016	866,688
2017	679,740
Thereafter	992,984
Total	$ 2,756,386

The debt agreement relating to the Central Area Health Center contains various covenants. At December 31, 2012, CDCHC did not meet the required debt service coverage ratio and was in breach of the agreement. The bank has waived that requirement of the agreement as of December 31, 2012.

The City of Seattle requires interest at less than market rates. Interest expense on the note has been recorded at a market rate of 8 percent and an offsetting amount has been recorded as an in-kind contribution and in-kind expense. Contributed interest amounts for December 31, 2012 and 2011, totaled $60,460 for each year.

NOTE 7 LEASED FACILITIES AND EQUIPMENT

CDCHC leased additional space under a noncancelable lease agreement during December 31, 2012 and 2011. The agreement ended with the purchase of the administrative building.

Rent expense for operating leases totaled $54,184 and $104,434 for the years ended December 31, 2012 and 2011, respectively.

CDCHC leases certain equipment under noncancelable capital leases. At December 31, 2012 and 2011, the equipment had a recorded cost of $36,054, and related accumulated depreciation at December 31, 2012 and 2011, of $21,051 and $18,023, respectively. Total monthly payments of $1,063 include copier maintenance, supplies, and interest of 33 percent per annum.

NOTE 7 LEASED FACILITIES AND EQUIPMENT (CONTINUED)

Scheduled capital lease obligations are as follows:

Equipment lease disclosure:

Year Ending December 31,	Amount
2013	$ 10,460
2014	11,195
Total	21,655
Less: Amount Representing Interest	(5,705)
Total Obligation	15,950
Amount Classified as Current	10,460
Total Obligation, Net	$ 5,490

NOTE 8 MALPRACTICE INSURANCE

CDCHC 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. CDCHC has purchased malpractice insurance for activities not covered under the FTCA and is covered on a claims-made basis.

CDCHC is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Country Doctor Community Health Centers' future financial position or results of operations.

NOTE 9 MANAGED CARE AND SPECIALTY POOLS

CDCHC is a member of the Community Health Network of Washington (CHNW), a managed care network formed by 21 community and migrant health centers throughout the state of Washington to participate in the managed care marketplace. CHNW is a nonprofit 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 CHNW be unable to meet its financial obligations. CHNW believes that its assets are sufficient to meet its financial obligation.

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

NOTE 9 MANAGED CARE AND SPECIALTY POOLS (CONTINUED)

As a member of CHP, CDCHC has agreed to serve as a provider of primary care services for a certain dollar amount per member, per month, and to provide case management services to these same members related to specialty and hospital services. In return, CDCHC will participate in any savings realized by CHP in providing these services, based upon a formula determined by the board of directors of CHP. The plan year for determining these savings follows the calendar year. This income is accrued as it becomes known by CDCHC, generally at or near the time cash is received. The estimate is based on the preliminary settlement statement prepared by CHP for the most recently completed plan year. CDCHC receives distributions of these savings over a 15 to 18 month period following the end of a plan year. Included in other revenue on the statements of activities and changes in net assets are $174,520 and $383,760 of hospital and specialty pool revenues for the years ended December 31, 2012 and 2011, respectively.

NOTE 10 PRACTICE TECHNOLOGY SERVICES ORGANIZATION

CDCHC is a participant in the Practice Technology Services Organization (PTSO), along with other community health centers in the state of Washington. The PTSO was formed in 2004 in order to realize such benefits as group discount purchasing, shared database management and support, grant opportunities, and standardized processes and data. In order to participate in the PTSO, CDCHC invested a level of funding of costs for equipment, membership fees, software license costs, start-up and operating costs, and service fees. CDCHC will receive a future benefit from the use of the shared database management system. Accordingly, the amounts have been capitalized and will be amortized over the useful lives of the hardware and software license. For the years ended December 31, 2012 and 2011, $31,177 and $81,807 of PTSO costs were amortized, respectively.

NOTE 11 ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM

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 CDCHC continuing to meet the escalating meaningful use criteria. For the first payment year, CDCHC must attest, subject to an audit, that it met the meaningful use criteria for a continuous 90-day period. For the subsequent payment year, CDCHC must demonstrate meaningful use for the entire year. The incentive payments are generally made over a four-year period.

CDCHC received incentive payments of approximately $85,000 and $191,250 for the years ended December 31, 2012 and 2011, respectively, which are included in other revenue.

NOTE 12 RETIREMENT PLAN

CDCHC has a 401(k) defined contribution retirement plan (the Plan) available to all eligible employees. CDCHC makes contributions to the Plan for participants in accordance with requirements specified in the Plan documents. During the years ended December 31, 2012 and 2011, CDCHC's contributions to the Plan were $264,098 and $260,231, respectively.

NOTE 13 NET ASSETS DESIGNATED BY THE BOARD OF DIRECTORS

The board of directors has designated net assets to be used for the following purposes at December 31:

	2012	2011
Operating Reserves	$ 1,349,057	$ 1,624,914
Managed Care Loss Reserve	50,000	50,000
	$ 1,399,057	$ 1,674,914

NOTE 14 PERMANENTLY RESTRICTED NET ASSETS

At December 31, 2012 and 2011, CDCHC had $83,055 of permanently restricted net assets, the income from which can be used to fund operations.

NOTE 15 MEDICAID FUNDING

A CMS audit of the State of Washington Department of Social and Health Services (the State) 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 is currently being negotiated, with the results to be finalized for July 1, 2009, and the changes retroactive to January 1, 2009. As part of the resolution, new rates for calculating managed care enhancements were provided to the State 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 the State claiming a settlement due from CDCHC, the potential liability ranges from zero up to $381,000. CDCHC is among multiple other federally qualified health centers in Washington who have contested the legality of the settlement and has proceeded with legal action, asserting the State cannot retroactively adjust a contract rate.

NOTE 15 MEDICAID FUNDING (CONTINUED)

As a result of the state of Washington's supplemental budget for the period January-June, 2011, and the state's biennial budget for the period July 1, 2011 through June 30, 2012, the Health Care Authority implemented two separate changes to the Medicaid payment rates for CDCHC and other FQHC's in calendar year 2011. CDCHC was informed that these rate changes would be in effect during specified periods of time in 2011. However, the state did not adjust its payment schedules and continued to pay CDCHC at the higher 2011 rate that was in effect at the beginning of the year. CDCHC has recorded an accrual of approximately $287,000 for 2012 and 2011. This is management's best estimate of the total liability that will be due back to the state once the reconciliations are completed and the litigation is settled. The amount reported at December 31, 2010 was based on the facts known at that time. During 2012, management evaluated the amount of the liability accrued and determined that the amount was sufficient to cover the probable amount for the 2009 settlement and subsequent amounts. Any change to the estimate will be adjusted in future periods as the facts become known.

NOTE 16 COMMITMENTS AND CONTINGENCIES

Grants

CDCHC has received 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 by the grantor may become a liability of CDCHC.

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
SCHEDULE OF FUNCTIONAL EXPENSES
YEAR ENDED DECEMBER 31, 2012
(WITH SUMMARIZED INFORMATION FOR YEAR ENDED DECEMBER 31, 2011)
(SEE INDEPENDENT AUDITORS' REPORT)

	Program Services				Supporting Services				
	Medical Services	Dental Services	Other Programs	Total Program Services	Management and General	Fundraising	Total Supporting Services	2012 Total	2011 Total
Salaries and Wages	$ 5,241,188	$ -	$ 726,854	$ 5,968,042	$ 531,934	$ 83,031	$ 614,965	$ 6,583,007	$ 6,478,976
Payroll Taxes and Fringe Benefits	1,285,619	-	176,781	1,462,400	245,849	21,273	267,122	1,729,522	1,654,160
Total Personnel	6,526,807	-	903,635	7,430,442	777,783	104,304	882,087	8,312,529	8,133,136
Professional Fees	165,106	-	85,247	250,353	176,340	-	176,340	426,693	423,189
Lab Fees	4,008	-	-	4,008	-	-	-	4,008	10,898
Purchased Services	80,081	-	341	80,422	4,681	26	4,707	85,129	75,436
PTSO Purchased Services	263,881	-	20,291	284,172	5,797	-	5,797	289,969	241,815
Contracted Services	50,044	-	24,666	74,710	-	-	-	74,710	106,646
Pharmaceuticals	204,242	-	433	204,675	-	-	-	204,675	196,463
In-Kind Pharmaceuticals	262,995	-	-	262,995	-	-	-	262,995	234,295
Other Health Care Supplies	148,801	-	16	148,817	39	-	39	148,856	123,396
Office Supplies, Postage, Delivery	46,069	251	6,055	52,375	26,706	4,823	31,529	83,904	98,235
Telephone	61,039	-	13,627	74,666	11,823	876	12,699	87,365	85,697
Occupancy	161,949	31,317	40,010	233,276	113,554	7,746	121,300	354,576	390,817
In-Kind Mortgage Interest	-	-	-	-	60,460	-	60,460	60,460	60,460
Insurance	5,691	2,069	414	8,174	80,959	-	80,959	89,133	76,040
Equipment Rental and Maintenance	19,554	341	13,388	33,283	11,277	2,222	13,499	46,782	53,551
Printing and Publications	14,680	-	571	15,251	3,833	10,190	14,023	29,274	51,819
Conference, Travel and Training	23,820	-	3,404	27,224	9,985	327	10,312	37,536	173,577
Miscellaneous	49,236	-	3,628	52,864	90,340	1,875	92,215	145,079	38,359
Fundraising	-	-	-	-	-	44,697	44,697	44,697	44,396
Bad Debt	582,298	-	-	582,298	-	-	-	582,298	209,798
Total Expenses Before Depreciation and Amortization	8,670,301	33,978	1,115,726	9,820,005	1,373,577	177,086	1,550,663	11,370,668	10,828,023
Depreciation and Amortization	338,640	26,542	24,914	390,096	24,146	82	24,228	414,324	457,000
Total Expenses	$ 9,008,941	$ 60,520	$ 1,140,640	$ 10,210,101	$ 1,397,723	$ 177,168	$ 1,574,891	$ 11,784,992	$ 11,285,023

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INDEPENDENT AUDITORS' 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
Country Doctor Community Health Centers
Seattle, Washington

We have audited, in accordance with the 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 Country Doctor Community Health Centers, which comprise the statement of financial position as of December 31, 2012, and the related statements of activities and changes in net assets and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated June 19, 2013.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Country Doctor Community Health Centers' internal control over financial reporting (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 Country Doctor Community Health Centers' internal control. Accordingly, we do not express an opinion on the effectiveness of Country Doctor Community Health Centers' internal control.

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. 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.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Country Doctor Community Health Centers' financial statements are free from 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*.

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 result 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 entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Bellevue, Washington
June 19, 2013

CliftonLarsonAllen LLP
www.cliftonlarsonallen.com

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
Country Doctor Community Health Centers
Seattle, Washington

Report on Compliance for Each Major Federal Program

We have audited Country Doctor Community Health Centers' compliance with the types of compliance requirements described in the *OMB Circular A-133 Compliance Supplement* that could have a direct and material effect on each of Country Doctor Community Health Centers' major federal programs for the year ended December 31, 2012. Country Doctor Community Health Centers' major federal programs are identified in the summary of auditors' 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.

Auditors' Responsibility

Our responsibility is to express an opinion on compliance for each of Country Doctor Community Health Centers' major federal programs 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 Country Doctor Community Health Centers' 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 each major federal program. However, our audit does not provide a legal determination of Country Doctor Community Health Centers' compliance.

Opinion on Each Major Federal Program

In our opinion, Country Doctor Community Health Centers complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended December 31, 2012.

Report on Internal Control Over Compliance

Management of Country Doctor Community Health Centers 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 Country Doctor Community Health Centers' internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each 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 Country Doctor Community Health Centers' 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.

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 or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

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 result of that testing based on the requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Bellevue, Washington
June 19, 2013

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
YEAR ENDED DECEMBER 31, 2012

Pass-Through Grantor/ Program Title	Federal CFDA Number	Pass-Through Number	Federal Expenditures
Department of Health and Human Services:			
Health Centers Cluster:			
Community Health Centers Section 330	93.224		$ 996,921
Pass-Through Program From			
Public Health Seattle and King County:			
Healthcare for the Homeless	93.224	D40927D	81,000
Total for CFDA 93.224			1,077,921
Affordable Care Act (ACA) Grants for New and			
Expanded Services under the Health Center Program	93.527		572,315
Total for Health Centers Cluster			1,650,236
Grants to Provide Outpatient Early Intervention			
Services in Respect to HIV Disease	93.918		514,628
Pass-Through Program From			
Public Health Seattle and King County:			
Medicaid Adminstrative Match Program	93.778	D40769D	75,000
HIV Emergency Relief Project			
Grants - City of Seattle	93.914	D40040D/D40973D	208,082
ACA Centers for Disease Control and Prevention			
Investigations and Technical Assistance -			
Breast, Cervical, and Colon Health Program	93.283	D40791D	26,940
Total Department of Health and Human Services			2,474,886
Department of Agriculture:			
Pass-Through Program From			
Public Health - Seattle & King County:			
Special Supplemental Nutrition Program for			
Women, Infants and Children	10.557	D40938A	44,679
Department of Housing and Urban Development:			
Pass-Through Program From City of Seattle			
Department of Housing and Human Services:			
Community Development Block Grant (Loan)	14.218	ASA #3987/94	755,749
Total Expenditures of Federal Awards			$ 3,275,314

Note - This schedule includes the federal grant activity of CDCHC and is presented on the accrual basis of accounting. The information 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

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COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
SCHEDULE OF AUDIT FINDINGS AND QUESTIONED COSTS
YEAR ENDED DECEMBER 31, 2012

Section I – 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	Health Centers Cluster
93.527	Affordable Care Act (ACA) Grants for New and Expanded Services under the Health Center Program
14.218	Community Development Block Grant

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

None.

Section III – Federal Award Findings

None

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
CORRECTIVE ACTION PLAN
YEAR ENDED DECEMBER 31, 2012

CORRECTIVE ACTION PLAN

The current year schedule of audit findings and questioned costs reported no matters in Section II – Financial Statement Findings, nor in Section III – Federal Award Findings. Therefore, no corrective action plan is necessary nor has one been prepared.

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
YEAR ENDED DECEMBER 31, 2012

There were no prior audit findings.