FINANCIAL STATEMENTS

OneCare Vermont Accountable Care Organization, LLC
Year Ended December 31, 2022
With Report of Independent Auditors

Ernst & Young LLP

OneCare Vermont Accountable Care Organization, LLC

Financial Statements

Year Ended December 31, 2022

Contents

Report of Independent Auditors 1

Financial Statements

Statement of Financial Position 3
Statement of Activities 4
Statement of Cash Flows 5
Notes to Financial Statements 6

Ernst & Young LLP
One Manhattan West
New York, NY 10001-8604

Tel: +1 212 773 3000
ey.com

Building a better working world

Report of Independent Auditors

The Board of Managers
OneCare Vermont Accountable Care Organization, LLC

Opinion

We have audited the financial statements of OneCare Vermont Accountable Care Organization, LLC (the Organization), which comprise the statement of financial position as of December 31, 2022, and the related statements of activities and cash flows for the year then ended, and the related notes (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Organization at December 31, 2022, and the changes in its net assets and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Organization and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management 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, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Building a better working world

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit 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, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Ernst & Young LLP

August 24, 2023

OneCare Vermont Accountable Care Organization, LLC

Statement of Financial Position

December 31, 2022

Assets	
Current assets:	
Cash and cash equivalents	$ 33,497,335
Accounts receivable	32,039
Accounts receivable from participants, contract risk settlements	6,897,489
Accounts receivable from payers, contract risk settlements	16,252,499
Prepaid expenses and other assets	406,578
Total current assets	57,085,940
Property and equipment, net	24,774
Total assets	$ 57,110,714
Liabilities and net assets	
Current liabilities:	
Accounts payable and accrued expenses	$ 23,677,555
Accounts payable to participants, contract risk settlements	6,687,025
Accounts payable to payers, contract risk settlements	14,025,712
Due to related parties	2,739,550
Current portion of deferred revenue	77,132
Total current liabilities	47,206,974
Deferred revenue, less current portion	1,742,976
Other long-term liabilities	280,111
Total liabilities	49,230,061
Net assets:	
Without donor restrictions	7,880,653
Total net assets	7,880,653
Total liabilities and net assets	$ 57,110,714

See accompanying notes.

OneCare Vermont Accountable Care Organization, LLC

Statement of Activities

Year Ended December 31, 2022

Revenue:	
Participant revenue	$ 23,795,568
Other revenue	272,391
Total revenue	24,067,959
Expenses:	
Population health management expenses:	
Care reform initiatives	9,225,091
Settlement expense	328,400
Total population health management expense	9,553,491
Other operating expenses:	
Salaries, payroll taxes and fringe benefits	8,185,684
Software, software licenses and software maintenance	2,297,813
Consulting, legal and other purchased services	1,935,632
Travel, supplies and other	1,194,534
Total other operating expenses	13,613,663
Total expenses	23,167,154
Increase in net assets without donor restrictions	900,805
Net assets at beginning of period	6,979,848
Net assets at end of period	$ 7,880,653

See accompanying notes.

OneCare Vermont Accountable Care Organization, LLC

Statement of Cash Flows

Year Ended December 31, 2022

Cash flows from operating activities	
Change in net assets	$ 900,805
Adjustments to reconcile change in net assets to net cash provided by operating activities:	
Depreciation and amortization expense	8,155
Changes in operating assets and liabilities:	
Accounts receivable	97,364
Accounts receivable from participants, contract risk settlements	(6,167,035)
Accounts receivable from payers, contract risk settlements	7,999,551
Prepaid expenses and other assets	(54,173)
Due to related parties	(400,044)
Accounts payable and accrued expenses	16,488,974
Accounts payable to participants, contract risk settlements	(9,576,026)
Accounts payable to payers, contract risk settlements	5,526,697
Deferred revenue	(95,028)
Other long-term liabilities	280,111
Net cash provided by operating activities	15,009,351
Investing activities	
Proceeds from sale of property and equipment	4,772
Net cash provided by investing activities	4,772
Net increase in cash and cash equivalents	15,014,123
Cash and cash equivalents:	
Beginning of year	18,483,212
End of year	$ 33,497,335

See accompanying notes.

OneCare Vermont Accountable Care Organization, LLC

Notes to Financial Statements

December 31, 2022

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) (whose sole corporate member is the University of Vermont Health Network, UVM Health Network), a Vermont not-for-profit corporation, and Dartmouth-Hitchcock Health (DHH), a New Hampshire not-for-profit corporation. On September 30, 2021, DHH surrendered its membership in OneCare, and UVM Medical Center transferred its membership status to its parent organization, UVM Health Network. On October 1, 2021, the Organization amended its Operating Agreement such that UVM Health Network became its sole corporate member. In accordance with OneCare's limited liability corporation structure, limitations exist on the liability of the sole corporate member.

The Organization's mission is to partner with local health care providers to transform Vermont's health care system to one that focuses on health goals by providing actionable data and innovative payments that foster better outcomes for all. The Organization is focused on three core strategies: network performance management, data and analytics, and payment reform. The Organization supports and coordinates with an extensive, statewide network of providers and communities implementing health care payment reform and population health management.

OneCare entered into population-based "next generation" accountable care program agreements for performance year 2022 with the State of Vermont Department of Vermont Health Access (DVHA) for Vermont Medicaid, the Centers for Medicare and Medicaid Services (CMS) for Medicare, BlueCross BlueShield of Vermont (BCBSVT) and MVP Health Care, Inc. (MVP). These agreements are designed to align with the Vermont All-Payer Accountable Care Organization Model agreement between the State of Vermont and CMS. These agreements contain risk sharing arrangements and the provision of funding that OneCare is to use to further health care reform payment models.

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), 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 contractual agreement with OneCare and has agreed to become and remain accountable for the quality, cost and overall care of attributed lives.

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).

Net Assets

Net assets and revenues and expenses are classified based on the existence or absence of donor-imposed restrictions.

Net assets without donor restrictions – Net assets without donor restrictions are not subject to donor-imposed stipulations. Net assets without donor restrictions may be designated for specific purposes.

Net assets with donor restrictions – The Organization has no net assets with donor restrictions. To the extent applicable in the future, this classification applies to net assets subject to donor-imposed stipulations that are maintained in perpetuity by the Organization and net assets subject to donor-imposed stipulations that may be satisfied by actions of the Organization that will expire with the passage of time or the occurrence of specific events.

Use of Estimates

The preparation of financial statements in accordance with GAAP 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 dates of the financial statements. Estimates also affect the amounts of revenues and expenses reported during the periods. The Organization's significant estimates include either a receivable or payable for the year-end risk settlements under each payer contract, along with amounts due to or from Participants based on achieving defined annual quality metrics. Accordingly, actual results could differ from those estimates.

2. Significant Accounting Policies (continued)

New Accounting Guidance

In February 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (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, on 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 Organization adopted the standard on January 1, 2022 following the modified retrospective method of application. As such, prior period financial statement amounts and disclosures were not adjusted to reflect the provisions of the new standard. There was no cumulative-effect adjustment to the January 1, 2022 opening net assets as a result of the adoption. The Organization has made the transition-specific election to apply the package of practical expedients which allows for the carryforward of historical assessments of (1) whether contracts are or contain leases, (2) lease classification and (3) initial direct costs. Additionally, for operating leases entered into prior to January 1, 2022, the Organization has elected to utilize the operating leases' remaining lease term as of the date of adoption to determine the discount rate used to initially measure the liability. Management determined the impact of the adoption of ASU 2016-02 on the financial statements is not material, and thus certain other accounting policy elections and quantitative and qualitative information related to the adoption are omitted from disclosure.

In June 2016, the FASB issued ASU 2016-13, Financial Instruments – Credit Losses (Topic 326): *Measurement of Credit Losses on Financial Instruments*. The new credit losses standard changes the impairment model for most financial assets and certain other instruments. For trade and other receivables, contract assets recognized as a result of applying ASU 2014-09, *Revenue from Contracts with Customers* (Topic 606), loans and certain other instruments, entities will be required to use a new forward looking "expected loss" model that generally will result in earlier recognition of credit losses than under today's incurred loss model. ASU 2016-13 is effective for annual periods beginning after December 15, 2022. The Organization has not completed the process of evaluating the impact of ASU 2016-13 on its financial statements.

2. Significant Accounting Policies (continued)

Participant Revenue

The majority of the contractual amounts received by the Organization represent pass-through transactions (not recorded as revenue) as further described below in "Other Activity Under Payer Contracts."

The Organization recognizes revenue for services provided to customers in an amount that reflects the consideration to which the Organization expects to be entitled in exchange for those services. At contract inception, the Organization identifies the performance obligation for each promise to transfer a service that is distinct. For the majority of the Organization's operations, the primary performance obligation is to provide various support services, such as data reporting software and support, training, data analysis, data reporting and clinical leadership. The consideration received for services may include variable components. Variable consideration is included in the transaction price to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved. The Organization satisfies its performance obligations and recognizes revenue ratably over the period in which services are provided to Participants.

The Organization receives financial support from Participants to fund its operations. Participant revenue is comprised of participation fees and Medicaid Participant supplemental fees. A summary of participant revenue for the year ended December 31, 2022 is as follows:

Participation fees	$ 20,435,129
Medicaid participant supplemental fees	3,360,439
Total participant revenue	$ 23,795,568

Participation Fees

Participation fees are approved by the Organization's Board of Managers on an annual basis based on budgeted expenditures for the purpose of funding operations. Participation fees are billed at a monthly, predetermined rate for each Participant. Revenue is recognized on a monthly basis as expenses are incurred or services are performed.

As the Organization's annual budget is the basis for establishing participation fees, it is expected that variation between actual and budgeted expenses will occur in the normal course of business, which may result in a profit or loss for the Organization. If this type of variation occurs, the Board

2. Significant Accounting Policies (continued)

of Managers may, at their discretion, issue credits to Participants or, in the case of a loss, increase participation fees. Such retroactive changes to participation fees would be considered a change in the transaction price that constitutes variable consideration. In 2022, the Board did not take action to either increase or decrease the participation fees at the conclusion of the fiscal year, thus no changes were recognized as variable consideration.

Medicaid Participant Supplemental Fees

Medicaid participant supplemental fees are collected from Participants in the Medicaid DVHA program to fund operations of the Organization, including administration of care coordination and prevention initiatives previously funded directly by DVHA.

Contract Asset/Liability Balances recorded as Deferred Revenue

The Organization satisfies its performance obligations when it provides the Participants with various support services. The timing of the Organization's performance may differ from the timing of the Participants' payments, which may result in the recognition of a contract asset or a contract liability. At December 31, 2022, there were no material contract assets with customers.

A summary of the Organization's contract liabilities, recorded in current and long-term deferred revenue at December 31, 2022 are as follows:

Beginning balance	$ (1,915,136)
Revenue recognized	873,691
Revenue deferred	(778,663)
Ending balance	$ (1,820,108)

Amounts not recognized relate to performance obligations under participation agreements and are primarily associated with population health management programs and initiatives deferred to a future year. Amounts will be recognized as revenue in the future when these population health management programs are implemented, either through achievement of stated objectives or expenditures of funds. New deferrals in 2022 relate to cash received from 2021 performance year settlements.

2. Significant Accounting Policies (continued)

Population Health Management Expenses

The Organization operates quality improvement and cost control initiatives that include funds to be distributed to Participants based on results in accordance with Organization policy. These initiatives are designed to incentivize Participants to deliver high quality care and manage health care cost growth. Population health management expenses are recorded as incurred.

Contract Risk Settlement Guarantees

The Organization has agreed to risk-based medical spending targets for the full attributed populations during the performance year, which is from January 1 to December 31. The Organization is liable to the payers for shared losses if actual costs exceed the established targets or is entitled to shared savings if actual costs are less than the targets (within established corridors). At the execution of each payer contract, the Organization records a guarantee liability under FASB Accounting Standards Codification (ASC) Topic 460, *Guarantees*, to indemnify the payer for shared losses if the estimated costs that underlie the risk arrangement exceed target costs. Under Topic 460, such guarantee liabilities are measured at fair value on the statement of financial position with an entry to expense (recorded at time of contract execution) on the statement of activities; the liability is amortized (via a reversal of expense) over the term of the contract as the stand-ready obligation expires. All of the Organization's risk arrangement contracts are for single year terms.

The Organization executed risk arrangement contracts for performance year 2023 with CMS and DVHA in December 2022. Management concluded at the inception of the 2022 and 2023 performance year agreements with these payers that it would not be probable for the contracts to result in shared losses based upon the contractual cost targets and shared loss caps and upon historical experience, and has assessed the fair value of shared losses to be de minimis. Accordingly, no amounts have been recorded as guarantee liabilities at December 31, 2022 and there is no impact to the statement of activities for the Organization's guarantee liabilities to CMS or DVHA for the year ended December 31, 2022. The Organization executed a risk arrangement contract for performance year 2023 with MVP in February 2023. Shared savings under the 2022 CMS and DVHA contracts are expected and thus receivables were recorded at December 31, 2022.

2. Significant Accounting Policies (continued)

No performance year 2023 risk arrangement contract has been executed with BCBSVT. At the inception of the performance year 2022 risk arrangement contract with BCBSVT in January 2022, management concluded it was highly likely shared losses would be realized up to the contract cap and recorded the fair value of a stand-ready obligation accordingly. At the close of the 2022 performance year, actual costs exceeded established targets, and thus a contingent liability was recorded in line with ASC Topic 450, *Contingencies*, for $125,000 (as noted in the table below).

The Organization records, as an asset or liability, the savings or losses estimated under each contract either due from or due to the payers. Participants are responsible to fund any amount due to the payers for losses or will receive a distribution of savings under the contracts. Exceptions include all savings or losses under the BCBSVT contract and certain risk mitigation agreements approved by the Organization's Board of Managers. Amounts are recorded as settlement expense on the statement of activities and resulted in expense of $328,400 for the year ended December 31, 2022.

The Organization recorded changes in shared savings and loss estimates for final settlements received from payers during the year ended December 31, 2022 related to the performance year ended December 31, 2021, including an unfavorable change in estimate of $35,250 related to BCBSVT and a favorable change in estimate of $715,776 related to DVHA. Due to the contract provisions for the settlement arrangements, the BCBSVT change in estimate of shared losses impacted the statement of activities.

Receivables from and payables to payers related to risk arrangements were recorded within accounts receivable from payers, contract risk settlements and accounts payable to payers, contract risk settlements on the statement of financial position at December 31, 2022 and consist of the following:

Medicare shared savings	$ 9,625,106
Less shared savings advances	(9,073,983)
Total receivable from CMS	551,123
Medicaid shared savings receivable from DVHA	11,109,711
BCBSVT shared loss payable to BCBSVT	125,000

2. Significant Accounting Policies (continued)

Other Activity Under Payer Contracts

The guarantees assumed by OneCare as described above are for the risk-sharing provisions of its payer contracts only. The majority of the activity under these contracts (such as payments made under an alternative reimbursement mechanism to fee for service for Participants) is treated by the Organization as pass-through activity on behalf of the Participants.

Under the CMS and BCBSVT contracts, as part of the settlement for the performance year, the payer will compare the difference between the total payments paid to the Organization and the fee for service equivalent for services rendered by Participants (All-Inclusive Population-Based Payment (AIPBP) Reconciliation or Fixed Prospective Payment (FPP) Reconciliation). An excess of payments paid over fee for service equivalent will result in recoupment from CMS or BCBSVT. CMS reviews its reconciliation 18 months after the end of the performance year. Under the DVHA contract, as part of the settlement for the performance year, the payer will reassess its patient attribution for changes in patient type (for example, child to adult). Any changes result in either additional payment to or recoupment from DVHA (the Medicaid Eligibility Group (MEG) Reclass).

Both the AIPBP and FPP Reconciliations and MEG Reclass are pass-through activity to Participants. The Organization records, as an asset or liability, the amounts estimated under each contract either due from or due to the payers, as well as a corresponding receivable due to or due from the Participants. There is no impact to the statement of activities from the pass-through activity.

During the year ended December 31, 2022, the Organization recorded favorable changes in estimates of $750,270 related to the DVHA contract and $512,120 related to the CMS AIPBP Reconciliation for the year ended December 31, 2021. As these changes in estimates related to pass-through activity, neither change impacted the statement of activities.

2. Significant Accounting Policies (continued)

A summary of the pass-through other than risk arrangement transactions under each of the Organization's 2022 performance year contracts is as follows for the year ended December 31, 2022:

Vermont Medicaid Next Generation ACO Program:	
Fixed prospective payments (FPP) paid	$ 176,240,899
Provider Reform Support paid	6,454,362
MEG Reclass receivable	1,714,512
Total DVHA	$ 184,409,773
CMS Vermont Modified Next Generation ACO Program:	
AIPBP paid	$ 263,226,509
AIPBP Reconciliation payable	(13,785,969)
Total CMS	$ 249,440,540
BCBSVT Commercial Next Generation ACO Program:	
FPP paid	$ 5,447,513
Primary care support funds paid	747,653
FPP Reconciliation payable	(114,743)
Total BCBSVT Commercial	$ 6,080,423
BCBSVT Primary Payer Program:	
Population health management fee paid	$ 2,572,190
Total BCBSVT Primary Payer Program	$ 2,572,190
MVP Health Plan:	
Population health management fees paid	$ 347,802
Total MVP Health Plan	$ 347,802

Included in above are payments to related parties (Note 4).

2. Significant Accounting Policies (continued)

Cash and Cash Equivalents

Cash and cash equivalents include all liquid investments with maturities of three months or less when purchased. Cash and cash equivalents comprise all of the Organization's assets that could be made available for general expenditures within one year.

Accounts Receivable

Accounts receivable typically consists of amounts due from payers outside the annual settlement process. Accounts receivable are stated at amounts billed, net of related reserves, as applicable for revenue earned or pass-through dollars to be received under payer contracts.

Prepaid Expenses and Other Assets

Prepaid expenses and other 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 and amortization. Depreciation and amortization 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 are shown in the table below as of December 31, 2022:

Furniture and fixtures	$ 49,549
Leasehold improvements	9,953
Total	59,502
Less: accumulated depreciation and amortization	(34,728)
Net property and equipment	$ 24,774

2. Significant Accounting Policies (continued)

Depreciation and amortization expense was $8,155 for the year ended December 31, 2022. The Organization wrote off $1,277 of accumulated depreciation on property and equipment sold at book value in the year ended December 31, 2022.

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 any other transactions that may occur between the two organizations outside of population health management payments (see Note 4).

Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses include amounts due to vendors, employees and Participants.

Income Taxes

In April 2021, the Organization was granted 501(c)(3) tax filing status by the federal government retroactive to October 2020, but continued to be organized as a limited liability corporation and presented financial statements consistent with those of a business entity until October 1, 2021, when the operating agreement of the Organization was changed such that the Organization qualified for not-for-profit accounting and tax treatment. As a not-for-profit organization as described in Section 501(c)(3) of the Internal Revenue Code (the Code), the Organization is exempt from federal income taxes on related income pursuant to Section 501(a) of the Code. The Organization is also exempt from state and local income taxes.

3. Line of Credit

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 Vermont Modified Next Generation ACO Model participation agreement. The loan agreement was guaranteed by Dartmouth-Hitchcock and UVM Medical Center. On April 18, 2022, the Organization renewed the TD Bank loan agreement in the amount of $15,000,000 with UVM Health Network as the sole guarantor. Subsequent to renewal, a standby letter of credit was issued against the line of credit for the 2022 CMS financial guaranty

3. Line of Credit (continued)

not to exceed $5,636,291. In August 2023, an additional standby letter of credit was issued against the line of credit for the 2023 CMS financial guaranty not to exceed $5,990,067. Any amounts outstanding on the line of credit bear interest at a rate equal to the 1- month Secured Overnight Lending Rate plus an applicable margin. For all periods presented there are no amounts outstanding. The loan agreement requires the Organization to provide TD Bank with audited financial statements 210 days after its fiscal year-end, which was extended by 60 days for the 2021 audit.

4. Related Party Transactions

The Organization, given the nature of its business and relationship with the UVM Health Network, has entered into various transactions with Participants that are affiliates of the UVM Health Network, including UVM Medical Center, Central Vermont Medical Center and Porter Medical Center, during the ordinary course of business. The following amounts have been recorded in the Organization's statement of financial position separate from the balance of due to related parties included on the statement of financial position at December 31, 2022. The net of contract risk settlements and the CMS AIPBP settlement is recorded as either an accounts receivable from participants, contract risk settlements or as an accounts payable to participants, contract risk settlement.

	UVM Health Network
Contract risk settlement shared savings and shared losses	$ 5,268,609
Other activity under payer contracts	(2,444,896)

The following amounts have been recorded as revenue (expense) in the Organization's statement of activities for the year ended December 31, 2022:

	UVM Health Network
Participation fees	$ 9,092,141
Expense reimbursements	(11,393,915)

4. Related Party Transactions (continued)

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. These expenses are reimbursed to UVM Medical Center by the Organization.

Additionally, population health management expenses are incurred with all Participants, including UVM Health Network in the normal course of business by the Organization.

5. 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, 2022, 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 accounts receivable by type at December 31, 2022 is as follows:

Accounts receivable:	
Participating providers	30%
DVHA	65
CMS	5
	100%

6. Functional Expenses

The functional expenses related to the fulfillment of the Organization's mission are as follows:

	Population Health Management	Management and General	Total
Year Ended December 31, 2022			
Care reform initiatives	$ 9,225,091	$ –	$ 9,225,091
Settlement expense	328,400	–	328,400
Salaries, payroll taxes and fringe benefits	5,188,560	2,997,124	8,185,684
Software, software licenses and software maintenance	2,248,207	49,606	2,297,813
Consulting, legal and purchased services	1,128,964	806,668	1,935,632
Travel, supplies and other	191,813	1,002,721	1,194,534
Total	$ 18,311,035	$ 4,856,119	$ 23,167,154

7. Contingencies

The Organization is party to various legal proceedings and potential claims arising in the ordinary course of 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 applicable accounting guidance.

8. Subsequent Events

The Organization has assessed the impact of subsequent events through August 24, 2023 the date the financial statements were available to be issued and has concluded that, except as disclosed in Note 3, there were no such events that require adjustment to the financial statements or disclosure in the notes to the accompanying financial statements.

EY | Building a better working world

EY exists to build a better working world, helping to create long-term value for clients, people and society and build trust in the capital markets.

Enabled by data and technology, diverse EY teams in over 150 countries provide trust through assurance and help clients grow, transform and operate.

Working across assurance, consulting, law, strategy, tax and transactions, EY teams ask better questions to find new answers for the complex issues facing our world today.

ey.com