KPMG

CAREOREGON, INC. AND SUBSIDIARIES

Consolidated Financial Statements
(With Supplementary Information)

December 31, 2021 and 2020

(With Independent Auditors' Report Thereon)

CAREOREGON, INC. AND SUBSIDIARIES

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KPMG LLP
Suite 3800
1300 South West Fifth Avenue
Portland, OR 97201

Independent Auditors' Report

The Board of Directors
CareOregon, Inc. and Subsidiaries:

Opinion

We have audited the consolidated financial statements of CareOregon, Inc. and Subsidiaries and its subsidiaries (the Company), which comprise the consolidated statements of financial position as of December 31, 2021 and December 31, 2020, and the related consolidated statements of activities, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

In our opinion, the accompanying consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2021 and December 31, 2020, and the results of its operations and its cash flows for the years then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Consolidated Financial Statements section of our report. We are required to be independent of the Company and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. 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 Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with U.S. generally accepted accounting principles, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditors' Responsibilities for the Audit of the Consolidated Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' 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 consolidated 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 consolidated 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 consolidated 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 Company'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 consolidated financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Company'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.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The supplementary information listed in the table of contents is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with GAAS. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

KPMG LLP

Portland, Oregon
April 27, 2022

CAREOREGON, INC. AND SUBSIDIARIES

Consolidated Statements of Financial Position

December 31, 2021 and 2020

Assets	**2021**	**2020**
Current assets:		
Cash and cash equivalents	$ 181,153,084	167,089,719
Investments – unrestricted	699,966,457	516,871,625
Maternity case rate receivable	4,041,172	3,124,007
Reinsurance recoveries receivable	2,804,617	2,197,105
Interest receivable	2,144,963	2,137,278
Pharmacy rebates receivable	5,877,556	8,913,027
Premium receivable	19,814,858	13,679,081
Risk corridor receivable	7,790,695	7,983,747
Pay for performance incentive receivable	58,521,482	16,314,757
Other receivables	6,833,063	5,979,524
Prepaid expenses and other current assets	35,389,549	7,955,645
Total current assets	1,024,337,496	752,245,515
Assets limited as to use:		
Investments – statutory reserves	373,037	304,899
Investments – contractual reserves	18,637,157	13,705,808
Total assets limited as to use	19,010,194	14,010,707
Property, building and equipment, net	15,355,729	16,766,181
Other assets:		
Other assets	4,567,840	283,569
Surplus note receivable	32,740,704	20,710,000
Total other assets	37,308,544	20,993,569
Total assets	$ 1,096,011,963	804,015,972

(Continued)

CAREOREGON, INC. AND SUBSIDIARIES

Consolidated Statements of Financial Position

December 31, 2021 and 2020

Liabilities and Net Assets	**2021**	**2020**
Current liabilities:		
Accrued medical claims payable	$ 175,942,315	143,577,538
Claims adjudicated pending payment	8,988,748	9,159,492
Managed care contracts payable	—	628,059
Accounts payable and accrued expenses	62,316,975	41,830,168
Risk corridor payable	15,540,201	1,626,498
Accrued payroll and benefits	24,890,359	16,292,323
Premium recoupment payable	43,043,518	22,812,393
Pay for performance incentive payable	71,019,932	58,111,836
Other current liabilities	1,588,152	688,637
Total current liabilities	403,330,200	294,726,944
Other liabilities	4,473,486	—
Net assets:		
Without donor restrictions	687,667,707	508,546,965
With donor restrictions	540,570	742,063
Total net assets	688,208,277	509,289,028
Total liabilities and net assets	$ 1,096,011,963	804,015,972

See accompanying notes to consolidated financial statements.

CAREOREGON, INC. AND SUBSIDIARIES

Consolidated Statements of Activities

Years ended December 31, 2021 and 2020

	2021	2020
Revenues:		
Net premium	$ 2,064,973,947	1,851,417,007
Net patient service	9,554,370	9,176,917
Management services	14,103,401	12,333,682
Other	1,434,300	944,028
Total revenues	2,090,066,018	1,873,871,634
Operating expenses:		
Purchased healthcare	1,727,340,560	1,615,222,556
Salaries and benefits – medical	12,388,984	7,513,704
Salaries and benefits – other	101,739,833	91,584,397
Claims administration	6,991,025	5,945,661
Other administrative	46,849,678	40,539,295
Management services	17,109,391	15,155,634
Charitable contributions	11,488,841	2,743,431
Total operating expenses	1,923,908,312	1,778,704,678
Revenues over operating expenses	166,157,706	95,166,956
Other income (expense):		
Investment income	13,892,098	34,534,250
Other expense	(929,062)	(30,161)
Total other income (expense)	12,963,036	34,504,089
Change in net assets without donor restrictions	$ 179,120,742	129,671,045

See accompanying notes to consolidated financial statements.

CAREOREGON, INC. AND SUBSIDIARIES

Consolidated Statements of Changes in Net Assets

Years ended December 31, 2021 and 2020

		2021	2020
Net assets without donor restrictions:			
Change in net assets without donor restrictions	$	179,120,742	129,671,045
Net assets with donor restrictions:			
Change in net assets with donor restrictions		(201,493)	618,119
Change in net assets		178,919,249	130,289,164
Net assets, beginning of year		509,289,028	378,999,864
Net assets, end of year	$	688,208,277	509,289,028

See accompanying notes to consolidated financial statements.

CAREOREGON, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2021 and 2020

		2021	2020
Cash flows from operating activities:			
Change in net assets	$	178,919,249	130,289,164
Adjustments to reconcile change in net assets to net cash provided by operating activities:			
Depreciation and amortization		3,414,436	3,464,416
Change in net unrealized and realized loss (gain) on investments		5,236,586	(23,922,734)
Net discount and premium amortization on fixed-income investments		(1,418,285)	(194,278)
Loss (gain) on disposal of property, building and equipment		58,718	(1,458)
Changes in operating assets and liabilities:			
Maternity case rate receivable		(917,165)	1,261,772
Reinsurance recoveries receivable		(607,512)	(226,843)
Interest receivable		(7,685)	(180,142)
Pharmacy rebates receivable		3,035,471	(3,526,920)
Premium receivable		(6,135,777)	(4,015,097)
Risk corridor receivable		193,052	(1,770,855)
Pay for performance incentive receivable		(42,206,725)	1,585,243
Other receivables		(853,539)	(2,863,807)
Prepaid expenses and other current assets		(27,433,904)	(941,571)
Other assets		(186,992)	20,518
Accrued medical claims payable		32,364,777	29,458,644
Claims adjudicated pending payment		(170,744)	(2,038,947)
Managed care contract payable		(628,059)	611,851
Accounts payable and accrued expenses		20,569,103	22,956,718
Risk corridor payable		13,913,703	987,119
Accrued payroll and benefits		8,598,036	3,040,647
Premium recoupment payable		20,231,125	21,770,010
Pay for performance incentive payable		12,908,096	28,347,079
Other current liabilities		899,515	478,323
Other liabilities		(600,396)	—
Net cash provided by operating activities		219,175,084	204,588,852

(Continued)

CAREOREGON, INC. AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2021 and 2020

	2021	2020
Cash flows from investing activities:		
Proceeds from investment sales	$ 138,203,996	69,683,257
Purchase of investments	(330,116,616)	(186,263,786)
Proceeds from sale of property, building and equipment	—	25,706
Purchase of property, building and equipment	(1,086,099)	(2,426,921)
Issuance of surplus note receivable	(32,823,000)	(20,710,000)
Repayment on surplus note receivable	20,710,000	—
Net cash used in investing activities	(205,111,719)	(139,691,744)
Net increase in cash and cash equivalents	14,063,365	64,897,108
Cash and cash equivalents, beginning of year	167,089,719	102,192,611
Cash and cash equivalents, end of year	$ 181,153,084	167,089,719
Supplementary cash flow information:		
Cash paid for interest	$ 543	1,441
Cash paid for income taxes	39,898	31,208
Non-cash investing and financing activities:		
Operating lease recognized via adoption of ASC 842	$ 5,014,842	—

See accompanying notes to consolidated financial statements.

(1) Nature of Business and Organization

CareOregon, Inc. (CareOregon) has contracted with several Coordinated Care Organizations (CCOs) and with the Oregon Health Authority (OHA) to manage care and provide healthcare services to Medicaid enrollees. CareOregon contracts with a network of community and private medical providers throughout the State of Oregon, paying negotiated fees for health services to these providers. The contracts with the CCOs and OHA are renewable after terms ranging from one to five years.

CareOregon is organized and operated exclusively for charitable, educational, and scientific purposes, including, for such purposes, making distributions to organizations that qualify as exempt organizations under Section 501(c)(3) of the Internal Revenue Code of 1986 (IRC). CareOregon's mission is to inspire and partner to create quality and equity in individual and community health. CareOregon's vision is healthy communities for all individuals, regardless of income or social circumstances.

CareOregon has organized its activities around the principles of the Triple Aim, as articulated by the Institute for Healthcare Improvement, to achieve high standards of population health for its members, to promote and provide health and other care, which is patient centered and results in high levels of patient satisfaction, and to provide services at reasonable per capita costs.

CareOregon works strategically with its board of directors, provider network and community benefit organizations and demonstrates its commitment to eliminate health disparities for its members of color and those most harmed by systematic and structural oppression by playing a vital role in non-traditional medical and/or social determinants of health spending in the communities it serves. CareOregon focuses on its members' access to essential services such as housing, education and healthy food, and care integration by ensuring its members have access to culturally and linguistically appropriate care that is coordinated across primary, specialty, behavioral and oral health.

CareOregon has two wholly owned limited liability company (LLC) CCOs: Columbia Pacific CCO, LLC and Jackson County CCO, LLC. All covered members of these health plans are covered by the Oregon Health Plan (OHP) and associated risks related to the members are transferred from these CCOs to CareOregon as well as the members of an independently formed CCO, Health Share of Oregon (Health Share), through risk delegation agreements.

CareOregon holds Management Service Agreements (MSAs) with its subsidiaries. CareOregon also holds an Administrative Service Agreement (ASA) with Health Share. Under the terms of the MSAs or ASA, the entities utilize CareOregon's personnel, office space, equipment, computer systems, software, and operating methodologies to operate their business.

The consolidated financial statements include the financial statements of CareOregon and following subsidiaries (the Organization):

(a) Coordinated Care Organizations

Columbia Pacific CCO, LLC – CareOregon formed a wholly owned, single-member subsidiary, Columbia Pacific CCO, LLC (Columbia Pacific) in April 2012. Columbia Pacific serves OHP members in Clatsop, Columbia, and Tillamook counties of Oregon and is regulated by the OHA.

Jackson County CCO, LLC – CareOregon formed a wholly owned, single-member subsidiary, Jackson County CCO, LLC (Jackson Care Connect) in May 2012. Jackson Care Connect serves OHP members in Jackson County of Oregon and is regulated by the OHA.

(b) Other Subsidiaries

Health Plan of CareOregon, Inc. – CareOregon formed Health Plan of CareOregon, Inc. (Health Plan) in 2005 as a wholly owned subsidiary. Health Plan is a domestic Oregon nonprofit benefit corporation, wholly owned by CareOregon.

Health Plan is a Health Care Service Contractor (HCSC) domiciled in the state of Oregon and is regulated by the Department of Consumer and Business Services (DCBS), Division of Financial Regulation (the Insurance Division). Health Plan offers a Special Needs Medicare Advantage and Prescription Drug Plans (MA-PD Plan) with the Center for Medicare and Medicaid Services (CMS). The Special Needs MA-PD Plan primarily targets enrollment of Medicaid and Medicare dual eligible members.

Care Access LLC – Formed in July 2009, Care Access LLC (Care Access) purchased a medical office building in July 2009 to improve access to primary care services in the underserved Rockwood area of Gresham, Oregon. Care Access improved the building and receives rental income from its medical clinic tenant, Multnomah County Health Department.

Housecall Providers Services, LLC – Organized in April 2017 as an Oregon LLC and disregarded entity for tax purposes, Housecall Providers Services, LLC (HCP LLC) provides home-based care and hospice services.

Housecall Providers, PC – Organized in April 2017 as an Oregon professional corporation, Housecall Providers, PC (HCP PC) is 51% owned by CareOregon’s chief medical officer and 49% owned by CareOregon. Although CareOregon owns the minority interest of HCP PC, it retains ultimate control. Upon the dissolution of HCP PC, its net assets would be distributed to CareOregon, which makes CareOregon the primary beneficiary of HCP PC. For purposes of financial reporting, HCP PC is consolidated as a wholly owned subsidiary.

(2) Summary of Significant Accounting Policies

(a) Basis of Accounting and Presentation

The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in U.S. (GAAP). The Organization presents its financial statements in accordance with Financial Accounting Standards Board’s (FASB) Accounting Standards Codification (ASC) Topic 958, *Not-for-Profit Entities*. Under ASC Topic 958, the Organization is required to report information regarding its financial position and activities according to two classes of net assets: net assets without donor restrictions and net assets with donor restrictions.

(b) Principles of Consolidation

The consolidated financial statements include the accounts of CareOregon and its subsidiaries. All material interorganization transactions have been eliminated.

(c) Use of Estimates

In preparing the consolidated financial statements in conformity with GAAP, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities as of the date of the consolidated statement of financial position and revenue and expenses for the period. Actual results could differ from those estimates.

Significant estimates in these consolidated financial statements include accrued medical claims payable, investments, premium deficiency reserve (PDR), pay for performance (P4P) receivable and payable, and minimum medical loss ratio rebate liabilities.

(d) Concentrations of Risk

Financial instruments, which potentially subject the Organization to concentrations of credit risk, consist of cash and cash equivalents and investments – unrestricted. The Organization maintains its cash and cash equivalents in accounts that, at times, may exceed federally insured limits. Investments are primarily fixed-income securities and by their nature are subject to market interest rate fluctuations. Potential concentrations of credit risk exist due to market concentrations of high-quality-fixed-income investments, which react similarly to changing economic conditions.

The Organization’s revenue was primarily generated by providing healthcare services in accordance with the terms of OHA, Health Share or CMS contracts or by providing management services in accordance with the terms of the MSAs or ASA to the entities that contract with OHA. Loss of the contract or agreement due to nonrenewal, federal and state health policy changes, or legislative funding decisions could materially affect the financial position of the Organization. The OHA contracts are currently in effect through December 31, 2024. Health Share and CMS contracts are renewable on an annual basis.

Segments of the member population are served by concentrations of clinics and hospitals in counties throughout Oregon. Nonrenewal of provider contracts could result in limited member access to care. The Organization’s personnel, members, patients, and provider networks are geographically concentrated in the state of Oregon.

(e) Revenue Recognition

The Organization follows revenue recognition guidance under Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. The core principle behind ASC Topic 606 is that an entity should recognize revenue to depict the transfer of promised goods and services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for delivering those goods and services.

Disaggregation of revenue by contract type was as follows:

	2021	2020
Medicaid and related contracts	$ 1,846,843,956	1,651,607,922
Medicare contract	218,129,991	199,809,085
Patient services	9,554,370	9,176,917
Management service contracts	14,103,401	12,333,682
Other	1,434,300	944,028
	$ 2,090,066,018	1,873,871,634

Medicaid and related contracts – Medicaid premium revenues are derived from risk-based health insurance contracts with OHA or Health Share in which the premium is a capitated rate per member per month based on OHP member eligibility category (transaction price). The performance obligation is the Organization’s assumption of the economic risk of funding assigned members’ health care and related administrative costs. Medicaid premium revenues are recognized when the Organization satisfies the performance obligation, net of applicable gross premium tax.

Pay for performance (P4P) incentive is recognized as performance obligations are satisfied in the period earned. OHA incentivizes CCOs to perform against pre-defined metrics by setting aside a certain percentage of Medicaid capitation premium for P4P pool and paying based on the percentage of metrics met. Some examples of the metrics include clinical measures and member surveys. Each CCO determines how to use the funds. Amounts intended for providers or other spending are recorded as pay for performance incentive payables. The transaction price is defined in the CCO contract and initial allocation amount by CCO is published by OHA toward the end of each contract year. P4P incentive is recognized in the period earned based on these initial allocations and estimated percentage of the metrics met and is included in net premium revenue. For the years ended December 31, 2021 and 2020, the P4P incentive revenues were $60,604,842 and $76,266,526, respectively.

Maternity case rate premiums are paid based on a case rate established by OHA and are recognized as a maternity case rate receivable in the period that a birth occurs based on estimated number of births. For the years ended December 31, 2021 and 2020, maternity case rate premium revenue was $42,060,051 and $39,513,589, respectively.

OHA and the Organization share profit and losses on certain benefits within defined risk corridors around a target amount determined in the contract. Estimated adjustments from these risk corridors are reflected in premium revenue.

Qualified Directed Payments (QDP) are payments made by OHA to CCOs from three Quality and Access pools; Rural Type A & B hospitals, DRG (Diagnosis-Related Group) hospitals and Public Academic Health Centers. Such payments are then passed through to providers at rates set by the OHA. QDPs are tied to inpatient discharges and outpatient encounters by Medicaid members enrolled in a CCO. QDP payments are reported on a net basis and accordingly, are not recorded as premium revenue or purchased healthcare expenses. The QDP payments for the years ended December 31, 2021 and 2020 were $97,671,980 and $89,743,191, respectively.

Medicare contract – Medicare premium revenues are derived from risk-based health insurance contracts with CMS. Medicare premiums receivable and revenue are recorded when the Organization satisfies the performance obligation. Premiums earned represent amounts received from CMS for healthcare services and are recognized as revenue in the period in which the enrolled members are entitled to receive healthcare services. Costs incurred in connection with acquiring new insurance business, such as sales commissions, are expensed as incurred.

CMS calculates the premiums the Organization receives using risk scores assigned to its enrolled members. These risk scores are derived from the severity of illness evidenced by claims the Organization receives from providers and other data, which are submitted to CMS. The Organization recognized premium revenue and premium receivables from CMS for these risk score adjustments. For the years ended December 31, 2021 and 2020, prior year risk score adjustments included in premium revenue were $1,416,000 and $353,060, respectively. Risk score receivables are $4,953,288 and $6,131,470 at December 31, 2021 and 2020, respectively. These amounts are included on the consolidated statements of financial position as premium receivable.

The Medicare Part D federal reinsurance reimbursements and low-income cost sharing (LICS) subsidy payments received are typically advance payments from CMS and therefore, these subsidy amounts received in excess of payments made are reported as Medicare advances payable. The Medicare Part D federal reinsurance reimbursements and LICS subsidies are eventually recognized as a reduction in pharmacy claims paid as gross pharmacy claim expenses are recorded based on Prescription Drug Event data returned from CMS. The amounts of reimbursement and subsidy payments received for 2021 and 2020 were $47,384,668 and $43,201,354, respectively.

CMS and the Organization share profit and losses on the Medicare Part D benefit within defined risk corridors around a target amount determined in the contract. At December 31, 2021 and 2020, the Organization had an experience rating refund receivable of $4,768,313 and $2,987,700, respectively, and an increase in premiums earned of $2,372,980 and $2,475,091, respectively, related to the anticipated risk corridor adjustment. The amount of net premiums written by the Organization in the years ended December 31, 2021 and 2020 subject to retrospective rating features were $15,138,221 and $13,739,817, respectively.

Patient services – Net patient service revenue is recorded at the time clinical services are provided based on estimated amounts due from third-party payors and patients. Net patient service revenue is recorded net of contractual allowances and discounts. Accounts receivable related to net patient service revenue is included in other receivables.

Management services – Management services revenue is recognized in the period in which management services are provided. Under the terms of these contracts, the Organization is entitled to receive a monthly fee which is calculated at the transaction price defined in the agreements. Revenues are recognized as the Organization performs, or makes available, the applicable services to the client entities.

(Continued)

Other – Other revenue is recognized when performance obligations defined in the contract/agreement are satisfied and the transaction price defined in the contract is realized or realizable and earned. Contributions received are recognized under the guidance under ASC Topic 958 unless the agreement or arrangement related to the contribution received is determined to be an exchange transaction. In such cases, the Organization follows the revenue recognition guideline under ASC Topic 606.

(f) Minimum Medical Loss Ratios

As part of the Patient Protection and Affordable Care Act (Healthcare Reform), minimum medical loss ratios (MLR) were mandated for all commercial fully insured medical plans with annual rebates owed to policyholders if the actual loss ratios, calculated in a manner prescribed by the U.S. Department of Health and Human Services (HHS) fall below certain targets. HHS issued guidance specifying the types of costs that should be included in benefit expense for purposes of calculating MLR.

The target MLR for the Medicare plans is 85% for the years ended December 31, 2021 and 2020. CCOs are also required to maintain a minimum medical loss ratio of at least 85% for the total Medicaid member population for the three-year period ending December 31, 2024 and the year ended December 31, 2020. CCOs and Medicare plans are required to rebate to OHA, CMS or Health Share any dollar amounts short of these target ratios. For the year ended December 31, 2021, the Organization's MLRs for Medicaid contracts were below the minimum target levels. Accordingly, MLR rebate liabilities totaling $21,605,000 were included in premium recoupment payable as of December 31, 2021. No MLR rebate liability was deemed necessary for Medicaid contracts as of December 31, 2020. For the year ended December 31, 2020, the Organization's MLRs for Medicare contract were below the minimum target levels and MLR rebate liability of $20,217,000 was recorded as of December 31, 2020. This amount was adjusted to $20,236,000 as of December 31, 2021 based on required runout activities during 2021. No MLR liability was considered necessary related to plan year 2021 for medicare. The evaluations are subjected to an actuarial review and analysis.

(g) Risk Delegation Agreements

CareOregon accepts, through risk delegation agreements, the CCO health capitation and associated financial risk for Jackson Care Connect and Columbia Pacific CCOs' members and for those Health Share members assigned to CareOregon.

(h) Net Investment Income

Investment income consists of interest earnings, dividends, and both realized and unrealized gains and losses. Premiums and discounts on fixed-income securities are recognized as adjustments to investment income using the scientific interest method. Interest on fixed-income securities is recognized in income on an accrual basis. Investment income is presented net of investment transaction, custodial, and advisory fees, which are expensed as incurred. Interest and dividends represent amounts earned on investment holdings and are accrued when earned. Realized investment gains and losses are recorded upon sale of securities. Unrealized gains or losses represent net changes in fair market value.

(i) Reinsurance

In the normal course of business, the Organization seeks to limit its exposure to a loss on any single member, and to recover a portion of benefits paid by ceding reinsurance risks under excess coverage agreements. Reinsurance agreements do not relieve the Organization from its obligation to pay providers.

Amounts recoverable from reinsurance contracts are estimated in a manner consistent with the claim limits and conditions associated with the reinsurance policy. Reinsurance premiums and recoveries are reported as components of medical costs. In addition, the Organization is required to obtain certain reinsurance coverage as a contractor of OHA and CMS.

Total reinsurance premiums incurred in 2021 and 2020 were $7,715,842 and $6,015,810, respectively. Reinsurance recoveries earned in 2021 and 2020 were $3,649,001 and $2,168,400, respectively.

(j) Income Taxes

The Internal Revenue Service has recognized CareOregon and its subsidiaries as exempt from federal income taxes under provisions of Section 501(c)(3) of the Internal Revenue Code.

The Organization recognizes the tax benefit from uncertain tax positions only if it is more likely than not that the tax positions will be sustained on examination by the tax authorities, based on the technical merits of the position. The tax benefit is measured based on the benefit that has a greater than 50% likelihood of being realized upon ultimate settlement. The Organization recognizes interest and penalties related to income tax matters in interest expense and other administrative expenses, respectively.

(k) Fair Value Measurements

Fair value is the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction among market participants at the measurement date. Market participants are buyers and sellers who are independent, knowledgeable and willing and able to transact in the principal (or most advantageous) market for the asset or liability being measured.

Fair value is based on quoted market prices, when available, for identical or similar assets or liabilities. In the absence of quoted market prices, management determines the fair value of the Organization’s assets and liabilities using valuation models or third-party pricing services, both of which rely on market-based parameters when available, such as interest rate yield curves, option volatilities, and credit spreads. The valuation techniques used are based on observable and unobservable inputs.

Observable inputs are those assumptions, which market participants would use in pricing the particular asset or liability. These inputs are based on market data and are obtained from a source independent of the Organization.

Unobservable inputs are assumptions based on the Organization’s own information or estimate of assumptions used by market participants in pricing the asset or liability. Unobservable inputs are based on the best and most current information available on the measurement date.

ASC Topic 820, *Fair Value Measurement*, establishes a three-level valuation hierarchy for determining fair value that is based on the transparency of the inputs used in the valuation process. The inputs used in determining fair value in each of the three levels of the hierarchy are as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities

Level 2 – Either (i) quoted prices for similar assets or liabilities; (ii) observable inputs, such as interest rates or yield curves; or (iii) inputs derived principally from or corroborated by observable market data or other pricing sources with reasonable levels of transparency

Level 3 – Unobservable inputs

The hierarchy gives the highest ranking to Level 1 inputs and the lowest ranking to Level 3 inputs. The level in the fair value hierarchy within which the fair value measurement in its entirety falls is determined based on the lowest-level input that is significant to the overall fair value measurement.

The carrying amount is stated at fair value, and amounts are based on quoted market prices or alternative pricing sources with reasonable levels of transparency. Fair values and pricing methodology of investments are disclosed in notes 3 through 6.

(l) Cash and Cash Equivalents

The Organization considers cash to be cash in the bank or on hand and available for current use. Cash equivalents are investments with original maturities of three months or less at date of purchase and approximate fair value. Cash equivalents exclude such amounts held as part of the investment portfolio.

(m) Investments – Unrestricted

Investments are stated at fair market value based on quoted market prices as of the statement of financial position dates (notes 3 and 6). The Organization uses the specific-identification method for determining the cost basis and gain or loss on its investments. Changes in fair value are recorded in investment income.

(n) Investments – Statutory Reserves

The statutory reserves are required by the Insurance Division for Health Plan, and include treasury bonds and cash, stated at fair market value (note 4). Changes in fair value are recorded in investment income.

(o) Investments – Contractual Reserves

The contractual reserves are required by OHA for CareOregon, Columbia Pacific, and Jackson Care Connect and include cash and securities stated at fair market value. OHA requires these funds to be held for the purpose of making payments to providers in the event of CareOregon’s insolvency (note 5). Changes in fair value are recorded in investment income.

(p) Receivables

Receivables consist primarily of amounts owed to the Organization for capitated premiums, maternity case rate premiums, P4P payments, reinsurance recoveries, and pharmacy rebates receivables. The Organization does not require collateral or other security to support the recorded receivable amounts. Management has estimated an allowance against maternity case rate receivables based on an aging analysis and the likelihood of collection.

(q) Property, Building and Equipment, Net

Property, building and equipment, net are stated at cost, and are depreciated or amortized using the straight-line method over the estimated useful life. Useful lives are determined by the asset type, and can range from 3 to 30 years. Repairs and maintenance related to property, building and equipment are expensed as incurred. Land is not depreciated.

(r) Leases

Subsequent to adoption of ASC Topic 842, CareOregon determines if an arrangement is a lease or contains a lease at inception of a contract and when the terms of an existing contract are modified in order to determine if a lease liability and a right of use (ROU) asset should be recognized at the commencement of the lease. On the consolidated statements of financial position, ROU assets are included in other assets and the current portion of lease liabilities are included in other current liabilities, whereas the long-term portion of lease liabilities is included in other liabilities. The lease liability is initially and subsequently recognized based on the present value of its future lease payments. The ROU asset is measured throughout the lease term at the amount of the remeasured lease liability, plus unamortized initial direct costs, plus or minus any prepaid or accrued lease payments, less the unamortized balance of lease incentives, and any impairment recognized. Lease cost for lease payments is recognized on a straight-line basis over the lease term.

(s) Accrued Medical Claims Payable and Claims Adjudicated Pending Payment

Accrued medical claims payable represents an estimate of medical costs incurred, but not yet billed and processed, through the date of the consolidated statement of financial position. The claims adjudicated pending payment includes amounts billed, processed, and pending payment.

Management's evaluation of the adequacy of the accrued medical claims payable is based on a review of utilization data, and an actuarial review of historical claims experience. It is reasonably possible that the estimated accrued medical claims payable will change in the near term.

(t) Premium Deficiency Reserve

In accordance with FASB ASC Topic 450, *Contingencies*, the Organization records a PDR to recognize anticipated losses on contracts. A premium deficiency shall be recognized if the sum of expected claim costs, claim adjustment expenses, and maintenance costs exceeds related premiums revenue. The Organization uses anticipated investment income as a factor in the PDR calculation. The evaluations are subjected to an actuarial review and analysis. No PDR was deemed necessary for the Organization as of December 31, 2021 or 2020 based on anticipated financial performance.

(Continued)

(u) Managed Care Contracts Payable

The Organization accrues QDP payables as these payments are received from OHA in conjunction with their Medicaid premiums. Also included in managed care contracts payable is a 2.0% gross premium tax imposed on CCOs, payable to OHA on a quarterly basis.

(v) Medicare Advances

The Organization receives federal reinsurance and low-income cost sharing subsidy payments from CMS related to its Medicare Part D coverage. Amounts received are recorded as Medicare advances payable until the related claim payments are made. At December 31, 2021 and 2020, Medicare Part D subsidy payments received did not exceed expenses incurred, and therefore, the Organization recorded premium receivable.

(w) Risk Corridor Receivable or Payable

Risk corridor receivable or payable of the Organization includes receivables or liabilities related to the following risk sharing arrangements.

Medicare Part D – The federal government and the Organization share profit and losses on the Medicare Part D benefit around a target amount within defined risk corridors determined in the annual Medicare contract. At December 31, 2021 and 2020, the Organization had an experience rating refund receivable and revenue adjustments of $4,768,313 and $2,987,700, respectively, related to the anticipated risk corridor adjustment.

Hepatitis C (Hep C) – In 2017, OHA began providing a risk sharing arrangement with the CCO’s for Hep C services with no risk share if actual experience is within +/-5% of the target and 100% risk share if actual is more than 5% greater or lower than the target. With expenses less than target, the Organization had estimated payables of $13,392,273 for the year ended December 31, 2021 and the amount is included in the risk corridor payable. With expenses more than target, the Organization had estimated receivables of $4,790,043 for the year ended December 31, 2020 of which $2,997,388 is included in the risk corridor receivable as of December 31, 2021.

Cover All Kids (CAK) – In 2018, OHA began providing a risk sharing arrangement with the CCO’s for the services related to the CAK Program with no risk share if the actual expense is within +/-10% of the target, a 50% risk share if actual is 10 to 20% from target, and 100% share if actual is more than 20% greater or lower than the target. With expenses less than target, the Organization had estimated liabilities of $2,122,934 and $1,420,493 at December 31, 2021 and 2020, respectively, included in the risk corridor payable.

(x) Reclassifications

Certain reclassifications have been made to the 2020 consolidated financial statements to conform with the 2021 presentation.

(y) Recent Accounting Pronouncements

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*, to increase transparency and comparability among organizations by recognizing lease assets and lease liabilities on the balance sheet and disclosing key information about leasing arrangements. This standard has been early adopted on a prospective basis for CareOregon's 2021 consolidated financial statements with the practical expedients allowed. All expired or existing leases as of January 1, 2021 were operating leases under ASC Topic 840. Therefore, all expired or existing leases were determined to be operating leases under this standard. CareOregon recorded lease liabilities and ROU assets of $5,074,000 and $5,015,000, respectively, as a result of adoption of this standard.

In September 2020, the FASB issued ASU No. 2020-07, *Not-for-Profit Entities (Topic 958): Presentation and Disclosures by Not-for-Profit Entities for Contributed Nonfinancial Assets*, with the goal of increasing the transparency of contributed nonfinancial assets for not-for-profit entities through enhancements to presentation and disclosure. This standard is effective for the Organization's 2022 consolidated financial statements. Management is evaluating the impact this standard will have on the Organization's consolidated financial statements.

(z) Subsequent Events

Subsequent events are events or transactions that occur after the financial statement date but before consolidated financial statements are available to be issued. The Organization recognizes in the consolidated financial statements the effect of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated statements of financial position, including the estimates inherent in the process of preparing the consolidated financial statements.

The Organization has evaluated subsequent events through April 27, 2022, which is the date the consolidated financial statements were available to be issued.

(3) Investments – Unrestricted

The amortized cost basis and estimated fair market value of the Organization's unrestricted investments are as follows:

	December 31, 2021			
	Amortized cost	Unrealized gains	Unrealized losses	Fair market value
U.S. Treasury notes	$ 244,008,110	11,054,352	(1,789,277)	253,273,185
Canadian government agency bond	1,499,719	33,481	—	1,533,200
U.S. government agency bonds	77,874,893	717,458	(1,095,467)	77,496,884
Corporate bonds	164,446,266	3,752,333	(1,560,886)	166,637,713
Municipal bonds	29,661,191	589,553	(232,573)	30,018,171
Mutual and commingled funds	106,891,008	32,154,419	(788,370)	138,257,057
Other asset-backed securities	32,992,452	93,208	(335,413)	32,750,247
	$ 657,373,639	48,394,804	(5,801,986)	699,966,457

	December 31, 2020			
	Amortized cost	Unrealized gains	Unrealized losses	Fair market value
U.S. Treasury notes	$ 118,829,437	9,760,287	(52,790)	128,536,934
Canadian government agency bond	1,999,180	88,000	—	2,087,180
U.S. government agency bonds	79,757,181	2,700,651	(38,404)	82,419,428
Corporate bonds	152,555,590	9,336,009	(86,898)	161,804,701
Municipal bonds	24,644,144	1,203,396	—	25,847,540
Mutual and commingled funds	79,106,819	21,198,901	(429,428)	99,876,292
Other asset-backed securities	15,958,484	341,066	—	16,299,550
	$ 472,850,835	44,628,310	(607,520)	516,871,625

The amortized cost and fair value of bonds by contractual or effective maturity are as follows:

	December 31, 2021		December 31, 2020	
	Amortized cost	Fair market value	Amortized cost	Fair market value
Within 1 year	$ 22,688,940	22,888,356	27,527,587	27,851,262
1–5 years	307,546,161	312,086,607	220,593,159	230,632,257
5–10 years	206,919,703	210,010,557	134,119,686	144,525,968
10–20 years	4,216,344	4,966,992	5,432,194	5,872,983
Over 20 years	9,111,515	11,756,888	6,072,390	8,112,863
	$ 550,482,663	561,709,400	393,745,016	416,995,333

(4) Investments – Statutory Reserves

Investments – statutory reserves, as of December 31, 2021 and 2020, consist of U.S. Treasury Notes. These funds are required for Health Plan by the Insurance Division.

As of December 31, 2021, the amortized cost basis and estimated fair market value of the statutory reserves are $373,344 and $373,037, respectively, as compared to $299,766 and $304,899 as of December 31, 2020, respectively.

(5) Investments – Contractual Reserves

Investments – contractual reserves, as of December 31, 2021 and 2020, consist of government bonds, certificate of deposits, U.S. Treasury notes, and money market funds. These funds are restricted as to their use and are held to satisfy required risk-based reserves established by the OHA.

(Continued)

As of December 31, 2021, the amortized cost basis and the estimated fair market value of the contractual reserves are $18,718,114 and $18,637,157, respectively, as compared to $13,661,526 and $13,705,808 as of December 31, 2020, respectively.

(6) Fair Value of Investments

The table below shows the Organization's investments as of December 31, 2021 and 2020 measured at fair value on a recurring basis and indicates the fair value hierarchy of the valuation techniques utilized by the Organization to determine such fair value. Assets and liabilities are considered to be "fair value on a recurring basis" if fair value is regularly measured.

While estimates of fair value are based on management's judgment of the most appropriate factors, had the Organization disposed of such items at December 31, 2021 and 2020, the actual sales prices may have differed. Since market values may differ depending on various circumstances, the estimated fair values as of December 31, 2021 and 2020 should not necessarily be considered to apply at subsequent dates.

Investments measured at fair value comprise marketable securities and alternative investments. Marketable security fair values are based on quoted market prices. If a quoted market price is not available, fair value is estimated using quoted market prices for similar securities.

	Fair value measurements at December 31, 2021			
	Total	**Level 1**	**Level 2**	**Level 3**
Restricted reserves:				
Money markets	$ 3,683,564	3,683,564	—	—
Certificates of deposit	8,027,298	—	8,027,298	—
U.S. Treasury notes	5,322,932	5,322,932	—	—
U.S. agency bonds	1,976,400	—	1,976,400	—
Government:				
U.S. Treasury notes	253,273,185	253,273,185	—	—
Canadian government agency bonds	1,533,200	—	1,533,200	—
U.S. agency bonds	77,496,884	—	77,496,884	—
Corporate bonds	166,637,713	—	166,637,713	—
Municipal bonds	30,018,171	—	30,018,171	—
Mutual and commingled funds	138,257,057	138,257,057	—	—
Other asset-backed securities	32,750,247	—	32,750,247	—
	$ 718,976,651	400,536,738	318,439,913	—

	Fair value measurements at December 31, 2020			
	Total	Level 1	Level 2	Level 3
Restricted reserves:				
Money markets	$ 9,519,386	9,519,386	—	—
Certificates of deposit	2,686,932	2,686,932	—	—
U.S. Treasury notes	1,804,389	1,804,389	—	—
Government:				
U.S. Treasury notes	128,536,933	128,536,933	—	—
Canadian government agency bonds	2,087,180	—	2,087,180	—
U.S. agency bonds	82,419,428	—	82,419,428	—
Corporate bonds	161,804,701	—	161,804,701	—
Municipal bonds	25,847,540	—	25,847,540	—
Mutual and commingled funds	99,876,292	81,557,045	18,319,247	—
Other asset-backed securities	16,299,551	—	16,299,551	—
	$ 530,882,332	224,104,685	306,777,647	—

(7) Property, Building and Equipment, Net

Property, building and equipment, net at December 31 consists of the following:

	2021	2020
Land	$ 2,704,520	2,704,520
Building and improvements	23,655,859	23,510,040
Computer software	14,173,652	13,850,705
Computer equipment	3,999,253	4,934,429
Furniture and equipment	3,749,760	3,996,996
Other	919,380	528,848
	49,202,424	49,525,538
Less accumulated depreciation and amortization	(33,846,695)	(32,759,357)
	$ 15,355,729	16,766,181

Total depreciation and amortization expense at 2021 and 2020 was $3,414,436 and $3,464,416, respectively, and is included in other administrative expenses on the consolidated financial statements.

(8) Change in Accrued Medical Claims Payable

Accrued medical claims payable includes unpaid claims (both reported and unreported) and claims adjustment expense. Unpaid claims incurred but not reported represent an estimate of claims incurred for or on behalf of the Organization’s members that had not yet been reported to the Organization in the consolidated statements of financial position. Unpaid claims incurred but not reported are based on a number of factors including hospital admission data and prior claims experience, as well as claims processing patterns. Adjustments, if necessary, are made to medical expense in the period the actual claims costs are ultimately determined.

Claims adjustment expense represents costs incurred related to the claim settlement process, such as costs to record, process, and adjust claims. These expenses are calculated based on current claim adjustment costs.

For the years ended December 31, activity in the reserves for unpaid claims and claims adjustment expense was as follows:

	2021	2020
Balances at January 1	$ 143,577,538	114,118,894
Incurred related to:		
Current year	1,286,797,111	1,145,299,596
Prior years	(17,361,772)	(15,146,680)
Total incurred	1,269,435,339	1,130,152,916
Paid related to:		
Current year	1,112,794,092	1,003,995,003
Prior years	124,276,470	96,699,269
Total paid	1,237,070,562	1,100,694,272
Balances at December 31	$ 175,942,315	143,577,538

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities are reviewed and revised as information regarding actual claims payments becomes known.

As a result of changes in estimates of insured events in the prior years, the provision for unpaid claims and claims adjustment expense decreased by $ 17,361,772 and $15,146,680 in 2021 and 2020, respectively, due to actual expenses related to prior years totaling less than estimated by the Organization.

(9) Employee Benefit Plans

CareOregon has established a 401(k) plan covering all employees who are at least 18 years of age. CareOregon matches employee deferrals and allows supplemental discretionary employer contributions as determined each year by the Organization’s board of directors. CareOregon made 401(k) contributions of $8,009,424 and $6,282,247 for the years ended December 31, 2021 and 2020, respectively.

CareOregon has two voluntary deferred compensation plans under Sections 457(b) and 457(f) of the Internal Revenue Code. Qualification for participation in those plans is limited to management personnel. Section 457 plans result in unsecured liabilities owed by CareOregon to the participants for future payments. Should CareOregon become insolvent, the employee deferrals would be considered “unsecured assets” and, as such, would be available to satisfy all creditor claims. CareOregon made no voluntary employer contributions to Section 457 plans during 2021 and 2020. Contribution payable to Section 457 plans was $834,124 and $566,662 as of December 31, 2021 and 2020, respectively.

CareOregon has established an employee sabbatical plan for eligible employees. Employees are eligible to take sabbatical leave of 4 to 12 weeks, partially or fully paid by CareOregon, depending on the years of service. The eligibility was implemented retroactively for all eligible employees based on their prior service. The total sabbatical leave liability was $4,159,402 at December 31, 2021.

(10) Related-Party Transactions

In 2021 and 2020, the Organization's Boards of Directors included representatives from the following entities that maintain contractual agreements or other transactions with the Organization: Columbia Memorial Hospital, La Clinica, Legacy Medical Group, Multnomah County Health Department, Oregon Health & Science University, Trillium Family Services, SAIF Corporation, and Providence Medical Group. The contractual agreements cover transactions in the normal course of business for medical services, network development, rental agreements, operating agreements, and charitable contributions.

Health Share: CareOregon provides certain management services to Health Share including employee leasing, human resources, financial services, IT services, and customer services. Management services revenue earned under this agreement totaled $12,562,587 and $10,780,105 for the years ended December 31, 2021 and 2020, including leased employees' charges that represented 70% and 71% of management services revenue, respectively.

In August 2012, CareOregon and Health Share entered into a Grant Agreement. Under the agreement, CareOregon contributed $16,500,000 to Health Share to establish their restricted reserve account required under the OHA contract. This contribution was reflected in other administrative expenses. The contribution is required to be returned to CareOregon upon the occurrence of certain events defined in the Grant Agreement. Health Share is required to return all or a portion of the contribution to CareOregon in the event of dissolution or winding-up on or before September 1, 2022 or if the OHA terminates its agreement with Health Share on or before September 1, 2022. The amount of contribution to be returned to CareOregon is the amount remaining after discharge of all liabilities and obligations of Health Share. Further, if Health Share is in existence on September 1, 2022 and under the terms of the OHA contract, the amount of the primary and secondary reserve requirements for Health Share on September 1, 2022 is less than the amount of the grant, then Health Share shall return to CareOregon any portion of the grant that is in excess of the minimum reserves amount required to be maintained. The Grant Agreement releases restrictions on donated reserves after 10 years if reserves are still needed and Health Share is still operating under a similar Medicaid agreement with OHA.

In December 2020, CareOregon and Health Share entered into a surplus note agreement under the approval by OHA. Under the agreement, CareOregon contributed $20,710,000 to Health Share to maintain a sufficient level of risk-based capital required under the OHA contract. Other plan partners of Health Share concurrently entered into the same agreements with their respective share. The surplus note carries a variable interest determined by the 3-year U.S. Treasury rate and it matured on November 30, 2021. Principal and interest payments under the surplus note were made with approval by OHA. The note was renewed under the same term. While this surplus note has a maturity of less than 12 months, it was renewed with the same terms with the new amount deemed necessary for Health Share to meet the risk-based capital requirement and similar renewals are anticipated if necessary, in future years. Accordingly, the surplus note receivable is classified as a noncurrent asset on the accompanying consolidated statements of financial position. The balance of this surplus note including accrued interest at December 31, 2021 was $32,740,704.

(Continued)

CareOregon and Health Share have entered into an Integrated Community Network Participation Contract (ICN Contract), which is automatically renewed for successive one-year terms until it is terminated. The ICN Contract replaced RAE Agreement effective January 1, 2020 and CareOregon arranges for services to members on a fully capitated basis, where CareOregon retains the risk.

Capitated premium revenue received from Health Share under the ICN Contract or RAE Agreement during 2021 and 2020 equaled $1,238,211,667 and $714,534,416, respectively. Total amounts receivable from Health Share as of December 31, 2021 and 2020 were $2,570,136 and $1,190,114, respectively.

Multnomah County Health Department: Lease income from Multnomah County Health Department was $332,395 and $324,500 in 2021 and 2020, respectively.

(11) Lease Commitments

(a) Operating Lease Agreements – Lessee

The Organization holds commercial office lease contracts for some of its operating space. These lease contracts expire from March 2021 through October 2025.

The following table represents lease information as of and for the year ended December 31:

		2021
Operating lease cost	$	1,419,886
Short-term lease cost		67,205
Total lease cost	$	1,487,091
Operating lease liabilities	$	4,102,615
Operating lease ROU assets		4,056,460

Maturities of lease liabilities under non-cancellable operating leases as of December 31 are as follows:

Year ending December 31:		
2022	$	1,241,437
2023		1,072,448
2024		953,554
2025		835,625
2026		26,610
Total undiscounted lease payments		4,129,674
Less interest portion		(27,059)
Total lease liabilities	$	4,102,615

As of December 31, 2021, weighted average lease term of operating leases was 3.6 years and weight average discount rate was 0.4%.

Relevant leasing information for the year ended December 31, 2020, which applied the accounting requirements of ASC Topic 840, Leases, are as follows:

As of December 31, 2020, future minimum lease payments for the five years subsequent to and thereafter, under the noncancelable operating leases, that have initial or remaining lease terms in excess of a year were as follows:

Year ending December 31:		
2021	$	1,411,136
2022		1,149,624
2023		974,255
2024		850,975
2025 and thereafter		729,962
	$	5,115,952

Total lease expense was $1,385,983 for the years ended December 31, 2020.

(b) Lease Agreements – Lessor

The building owned by Care Access is leased to Multnomah County Health Department through August 1, 2022. The lease provides for a five-year extension and can be canceled by either party with six months written notice. Lease income earned was $332,395 and $324,500, for the years ended December 31, 2021 and 2020, respectively.

Future minimum lease payments from the building under this lease is $196,528 for the year ending December 31, 2022.

(12) Commitments and Contingencies

(a) Regulatory

The Organization is subject to numerous and complex laws and regulations of federal, state, and local governments, and accreditation requirements. Compliance with such laws, regulations, and accreditation requirements can be subject to retrospective review and interpretation, as well as regulatory actions. These laws and regulations include, but are not necessarily limited to, requirements of tax exemption, government reimbursement, government program participation, privacy and security, false claims, accreditation, and healthcare reform. In recent years, government activity has increased with respect to compliance and enforcement actions.

In the ordinary course of business operations, the Organization is subject to periodic reviews, investigations, and audits by various federal, state, and local regulatory agencies and accreditation agencies.

In February 2019, the Organization received a notification from CMS selecting its plan for risk adjustment data validation (RADV) audit to validate the coding practices of and documentation maintained by health care providers that supported payments for the contract year 2014 and 2015. As of December 31, 2021, the Organization recorded an estimated accrual for retrospective adjustments based on the samples tested by CMS in the amount of $127,000. No accrual has been established for potential extrapolated adjustments because it is not estimable at this point.

The Organization's compliance with a wide variety of rules and regulations and accreditation requirements applicable to its business may result in certain remediation activities and regulatory fines and penalties, which could be substantial. Where appropriate, reserves have been established for such sanctions.

(b) Industry Regulations

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations included, but are not necessarily limited to, matters such as licensure, accreditations, government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. Government activity continues with respect to investigations and allegations concerning possible violations of fraud, abuse statutes, and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties. Management is not aware of any noncompliance with government laws and regulations. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory or state actions known or unasserted at this time.

(c) Payments from Federal and State Healthcare Programs

Entities doing business with government payors, including Medicare and Medicaid, are subject to risks unique to the government contracting environment that are difficult to anticipate and quantify. Revenue is subject to adjustment as a result of examination by government agencies as well as auditors, contractors, and intermediaries retained by the federal, state, or local governments. Resolution of such audits or reviews often extend (and in some cases does not even commence until) several years beyond the year in which services were rendered and/or fees received.

(d) Other

A strain of coronavirus, identified in December 2019 (COVID-19), has spread globally including the geographic locations of the Organization's members. Although not completely measurable, the Organization's medical cost trend, access to labor, and supply chains are being impacted by the COVID-19 pandemic. Such events are generally outside of the Organization's control and can have a material adverse impact on its operations in 2022 and beyond. Management anticipates that the Organization may experience an increase in medial cost trend due to pent-up demand that could be significant.

(13) Net Assets with Donor Restrictions

Net assets with donor restrictions represents resources, which are subject to restrictions specified by the grantors or donors. As of December 31, 2021 and 2020, all of the Organization's net assets with donor restrictions were temporary in nature, specified for a particular purpose. During 2021 and 2020, net assets released from donor restrictions by incurring expenses satisfying the restricted purposes totaled $201,493 and $220,245, respectively. For the years ended December 31, 2021 and 2020, the Organization received grants totaling $0 and $838,364, respectively, that are restricted based on passage of time or other events.

(14) Board-Designated Net Assets

The Organization's governing boards have not designated any net assets without donor restrictions for the specific purposes as of December 31, 2021 or 2020.

(15) Functional Expenses

The consolidated financial statements report certain categories of expenses that are attributable to more than one program or supporting function. Therefore, these expenses require allocation on a reasonable basis that is consistently applied. The expenses that are allocated include salaries and benefits and other administrative expenses. Salaries and benefits are allocated based on estimated time and effort related to applicable entities, departments and/or specific functions. Other administrative expenses that are allocated include depreciation, office and occupancy and dues and subscription that are allocated based on specific identification, revenues, claim cost or member months.

Tables below present expenses by both their nature and their function for the year ended December 31, 2021 and 2020:

	For the year ended December 31, 2021			
	Member benefits	Management and general	Fund-raising	Total
Purchased healthcare	$ 1,727,340,560	—	—	1,727,340,560
Salaries and benefits – medical	12,388,984	—	—	12,388,984
Salaries and benefits – other	67,065,373	34,468,209	206,251	101,739,833
Claims administration	6,991,025	—	—	6,991,025
Other administrative	6,532,576	40,303,167	13,935	46,849,678
Management services	17,109,391	—	—	17,109,391
Charitable contributions	11,488,841	—	—	11,488,841
	$ 1,848,916,750	74,771,376	220,186	1,923,908,312

	For the year ended December 31, 2020			
	Member benefits	**Management and general**	**Fund-raising**	**Total**
Purchased healthcare	$ 1,615,222,556	—	—	1,615,222,556
Salaries and benefits – medical	7,513,704	—	—	7,513,704
Salaries and benefits – other	65,011,456	26,361,107	211,834	91,584,397
Claims administration	5,945,661	—	—	5,945,661
Other administrative	6,236,577	34,265,933	36,785	40,539,295
Management services	15,155,634	—	—	15,155,634
Charitable contributions	2,743,431	—	—	2,743,431
	$ 1,717,829,019	60,627,040	248,619	1,778,704,678

(16) Liquidity and Availability

The following table reflects the Organization’s financial assets as of the date of the consolidated statements of financial position, reduced by amounts not available for general use because of statutory, contractual or donor-imposed restrictions within one year of the date of the consolidated statements of financial position. Amounts not available can include amounts set aside for specific programs that could be drawn upon if the governing board approves that action.

	2021	**2020**
Financial assets at year-end	$ 900,129,735	697,972,051
Less those unavailable for general expenditures within one year due to:		
Statutory or contractual restrictions:		
Statutory reserve	(373,037)	(304,899)
Contractual reserves	(18,637,157)	(13,705,808)
Donor-imposed restrictions:		
Restricted by donor with purpose restrictions	(540,570)	(742,063)
Financial assets available to meet cash needs for general expenditures within one year	$ 880,578,971	683,219,281

The Organization is substantially supported by premium revenue established by OHA or the federal government. The Organization must maintain sufficient resources to meet those responsibilities to its members including but not limited to statutory and contractual reserves. As part of the Organization's liquidity management, it has a policy to structure its financial assets to be available as its general expenditures, liabilities, and other obligations come due. As of December 31, 2021 and 2020, the Organization held available financial assets, which consisted of cash and cash equivalents and investments – unrestricted, on hand to cover its normal operating expense for approximately 170 days and 140 days, respectively. The Organization invests cash in excess of daily requirements in investments – unrestricted. In the event of an unanticipated liquidity need, the Organization could draw upon unrestricted investments in the amount of $699,966,457 and $516,871,625 as of December 31, 2021 and 2020, respectively.

SUPPLEMENTARY INFORMATION – CONSOLIDATING SCHEDULES

CAREOREGON, INC. AND SUBSIDIARIES

Consolidating Schedule of Financial Position

December 31, 2021

Assets	CareOregon	Columbia Pacific LLC	Jackson Care Connect LLC	Other Subsidiaries	Combined	Eliminations	Consolidated
Current assets:							
Cash and cash equivalents	$ 138,728,096	18,589,398	13,460,202	10,375,388	181,153,084	—	181,153,084
Investments – unrestricted	631,723,051	5,105,864	4,320,372	58,817,170	699,966,457	—	699,966,457
Maternity case rate receivable	4,018,041	716,894	850,824	—	5,585,759	(1,544,587)	4,041,172
Reinsurance recoveries receivable	2,688,600	—	—	116,017	2,804,617	—	2,804,617
Interest receivable	1,874,463	8,673	8,930	252,897	2,144,963	—	2,144,963
Pharmacy rebates receivable	1,918,331	—	—	3,959,225	5,877,556	—	5,877,556
Premium receivable	7,041,001	332,271	555,283	13,406,303	21,334,858	(1,520,000)	19,814,858
Risk corridor receivable	3,022,381	1,392,675	2,351,916	4,768,313	11,535,285	(3,744,590)	7,790,695
Pay for performance incentive receivable	43,194,442	5,967,333	9,359,707	—	58,521,482	—	58,521,482
Other receivables	4,950,437	—	352,829	1,529,797	6,833,063	—	6,833,063
Prepaid expenses and other current assets	6,964,614	—	—	28,424,935	35,389,549	—	35,389,549
Intercompany receivable	12,203,223	12,900,100	1,400,471	712,456	27,216,250	(27,216,250)	—
Total current assets	858,326,680	45,013,208	32,660,534	122,362,501	1,058,362,923	(34,025,427)	1,024,337,496
Assets limited as to use:							
Investments – statutory reserves	—	—	—	373,037	373,037	—	373,037
Investments – contractual reserves	271,492	7,099,653	11,266,012	—	18,637,157	—	18,637,157
Total assets limited as to use	271,492	7,099,653	11,266,012	373,037	19,010,194	—	19,010,194
Property, building and equipment, net	13,308,583	—	145,507	1,901,639	15,355,729	—	15,355,729
Other assets:							
Other assets	3,689,754	—	424,134	453,952	4,567,840	—	4,567,840
Surplus note receivable	36,243,533	—	—	—	36,243,533	(3,502,829)	32,740,704
Total other assets	39,933,287	—	424,134	453,952	40,811,373	(3,502,829)	37,308,544
Total assets	$ 911,840,042	52,112,861	44,496,187	125,091,129	1,133,540,219	(37,528,256)	1,096,011,963
Liabilities and Net Assets							
Current liabilities:							
Accrued medical claims payable	$ 148,750,156	—	—	27,192,159	175,942,315	—	175,942,315
Claims adjudicated pending payment	7,661,797	—	—	1,326,951	8,988,748	—	8,988,748
Accounts payable and accrued expenses	44,170,611	12,820,849	7,837,308	552,794	65,381,562	(3,064,587)	62,316,975
Risk corridor payable	15,958,785	1,117,964	2,208,042	—	19,284,791	(3,744,590)	15,540,201
Accrued payroll and benefits	24,890,359	—	—	—	24,890,359	—	24,890,359
Premium recoupment payable	17,423,407	5,053,910	—	20,566,201	43,043,518	—	43,043,518
Pay for performance incentive payable	42,374,988	14,321,070	14,323,874	—	71,019,932	—	71,019,932
Intercompany payable	14,541,602	1,647,233	2,707,960	8,319,455	27,216,250	(27,216,250)	—
Other current liabilities	849,706	—	91,468	646,978	1,588,152	—	1,588,152
Total current liabilities	316,621,411	34,961,026	27,168,652	58,604,538	437,355,627	(34,025,427)	403,330,200
Other liabilities	3,992,936	—	332,537	3,650,842	7,976,315	(3,502,829)	4,473,486
Net assets:							
Without donor restrictions	591,225,695	17,151,835	16,994,998	62,295,179	687,667,707	—	687,667,707
With donor restrictions	—	—	—	540,570	540,570	—	540,570
Total net assets	591,225,695	17,151,835	16,994,998	62,835,749	688,208,277	—	688,208,277
Total liabilities and net assets	$ 911,840,042	52,112,861	44,496,187	125,091,129	1,133,540,219	(37,528,256)	1,096,011,963

See accompanying independent auditors' report.

CAREOREGON, INC. AND SUBSIDIARIES

Consolidating Schedule of Activities and Changes in Net Assets

Year ended December 31, 2021

	CareOregon	Columbia Pacific LLC	Jackson Care Connect LLC	Other Subsidiaries	Combined	Eliminations	Consolidated
Revenues:							
Net premium	$ 1,794,513,819	204,001,426	313,366,397	218,129,991	2,530,011,633	(465,037,686)	2,064,973,947
Net patient service	—	—	—	12,869,854	12,869,854	(3,315,484)	9,554,370
Management services	56,617,606	—	—	589,838	57,207,444	(43,104,043)	14,103,401
Other	603,886	7,578	50,000	891,324	1,552,788	(118,488)	1,434,300
Total revenues	1,851,735,311	204,009,004	313,416,397	232,481,007	2,601,641,719	(511,575,701)	2,090,066,018
Operating expenses:							
Purchased healthcare	1,494,598,348	197,202,003	308,729,878	194,224,527	2,194,754,756	(467,414,196)	1,727,340,560
Salaries and benefits – medical	9,374,801	—	—	3,014,183	12,388,984	—	12,388,984
Salaries and benefits – other	70,269,942	2,762,453	1,969,952	29,411,393	104,413,740	(2,673,907)	101,739,833
Claims administration	5,357,072	—	—	1,633,953	6,991,025	—	6,991,025
Other administrative	33,651,326	454,306	953,935	12,847,573	47,907,140	(1,057,462)	46,849,678
Management services	57,539,527	—	—	—	57,539,527	(40,430,136)	17,109,391
Charitable contributions	11,158,431	153,000	177,410	—	11,488,841	—	11,488,841
Total operating expenses	1,681,949,447	200,571,762	311,831,175	241,131,629	2,435,484,013	(511,575,701)	1,923,908,312
Revenues over operating expenses	169,785,864	3,437,242	1,585,222	(8,650,622)	166,157,706	—	166,157,706
Other income (expense):							
Investment income	15,334,665	(68,443)	(67,594)	(1,306,530)	13,892,098	—	13,892,098
Other expense	(729,062)	—	—	(200,000)	(929,062)	—	(929,062)
Total other income (expense)	14,605,603	(68,443)	(67,594)	(1,506,530)	12,963,036	—	12,963,036
Change in net assets without donor restrictions	184,391,467	3,368,799	1,517,628	(10,157,152)	179,120,742	—	179,120,742
Change in net assets with donor restrictions	—	—	—	(201,493)	(201,493)	—	(201,493)
Change in net assets	184,391,467	3,368,799	1,517,628	(10,358,645)	178,919,249	—	178,919,249
Net assets, beginning of year	411,189,228	13,783,036	14,477,370	69,839,394	509,289,028		509,289,028
Equity transfer	(4,355,000)	—	1,000,000	3,355,000	—	—	—
Net assets, end of year	$ 591,225,695	17,151,835	16,994,998	62,835,749	688,208,277	—	688,208,277

See accompanying independent auditors' report.