OneCare Vermont Accountable Care Organization, LLC

Financial Statements
December 31, 2018 and 2017

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Report of Independent Auditors

To the Board of Managers
of OneCare Vermont Accountable Care Organization, LLC

We have audited the accompanying financial statements of OneCare Vermont Accountable Care Organization, LLC (the "Organization"), which comprise the balance sheets as of December 31, 2018 and 2017, and the related statements of operations and comprehensive income, changes in members' equity, and of cash flows for the years then ended.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America; 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 the financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. 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 our 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, we consider internal control relevant to the Organization'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 Organization'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 OneCare Vermont Accountable Care Organization, LLC as of December 31, 2018 and 2017 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.

PricewaterhouseCoopers LLP

December 12, 2019

OneCare Vermont Accountable Care Organization, LLC
Balance Sheets
December 31, 2018 and 2017

	2018	2017
Assets		
Current assets		
Cash and cash equivalents	$ 18,867,852	$ 11,381,608
Restricted cash	5,524,849	-
Accounts receivable, trade	2,923,608	3,550,000
Accounts receivable from participants, contract risk settlement	22,029,890	-
Accounts receivable from payors, contract risk settlement	5,568,578	2,364,754
Prepaid expenses and other assets	136,678	209,030
Total current assets	55,051,455	17,505,392
Total assets	$ 55,051,455	$ 17,505,392
Liabilities and Equity		
Current liabilities		
Accounts payable and accrued expenses	$ 16,173,272	$ 7,341,536
Accounts payable to participants, contract risk settlement	1,812,942	2,364,754
Accounts payable to payors, contract risk settlement	25,642,666	-
Due to related parties	4,730,338	6,833,770
Deferred revenue and other liabilities	1,570,132	937,203
Note payable, related party	4,124,849	-
Total current liabilities	54,054,199	17,477,263
Total liabilities	54,054,199	17,477,263
Members' equity	50,000	50,000
Retained surplus (deficit)	947,256	(21,871)
Total members' equity	997,256	28,129
Total liabilities and members' equity	$ 55,051,455	$ 17,505,392

The accompanying notes are an integral part of these financial statements.

OneCare Vermont Accountable Care Organization, LLC
Statements of Operations and Comprehensive Income
Years Ended December 31, 2018 and 2017

	2018	2017
Revenue		
Contract revenue	$ 3,500,000	$ 6,307,531
Participation fees	17,397,929	2,462,519
Administrative revenue	1,814,430	1,038,892
Consulting revenue	902,449	216,000
Contract risk settlement revenue	588,195	-
Other revenue	212,707	-
Total revenue	24,415,710	10,024,942
Expenses		
Population health management expenses		
Care coordination and administrative	4,198,912	990,875
Value-based-incentive fund	4,003,539	-
Primary care reform and community investment	1,063,453	-
Contract risk settlement expense	445,333	-
Total population health management expenses	9,711,237	990,875
Other operating expenses		
Salaries, payroll taxes and fringe benefits	7,344,815	4,906,843
Software, licenses and maintenance	2,795,193	2,549,941
Consulting, legal and purchased services	1,746,953	941,319
Travel, supplies and other	1,848,385	635,964
Total other operating expenses	13,735,346	9,034,067
Total expenses	23,446,583	10,024,942
Net income and comprehensive income	$ 969,127	$ -

The accompanying notes are an integral part of these financial statements.

OneCare Vermont Accountable Care Organization, LLC
Statements of Changes in Members' Equity
Years Ended December 31, 2018 and 2017

	University of Vermont Medical Center	Dartmouth-Hitchcock Health	Total
Balances at January 1, 2017	$ 14,065	$ 14,064	$ 28,129
Net income and comprehensive income	-	-	-
Balances at December 31, 2017	$ 14,065	$ 14,064	$ 28,129
Net income and comprehensive income	484,564	484,563	969,127
Balances at December 31, 2018	$ 498,629	$ 498,627	$ 997,256

The accompanying notes are an integral part of these financial statements.

OneCare Vermont Accountable Care Organization, LLC
Statements of Cash Flows
Year Ended December 31, 2018 and 2017

	2018	2017
Cash flows from operating activities		
Net income	$ 969,127	$ -
Increase (decrease) in cash resulting from a change in		
Accounts receivable, trade	626,392	(3,549,999)
Accounts receivable from participants, contract risk settlement	(22,029,890)	-
Accounts receivable from payors, contract risk settlement	(3,203,824)	(2,364,754)
Prepaid expenses and other assets	72,352	(93,699)
Due to/from related parties	(2,103,432)	5,385,152
Accounts payable and accrued expenses	8,831,736	7,252,199
Accounts payable to participants, contract risk settlement	(551,812)	2,364,754
Accounts payable to payors, contract risk settlement	25,642,666	-
Deferred revenue and other liabilities	632,929	937,203
Net cash provided by operating activities	8,886,244	9,930,856
Cash flows from investing activities		
Net cash provided by investing activities	-	-
Cash flows from financing activities		
Issuance of note payable, related party	4,124,849	-
Net cash provided by financing activities	4,124,849	-
Net increase in cash and cash equivalents and restricted cash	13,011,093	9,930,856
Cash and cash equivalents and restricted cash		
Beginning of year	11,381,608	1,450,752
End of year	$ 24,392,701	$ 11,381,608
Supplemental cash flow information		
Cash paid for interest	$ 28,788	$ -

The accompanying notes are an integral part of these financial statements.

1. Organization

OneCare Vermont Accountable Care Organization, LLC (the "Organization" or "OneCare") was formed in May 2012 as a statewide Accountable Care Organization ("ACO"). The Organization was formed as a joint venture between the University of Vermont Medical Center, Inc. ("UVM Medical Center") (a wholly controlled subsidiary of the University of Vermont Health Network, "UVM Health Network"), a Vermont nonprofit corporation, and Dartmouth-Hitchcock Health ("Dartmouth-Hitchcock"), a New Hampshire nonprofit corporation. The Organization's mission is to enhance the effectiveness of patient and family centered care for all Vermonters and to optimize the delivery of care in order to improve outcomes and patient experience in support of a sustainable health care system under a predictable rate of growth. The Organization is focused on improved health, higher quality, lower cost increases and greater coordination of care for all attributed lives. The Organization joins an extensive, statewide network of providers and communities implementing health care payment reform and population health management.

The Organization's network of participating providers (the "Participants") includes Vermont hospitals (including UVM Medical Center) along with their employed physicians and providers, federally qualified health centers, independent practices, home health providers, designated agencies for mental health and substance abuse, area agencies on aging, and skilled nursing facilities. Each Participant has entered into an ACO Participant and Affiliate Participation agreement with OneCare and each Participant has agreed to become and remain accountable for the quality, cost and overall care of attributed lives.

OneCare has entered into population based "next generation" accountable care program agreements with State of Vermont Department of Vermont Health Access ("DVHA"), the Centers for Medicare and Medicaid ("CMS"), and BlueCross BlueShield of Vermont ("BCBSVT"). These agreements are designed to align with the Vermont All-Payer Accountable Care Organization Model agreement between the State of Vermont and CMS. The attribution of beneficiaries under these agreements occurs prospectively at the beginning of the program year. Beneficiaries cannot be added during the program year but beneficiaries may become ineligible for attribution during the program year for various reasons.

Through the Vermont Medicaid Next Generation ("VMNG") ACO program, an all-inclusive-population-based-payment ("AIPBP") is established to serve as the basis from which financial performance will be assessed. From the AIPBP, DVHA pays the Organization a monthly fixed prospective payment ('FPP"). The FPP amount is intended to provide funding for the Organization to pay its participating hospitals a fixed amount, based on attributed lives, which the hospitals accept in lieu of being paid for covered services on a fee for service basis. The Organization also makes payments on a per beneficiary basis to participating hospitals and providers. Medicaid fee-for-service payments from the State of Vermont continue for all other non-hospital provider Participants, for all providers who are not a Participant, and for all services that are not covered under the AIPBP. Other AIPBP components funded monthly include a Primary Care Case Management Fee ("PCCM"), and administrative funding of $6.50 per attributed beneficiary per month. In regard to the administrative fee, the Organization retains 50% and distributes 50% to the Participants. The Organization seeks to influence both the cost and quality of care for each attributed Vermont Medicaid beneficiary.

Through the CMS Vermont Modified Next Generation ACO Model participation agreement, CMS pays the Organization an AIPBP. Similar to the VMNG, the AIPBP amount is intended to provide funding for the organization to pay its participating hospitals a fixed amount, based on attributed lives, which the hospitals accept in lieu of being paid for covered services on a fee-for-service

basis. CMS fee-for-service payments continue for all non-hospital provider participants, for all providers who are not a Participant, and for all services that are not covered under the AIPBP.

Through the BCBSVT Commercial Next Generation Accountable Care Organization program agreement, BCBSVT and the Organization have entered into a two-sided risk arrangement with the only funds flowing through the Organization being a $3.25 per attributed life per month population management fee, to be distributed out to Participants.

In addition, the Organization has entered into a risk arrangement with UVM Medical Center whereby the members of UVM Medical Center's self-funded medical plan (the "Plan") utilizing a primary care physician within the Organization's network of providers are covered. UVM Medical Center pays $9.00 per member per month ("PMPM") to the Organization under this plan, $3.25 of which funds the Organization's operations and $5.75 of which is used for primary care and ACO based payment reform.

2. Significant Accounting Policies

Basis of Presentation

The accompanying financial statements have been prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States of America ("GAAP"). The Organization presents a classified balance sheet, and all assets and liabilities are considered current at December 31, 2018 and 2017.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Significant estimates include either a receivable or payable for the final year-end risk settlements under each payer contract, along with amounts due to Participants based on achieving defined annual quality metrics. Accordingly, actual results could differ from those estimates.

Revenue Recognition

Contract Revenue

The Organization has a contract with DVHA to perform complex care coordination, informatics, and to promote effective care interventions to improve health outcomes. Revenue resulting from the Organization's efforts is recognized as milestones under the contracts are achieved, as evidenced through deliverables to DVHA and payment is reasonably assured. The milestones are specified within each contract and include various tasks such as training and technical assistance on advanced analytics, supporting effective team-based care coordination and furthering existing State of Vermont efforts towards creating innovative, reliable and evidenced based population health strategies. These milestones are deemed substantive as the consideration earned corresponds to the Organization's performance to achieve the milestones, is based on completed tasks and is reasonable relative to all deliverables and payment terms in the contract. A summary of revenue under the DVHA contract for the years ended December 31, 2018 and 2017, respectively, are as follows:

	2018	2017
Health Information Technology	$ 3,500,000	$ 1,500,000
State Innovation Model	-	1,500,000
Centers for Medicare and Medicaid Innovation (CMMI)	-	1,999,548
Advanced Community Care Coordination	-	1,307,983
Total contract revenue	$ 3,500,000	$ 6,307,531

Participation Fees
The Organization charges Participants monthly fees for being part of the OneCare ACO. Revenue is recognized on a monthly basis as ACO administrative services are performed. To the extent the Board of Managers elects to provide credits back to Participants, these credits are recorded as a reduction to Participation Fees. Credits issued for the years ended December 31, 2018 and 2017 were $0 and $1,903,851, respectively.

Administrative Revenue
Administrative revenue represents amounts earned by OneCare to provide services under the VMNG and UVM Medical Center self-funded contracts. Revenue is recognized on a monthly basis as these services are performed.

Consulting Revenue
The Organization performs certain data management, reporting and support services to other organizations. Revenue is recognized on a monthly basis as these services are performed.

Other Revenue
Other revenue represents interest income and income from other initiatives outside of the Organization's four primary payor contracts.

Value-Based-Incentive Funds
The Organization has quality incentive programs ("VBIF") under each of its contracts which allow for funds to be distributed to Participants based on targeted quality measures. Under the arrangement with DVHA, the Organization is required to fund the VBIF to a prescribed level. DVHA allows the Organization to withhold monies from the FPP to fund the VBIF, however, in 2018 the Organization paid all FPP monies to Participants and separately funded, via participation fees, the VBIF pool in the amount of $1,757,059. Of this pool amount, the Organization retained 50% of the undistributed quality funds for ongoing quality improvement initiatives and 50% was paid to DVHA. In 2017, 100% of the undistributed quality funds were retained by the Organization. Total quality incentives earned by Participants for the years ended December 31, 2018 and 2017 were $1,493,500 and $350,250, respectively.

Under the arrangement with the UVM Medical Center, the Plan provides funding for the VBIF pool, which totaled $82,275 for the year-ended December 31, 2018. Under the arrangements with CMS and BCBSVT, the Organization funds the VBIF pool for Participants and has recognized expenses of $2,246,480 for the year ended December 31, 2018.

Contract Risk Settlements
The Organization has agreed to risk-based medical spending targets for the full attributed populations during the Performance Year, which is from January 1st to December 31st. The Organization is liable to the payors if actual costs exceed the established targets or is entitled to shared savings if actual costs are less than the targets (within established corridors). Additionally,

under the CMS contract, as part of the settlement for the performance year, CMS will compare the difference between the total monthly AIPBP to the fee for service equivalent. Any difference will either be paid to the Organization or will be recouped by CMS. The Organization records, as an asset or liability at December 31, 2018 and 2017, the savings or losses under each contract either due to or due from the payors. Participants will fund any amount due to the payors or will receive a distribution of savings under the contract (Note 5).

In 2018, OneCare entered into agreements with new Participants to limit these Participants' upside and downside risk under their participation agreements. Under the terms of these agreements, any settlement payments forfeited by these hospitals were recorded as contract risk settlement revenue or expense by the Organization. In 2018, this arrangement resulted in revenue to the Organization of $588,195 under the Medicare program, and an expense of $445,333 under the DVHA and BCBSVT programs. These amounts are included in contract risk settlement revenue or expense in the statement of operations and comprehensive income.

Other Activity Under Payor Contracts

Besides administrative revenue, all other activity associated with OneCare's accountable care program agreements are recorded on a net basis following the guidance in ASC 605-45, *Revenue Recognition*, and thus does not directly impact the Organization's statement of operations and comprehensive income.

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A summary of the activity under each of the Organization's contracts that is not reflected in the statement of operations and comprehensive income is as follows for the years ended December 31, 2018 and 2017, respectively:

	2018	2017
Vermont Medicaid Next Generation ACO Program		
FPP	$ 65,552,943	$ 47,435,653
PCCM	1,130,068	726,391
Administrative	1,542,161	2,077,771
Quality withhold	1,758,743	412,060
Total VMNG	$ 69,983,915	$ 50,651,875
CMS Vermont Modified Next Generation ACO Progam		
AIPBP	$ 173,123,576	$ -
Total CMS	$ 173,123,576	$ -
BCBSVT Commercial Next Generation ACO Program		
Population health management fee	$ 740,304	$ -
Total BCBSVT	$ 740,304	$ -
UVM Medical Center Self-Funded Medical Plan		
Population health management fees	$ 266,975	$ -
VBIF funding	82,275	-
Complex care coordination	82,400	-
Total UVM Medical Center self-funded medical plan	$ 702,835	$ -

Population Health Management Expenses
Population health management expenses are those expenses funded by the Organization that provide direct financial benefit to our Participants and network organizations via direct cash payments or mitigation of risk.

Cash and Cash Equivalents
Cash and cash equivalents include all liquid investments with maturities of three months or less when purchased.

Restricted Cash
In connection with the Organization's CMS Modified Next Generation ACO Model participation agreement, OneCare is required to provide a financial guarantee for repayment of amounts owed to CMS as shared losses and/or other monies owed. As such, funds totaling $4,124,849, the amount specified by CMS, have been placed in escrow and must be maintained until final settlement under the contract for the performance year, which is equivalent to the calendar year. Additionally, in connection with the VMNG participation agreement, the Green Mountain Care Board ("GMCB") required OneCare to attain a level of reserves for potential risk payments totaling $1,400,000 during 2018. These amounts are included as restricted cash and cash equivalents on the balance sheet.

Accounts Receivable, Trade
Accounts receivable consist primarily of revenue earned under the Organization's complex care coordination, informatics and other care intervention agreements with DVHA, participation fees and amounts due under consulting arrangements. Accounts receivable are stated at amounts billed, net of related reserves, as applicable. No collateral is required on these receivables (Note 3).

Prepaid Expenses and Other Current Assets
Prepaid expenses and other current assets include miscellaneous items primarily related to insurance, software licenses and software maintenance contracts.

Due to Related Parties
Due to related parties primarily includes operating expenses that are processed by UVM Medical Center and billed to the Organization, along with other transactions between the two organizations such as reimbursement activity from UVM Medical Center under the CMMI contract for which OneCare was a subrecipient in 2017.

Accounts Payable and Accrued Expenses
Accounts payable and accrued expenses primarily includes amounts due to Participants including January FPP payments received by the Organization from DVHA in December of the previous year and amounts due for favorable quality results under the VBIF. Throughout 2018, the Organization received complex care coordination funding from DVHA as stipulated in their agreement, however, based on the mix of attributed lives, all funding was not able to be used and thus the unspent funds are due back to DVHA. As of December 31, 2017, this account also included certain other credits issued to providers related to participation fees previously paid, as voted on by the Board of Managers (Note 4).

Deferred Revenue and Other Liabilities
Cash received from DVHA or Participants as advance deposits for undelivered services, are recorded within deferred revenue until the services are performed. Revenue related to ACO contracts or other remaining undelivered performance obligations is deferred and recognized upon completion of the underlying performance criteria.

Income Taxes
The Organization is a for-profit limited liability corporation, which elected to be treated as a partnership for tax purposes; therefore, any income passes through to the non-profit members and is treated as business related income. Accordingly, no provision for federal or state income taxes has been made in the financial statements.

Members' Equity
Each founding member made an initial contribution of $25,000. Each of the members agreed to make additional capital contributions in an amount equal to fifty percent of capital requirements of the Organization determined by the operating and capital budget approved by the Organization's Board of Managers. No member may make additional contributions of capital, withdraw capital, lend or advance, or receive interest on capital, without unanimous consent of the Board of Managers. Any profits or losses of the Organization are allocated among the members based on the percentage of capital contribution.

Reclassifications
Certain amounts in the 2017 financial statements have been reclassified to conform to the 2018 presentation.

New Accounting Guidance
On January 1, 2018, the Organization early adopted ASU 2016-18, *Statement of Cash Flows, Restricted Cash*. This ASU clarified that restricted cash and restricted cash equivalents should be included in total cash and cash equivalents when reconciling the beginning and ending balances in the statement of cash flows. Transfers of cash and cash equivalents between restricted and unrestricted classifications should not be presented in the statement of cash flows; however, the Organization had no transfers in 2018 or 2017. Additionally, the Organization had no restricted cash at December 31, 2017 and thus there was no impact on the statement of cash flows for the year-ended December 31, 2017.

3. Accounts Receivable, Trade

Accounts receivable consisted of the following at December 31, 2018 and 2017:

	2018	2017
Participation fees	$ 1,995,336	$ 203,460
Contract receivables	-	3,328,540
Consulting	821,721	18,000
Other	106,551	-
Total accounts receivable, trade	$ 2,923,608	$ 3,550,000

4. Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses consisted of the following at December 31, 2018 and 2017:

	2018	2017
Due to participants, FPP	$ 9,430,512	$ 6,539,132
Due to participants, VBIF	3,761,750	350,250
Due to DVHA	1,351,591	-
Trade payables	1,461,914	452,154
Due to payors, VBIF	167,505	-
Total accounts payable and accrued expenses	$ 16,173,272	$ 7,341,536

5. Contract Risk Settlements with Payors

Contract risk settlements receivable from and payable to the payors consisted of the following at December 31, 2018 and 2017:

	2018	2017
CMS	$ 5,568,578	$ -
Medicaid	-	2,364,754
Total accounts receivable from payors, contract risk settlement	$ 5,568,578	$ 2,364,754

CMS	$ 23,193,034	$ -
Medicaid	1,540,534	-
BCBSVT	909,098	-
Total accounts payable to payors, contract risk settlement	$ 25,642,666	$ -

6. Line of Credit

The Organization and UVM Medical Center entered into an irrevocable line of credit in an amount not to exceed $2,800,000 for repayment of the risk-based spending target under the VMNG program. This line of credit expired on March 28, 2019, which as per the agreement was 90 days after the final settlement of the 2017 Performance Year. There were no draws on the line of credit during fiscal year 2018 or 2017.

7. Note Payable, Related Party

In 2018, the Organization entered into a note payable totaling $4,124,849 with UVM Health Network in order to establish the escrow account required under the provisions of the CMS Modified Next Generation ACO Model participation agreement. Interest (at a rate of 3.75%) is payable monthly commencing on July 1, 2018 and all principal is due and payable by December 31, 2019. At December 31, 2018, accrued interest was $39,100 and is included in accounts payable and accrued expenses.

8. Related-Party Transactions

The Organization, given the nature of its business and relationship with the UVM Health Network has entered into various transactions with Participating affiliates of the UVM Health Network, including: UVM Medical Center, Central Vermont Medical Center ("CVMC") and Porter Medical Center ("PMC") during the ordinary course of business.

The following amounts have been recorded as accounts receivable/(payable) in the Organization's balance sheet at December 31, 2018 and 2017, respectively:

	UVM Medical Center		Other Network Affiliates	
	2018	2017	2018	2017
Participation fees receivable/(payable)	$ 1,130,842	$ 180,067	$ 459,043	$ (101,217)
UVM Medical Center self-funded medical plan premiums receivable	$ 662,106	$ -	$ -	$ -
Contract risk settlement	$ (1,195,823)	$ (1,809,335)	$ (755,509)	$ (396,769)
CMS AIPBP receivable	$ 14,436,757	$ -	$ 3,339,328	$ -

The following amounts have been recorded as revenue/(expenses) in the Organization's statement of operations and comprehensive income for the years ended December 31, 2018 and 2017, respectively:

	UVM Medical Center		Other Network Affiliates	
	2018	2017	2018	2017
Participation fees	$ 9,205,542	$ 1,587,410	$ 3,800,448	$ 306,858
Administrative expense reimbursements	$ (5,342,211)	$ (8,333,770)	$ -	$ -

UVM Medical Center provides various administrative services to the Organization, including the processing of payroll and accounts payable transactions. All employees of the Organization are UVM Medical Center employees and are covered under UVM Medical Center's insurance policies and employee benefit plans.

Included within operating expenses are $194,437 and $190,593 of rental expense (excluding common area and maintenance charges) for the years ended December 31, 2018 and 2017, respectively, related to office space. UVM Medical Center bills the Organization monthly for rental expense; however, there is no formal agreement with UVM Medical Center under this arrangement.

The Organization has a services agreement to provide data management and reporting services to Adirondacks ACO, LLC, an ACO operating in the State of New York. One of the partners to the Adirondacks ACO is Champlain Valley Physicians Hospital, a wholly controlled subsidiary of the UVM Health Network. The Organization recorded $216,000 in revenue related to this services agreement for the year ended December 31, 2018 and 2017. Additional consulting services and

shared employees also resulted in the Organization recording $669,983 in revenue for the year ended December 31, 2018.

9. Concentration of Credit Risk

Financial instruments that potentially subject the Organization to concentration of credit risk consist principally of cash and cash equivalents. At December 31, 2018 and 2017, one financial institution held all of the Organization's cash and cash equivalents. The Organization maintains balances in operating accounts above federally insured limits.

A summary of revenue and accounts receivable by type is as follows for the years-ended December 31, 2018 and 2017, respectively:

Revenue

	2018	2017
Participating providers	73%	25%
Medicaid	21%	73%
Contracted commercial plans	2%	0%
Other organizations	4%	2%
	100%	100%

Accounts receivable

	2018	2017
Participating providers	79%	4%
Medicaid	0%	96%
Contracted commercial plans	18%	0%
Other organizations	3%	0%
	100%	100%

10. Contingencies

The Organization is party in various legal proceedings and potential claims arising in the ordinary course of its business. In addition, the health care industry as a whole is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations is subject to government review and interpretation as well as regulatory actions, which could result in the imposition of significant fines and penalties. Management does not believe that these matters will have a material adverse effect on the Organization's financial position or results of operations.

The Organization is not currently party to any material legal proceedings. At each reporting date, the Organization evaluates whether a potential loss amount or a potential range of losses is probable and reasonably estimable under the provisions of the authoritative guidance that addresses accounting for contingencies.

11. Subsequent Events

On June 26, 2019, Springfield Hospital, Inc. ("Springfield"), a Participating hospital, filed for Chapter 11 bankruptcy protection. At December 31, 2018, the Organization had accounts receivable from Springfield totaling $650,153 and accounts payable to Springfield of $542,118. Accounts receivable have been collected subsequent to year-end via deductions to Springfield's 2019 monthly FPPs, as agreed to by both parties.

The Organization has assessed the impact of subsequent events through December 12, 2019, the date the audited financial statements were available for issuance and has concluded that there were no such events that require adjustment to the audited financial statements or disclosure in the notes to the audited financial statements other than as noted above.