OZARK TRI-COUNTY HEALTH CARE CONSORTIUM D/B/A
ACCESS FAMILY CARE

FINANCIAL STATEMENTS
AND
INDEPENDENT AUDITORS' REPORT
YEARS ENDED APRIL 30, 2017 AND 2016

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Independent Auditors' Report

Board of Directors
Ozark Tri-County Health Care Consortium
d/b/a Access Family Care
Neosho, Missouri

We have audited the accompanying financial statements of Ozark Tri-County Health Care Consortium d/b/a Access Family Care (a not-for-profit organization) (the "Organization"), which comprise the balance sheets as of April 30, 2017 and 2016, and the related statements of operations 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 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 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 opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Ozark Tri-County Health Care Consortium d/b/a Access Family Care as of April 30, 2017 and 2016, 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.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated September 28, 2017, on our consideration of the Organization's 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 Ozark Tri-County Health Care Consortium d/b/a Access Family Care's internal control over financial reporting and compliance.

Anders Minkler Huber & Helm LLP

September 28, 2017

Ozark Tri-County Health Care Consortium
d/b/a Access Family Care
Balance Sheets
April 30, 2017 and 2016

Assets

	2017	2016
Current Assets		
Cash and cash equivalents	$ 2,529,115	$ 2,200,990
Assets limited as to use	201,204	200,000
Patient accounts receivable, net	1,048,145	972,818
Estimated amounts due from third-party payers	106,785	386,881
Grants receivable	411,339	300,552
Inventory	191,517	216,740
Prepaid expenses and other current assets	433,668	386,337
Total Current Assets	4,921,773	4,664,318
Investments in Limited Liability Companies	66,116	74,133
Property and Equipment, net	7,128,119	6,490,834
Total Assets	$ 12,116,008	$ 11,229,285

Liabilities and Net Assets

Current Liabilities		
Accounts payable	$ 262,311	$ 256,795
Accrued expenses and other current liabilities	1,101,103	997,898
Estimated amounts due to third-party payers	37,146	-
Deferred revenue	86,061	38,759
Total Current Liabilities	1,486,621	1,293,452
Net Assets		
Unrestricted	10,629,387	9,934,729
Temporarily restricted	-	1,104
Total Net Assets	10,629,387	9,935,833
Total Liabilities and Net Assets	$ 12,116,008	$ 11,229,285

Ozark Tri-County Health Care Consortium
d/b/a Access Family Care
Statements of Operations and Changes in Net Assets
Years Ended April 30, 2017 and 2016

	2017	2016
Unrestricted Revenues, Gains and Other Support		
Patient service revenue, net of contractual adjustments	$ 11,338,794	$ 9,873,918
Provision for uncollectible accounts	(463,821)	(473,731)
Net patient service revenue	10,874,973	9,400,187
Grant revenue	5,757,084	5,179,300
Other operating revenue and support	467,276	74,765
Net assets released from restrictions	1,104	-
Total Unrestricted Revenues, Gains and Other Support	17,100,437	14,654,252
Expenses		
Salaries and wages	9,617,718	8,489,555
Employee benefits	2,074,476	1,705,511
Supplies and other	4,117,181	3,756,341
Rent	78,428	60,532
Pharmaceutical costs	245,767	18,396
Depreciation	559,432	515,554
Total Expenses	16,693,002	14,545,889
Operating Income	407,435	108,363
Other Income (Loss)		
Interest income, net	3,991	2,280
Loss on sale of equipment	(14,270)	(8,720)
Total Other Income (Loss)	(10,279)	(6,440)
Excess of Revenues Over Expenses	397,156	101,923
Non-operating Grant Revenue	227,074	270,680
Grants for Acquisition of Property and Equipment	70,428	224,205
Change in Unrestricted Net Assets	694,658	596,808
Temporarily Restricted Net Assets		
Net assets released from restrictions	(1,104)	-
Change in Temporarily Restricted Net Assets	(1,104)	-
Change in Net Assets	693,554	596,808
Net Assets, Beginning of Year	9,935,833	9,339,025
Net Assets, End of Year	$ 10,629,387	$ 9,935,833

Ozark Tri-County Health Care Consortium
d/b/a Access Family Care
Statements of Cash Flows
Years Ended April 30, 2017 and 2016

	2017	2016
Cash Flows From Operating Activities		
Change in net assets	$ 693,554	$ 596,808
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Noncash contribution revenue	(314,201)	-
Depreciation	559,432	515,554
Loss on sale of equipment	14,270	8,720
Grants for acquisition of property and equipment	(70,428)	(224,205)
(Increase) decrease in assets		
Patient accounts receivable, net	(26,453)	(159,420)
Estimated amounts due from third-party payers	280,096	493,031
Grants receivable	(101,891)	(63,774)
Inventory	25,223	(200,796)
Prepaid expenses and other current assets	(44,832)	(11,944)
Increase (decrease) in liabilities		
Accounts payable	(57,844)	(54,084)
Accrued expenses and other current liabilities	85,552	(71,655)
Estimated amounts due to third-party payers	37,146	(308,905)
Deferred revenue	47,302	(2,615)
Net Cash Provided by Operating Activities	1,126,926	516,715
Cash Flows From Investing Activities		
Proceeds from sale of assets limited to use	200,000	220,483
Purchase of assets limited as to use	(201,204)	(200,000)
Distribution from investment in limited liability company	8,017	2,005
Purchases of property and equipment	(876,042)	(569,579)
Net Cash Used in Investing Activities	(869,229)	(547,091)
Cash Flows From Financing Activities		
Proceeds from grant for acquisition of property and equipment	70,428	224,205
Net Cash Provided by Financing Activities	70,428	224,205
Net Increase in Cash and Cash Equivalents	328,125	193,829
Cash and Cash Equivalents, Beginning of Year	2,200,990	2,007,161
Cash and Cash Equivalents, End of Year	$ 2,529,115	$ 2,200,990

Noncash Investing Activities

During the year ended April 30, 2017, the Organization recorded noncash contribution revenue of $314,201 for the merger of Area Community Health Emissaries, Inc. as discussed in Note 3.

Ozark Tri-County Health Care Consortium
d/b/a Access Family Care
Notes to Financial Statements
April 30, 2017 and 2016

1. Nature of Operations and Basis of Presentation

Organization

Ozark Tri-County Health Care Consortium d/b/a Access Family Care (the "Organization") is a not-for-profit organization whose mission and principal activities are to improve the health of the medically underserved of greater southwest Missouri through direct services and collaborative efforts. The Organization's revenues and other support are derived principally from providing medical, dental, and other related health care services through clinics located in southwest Missouri. The Organization is approved as a Federally Qualified Health Center ("FQHC") for both Medicare and Medicaid reimbursement purposes.

Basis of Presentation

The accompanying financial statements have been prepared in accordance with the provisions of the Financial Accounting Standards Board ("FASB"), Accounting Standards Codification (the "FASB ASC"), which is the source of authoritative, non-governmental accounting principles generally accepted in the United States of America ("GAAP"). All references to authoritative accounting guidance contained in our disclosures are based on the general accounting topics within the FASB ASC.

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

Unrestricted net assets - Net assets that are not subject to donor-imposed stipulations.

Temporarily restricted net assets - Net assets subject to donor-imposed stipulations that may or will be met, either by actions of the Organization and/or the passage of time. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of operations and changes in net assets as net assets released from restrictions. As of April 30, 2017, there were no temporarily restricted net assets.

Permanently restricted net assets - Net assets subject to donor-imposed stipulations required to be maintained permanently by the Organization. The income earned on any related investments would also be subject to donor-imposed stipulations. As of April 30, 2017 and 2016, there were no permanently restricted net assets.

2. Summary of Significant Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Fair Value Measurements

The Organization follows guidance issued by the FASB on fair value measurements, which establishes a framework for measuring fair value, clarifies the definition of fair value within that framework, and expands disclosures about the use of fair value measurements. This guidance applies whenever fair value is the applicable measurement. The three general valuation techniques used to measure fair value are the market approach, cost approach, and income approach.

Cash and Cash Equivalents

The Organization considers all short-term investments with an original maturity of three months or less at the time of purchase to be cash equivalents.

Assets Limited as to Use

Assets limited as to use consist of a certificate of deposit with a financial institution as collateral for a portion of the bank debt. Since the Organization's line of credit borrowings are secured by the assets limited as to use, these assets cannot be expended until the line of credit matures.

Patient Accounts Receivable

Patient accounts receivable are uncollateralized obligations for services rendered reported at net realizable amounts due from third-party payers, patients, and others. As a service to the patient, the Organization bills third-party payers directly and bills the patient when the patient's liability is determined. Patient accounts receivable are due in full when billed.

The Organization provides an allowance for doubtful accounts equal to the estimated losses that will be incurred in the collection of accounts receivable. This estimate is based on historical experience with each of its major payer sources to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payer sources in evaluating the sufficiency of the allowance for doubtful accounts.

For receivables associated with services provided to patients who have third-party insurance coverage, the Organization analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary.

For receivables associated with self-pay patients, the Organization assesses the self-pay patient's ability to pay in the period of service and provides an allowance for doubtful accounts and a provision for bad debts, if necessary, for patients who are unable or unwilling to pay for the portion of the bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged against the allowance for doubtful accounts.

The Organization's process for calculating the allowance for doubtful accounts for self-pay patients has not significantly changed from April 30, 2017 and 2016. The Organization has not significantly changed its charity care or uninsured discount policies during fiscal year April 30, 2017.

Grants Receivable

Grants receivable includes amounts due from various funding sources under binding contracts with the Organization for services rendered prior to year-end.

Inventory

Inventory is stated at the lower of cost or market. Cost is determined by the average cost method, and market is considered the lower of prevailing replacement cost or net realizable value.

Investments in Limited Liability Companies

As of April 30, 2017 and 2016, the Organization has invested $49,474 in a noncontrolling interest of a limited liability company (the "LLC-1") that holds a noncontrolling interest in a company that operates a Medicaid managed care plan in the State of Missouri. The Organization's investment in LLC-1 is carried at cost. Distributed earnings from accumulated earnings of LLC-1 are recorded as income in the period received. Distributed earnings in excess of accumulated earnings are considered a return of investment and recorded as a reduction of the cost of the investment. Management does not believe impairment exists because the Organization did not identify any events or changes in circumstances that might have a significant adverse effect on the value of the investment. As a condition of the investment, the Organization has committed up to $50,000 to LLC-1.

As of April 30, 2017 and 2016, the Organization has invested $23,050 in a noncontrolling interest of a limited liability company (the "LLC-2") that holds a noncontrolling interest in a company that operates an independent practice association in the State of Missouri. During the years ended April 30, 2017 and 2016, the Organization received return of capital distributions of $8,017 and $2,005, respectively, from LLC-2. The Organization's investment in LLC-2 is carried at cost. Distributed earnings from accumulated earnings of LLC-2 are recorded as income in the period received. Distributed earnings in excess of accumulated earnings are considered a return of investment and recorded as a reduction of the cost of the investment. Management does not believe impairment exists because the Organization did not identify any events or changes in circumstances that might have a significant adverse effect on the value of the investment.

Property and Equipment

Property and equipment acquisitions with a life of 3 years or greater and a cost in excess of $5,000 are capitalized and recorded at cost, while maintenance and repairs are expensed as incurred. Donated assets are recorded at fair value at the date of donation. Such donations are reported as increases in unrestricted net assets unless the donor has restricted the donated asset to a specific purpose or period of time. When assets are sold or otherwise disposed of, the related cost and accumulated depreciation are removed from the accounts. Any gain or loss arising from such disposition is included as income or expense in the year of disposition.

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

Depreciation is computed using the straight-line method over the estimated useful lives of the assets.

The estimated lives for computing depreciation on property and equipment are:

Classification	Years
Buildings and improvements	4-40
Furniture, equipment, and software	3-20
Vehicles	3

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 are 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 April 30, 2017 and 2016.

Deferred Revenue

Deferred revenue consists of payments received from granting authorities. These payments will be recognized as income in the period in which they are earned.

Net Patient Service Revenue Recognition

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 adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final adjustments are determined.

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, as noted above. For uninsured patients that do not qualify for charity care, the Organization recognizes revenue on the basis of its standard rates for services provided or on the basis of discounted rates, if negotiated. On the basis of historical experience, a certain portion of the Organization's uninsured patients will be unable or unwilling to pay for the services provided. As a result, the Organization records a provision for bad debts related to uninsured patients in the period the services are provided. This provision for uncollectible accounts is presented on the statements of operations and changes in net assets as a component of net patient service revenue.

Third-Party Rate Adjustments and Revenue

Revenue from the Medicare and Medicaid programs accounted for 74 and 72 percent of the net patient service revenue for the years ended April 30, 2017 and 2016, respectively. Revenue from Medicare is based on a prospective payment system and revenue from Medicaid is based on cost reimbursement principles. These payments are subject to audit and retroactive adjustment by the respective third-party fiscal intermediaries. Laws and regulations governing these programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

Net patient service revenue for the year ended April 30, 2017 increased $399,679 due to prior-year retroactive adjustments in excess of amounts previously estimated.

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 granting agencies and, as a result of such audits, adjustments could be required.

Electronic Health Records Incentive Program

Enacted as part of the *American Recovery and Reinvestment Act of 2009*, the Electronic Health Records Incentive Program provides for one-time incentive payments under both the Medicare and Medicaid programs to eligible hospitals and physicians 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 up to four years based upon a statutory formula, as determined by the state, which is approved by the Centers for Medicare and Medicaid services. Payments under both programs are 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 under both programs is determined based upon an audit by the fiscal intermediary. 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.

During the year ended April 30, 2017, the Organization partially completed the stage 2 requirements under the Medicaid program and has recorded revenue of approximately $42,000, which is included in non-operating grant revenue within the statements of operations and changes in net assets. The Organization did not recognize any revenue during the year ended April 30, 2016.

Contributions

Contributions, including unconditional promises to give, are recorded as received. All contributions are available for unrestricted use unless specifically restricted by the donor. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statements of operations and changes in net assets as net assets released from restrictions. Conditional promises to give are recognized when the conditions on which they depend are substantially met. Donor restricted contributions in which the restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

Donations of property and equipment are recorded as support at their estimated fair value at the date of donation. Assets donated with explicit restrictions regarding their use and contributions of cash that must be used to acquire property and equipment are reported as restricted support. The Organization reclassifies temporarily restricted net assets to unrestricted net assets each year in the amount of the donated property and equipment's depreciation expense.

Donated Materials and Services

Donated noncash assets are recorded as contributions at their fair values at the date of donation. There were no donations of noncash assets during each of the years ended April 30, 2017 and 2016.

Donated services are recognized as contributions if the services create or enhance nonfinancial assets or require specialized skills, are performed by people with those skills, and would otherwise be purchased by the Organization. Volunteers provided various services throughout the year that are not recognized as contributions in the financial statements since the recognition criteria were not met.

Charity Care

The Organization provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Organization does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Charity care totaled $33,207 and $31,436 for the years ended April 30, 2017 and 2016, respectively.

Functional Expense Allocation

The Organization allocates expenses on a functional basis among various programs and supporting activities. Expenses that can be identified with a specific program and supporting activity are allocated directly according to their natural expenditure classifications. Other expenses that are common to several functions are allocated by various statistical bases.

Income Taxes

The Organization is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code (the "Code"), except on net income derived from unrelated business activities as defined in the Code. Accordingly, the Organization files as a tax exempt organization.

The Organization follows guidance issued by the FASB on accounting for income taxes and has evaluated its tax positions, expiring statutes of limitations, audits, proposed settlements, changes in tax law and new authoritative rulings, and believes that no provision for income taxes is necessary to cover any uncertain tax positions. The Organization's returns for tax years 2013 and later remain subject to examination by taxing authorities.

Operating Revenues and Expenses

The Organization's statements of operations and changes in net assets distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services. Operating expenses are all expenses incurred to provide health care services. Changes in unrestricted net assets which are excluded from operating income include interest income, loss on sale of equipment, and contributions of long-lived assets.

Subsequent Events

The Organization has evaluated subsequent events through September 28, 2017, the date the financial statements were available to be issued.

Recent Accounting Pronouncements

Revenue Recognition from Contracts with Patients

The FASB has issued new guidance on the recognition of revenue from contracts with customers. This guidance requires an entity to recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. To achieve this, an entity should apply a five step process to (1) identify the contract(s) with a customer, (2) identify the performance obligations in the contract, (3) determine the transaction price, (4) allocate the transaction price to the performance obligations in the contract, and (5) recognize revenue when (or as) the entity satisfies a performance obligation. The guidance also requires an entity to disclose sufficient information to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. The guidance will be required for the first fiscal year beginning after December 15, 2018. The Organization is still evaluating the effect the new guidance will have on its financial statements.

Leases

The FASB has issued new guidance on the recognition of lease assets and lease liabilities by lessees for those leases previously classified as operating leases. The guidance requires a lessee to recognize in the statement of financial position a liability to make lease payments and a right-of-use asset representing its right to use the underlying asset for the lease term. When measuring assets and liabilities arising from a lease, a lessee (and a lessor) should include payments to be made in optional periods only if the lessee is reasonably certain to exercise an option to extend the lease or not to exercise an option to terminate the lease. Similarly, optional payments to purchase the underlying asset should be included in the measurement of lease assets and lease liabilities only if the lessee is reasonably certain to exercise that purchase option. For leases with a term of 12 months or less, a lessee is permitted to make an accounting policy election by class of underlying asset not to recognize lease assets and lease liabilities. If a lessee makes this election, it should recognize lease expense for such leases generally on a straight-line basis over the lease term. The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee have not significantly changed from previous GAAP. There continues to be a differentiation between finance leases and operating leases. However, the principal difference from previous guidance is that the lease assets and lease liabilities arising from operating leases should be recognized in the statement of financial position. The guidance will be required for the first fiscal year beginning after December 15, 2019. The Organization has not yet evaluated the significance the new guidance will have on its financial statements.

Not-for-Profit Entities

The FASB has issued new guidance on financial reporting for not-for-profit entities. The guidance requires a not-for-profit entity to present on the face of the statement of financial position amounts for two classes of net assets at the end of the period, rather than for the currently required three classes. That is, a not-for-profit entity will report amounts for net assets with donor restrictions and net assets without donor restrictions, as well as the currently required amount for total net assets. The guidance also requires a not-for-profit entity to present on the face of the statement of activities the amount of the change in each of the two classes of net assets rather than that of the currently required three classes. Not-for-profit entities will continue reporting the currently required amount of the change in total net assets for the period. The guidance also requires a not-for-profit entity to continue to present on the face of the statement of cash flows the net amount for operating cash flows using either the direct or indirect method of reporting but no longer requires the presentation or disclosure of the indirect method (reconciliation) if using the direct method. The guidance also requires enhanced disclosures about the following:

- Amounts and purposes of governing board designations, appropriations, etc.,
- Composition of net assets with donor restrictions at the end of the period,
- Qualitative information that communicates how an entity manages its liquid resources,
- Quantitative and additional qualitative information as necessary that communicates the availability of an entity's financial assets,
- Amounts of expenses by both their natural classification and their functional classification,
- Method(s) used to allocate costs among program and support functions,
- Underwater endowment funds.

The guidance also requires that the Organization report investment return net of external and direct internal investment expenses and no longer require disclosure of those netted expenses. The guidance also require that the Organization use, in the absence of explicit donor stipulations, the placed-in-service approach for reporting expirations of restrictions on gifts of cash or other assets to be used to acquire or construct a long-lived asset.

The guidance will be required for the first fiscal year beginning after December 15, 2017. Based on a preliminary analysis, the Organization has not yet determined what impact, if any, this new guidance will have on its financial statements.

3. Merger

On October 1, 2016, the Organization merged with Area Community Health Emissaries, Inc. (a not-for-profit organization) ("ACHE"). The results of ACHE's operations have been included in the financial statements since that date. ACHE is a not-for-profit corporation of dental clinics located in southwest Missouri. As a result of the merger, the Organization recognized a contribution of $330,684.

Current assets	$ 77,091
Property and equipment, net	334,945
Total assets acquired	412,036
Current liabilities	81,352
Total liabilities assumed	81,352
Contribution	$ 330,684

The fair value of the assets merged into the Organization includes receivables with a fair value of $48,874. The gross amount due under the contracts is $129,497, of which $80,623 is expected to be uncollectible.

4. Fair Value Measurements

The framework for measuring fair value establishes a fair value hierarchy which prioritizes the inputs to valuation techniques used to measure fair value into Levels 1, 2, and 3. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3). The three levels of the fair value hierarchy are described as follows:

Level 1 — Inputs to the valuation methodology are unadjusted quoted prices for identical instruments in active markets.

Level 2 — Inputs to the valuation methodology to include quoted prices for similar instruments in active markets, quoted prices for identical or similar instruments in inactive markets, inputs other than quoted prices that are observable for the instrument, or inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3 — Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The instruments' fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Carrying amounts of certain financial instruments such as cash and cash equivalents, assets limited as to use, patient accounts receivable, grants receivable, estimated amounts due from and to third-party payers, accounts payable, and accrued expenses and other current liabilities approximate fair value due to their short maturities or because the terms are similar to market terms. There have been no changes in the methodologies used at April 30, 2017 and 2016.

On October 1, 2016, the Organization acquired the all of the assets and liabilities of ACHE. Under GAAP, the assets and liabilities are to be recorded at fair value. Following is a description of the valuation methodologies used for instruments measured at fair value.

Level 2 Investments consist of certificate of deposits. These securities are valued based on relevant observable information such as market interest rates, yield curves, prepayment risk and credit risk generated by market transactions involving identical or comparable assets or liabilities.

The fair value of investments measured as of April 30, is as follows:

	2017			
	Fair Value Measurements			
	Total	Level 1	Level 2	Level 3
Certificate of deposit ("assets limited as to use")	$ 201,204	$ -	$ 201,204	$ -
	$ 201,204	$ -	$ 201,204	$ -

	2016			
	Fair Value Measurements			
	Total	Level 1	Level 2	Level 3
Certificate of deposit ("assets limited as to use")	$ 200,000	$ -	$ 200,000	$ -
	$ 200,000	$ -	$ 200,000	$ -

Following is a description of the valuation methodologies used for assets and liabilities measured at fair value on a nonrecurring basis.

Level 3 — Patient accounts receivable, grants receivable, prepaid expenses and other current assets, property and equipment, accounts payable, and accrued expenses and other current liabilities. These are valued based upon the estimated fair values as determined by management. Inputs used in estimating fair value included collectibility, asset condition, and expected remaing life.

The fair value of assets and liabilities measured on a nonrecurring basis at October 1, 2016, is as follows:

	Fair Value Measurements			
	Total	Level 1	Level 2	Level 3
Patient accounts receivable, net	$ 48,874	$ -	$ -	$ 48,874
Grants receivable	8,895	-	-	8,895
Prepaid expenses and other current assets	2,499	-	-	2,499
Property and equipment	334,945	-	-	334,945
Accounts payable	(63,360)	-	-	(63,360)
Accrued expenses and other current liabilities	(17,652)	-	-	(17,652)
	$ 314,201	$ -	$ -	$ 314,201

5. Patient Accounts Receivable

Patient accounts receivable, net, at April 30, consist of the following:

	2017	2016
Medicare	$ 188,350	$ 369,018
Medicaid	887,393	604,167
Other third-party payers	556,373	574,782
Self-pay	262,432	210,263
	1,894,548	1,758,230
Less allowance for uncollectible accounts	846,403	785,412
	$ 1,048,145	$ 972,818

6. Grants Receivable

Grants receivable at April 30, are as follows:

	2017	2016
Community Health Center	$ 201,171	$ 93,503
MPCA Behavioral Health	28,386	26,351
MPCA Chronic Disease Collaborative	1,925	2,150
MPCA Women and Minority Health Care	8,166	5,421
MPCA Community Health Worker Supplemental	10,017	-
Show Me Healthy Women	11,583	6,775
Health Home Initiative - Medicaid	96,345	89,462
Electronic Health Record Incentive Payments - Medicaid	21,250	-
Missouri Foundation for Health	7,146	-
Collaborative for Dental Care	-	17,002
RCHN Community Health Foundation	-	11,989
FQHC Service Expansion	-	10,426
United Community Fund of Neosho	2,000	-
United Way of Carthage	650	-
340B Drug Program	22,700	37,473
	$ 411,339	$ 300,552

7. Property and Equipment

Property and equipment at April 30, is as follows:

	2017	2016
Land	$ 528,935	$ 458,935
Buildings and improvements	8,059,255	7,417,088
Furniture, equipment, and software	3,349,808	2,829,638
Vehicles	87,649	101,916
Construction in progress	68,886	110,423
	12,094,533	10,918,000
Less accumulated depreciation	4,966,414	4,427,166
	$ 7,128,119	$ 6,490,834

Depreciation expense for the years ended April 30, 2017 and 2016 totaled $559,432 and $515,554, respectively.

Construction in progress at April 30, 2017 and 2016, is related to the expansion of the technology center in Branson, Missouri, in addition to architectural fees related to clinic expansion.

8. Line of Credit

The Organization has a line of credit agreement (the "Agreement") of $500,000 scheduled to expire on November 15, 2017. Borrowings are charged interest at 3.27 percent and secured by a certificate of deposit. At April 30, 2017 and 2016, there were no borrowings outstanding under the Agreement.

9. Temporarily Restricted Net Assets

Temporarily restricted net assets are available for the following purposes or periods at April 30, as follows:

	2017	2016
Gardasil Dispensing Grant	$ -	$ 1,104
	$ -	$ 1,104

Net assets were released from donor restrictions and written off due to expiration of the vaccine during the years ended April 30, as follows:

	2017	2016
Gardasil Dispensing Grant	$ 1,104	$ -
	$ 1,104	$ -

10. Net Patient Service Revenue

The Organization operates as a FQHC for both Medicare and Medicaid 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 prospective payment system. The Organization is reimbursed for cost reimbursable items at a prospective 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.

Medicaid - Covered FQHC services rendered to Medicaid 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 Medicaid fiscal intermediary.

Other payers - The Organization has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates, per discharge, discounts from established charges, and prospectively determined daily rates.

Laws and regulations governing the Medicare and Medicaid 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.

The Organization has also entered into payment agreements with certain commercial insurance carriers. The basis for payment to the Organization under these agreements includes prospectively determined rates and discounts from established charges.

A summary of patient service revenue, contractual adjustments, slide adjustments, and provision for uncollectible accounts for the years ended April 30, are as follows:

	2017	2016
Gross Patient Service Revenue		
Medicare	$ 1,174,244	$ 838,977
Medicaid	8,509,981	6,480,692
Other	7,530,615	7,230,712
	17,214,840	14,550,381
Contractual Adjustments		
Medicare	(612,090)	(257,936)
Medicaid	(1,060,658)	(265,847)
Other	(2,348,689)	(1,739,474)
	(4,021,437)	(2,263,257)
Slide Adjustments	(1,854,609)	(2,413,206)
Net Patient Service Revenue	11,338,794	9,873,918
Provision for Uncollectible Accounts	(463,821)	(473,731)
	$ 10,874,973	$ 9,400,187

11. Retirement Plans

The Organization maintains a contributory retirement savings plan under Section 401(k) of the Internal Revenue Code covering substantially all employees who meet certain eligibility requirements. Employer contributions to the plan totaled $269,055 and $232,640 for the years ended April 30, 2017 and 2016, respectively.

12. Risks and Uncertainties

Concentration of Credit Risk

The mix of receivables from patients and third-party payers at April 30, is as follows:

	2017	2016
Medicare	8 %	24 %
Medicaid	64	54
Self-pay and other third-party payers	28	22
	100 %	100 %

Financial instruments, which potentially subject the Organization to concentrations of credit risk, consist principally of cash and cash equivalents, assets limited as to use, patient accounts receivable, grants receivable, and amounts due from third-party payers. The Organization maintains its cash and cash equivalents and assets limited as to use (the "Funds") primarily with five financial institutions. Funds at these banks are insured by the Federal Deposit Insurance Corporation ("FDIC") up to $250,000. At April 30, 2017, the Organization had $2,319,916 of funds in excess of amounts insured by the FDIC. The Organization performs ongoing credit evaluations of its patients and third-party payers and maintains allowances, as needed, for potential credit losses. Although the Organization is directly affected by the financial stability of its patients and third-party payer base, management does not believe significant credit risk exists at April 30, 2017.

Professional Liability Coverage and 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 for 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 FASB ASC requires a health care provider to accrue the expense of its share of malpractice claim costs, if any, for any reported and unreported incidents of potential improper professional service occurring during the year by estimating the probable ultimate costs of the incidents. Based upon the Organization's claim experience, no such accrual has been made. It is reasonably possible that this estimate could change materially in the near term.

The Organization has additional malpractice insurance coverage to provide protection for professional liability losses for items not covered under the FTCA on a claims-made basis subject to a limit of $1 million per claim with $3 million annual aggregate limit. In addition, the Organization has physician professional liability coverage for a certain physician on a claims-made basis subject to a limit of $1 million per claim with $3 million annual aggregate limit.

13. Commitments and Contingencies

Leases

The Organization leases land, an office building, and equipment under noncancelable operating leases. Future minimum lease payments at April 30, 2017 are as follows:

Years Ending April 30,	
2018	$ 66,271
2019	44,519
2020	23,348
2021	7,856
2022	6,449
Thereafter	151,200
	$ 299,643

Rent expense related to operating leases for the years ended April 30, 2017 and 2016 totaled $78,428 and $60,532, respectively.

Contingencies

During the year ended June 30, 2006, Organization management identified certain services being performed by an employed nurse practitioner beyond the scope of services permitted by the nurse practitioner's medical license. Once management became aware of this situation, appropriate clinical service changes were made and investigations were performed to identify the length of time that such services had been rendered and billed to third-party payers. The Organization's management has identified an estimated $115,000 of inappropriate payments received by the Organization related to services provided to Medicare and Medicaid beneficiaries and, accordingly, has included a provision of this amount in the financial statements. No provision has been made in the financial statements for any adverse outcome related to other third-party payers as the amount of any such loss is not reasonably estimable. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

During the year ended April 30, 2011, Organization management identified certain services being performed by certain nurse practitioners with expired medical licenses. Once management became aware of this situation, appropriate clinical service changes were made and investigations were performed to identify the length of time that such services had been rendered and billed to third-party payers. The Organization's management has identified an estimated $42,000 of inappropriate payments received by the Organization related to services provided to Medicare, Medicaid, and insurance beneficiaries and, accordingly, has included a provision of this amount in the financial statements, less amounts repaid. Through April 30, 2017, approximately $30,000 has been repaid to Medicaid. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Current economic conditions have made it difficult for certain of the Organization's patients to pay for services rendered. As employers make adjustments to health insurance plans or more patients become unemployed, services provided to self-pay and other payers may impact net patient service revenue. Further, the effect of economic conditions in Missouri may have an adverse effect on cash flows related to the Medicaid program.

14. Functional Expenses

The Organization provides health care services to residents within its service area. Expenses related to providing these services for the years ended April 30, are as follows:

	2017	2016
Health care services	$ 11,456,781	$ 10,033,608
General and administrative	5,236,221	4,512,281
	$ 16,693,002	$ 14,545,889