OneCare Vermont Accountable Care Organization, LLC

Financial Statements
December 31, 2019 and 2018

OneCare Vermont Accountable Care Organization, LLC
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December 31, 2019 and 2018

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, 2019 and 2018, 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, 2019 and 2018 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 22, 2020

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OneCare Vermont Accountable Care Organization, LLC
Balance Sheets
December 31, 2019 and 2018

	2019	2018
Assets		
Current assets		
Cash and cash equivalents	$ 17,917,788	$ 18,867,852
Restricted cash	9,883,775	5,524,849
Accounts receivable	2,726,501	2,923,608
Accounts receivable from participants, contract risk settlement	12,216,624	22,029,890
Accounts receivable from payors, contract risk settlement	4,717,550	5,568,578
Prepaid expenses and other assets	213,727	136,678
Total current assets	47,675,965	55,051,455
Property and equipment, net	53,312	-
Total assets	$ 47,729,277	$ 55,051,455
Liabilities and Equity		
Current liabilities		
Accounts payable and accrued expenses	$ 9,139,617	$ 16,173,272
Accounts payable to participants, contract risk settlement	3,266,266	1,812,942
Accounts payable to payors, contract risk settlement	18,788,225	25,642,666
Due to related parties	2,467,329	4,730,338
Current portion of deferred revenue and other liabilities	790,678	1,570,132
Note payable	4,124,849	4,124,849
Total current liabilities	38,576,964	54,054,199
Long-term deferred revenue and other liabilities	3,465,884	-
Total long-term liabilities	3,465,884	-
Total liabilities	42,042,848	54,054,199
Members' equity	50,000	50,000
Retained surplus	5,636,429	947,256
Total members' equity	5,686,429	997,256
Total liabilities and members' equity	$ 47,729,277	$ 55,051,455

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, 2019 and 2018

	2019	2018
Revenue		
Contract revenue	$ 10,771,692	$ 3,500,000
Participation fees	25,842,028	17,397,929
Administrative revenue	2,697,815	1,814,430
Consulting revenue	355,289	995,856
Settlement revenue	415,240	588,195
Other revenue	362,384	119,300
Total revenue	40,444,448	24,415,710
Expenses		
Population health management expenses		
Care reform initiatives	19,688,249	9,265,904
Settlement expense	725,576	445,333
Total population health management expenses	20,413,825	9,711,237
Other operating expenses		
Salaries, payroll taxes and fringe benefits	7,721,134	7,344,815
Software, software licenses and software maintenance	2,600,557	2,795,193
Consulting, legal and purchased services	2,622,296	1,746,953
Travel, supplies and other	2,397,463	1,848,385
Total other operating expenses	15,341,450	13,735,346
Total expenses	35,755,275	23,446,583
Net income and comprehensive income	$ 4,689,173	$ 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, 2019 and 2018

	University of Vermont Medical Center	Dartmouth-Hitchcock Health	Total
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
Net income and comprehensive income	2,344,586	2,344,587	4,689,173
Balances at December 31, 2019	$ 2,843,215	$ 2,843,214	$ 5,686,429

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, 2019 and 2018

	2019	2018
Cash flows from operating activities		
Net income and comprehensive income	$ 4,689,173	$ 969,127
Adjustments to reconcile net income and comprehensive income to net cash provided by operating activities		
Depreciation expense	6,189	-
Increase (decrease) in cash resulting from a change in		
Accounts receivable, trade	197,107	626,392
Accounts receivable from participants, contract risk settlement	9,813,266	(22,029,890)
Accounts receivable from payors, contract risk settlement	851,028	(3,203,824)
Prepaid expenses and other assets	(77,049)	72,352
Due to/from related parties	(2,263,009)	(2,103,432)
Accounts payable and accrued expenses	(7,033,655)	8,831,736
Accounts payable to participants, contract risk settlement	1,453,324	(551,812)
Accounts payable to payors, contract risk settlement	(6,854,441)	25,642,666
Deferred revenue and other liabilities	2,686,430	632,929
Net cash provided by operating activities	3,468,363	8,886,244
Cash flows from investing activities		
Purchases of property and equipment	(59,501)	-
Net cash used in investing activities	(59,501)	-
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	3,408,862	13,011,093
Cash and cash equivalents and restricted cash		
Beginning of year	24,392,701	11,381,608
End of year	$ 27,801,563	$ 24,392,701
Supplemental disclosure of cash flow information:		
Cash paid for interest	$ 195,930	$ 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 ("D-HH"), 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, Dartmouth-Hitchcock (a New Hampshire hospital whose sole corporate member is D-HH), 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 a Risk-Bearing Participant & Preferred Provider 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 the 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 an administrative payment of $6.50 per attributed beneficiary per month of which, the Organization retains 50% and distributes 50% to the Participants. In 2018, the AIPBP also included a Primary Care Case Management Fee ("PCCM"). 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. Under this agreement, CMS has agreed to advance potential shared savings to OneCare. OneCare uses these dollars to fund programs related to the Vermont Blueprint for Health programs. All monies advanced is at risk and is subject to potential repayment.

Through the BCBSVT Commercial Next Generation Accountable Care Organization program agreement, BCBSVT and the Organization have entered into a risk arrangement specific to BCBSVT's Qualified Health Plan. In 2019 and 2018, OneCare received a $3.25 per attributed beneficiary per month fee all of which has or will be distributed to providers.

In 2019, OneCare entered into an agreement to implement a Care Management program specific to BCBSVT's Large Group Primary Payer population. Under this arrangement, OneCare received a $3.25 per attributed beneficiary per month fee all of which has or will be distributed to providers.

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. In 2019, UVM Medical Center paid $3.25 per attributed beneficiary per month to the Organization under this plan, which was used for primary care and ACO based payment reform and distributed to Participants. In 2018, UVM Medical Center paid $9.00 per attributed beneficiary per month to the Organization under this plan, $3.25 of which funded the Organization's operations and was recorded as revenue and $5.75 of which was used for primary care and ACO based payment reform and distributed to Participants.

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").

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 payor 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 primary prevention initiatives. In 2019, the Organization adopted ASU 2018-08, *Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*. While the Organization is a for-profit entity, they made a policy election to adopt this standard prospectively when accounting for non-exchange transactions and it did not have a material impact on the Organization's financial statements. The new guidance clarifies the definition of an

exchange transaction and the criteria for evaluating when non-exchange transactions are unconditional or conditional. As a result of the adoption of this pronouncement, the programs within contract revenue were deemed to be non-exchange transactions and revenue is recognized when conditions (if any) are met. In 2018, revenue resulting from the Organization's efforts was recognized when milestones under the contract were achieved, as evidenced through deliverables to DVHA and payment was reasonably assured. The conditions (i.e. 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. Revenue is earned once the Organization's performance to achieve the milestones is completed and thus deemed unconditional. A summary of revenue under the DVHA contract for the years ended December 31, 2019 and 2018, respectively, are as follows:

	2019	2018
Health Information Technology	$ 4,250,000	$ 3,500,000
Primary Prevention Development Funding	1,100,000	-
Complex Care Coordination	5,421,692	-
Total contract revenue	$ 10,771,692	$ 3,500,000

Participation Fees
The Organization charges Participants monthly fees that are used to fund OneCare administrative costs, population health management and care coordination fees, payment pilots, the Value Based Incentive Fund ("VBIF") and other OneCare board-approved programs. Revenue is recognized on a monthly basis to the extent identified services have been performed.

Administrative Revenue
Administrative revenue represents amounts earned by OneCare to provide services under the VMNG contract in 2019 and the VMNG and UVM Medical Center self-funded contracts in 2018. 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 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 both 2019 and 2018 the Organization paid all FPP monies to Participants and separately funded, via participant fees, the VBIF pool in the amount of $4,056,334 and $1,757,059, respectively. Total quality incentives earned by Participants for the years ended December 31, 2019 and 2018 were $3,853,517 and $1,493,500, respectively. The Organization retains 50% of the undistributed quality funds for ongoing quality improvement initiatives. The remaining 50% is payable to DVHA.

Under the arrangements with CMS, the Organization funded the VBIF pool for Participants in the amounts of $2,479,049 and $1,744,142 for the years ended December 31, 2019 and 2018, respectively. Total quality incentives earned by Participants were $2,277,750 and $1,744,142 in 2019 and 2018, respectively.

Under the arrangement with BCBSVT, the Organization funded the VBIF pool for Participants in the amounts of $524,151 and $516,257 for the years ended December 31, 2019 and 2018, respectively. Total quality incentives earned by Participants were $422,233 and $432,564 in 2019 and 2018, respectively.

Under the UVM Medical Center's Plan in 2019, the contract specified that the VBIF pool would be funded only through shared savings achieved. No shared savings were earned, therefore no pool exists in 2019. In 2018, the Plan provided funding for the VBIF pool, which totaled $82,725, however, it was agreed these dollars would be distributed based on 2019 results. Total quality incentives earned by Participants in 2019 from the 2018 pool were $56,137.

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 payers if actual costs exceed the established targets or is entitled to shared savings if actual costs are less than the targets (within established corridors). The Organization records, as an asset or liability at December 31, 2019 and 2018, the savings or losses under each contract either due from or due to the payers. Participants will fund any amount due to the payers or will receive a distribution of savings under the contracts (Note 4). 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 result in additional payment to, or a recoupment from, CMS. CMS reviews this reconciliation 18 months after initial settlement. The impact of this 18 month review on the CMS AIPBP 2018 settlement resulted in a recoupment from CMS of $791,792. In November 2020, the Board of Managers voted to pay these dollars to Participants upon receipt. This settlement has been recorded within contract risk settlements on the balance sheet as of December 31, 2019. The Organization cannot estimate the impact of the 18 month review of the AIPBP Reconciliation as it relates to the 2019 CMS contract and thus will record this settlement in subsequent years once known. This amount could be material.

OneCare enters into agreements with Participants as deemed necessary to limit these Participants' upside and downside risk under their participation agreements. Under the terms of these agreements, any settlements forfeited by these participants are recorded as contract risk settlement revenue or expense by the Organization. This arrangement resulted in expense to the Organization of $310,336 in 2019 and income to the Organization of $142,862 in 2018. These amounts are included in contract risk settlement revenue or expense in the statement of operations and comprehensive income.

Other Activity Under Payor Contracts

Other than administrative revenue and contract revenue under the VMNG contract, all other activity associated with OneCare's accountable care payor contracts is treated on a pass-through basis and does not represent revenue or expense to the Organization following the guidance in ASC 605-45, *Revenue Recognition*.

A summary of the cash flows 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, 2019 and 2018, respectively:

	2019	2018
Vermont Medicaid Next Generation ACO Program		
FPP	$ 112,650,242	$ 67,311,686
PCCM	-	1,130,068
Administrative	2,697,815	1,542,161
Total VMNG	$ 115,348,057	$ 69,983,915
CMS Vermont Modified Next Generation ACO Program		
AIPBP	$ 240,135,708	$ 173,123,576
Total CMS	$ 240,135,708	$ 173,123,576
BCBSVT Commercial Next Generation ACO Program		
Population health management fee	$ 702,465	$ 740,304
Total BCBSVT	$ 702,465	$ 740,304
BCBSVT Large Group Primary Payer		
Population health management fee	$ 1,419,187	$ -
Total BCBSVT	$ 1,419,187	$ -
UVM Medical Center Self-funded Medical Plan		
Population health management fees	$ 372,457	$ 266,975
VBIF funding	-	82,275
Complex care coordination	-	82,400
Total UVM Medical Center Self-funded Medical Plan	$ 372,457	$ 431,650

Population Health Management Expenses
Population health management expenses are those expenses funded by the Organization that provide direct financial benefit to 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 $5,983,775 and $4,124,849, in 2019 and 2018, the amount specified by CMS, have been placed in escrow and must be maintained until final settlement under the contract for the Performance 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

$3,900,000 and $1,400,000 during 2019 and 2018, respectively. 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, amounts due under consulting arrangements and amounts due from payors outside the annual settlement process. Accounts receivable are stated at amounts billed, net of related reserves, as applicable (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.

Property and equipment
Property and equipment are shown at cost when purchased, net of accumulated depreciation. Depreciation is calculated on a straight-line basis over the estimated useful lives of 7 years for furniture and fixtures and 22 months for leasehold improvements, which is the remaining term of the existing lease. Property and equipment as of December 31, 2019 and 2018 are shown in the table below:

	2019	2018
Furniture and Fixtures	$ 49,548	$ -
Leasehold Improvements	9,953	-
Total	$ 59,501	-
Less: accumulated depreciation	(6,189)	-
Net property and equipment	$ 53,312	$ -

Depreciation expense was $6,189 in 2019 and $0 in 2018.

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.

Accounts Payable and Accrued Expenses
Accounts payable and accrued expenses includes amounts due to vendors and Participants, including amounts due for favorable quality results under the VBIF. Amounts due to Participants were $7,277,797 and $13,192,262 at December 31, 2019 and 2018, respectively. The Organization received complex care coordination funding from DVHA throughout 2019 and 2018 and in both years the mix of attributed lives was such that not all monies were spent. As such, unspent funds recorded as due back to DVHA were $78,308 and $1,351,591 at December 31, 2019 and 2018, respectively.

Deferred Revenue
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. Deferred revenue classified as a long-term

liability represents participation fees paid by Participants specific to programs that did not take place in 2019 and thus performance obligations have not been met. These programs are not expected to take place until 2021.

Reinsurance Policy/Risk Mitigation
The Organization entered into a risk transfer agreement with Hannover Life Reassurance Company of America LTD related to the CMS Vermont Modified Next Generation ACO Model for the 2019 and 2018 performance years.

In 2019, the agreement provided for an arrangement whereby payment would accrue to the Organization equal to 90% of total actual expenditures in excess of the attachment point (103% of final benchmark) and up to the detachment point (105.5% of final benchmark). For 2018, the range was 102.5% through 105%. Calculations performed at each year-end determined that claims spend for each year was below the respective threshold and therefore there were no accounts receivable or payable under this arrangement at December 31, 2019 and 2018.

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 2018 financial statements have been reclassified to conform to the 2019 presentation.

New Accounting Guidance
On January 1, 2019, the Organization adopted ASU 2016-15 (*Statement of Cash Flows: Classification of Certain Cash Receipts and Cash Payments)*, which provides clarification on classifying a variety of activities within the Statements of Cash Flows. The adoption of this standard did not have a material impact to the Organization's statements of cash flows.

In May 2014, the FASB issued ASU 2014-09 *Revenue from Contracts with Customers*. This standard implements a single framework for recognition of all revenue earned from customers. This framework ensures that entities appropriately reflect the consideration to which they expect to be entitled in exchange for goods and services by allocating transaction price to identified performance obligations and recognizing revenue as performance obligations are satisfied. Qualitative and quantitative disclosures are required 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 standard was effective for the Organization in 2019, however, as a response to COVID-19, the FASB allowed for the effective date to be extended by one year, and the Organization elected this deferral and will adopt this standard in 2020. The Organization

continues to evaluate the impact of this standard and does not expect it will have a material impact on the financial statements.

In February 2016, the FASB issued ASU 2016-02, *Leases*, which requires a lessee to recognize a right-of-use asset and a lease liability for most leases, initially measured at the present value of the lease payments, in its balance sheet. The standard also requires a lessee to recognize a single lease cost, calculated so that the cost of the lease is allocated over the lease term, on a generally straight-line basis. The guidance also expands the required quantitative and qualitative disclosures surrounding leases. The ASU is effective for fiscal years beginning after December 15, 2019, or fiscal year 2020 for the Organization. FASB allowed for the effective date to be extended by one-year in response to COVID-19, however, early adoption is permitted. The Organization is evaluating the impact of the new guidance on the financial statements.

3. Accounts Receivable, Trade

Accounts receivable consisted of the following at December 31, 2019 and 2018:

	2019	2018
Participation fees	$ 1,121,332	$ 1,995,336
Contract receivables	1,404,379	-
Consulting	-	821,721
Other	200,790	106,551
Total accounts receivable, trade	$ 2,726,501	$ 2,923,608

4. Contract Risk Settlements with Payors

Contract risk settlements receivable from and payable to the payors consisted of the following at December 31, 2019 and 2018:

	2019	2018
CMS	$ 4,717,550	$ 5,568,578
Total accounts receivable from payors, contract risk settlement	$ 4,717,550	$ 5,568,578

CMS	$ 12,272,929	$ 23,193,034
Medicaid	6,505,293	1,540,534
BCBSVT	10,003	909,098
Total accounts payable to payors, contract risk settlement	$ 18,788,225	$ 25,642,666

5. 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 and was not renewed. There were no draws on the line of credit during fiscal year 2019 or 2018.

6. Note Payable

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, 2020. Accrued interest was fully paid at December 31, 2019. In 2018 accrued interest of $39,100 is included in accounts payable and accrued expenses. As of September 30, 2020 the note was paid in full.

7. Related-Party Transactions

The Organization, given the nature of its business and relationship with the UVM Health Network and D-HH has entered into various transactions with D-HH and 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, 2019 and 2018, respectively:

	UVM Medical Center		Other Related Organizations	
	2019	2018	2019	2018
Participation fees receivable	$ -	$ 1,130,842	$ 1,126,379	$ 635,430
UVM Medical Center self-funded medical plan premiums receivable	$ 372,457	$ 662,106	$ -	$ -
Contract risk settlement	$ (3,118,916)	$ (1,195,823)	$ 2,824,151	$ (1,046,306)
CMS AIPBP settlement	$ 4,898,386	$ 14,436,757	$ (727,953)	$ 3,339,328

The following amounts have been recorded as revenue/(expense) in the Organization's statement of operations and comprehensive income for the years ended December 31, 2019 and 2018, respectively:

	UVM Medical Center		Other Related Organizations	
	2019	2018	2019	2018
Particpation fees	$ 11,751,051	$ 8,914,153	$ 5,160,038	$ 4,319,685
Administrative expense reimbursements	$ (3,206,744)	$ (5,342,211)	$ -	$ -

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 $240,662 and $194,437 of rental expense (excluding

common area and maintenance charges) for the years ended December 31, 2019 and 2018, 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 years ended December 31, 2019 and 2018. Additional consulting services and shared employees also resulted in the Organization recording $669,983 in revenue for the year ended December 31, 2018. In 2019, the consulting services and shared employees component of this agreement was terminated.

8. Concentration of Credit Risk

Financial instruments that potentially subject the Organization to concentration of credit risk consist principally of cash, restricted cash and cash equivalents. At December 31, 2019 and 2018, 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, 2019 and 2018, respectively:

Revenue

	2019	2018
Participating providers	65%	73%
Medicaid	33%	21%
Contracted commercial plans	0%	2%
Other organizations	2%	4%
	100%	100%

Accounts Receivable

	2019	2018
Participating providers	68%	79%
Medicaid	7%	0%
CMS	24%	0%
Contracted commercial plans	0%	18%
Other organizations	1%	3%
	100%	100%

9. 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.

10. Subsequent Events

In March 2020, the outbreak of COVID-19 caused domestic and global disruption in operations for health care providers and associated organizations, including the postponement of elective and non-urgent care. Potential adverse consequences of COVID-19 include a temporary statewide de-prioritization of value-based care initiatives, inability of the payers to set fair total cost of care targets, aversion to healthcare cost risk, and competition for funding. Future uncertainty related to COVID-19 remains due to the delayed nature of health care cost reporting and final settlement under each of our payer contracts.

On March 5, 2020, the Organization entered into a loan agreement with TD Bank with a total commitment of $10,000,000. Under the agreement, a line of credit is available that can be used solely for the issuance of standby letters of credit in favor of CMS to support the financial guarantees in connection with the CMS accountable care program agreement. The line of credit expires on the loan maturity date of March 5, 2022. Any amounts outstanding bear interest at a rate equal to LIBOR plus an applicable margin. The loan agreement is guaranteed by Dartmouth-Hitchcock, and either the UVM Medical Center or UVM Health Network. The loan agreement requires the Organization to provide TD Bank with audited financial statements 210 days after its fiscal year-end. In 2020, the Organization received an extension of this requirement through December 25, 2020.

The Organization has assessed the impact of subsequent events through December 22, 2020, the date the audited financial statements were available 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.