

Community Care, Inc. and Related Corporation

Financial and Compliance Report
December 31, 2023

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RSM US LLP

Independent Auditor's Report

Board of Directors
Community Care, Inc.

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of Community Care, Inc. and Related Corporation (collectively, the Organization), which comprise the consolidated statements of financial position as of December 31, 2023 and 2022, the related consolidated statements of activities 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 consolidated financial position of the Organization as of December 31, 2023 and 2022, and the changes in its net assets and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the *Wisconsin Department of Health Services (DHS) Family Care Audit Guide*, issued by the Wisconsin Department of Health Services. 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 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 Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated 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 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 Organization's ability to continue as a going concern within one year after the date the consolidated financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the 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 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, *Government Auditing Standards* and the *DHS Family Care Audit Guide* 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, *Government Auditing Standards* and the *DHS Family Care Audit Guide*, 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 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 consolidated 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.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The additional columns on pages 6 and 7 for Community Care Programs, Family Care, PACE, Partnership, and Management and Administration as presented in the consolidated statements of activities for 2023 and 2022 are presented for purposes of additional analysis of the consolidated financial statements, rather than to present information regarding the changes in net assets of the individual programs and are not a required part of the consolidated financial statements. The accompanying schedule of expenditures of state awards and the schedule of grant revenues and expenditures by funding source are presented for purposes of additional analysis, and to comply with the *DHS Family Care Audit Guide*, and are not required parts 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 audits 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 auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards* and the *DHS Family Care Audit Guide*, we have also issued our report dated May 1, 2024, on our consideration of Community Care, Inc.'s internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Community Care, Inc.'s internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and the *DHS Family Care Audit Guide* in considering Community Care, Inc.'s internal control over financial reporting and compliance.

RSM US LLP

Minneapolis, Minnesota
May 1, 2024

Community Care, Inc. and Related Corporation

**Consolidated Statements of Financial Position
December 31, 2023 and 2022**

	2023	2022
Assets		
Current assets:		
Cash and cash equivalents	\$ 177,741,338	\$ 167,852,457
Accounts receivable, net of allowances of \$13,055,307 and \$8,396,496, in 2023 and 2022, respectively	20,917,174	11,203,442
Prepaid expenses and other assets	3,366,579	3,071,525
Total current assets	202,025,091	182,127,424
Property and equipment:		
Land and land improvements	1,341,128	1,341,128
Buildings and improvements	11,576,319	11,407,968
Equipment and furnishings	4,032,590	3,968,846
Computer equipment and software	10,375,044	9,894,668
	27,325,081	26,612,610
Less accumulated depreciation	18,742,292	18,224,725
	8,582,789	8,387,885
Other assets:		
Investments	78,122,716	74,890,427
Assets limited as to use	11,074,438	10,248,172
Operating lease right-of-use assets, net	1,733,227	2,324,799
Other assets	84,186	84,186
	91,014,567	87,547,584
	\$ 301,622,447	\$ 278,062,893

(Continued)

Community Care, Inc. and Related Corporation

Consolidated Statements of Financial Position (Continued)
December 31, 2023 and 2022

	2023	2022
Liabilities and Net Assets		
Current liabilities:		
Reported and estimated claims	\$ 69,867,431	\$ 67,004,619
Accounts payable	28,194,159	28,587,586
Accrued liabilities:		
Payroll and benefits	8,778,308	8,895,947
Other	6,110,157	1,729,087
Current portion of operating lease liabilities	792,688	824,598
Total current liabilities	113,742,743	107,041,837
Operating lease liabilities, less current portion	968,543	1,525,830
Total liabilities	114,711,286	108,567,667
Commitments and contingencies		
Net assets:		
Net assets without donor restrictions	169,154,404	151,125,763
Net assets without donor restrictions, board-designated	17,756,757	18,369,463
Total net assets	186,911,161	169,495,226
	\$ 301,622,447	\$ 278,062,893

See notes to consolidated financial statements.

Community Care, Inc. and Related Corporation

Consolidated Statement of Activities Year Ended December 31, 2023

	2023							2022*	
	Community Care		Community Care Health Plan			Management and Administration	Eliminations	Total	Total
	Community Care Programs	Family Care Standard	PACE	Partnership					
Operating revenue and support:									
Capitation revenue	\$ -	\$ 647,628,755	\$ 51,361,082	\$ 72,730,824	\$ -	\$ -	\$ 771,720,661	\$ 717,606,294	
Grants and reimbursements	22,587,468	-	-	-	-	(21,262,880)	1,324,588	1,407,659	
Client pay portion	-	83,244,323	2,243,982	4,508,591	-	-	89,996,896	77,364,353	
Total operating revenue and support	22,587,468	730,873,078	53,605,064	77,239,415	-	(21,262,880)	863,042,145	796,378,306	
Operating expenses:									
Wages and benefits	13,130,559	48,162,702	3,860,683	4,191,040	-	-	69,344,984	66,283,435	
Contract client services	-	647,517,837	46,932,028	66,870,012	-	(21,262,880)	740,056,997	656,993,207	
Other direct expenses	6,613,040	4,036,884	249,473	162,896	-	-	11,062,293	9,845,870	
Allocated general, administrative and occupancy expenses	2,184,396	21,724,579	3,219,246	3,846,307	(1,254,475)	-	29,720,053	27,700,748	
Premium deficiency reserve	-	-	1,636,417	1,213,057	-	-	2,849,474	-	
Depreciation	97,245	8,075	1,160	-	1,218,090	-	1,324,570	1,209,602	
Interest	-	-	-	-	36,385	-	36,385	50,371	
Total operating expenses	22,025,240	721,450,077	55,899,007	76,283,312	-	(21,262,880)	854,394,756	762,083,233	
Operating income (loss)	562,228	9,423,001	(2,293,943)	956,103	-	-	8,647,389	34,295,073	
Other income (expense):									
Investment income (loss)	-	7,301,217	375,271	541,724	849,635	-	9,067,847	(3,056,570)	
Income tax benefit (expense)	-	-	129,492	(321,353)	-	-	(191,861)	81,294	
Other	-	10,000	-	-	(117,440)	-	(107,440)	4,156	
Total other income (expense)	-	7,311,217	504,763	220,371	732,195	-	8,768,546	(2,971,120)	
Change in net assets without donor restrictions	\$ 562,228	\$ 16,734,218	\$ (1,789,180)	\$ 1,176,474	\$ 732,195	\$ -	17,415,935	31,323,953	
Net assets, beginning of year							169,495,226	138,171,273	
Net assets, end of year							\$ 186,911,161	\$ 169,495,226	

*See following page for presentation of the complete consolidated statement of activities for the year ended December 31, 2022.

See notes to consolidated financial statements.

Community Care, Inc. and Related Corporation

Consolidated Statement of Activities Year Ended December 31, 2022

	Community Care		Community Care Health Plan		Management and Administration	Eliminations	Total
	Community Care Programs	Family Care Standard	PACE	Partnership			
Operating revenue and support:							
Capitation revenue	\$ -	\$ 599,249,028	\$ 48,784,251	\$ 69,573,015	\$ -	\$ -	\$ 717,606,294
Grants and reimbursements	24,237,706	-	-	-	-	(22,830,047)	1,407,659
Client pay portion	-	71,314,833	1,900,718	4,148,802	-	-	77,364,353
Total operating revenue and support	<u>24,237,706</u>	<u>670,563,861</u>	<u>50,684,969</u>	<u>73,721,817</u>	<u>-</u>	<u>(22,830,047)</u>	<u>796,378,306</u>
Operating expenses:							
Wages and benefits	14,530,345	44,281,985	3,643,503	3,827,602	-	-	66,283,435
Contract client services	-	570,457,778	43,370,846	65,994,630	-	(22,830,047)	656,993,207
Other direct expenses	6,638,105	2,633,197	326,231	248,337	-	-	9,845,870
Allocated general, administrative and occupancy expenses	2,367,202	19,296,355	3,137,120	4,048,697	(1,148,626)	-	27,700,748
Premium deficiency reserve	-	-	-	-	-	-	-
Risk share (should this be netted against premiums)	-	-	-	-	-	-	-
Depreciation	75,198	35,457	692	-	1,098,255	-	1,209,602
Interest	-	-	-	-	50,371	-	50,371
Total operating expenses	<u>23,610,850</u>	<u>636,704,772</u>	<u>50,478,392</u>	<u>74,119,266</u>	<u>-</u>	<u>(22,830,047)</u>	<u>762,083,233</u>
Operating income (loss)	<u>626,856</u>	<u>33,859,089</u>	<u>206,577</u>	<u>(397,449)</u>	<u>-</u>	<u>-</u>	<u>34,295,073</u>
Other income (expense):							
Investment loss	-	(3,414,303)	(200,199)	(303,283)	861,215	-	(3,056,570)
Income tax expense	-	-	1,178	80,116	-	-	81,294
Other	-	7,000	-	1,000	(3,844)	-	4,156
Total other income (expense)	<u>-</u>	<u>(3,407,303)</u>	<u>(199,021)</u>	<u>(222,167)</u>	<u>857,371</u>	<u>-</u>	<u>(2,971,120)</u>
Change in net assets without donor restrictions	<u>\$ 626,856</u>	<u>\$ 30,451,786</u>	<u>\$ 7,556</u>	<u>\$ (619,616)</u>	<u>\$ 857,371</u>	<u>\$ -</u>	<u>31,323,953</u>
Net assets, beginning of year							<u>138,171,273</u>
Net assets, end of year							<u>\$ 169,495,226</u>

See notes to consolidated financial statements.

Community Care, Inc. and Related Corporation

Consolidated Statements of Cash Flows
Years Ended December 31, 2023 and 2022

	2023	2022
Cash flows from operating activities:		
Change in net assets	\$ 17,415,935	\$ 31,323,953
Adjustments to reconcile the change in net assets to net cash provided by operating activities:		
Depreciation	1,324,570	1,209,602
Change in net realized and unrealized (gain) loss on investments and assets limited as to use	(2,135,346)	4,916,003
Changes in operating assets and liabilities:		
Accounts and grants receivable	(9,713,732)	10,885,388
Prepaid expenses and other assets	(295,054)	(771,233)
Reported and estimated claims	2,862,812	14,282,215
Accounts payable	(393,427)	18,534,516
Accrued payroll and benefits	(117,639)	1,203,354
Other accrued liabilities	4,381,070	346,471
Operating leases	2,375	2,487
Net cash provided by operating activities	13,331,564	81,932,756
Cash flows from investing activities:		
Purchases of property and equipment	(1,403,523)	(986,358)
Proceeds from sale of property and equipment	-	435
Purchases of investments and assets limited as to use	(26,669,665)	(45,760,551)
Proceeds from maturities of investments and assets limited as to use	23,237,963	2,887,500
Investment income, net of fees	1,392,542	478,005
Net cash used in investing activities	(3,442,683)	(43,380,969)
Net increase in cash, cash equivalents and restricted cash	9,888,881	38,551,787
Cash, cash equivalents and restricted cash, beginning of year	167,852,457	129,300,670
Cash, cash equivalents and restricted cash, end of year	\$ 177,741,338	\$ 167,852,457

See notes to consolidated financial statements.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 1. Nature of Operations and Basis of Consolidation

Community Care, Inc. (CC) is a Section 501(c)(3) community-based, not-for-profit, non-stock corporation, that provides coordinated long-term health care and social services to at-risk adult populations.

Community Care health Plan, Inc. (CCHP) was formed by CC and was incorporated on June 14, 2004, under Section 501(c)(4) of the Internal Revenue Code and Chapter 613 of the Wisconsin Statutes as a not-for-profit, nonstock, Health Maintenance Organization (HMO). The State of Wisconsin granted CCHP its HMO licensure on August 12, 2004, and operations commenced on July 1, 2005. CCHP was formed by CC to comply with the rules and laws of the State of Wisconsin and the Office of the Commissioner of Insurance of the State of Wisconsin (OCI). CCHP provides coordinated long-term health care and social services to at-risk adult populations in southeastern Wisconsin.

Because CC is the sole member of CCHP, approves CCHP's board of directors and because of an economic interest, CCHP is consolidated for the years ended December 31, 2023 and 2022. The above entities are collectively referred to as the Organization.

The Organization provides the following significant programs:

Family Care (FC): FC is a Medicaid capitated long-term care program. Members are 18 years or older and include frail elderly, physically disabled and developmentally disabled members. Members must meet both functional and financial eligibility requirements. The program objective is to provide cost-effective, comprehensive and flexible long-term care that will foster members' independence and quality of life, while recognizing the need for interdependence and support. The service area includes 15 counties in southeastern and east central Wisconsin.

Community Care Health Plan: CCHP is composed of two long-term care managed care programs: the Program for All-Inclusive Care for the Elderly (PACE) and Family Care Partnership (FCP). The programs provide fully integrated care which includes all Medicare and Medicaid services. PACE members must be 55 years or older, while FCP members must be 18 years or older. Both programs include frail elderly, physically disabled and developmentally disabled members. Members must be at nursing home level of care and meet financial eligibility requirements. The service area includes nine counties in southeastern and east central Wisconsin.

Basis of consolidation: The consolidated financial statements include the accounts of CC and its related corporation, CCHP. All significant inter-entity transactions are eliminated in consolidation.

Note 2. Basis of Presentation and Summary of Significant Accounting Policies

Basis of presentation: The Organization presents its consolidated financial statements on the accrual basis of accounting in accordance with the accounting principles generally accepted in the United States of America (U.S. GAAP). Net assets, revenues, expenses, gains and losses are classified based on the existence or absence of donor restrictions as follows:

Net assets without donor restrictions—Net assets that are available for use in the general operations of the Organization and are not subject to donor-imposed stipulations.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 2. Basis of Presentation and Summary of Significant Accounting Policies (Continued)

The Board of Directors established the designation of Community Care Health Plan to account for the accumulated increase in net assets realized under the Organization's CCHP program since its inception. This is reported as, net assets without donor restrictions—board designated, in the consolidated statements of financial position. The Board may, at its discretion, subsequently designate the use of CCHP's cash, cash equivalents and investments for CC's general operating purposes.

Net assets with donor restrictions—Net assets subject to donor-imposed restrictions. Some donor restrictions are temporary in nature, such that they will be met either by actions of the Organization and/or the passage of time. Other donor restrictions are perpetual in nature, whereby the donor has stipulated the funds be maintained in perpetuity. The Organization had no net assets with donor restrictions at December 31, 2023 or 2022.

Use of estimates in preparation of consolidated financial statements: The preparation of the consolidated financial statements in conformity with U.S. 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 date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Estimated retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are settled.

Reported and estimated claims consist of unpaid claims reported to the Organization and an estimated liability for medical claims incurred on or before December 31, which have not been reported to the Organization by that date. Estimated claims payable are based on historical trends and cost projections. An independent actuary reviewed the estimates made by the Organization as of December 31, 2023 and 2022. Management believes the estimates are reasonable approximations of the incurred but not reported medical claims. However, it is reasonably possible that the claims presented for payment may not follow past trends and, therefore, may be more or less than the \$69,867,431 liability recorded in the consolidated statement of financial position as of December 31, 2023. It is the opinion of management that the difference will not have a material effect on the Organization's net assets or results of operations. The methods for making such estimates and for establishing the resulting liability are continually reviewed and adjustments are reflected in the period determined. There have been no significant changes to the Organization's methodologies during the years ended December 31, 2023 and 2022.

Cash and cash equivalents: The Organization considers all highly liquid debt instruments purchased with original maturities of three months or less to be cash equivalents. The Organization maintains deposits in financial institutions that consistently exceed the Federal Deposit Insurance Corporation limits. The Organization has not experienced any losses in such accounts and management believes it is not exposed to any significant credit risk.

The Organization is a fiscal agent for certain elderly and disabled adults. At December 31, 2023 and 2022, the Organization held approximately \$95,000 and \$97,000, respectively, of funds on behalf of its clients. These accounts are included in cash and cash equivalents and accounts payable on the consolidated statements of financial position.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 2. Basis of Presentation and Summary of Significant Accounting Policies (Continued)

Accounts and grants receivable: The Organization adopted Accounting Standards Codification (ASC) 326, using a modified retrospective approach. ASC 326 requires measurement and recognition of expected credit losses for financial assets held. Estimating credit losses based on risk characteristics requires significant judgment by the Organization. Significant judgments include assessing current economic conditions and the extent to which they would be relevant to the existing characteristics of the Organization's financial assets, the estimated life of financial assets and the level of reliance on historical experience in light of economic conditions. The majority of accounts and grants receivable are due from governmental and granting agencies. The terms of payments are specified in the agreements with the governmental and granting agencies. Past due amounts are written off after management has used reasonable collection efforts.

Property and equipment: Purchases of property and equipment in excess of \$2,500 are capitalized at historical cost, and are depreciated over the estimated useful lives of the assets using the straight-line method as follows:

Land improvements	3-25 years
Building and improvements	5-30 years
Equipment and furnishing	5-20 years
Computer equipment and software	3-5 years

Donated property and equipment are recorded at fair value on the date of the gift. Maintenance and repair costs are charged to expense as incurred, and improvements are capitalized. When property and equipment are retired or sold, the related cost and accumulated depreciation are removed from accounts, and the gain or loss on disposition is reflected in the consolidated statements of activities.

Investments: The Organization reports investments at fair value, with net appreciation or depreciation reported in the consolidated statements of activities, net of investment expenses. The Organization's investments are exposed to various risks, such as interest rates and market and credit risks. Due to the level of risk associated with certain investments and the level of uncertainty related to changes in the values of investments, it is at least reasonably possible that changes in risk in the near term would materially affect the Organization's investment holdings.

Assets limited as to use: The Organization is required by the Wisconsin Department of Health Services (DHS) to maintain a surplus of liquid assets for the Family Care Program to provide continuity of care for enrolled members, accountability to taxpayers and effective program administration including the ability to manage operations. At December 31, 2023 and 2022, the Organization has invested its restricted use funds of \$7,915,438 and \$7,189,172, respectively, in U.S. Government and agency securities which are reported in assets limited as to use on the consolidated statements of financial position. The required surplus at December 31, 2023 and 2022, was \$7,048,444 and \$6,929,001, respectively.

Under the terms of CC's contract with DHS, CC is also required to maintain a solvency fund, which provides for continuity of services and smooth transition of members from the existing Managed Care Organization (MCO) to another entity or in the event the existing MCO becomes irreversibly insolvent. At December 31, 2023 and 2022, the Organization has deposited \$3,159,000 and \$3,059,000, respectively, into an account designated by DHS and held by the Wisconsin Department of Administration to meet this requirement. As these funds are still the assets of the Organization, they are included in assets limited as to use on the consolidated statements of financial position. The required deposits at December 31, 2023 and 2022, were \$3,155,080 and \$3,044,980, respectively.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 2. Basis of Presentation and Summary of Significant Accounting Policies (Continued)

Leases: Leases are presented in accordance with Financial Accounting Standards Board (FASB) ASC Topic 842, Leases. Under ASC Topic 842, a lease is a contract, or part of a contract, that conveys the right to control the use of identified property, plant or equipment (i.e., an identified asset) for a period of time in exchange for consideration. The Organization's contracts determined to be or contain a lease include explicitly or implicitly identified assets where the Organization has the right to obtain substantially all of the economic benefits of the assets and has the ability to direct how and for what purpose the assets are used during the lease term. The Organization determines if an arrangement is or contains a lease at inception, which is the date on which the terms of the contract are agreed to, and the agreement creates enforceable rights and obligations. Leases are classified as either operating or finance. For operating leases, the Organization has recognized a lease liability equal to the present value of the remaining lease payments and a right of use asset equal to the lease liability, subject to certain adjustments, such as prepaid rents. The Organization uses a risk-free interest rate, based on the United States Treasury rates, to determine the present value of the lease payments.

The Organization's leases are primarily related to real estate used in its operations. Real estate leases have initial terms up to five years in length. Certain leases include renewal, termination or purchase options. Under ASC Topic 842, the lease term at the lease commencement date is determined based on the non-cancellable period for which the Organization has the right to use the underlying asset, together with any periods covered by an option to extend the lease if the Organization is reasonably certain to exercise that option, periods covered by an option to terminate the lease if the Organization is reasonably certain not to exercise that option and periods covered by an option to extend (or not to terminate) the lease in which the exercise of the option is controlled by the lessor.

Operating leases utilize a straight-line lease expense pattern. The Organization's lease agreements do not contain any residual value guarantees or restrictive covenants.

The Organization has made an accounting policy election not to recognize right-of-use assets and lease liabilities for leases with a lease term of 12 months or less, including renewal options that are reasonably certain of exercise. Instead, lease payments for these leases are recognized as lease cost on a straight-line basis over the lease term.

ASC Topic 842 includes a number of reassessment and re-measurement requirements for lessees based on certain triggering events or conditions, including whether a contract is or contains a lease, assessment of lease term and purchase options, measurement of lease payments, assessment of lease classification and assessment of the discount rate. The Organization reviews the reassessment and re-measurement requirements and did not identify any events or conditions during the years ended December 31, 2023 or 2022, that required a reassessment or re-measurement. In addition, there were no impairment indicators identified during the years ended December 31, 2023 or 2022, that required an impairment test for the Organization's right-of use assets or other long-lived assets in accordance with ASC 360-10.

Certain of the Organization's leases include non-lease components that transfer a distinct service to the Organization, such as common area maintenance. The Organization has elected not to separate the accounting for lease components and non-leases components, for all classes of leased assets.

Certain of the Organization's leases include variable lease costs. These variable payments typically represent additional services transferred to the Organization and are recorded in lease expense in the period incurred.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 2. Basis of Presentation and Summary of Significant Accounting Policies (Continued)

Contracts with the Wisconsin Department of Health Services: The Organization has annual contracts with DHS to provide services to qualified Medicaid recipients (the Contracts). The Contracts represent the Organization's source of capitation revenue January through December each year. The Organization or DHS may terminate the Contracts with 30 days written notice. Termination of this contract would create a material adverse event for the Organization.

Revenue recognition: Revenue from contracts with members (customers) are reported at amounts that reflect the consideration to which the Organization expects to be entitled in exchange for providing the goods and services in the benefits packages included in the Family Care, PACE and FCP programs and the room and board to members. The Organization has third-party provider agreement contracts with DHS and the Centers for Medicare and Medicaid Services (CMS), whereby DHS and CMS pay for some or all of the services the Organization provides to its members. Capitation payments from DHS and CMS are received at prospectively determined rates, paid per member per month and are included in capitation revenue in the consolidated statements of activities.

Members may be required to pay for a part of their care via a cost share program in order to be eligible for Medicaid. The cost share is determined by the Income Maintenance Office and is based on member income, marital status and allowable Medicaid credits. Capitation payments are reduced by the amount of cost share paid by the members. Cost share, reduced by an implicit discount for allowance for non-payment of rent, is included in client pay portion in the consolidated statements of activities. Based on past experience with DHS and CMS, the Organization concludes that the transaction price (the capitation payment) is collectible.

Room and board are billed to members monthly. Based on customary business practice, the Organization supplements the member's payment of room and board as members cannot be dis-enrolled for nonpayment. The subsidized portion of room and board is not recognized as revenue and is considered an implicit price concession. The transaction price for room and board revenue is determined based on formulas approved by DHS, less this implicit price concession. Room and board, reduced by the implicit discount for subsidized rent, is included in client pay portion in the consolidated statements of activities.

Revenue from governmental grants is recognized over time in the period the related expense is incurred. Governmental grant awards are generally subject to renewal by the grantor agencies on an annual basis.

Revenue is recognized as performance obligations are satisfied. Performance obligations are determined based on the nature of the services provided by the Organization. If certain criteria are met, individual contracts that are entered into at or near the same time are combined for accounting purposes. The Organization recognizes the DHS and CMS capitated revenue as a single contract. As members can terminate the contract on a daily basis with no penalty for termination, revenue is recognized daily. The Organization believes this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to the members receiving the benefits package included in the DHS and CMS contracts.

Because all of its performance obligations relate to contracts with a duration of one year or less, the Organization has elected to apply the optional exemption provided in ASC 606-10-50-14(b) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are not satisfied or partially satisfied at the end of the reporting period. However, generally there are no performance obligations unsatisfied or partially satisfied at the end of a reporting period.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 2. Basis of Presentation and Summary of Significant Accounting Policies (Continued)

The Organization determines the transaction price for the capitation payments based on the per member per month capitation payments as set by DHS and CMS. However, the DHS and CMS capitation amounts include variable consideration for retroactive revenue adjustments related to settlement adjustments subsequent to the year the service was performed. Retroactive settlement adjustments include Medicare Advantage, Medicare Part D, Medicaid only, pay for performance adjustments and risk corridor provisions for the years ended December 31, 2023 and 2022. Retroactive settlement adjustments were discontinued for high-cost risk pool for the year ended December 31, 2022.

These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Organization's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available) or as years are settled or are no longer subject to such audits, reviews and investigations.

The following is a summary of the more significant retroactive settlements the Organization considers when determining the estimated transaction price:

CMS—Medicare revenue

Medicare Advantage—The Organization contracts with CMS to provide coverage under the Medicare Advantage program. Under this contract, revenues are recognized based on the estimated number of eligible members per month multiplied by the contracted monthly capitation rate, which is adjusted for member health status. The Organization has an arrangement with CMS for certain Medicare products, whereby periodic changes in its risk-factor adjustment scores for hierarchical condition category codes (HCC risk scores) result in changes to health plan services premium revenues. CMS uses a risk-adjustment model to determine the premium amount it pays for each member. The CMS risk-adjustment model allocates premiums paid to all Medicare Advantage plans according to the health status of each beneficiary enrolled and pays more for Medicare members with higher HCC risk scores. Under this risk-adjustment methodology, all Medicare Advantage health plans must capture, collect and submit certain necessary diagnosis code information from encounter data obtained from inpatient and ambulatory treatment settings to CMS within prescribed deadlines. CMS uses this diagnosis code information to calculate members' HCC risk scores. The HCC risk scores, in turn, determine the risk-adjusted premiums payable to the Medicare Advantage organizations. CMS reviews the submissions and establishes the HCC risk scores generally at the beginning of the calendar year, and then adjusts the HCC risk scores on two separate occasions on a retroactive basis. The first adjustment (the Mid-Year HCC Risk Score Reconciliation) for a given fiscal year will be effective for the July reporting period. The Mid-Year HCC Risk Score Reconciliation involves updating the initial HCC risk scores using more recently available diagnosis code information. CMS then issues a final HCC risk score reconciliation adjustment for that fiscal year in the following year.

The Organization recognizes changes in receivables previously recorded when the amounts to be received become determinable and supportable, and collectability is reasonably assured.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 2. Basis of Presentation and Summary of Significant Accounting Policies (Continued)

Based on the Organization's evaluation of estimated settlements for CMS risk-factor adjustment scores, the Organization recorded receivables of approximately \$225,000 and \$144,000 at December 31, 2023 and 2022, respectively, within accounts and grants receivable in the consolidated statements of financial position. Because the recorded revenue is based on the best estimate at that time, the actual payment received from CMS for risk-adjustment reimbursement settlements may be different than the amounts initially recognized in the consolidated financial statements. Changes in the estimates for the risk adjustment are included in the consolidated statement of activities in the period they become known.

Medicare Part D—The Organization covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments the Organization receives monthly from CMS and its members, which are determined from an annual bid, represent amounts for providing prescription drug insurance coverage. The Organization recognizes capitation revenue for providing this coverage ratably over the term of the annual contract. The CMS payment is subject to risk-sharing through the Medicare Part D risk-sharing corridor provisions. The Organization recorded amounts due from Medicare Part D of approximately \$453,000 and \$2,070,000 at December 31, 2023 and 2022, respectively, in accounts and grants receivable in the consolidated statements of financial position. The Organization has recorded a liability due to Medicare Part D of approximately \$1,712,000 and \$341,000 at December 31, 2023 and 2022, respectively, in accrued liabilities: other in the consolidated statements of financial position.

DHS—Medicaid revenue

Medicaid-only adjustment—This represents the final reconciliation of the capitation payment for the percentage of Medicaid-only members for the term of the annual contract. This settlement applies only to the FCP program.

Pay for performance—This represents consideration the Organization may receive based on its performance in certain designated areas such as Competitive Integrated Employment for members and member survey results. A portion of the monthly capitation payment is withheld and placed in a pool to be distributed among the managed care organizations in the State of Wisconsin once the results of the pay for performance are tabulated. At December 31, 2023 and 2022, the settlement amounts are receivables of approximately \$2,651,000 and \$2,304,000, respectively.

Risk corridor provision—Beginning with the year ended December 31, 2021, the Organization was subject to a risk corridor provision for its contract with DHS whereby the Organization's actual costs are compared to targeted costs based on membership. Variances exceeding certain thresholds may result in DHS making additional payments to the Organization or may require the Organization to refund to DHS a portion of premiums received. Based on a comparison of the actual and targeted costs for the years ended December 31, 2023 and 2022, the Organization estimated a risk corridor payable of \$24,298,562 and \$25,594,698, respectively, which is included in accounts payable on the consolidated statements of financial position and as a reduction to capitation revenue within the consolidated statements of activities. For the years ended December 31, 2023 and 2022, the Organization estimated a risk corridor receivable of \$1,994,967 and \$0, respectively, which is included in accounts receivable on the consolidated statement of financial position and as an addition to capitation revenue within the consolidated statements of activities.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 2. Basis of Presentation and Summary of Significant Accounting Policies (Continued)

Premium deficiency reserve: Premium deficiency reserves are recognized when it is probable that expected claim expenses will exceed future premiums on existing health contracts. The Organization considers anticipated investment income when calculating its premium deficiency reserves. As of December 31, 2023, the Organization recorded a premium deficiency reserve of approximately \$2,849,000, related to expected losses in 2024, within other liabilities on the consolidated statements of financial position. The Organization did not record a premium deficiency reserve as of December 31, 2022.

Operating income (loss): The consolidated statements of activities include an intermediate measure of operations, operating income (loss), which represents the activity of the ongoing operation of the Organization. Other income and expense excluded from operating income (loss) consists primarily of investment income and other nonrecurring transactions that are viewed as being outside the Organization's primary activities.

Contract client services: The Organization has entered into agreements with providers for certain health care services on a contractual fee-for-service basis. Costs of these services are recognized as an expense in the period the service is provided and are recorded as claims are incurred. Costs incurred but not reported are recorded based upon the forecast cost method. Any adjustments between the estimates and the actual claims are included in the consolidated statement of activities in the period they become known.

Functional allocation of expenditures: The Organization allocates administrative and general (A&G) costs using a logical and consistent basis based upon usage. All programs, grants or departments receive an A&G allocation based upon the policy regardless of funding source requirements. A&G expenses are those costs which support and provide benefit to all parts of the business. This is contrasted with direct costs which provide service and support to specific programs or individuals. The internal definition of what constitutes A&G is in accordance with the DHS Managed Care Administrative Cost Model Guidelines. The Organization has two levels of A&G expenses:

- Corporate A&G are those expenses not directly tied to a specific program and/or service. These are traditional A&G services that typically benefit most departments.
- Program A&G are those expenses that benefit programs but are not directly attributable to specific members.

Direct service support are those department expenses that are assigned to a direct service functional area or to care management. Direct Service and Care Management, included in contract client services on the consolidated statements of activities, charges the cost of these services back to the programs for which they are serving based on a per unit rate. A&G is allocated to the Direct Service and Care Management areas and is incorporated into the rate charged to the programs.

In general, expenses are allocated to end sites based on their percent share of CCI cumulative expenses, i.e., Family Care, CCHP, Internal Services, etc. The cumulative total may be expanded or narrowed to best represent the department being allocated. For example, accounting A&G is allocated based on total expense. A county care management program will receive a percent of the accounting A&G expense based on its contribution to CCI's aggregate expenses. Other methods of allocation used are square feet (individual department use of the aggregate within a specified facility), members (members by site within CCHP or FC total) and FTEs (employees by department to CCI's aggregate). End sites are itemized down to their specific site/region, program and target group level.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 2. Basis of Presentation and Summary of Significant Accounting Policies (Continued)

Income taxes: CC is exempt from federal income taxes under Section 501(c)(3) of the Internal Revenue Code. The Internal Revenue Service has determined that CCHP is exempt from federal income tax under Section 501(c)(4) of the Internal Revenue Code. Accordingly, the accompanying consolidated financial statements do not include any amounts for federal corporate income taxes. However, CCHP is subject to State of Wisconsin property, income and franchise taxes. CC is exempt from state income taxes.

The Organization uses the liability method in accounting for CCHP's state income taxes. Deferred tax assets and liabilities are recorded for temporary differences between the tax basis of assets and liabilities and their amounts reported in the consolidated financial statements, using statutory tax rates in effect for the year in which the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the consolidated statements of activities in the period that includes the enactment date. As of December 31, 2023 and 2022, the Organization had deferred tax assets of approximately \$213,000 and \$405,000, respectively. Full valuation allowances are provided against these deferred tax assets due to uncertainty of their realization. For the years ended December 31, 2023 and 2022, the Organization had an income tax expense (benefit) related to CCHP's operations of approximately \$192,000 and \$(81,000), respectively. The Organization expenses interest and penalties on income taxes when they are known. There were no interest or penalties on income taxes in 2023 or 2022.

The Organization follows the provisions of ASC Topic 740, Income Taxes. As required by the uncertain tax position guidance in ASC Topic 740, the Organization recognizes the financial statement benefit of a tax position only after determining that the relevant tax authority would more likely than not sustain the position following an audit. For positions that meet the more likely than not threshold, the amount recognized in the consolidated financial statements is the largest benefit that has a greater than 50% likelihood of being realized upon ultimate settlement with the relevant tax authority. There were no significant matters determined by management to be unrecognized tax benefits taken or expected to be taken in a tax return that have been recorded in the Organization's consolidated financial statements for the years ended December 31, 2023 and 2022.

Recently adopted accounting pronouncements: In June 2016, the FASB issued Accounting Standards Update (ASU) 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, which created a new credit impairment standard for financial assets measured at amortized cost to be presented at the net amount expected to be collected, through an allowance for credit losses that are expected to occur over the remaining life of the asset, rather than incurred losses. The adoption of this standard did not have a material impact on the Organization's consolidated financial statements.

Subsequent events: Management of the Organization has evaluated subsequent events through May 1, 2024, the date the consolidated financial statements available to be issued, and determined no additional disclosures or adjustments were required with the exception of the following.

On February 21, 2024, Change Healthcare, a third-party service provider to the Organization, became aware of a cybersecurity incident (the Incident) causing a disruption across the health care industry. As a result of the Incident, the Organization does not know what, if any, Organization data, including personally identifiable information (PII) and/or protected health information (PHI), that has been compromised as a result of the Incident. At this time, the Organization is not aware of any legal claims asserted against the Organization and is not able to predict if the Incident will have a material adverse effect on the Organization's financial condition or results of operations.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 3. Liquidity and Availability

The following table represents financial assets available for general expenditures within one year of December 31:

	2023	2022
Financial assets at year-end:		
Cash and cash equivalents	\$ 177,741,338	\$ 167,852,457
Accounts and grants receivable	20,917,174	11,203,442
Investments	78,122,716	74,890,427
Total financial assets	276,781,228	253,946,326
Less amounts not available to be used within one year:		
Funds held for members	95,000	97,000
Financial assets available to meet general expenditures within one year	<u>\$ 276,686,228</u>	<u>\$ 253,849,326</u>

The Organization regularly monitors liquidity required to meet its annual operating needs and other contractual commitments while also striving to maximize the return on investment of its available funds.

As part of its liquidity management, the Organization's policy is to structure and manage its financial assets to be available to meet its general expenditure needs. Cash in excess of daily requirements is invested. To help manage unanticipated liquidity needs, the Organization has a line of credit agreement through September 15, 2024 of \$500,000, from January through May and August through December. For the months of June and July, the line of credit is for \$20,000,000. The Organization's 2024 budgeted revenue provides for a surplus monthly cash flow to meet general expenditures throughout the year.

Note 4. Investments and Assets Limited as to Use

The assessment of impairment and credit losses on investments is performed on a case-by-case basis. In its assessment, management takes into consideration current market conditions, issuer rating changes and trends, the creditworthiness of the obligator of the security, current analysts' evaluations, failure of the issuer to make scheduled interest or principal payments, and the Organization's lack of intent to sell the security or whether it is more likely than not that the Organization will be required to sell the debt security before its anticipated recovery, as well as other qualitative factors.

The amortized cost and fair value, together with the unrealized gains and losses, of investments and assets limited as to use are as follows at December 31:

	2023			
	Amortized Cost	Fair Value	Unrealized Gains	Unrealized Losses
U.S. Government and agency securities	\$ 92,479,285	\$ 89,197,154	\$ 602,246	\$ (3,884,377)
	2022			
	Amortized Cost	Fair Value	Unrealized Gains	Unrealized Losses
U.S. Government and agency securities	\$ 90,550,295	\$ 85,138,599	\$ 9,736	\$ (5,421,432)

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 4. Investments and Assets Limited as to Use (Continued)

Investments and assets limited as to use are reported as follows in the consolidated statements of financial position at December 31:

	2023	2022
Investments	\$ 78,122,716	\$ 74,890,427
Assets limited as to use	11,074,438	10,248,172
Total investments and assets limited as to use	<u>\$ 89,197,154</u>	<u>\$ 85,138,599</u>

Investment income consisted of the following for the years ended December 31:

	2023	2022
Interest and dividends	\$ 6,932,501	\$ 1,859,433
Change in net unrealized gains and losses on investments	2,129,565	(4,917,364)
Net realized gain on sale of investments	5,781	1,361
	<u>\$ 9,067,847</u>	<u>\$ (3,056,570)</u>

The amortized cost and estimated fair value of securities, by contractual maturities, are as follows at December 31, 2023:

	Amortized Cost	Fair Value
In one year or less	\$ 35,627,489	\$ 35,725,068
After one year through five years	43,499,201	41,066,159
After five years through ten years	13,352,595	12,405,927
	<u>\$ 92,479,285</u>	<u>\$ 89,197,154</u>

Expected maturities for U.S. Government and agency securities may differ from contractual maturities because borrowers may have the right to call or prepay obligations without penalty.

Note 5. Fair Value Measurements

Assets and liabilities carried at fair value are required to be classified and disclosed in one of the following three categories:

Level 1: Quoted market prices in active markets for identical assets and liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are not corroborated by market data.

In determining the appropriate levels, the Organization performs a detailed analysis of the assets and liabilities that are carried at fair value in the consolidated financial statements. All of the Organization's financial assets (see Note 4) measured at fair value on a recurring basis as of December 31, 2023 and 2022, are classified as Level 2.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 6. Line of Credit

The Organization has a line of credit agreement with a bank. The amount authorized and available under this agreement is \$500,000 from January 1 through May 31 and from August 1 through December 31 of each fiscal year. From June 1 through July 31 of each fiscal year, the available credit commitment is \$20,000,000. During 2022, the agreement was amended with a variable interest rate based on monthly Secured Overnight Financing Rate (SOFR) and was secured by the assets of the Organization. The interest rate determination per the agreement is the SOFR rate plus 2%, which is approximately 7.38% as of December 31, 2023. In addition, the agreement was extended through September 15, 2024. There were no amounts outstanding on the line of credit at December 31, 2023 or 2022.

Note 7. Reported and Estimated Claims

The following table provides a reconciliation of the beginning and ending balances of reported and estimated claims for the years ended December 31:

	<u>2023</u>	<u>2022</u>
Balance at beginning of year	\$ 67,004,619	\$ 52,722,404
Incurred related to:		
Current year	741,777,210	652,536,367
Prior years	(1,720,213)	4,456,840
Total incurred	<u>740,056,997</u>	<u>656,993,207</u>
Paid related to:		
Current year	671,909,779	585,531,748
Prior years	65,284,406	57,179,244
Total paid	<u>737,194,185</u>	<u>642,710,992</u>
Balance at end of year	<u>\$ 69,867,431</u>	<u>\$ 67,004,619</u>

The liability for claims unpaid as of January 1, 2023, developed slightly favorably due to lower than anticipated payments for medical claims as a result of favorable subsequent settlement of claims compared to original estimates. The liability for claims unpaid as of January 1, 2022, developed unfavorably due to higher than anticipated payments for medical claims as a result of a delay in several high-cost claims from 2021 that were outside of the original estimates. Estimates are increased or decreased as additional information becomes known regarding individual claims.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 8. Leases

The components of lease expense and supplemental cash flow information related to leases are as follows for the years ended December 31:

	2023	2022
Lease cost:		
Operating lease cost	\$ 949,777	\$ 927,472
Short-term lease cost	17,610	20,610
Variable lease cost	41,102	36,733
Total lease cost	<u>\$ 1,008,489</u>	<u>\$ 984,815</u>
Other information:		
Cash paid for amounts included in the measurement of lease liabilities:		
Operating cash flows from operating leases	\$ 949,777	\$ 927,472
Right-of-use assets obtained in exchange for new operating lease liabilities	-	51,066
Weighted-average remaining lease term—operating leases	4.5 years	4.6 years
Weighted-average discount rate—operating leases	2.92%	2.59%

As of December 31, 2023, maturities of the Organization's operating lease liabilities are as follows:

Years ending:		
2024		\$ 792,688
2025		459,585
2026		409,154
2027		172,245
2028		-
Total lease payments		<u>1,833,672</u>
Less imputed interest		<u>72,441</u>
Present value of lease liabilities		<u>\$ 1,761,231</u>

Note 9. Retirement Plan

CCI maintains a 401(k) plan for all employees who meet certain eligibility requirements. The Organization will match 100% of an employee's contribution up to 4% of the employee's salary as of December 31, 2023 and 2022. Any employee who does not contribute to the 401(k) plan will not receive an Organization match. Matching contributions expense totaled approximately \$2,176,000 and \$1,962,000 in 2023 and 2022, respectively.

Note 10. Major Funding Sources

The Organization received 89.6% and 90.1% of its total revenue and support from two unrelated funding sources during the years ended December 31, 2023 and 2022, respectively. Receivables from these two sources represent 84.1% and 80.0% of total accounts and grants receivable, net at December 31, 2023 and 2022, respectively.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 11. Reinsurance

The Organization has a reinsurance contract that protects against catastrophic inpatient claims. The maximum retention claim per member per year is \$275,000 and \$235,000 as of December 31, 2023 and 2022, respectively. The reinsurance contract is subject to an annual limit of \$2,000,000 per member.

The Organization paid reinsurance premiums of approximately \$142,000 and \$127,000 for each of the years ended December 31, 2023 and 2022, respectively. Reinsurance recoveries were approximately \$51,000 and \$344,000 for the years ended December 31, 2023 and 2022, respectively. At December 31, 2023 and 2022, amounts recoverable from reinsurers were approximately \$24,000 and \$78,000, respectively.

Reinsurance contracts do not relieve the Organization from its obligation to members. The Organization remains liable to its members for the portion reinsured to the extent that the reinsurance company does not meet the obligations assumed under the reinsurance contract.

Note 12. Insurance Accounting Practices

CCHP, as an HMO domiciled in the State of Wisconsin, is required to prepare its statutory basis financial statements in accordance with accounting practices prescribed or permitted by the OCI. The National Association of Insurance Commissioners' (NAIC) Accounting Practices and Procedures Manual, version 2023, effective March 1, 2023, (NAIC SAP) has been adopted as a component of prescribed or permitted practices by the State of Wisconsin. Such practices differ in certain respects from U.S. GAAP, primarily in the non-recording of certain assets, the method of accounting for and recording investments, the calculation and recording of deferred income taxes and the language and groupings used in the presentation and disclosure of the financial statements. CCHP has issued separate financial statements that comply with these requirements.

Health insurance companies are subject to certain risk-based capital (RBC) requirements as specified by the NAIC. The RBC standards establish uniform minimum capital requirements for insurance companies. The RBC formula applies various weighting factors to financial balances or various levels of activities based on the perceived degree of risk. At December 31, 2023 and 2022, the management of CCHP believes capital and surplus is in excess of the minimum requirements of all RBC action levels.

Under the laws of the State of Wisconsin, CCHP is required to maintain a compulsory surplus of at least the greater of \$750,000 or 3% of premiums earned by CCHP during the previous 12 months. CCHP is also required to maintain a security surplus of at least 137% of the compulsory surplus. At December 31, 2023 and 2022, CCHP exceeded these requirements.

Note 13. Risks and Uncertainties

CCHP's operating results and financial condition are affected by numerous factors and circumstances unique to the insurance industry, some of which it can neither predict nor control. Among them are: (1) statutorily-imposed regulatory capital requirements can limit an insurer's ability to underwrite new business or retain otherwise desirable risks; (2) an insurer's ability to enter into suitable reinsurance agreements is subject to prevailing conditions in reinsurance markets; (3) fluctuations in interest rates that affect the value and income yield of an insurer's investment portfolio in the short-term, and often affect default and prepayment rates over time; (4) inflationary pressures and medical costs affect the magnitude of claims and claims adjustment expenses; and (5) government-mandated health reform.

Community Care, Inc. and Related Corporation

Notes to Consolidated Financial Statements

Note 14. Commitments and Contingencies

Government contracts are subject to audit and adjustment by funding agencies. If government revenue is recorded for expenditures which are subsequently disallowed, the Organization may be required to repay the questioned costs to the funding agency. Management of the Organization is not aware of any disallowed expenditures that would have a material adverse effect on its consolidated financial statements.

CC's contract with the DHS requires compliance with several financial measures. Management believes that CC was in compliance with the risk reserve, solvency reserve, risk corridor and working capital requirements in 2023 and 2022.

The health care insurance industry is subject to numerous laws and regulations of federal, state and local governments. Laws and regulations concerning government programs, including DHS and CMS, are complex and subject to varying interpretation. These laws and regulations include matters such as reimbursement for patient services, Medicare and Medicaid fraud and abuse, etc. Government activity concerning possible fraud and abuse issues involving health care insurers and providers has increased, violations of which could possibly result in penalties, as well as repayments for patient services previously billed and recorded. Management believes that the Organization is in material compliance with fraud and abuse regulations, as well as other applicable government laws.

As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which, in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties and potential exclusion from the related programs. There can be no assurance that regulatory authorities will not challenge the Organization's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Organization.

Supplementary Information

Community Care, Inc. and Related Corporation

**Schedule of Expenditures of State Awards
Year Ended December 31, 2023**

	State Profile Number	Expenditures
Wisconsin Department of Health Services: Family Care, Family Care Partnership and PACE	N/A	<u>\$ 771,720,661</u>
Total state awards		<u><u>\$ 771,720,661</u></u>

The accompanying notes to schedule of expenditures of state awards are an integral part of this schedule.

Community Care, Inc. and Related Corporation

Notes to Schedule of Expenditures of State Awards

Note 1. Basis of Presentation

The accompanying schedule of expenditures of state awards (the Schedule) summarizes expenditures charged to state government grants and service contracts administered by CC and CCHP for the year ended December 31, 2023. The Schedule should be read in conjunction with Community Care Inc.'s consolidated financial statements.

For purposes of the Schedule, state awards include all grants, service contracts and similar agreements entered into directly between CC, CCHP, and agencies and departments of the state government. The Schedule has been prepared on the accrual basis of accounting. Revenue is recognized when allowable and related reimbursable expenditures are incurred and upon meeting the legal or contractual requirements of the funding source. Expenditures of government grant funds are to be used for the purposes specified by the funding source.

Family Care, Family Care Partnership and PACE: The information in the Schedule is presented to comply with the *Wisconsin Department of Health Services (DHS) Family Care Audit Guide*. The Family Care, Family Care Partnership and PACE programs are not considered by DHS to be federal financial assistance; therefore, the Single Audit Act and Subpart F of Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards* (Uniform Guidance) are not applicable.

State award expenditures: State award expenditures represent the capitated revenues earned by Community Care, Inc. in the Family Care, Family Care Partnership and PACE Health and Community Care Programs.

Note 2. Contingencies

All state awards are subject to review and audit by grantor agencies. Such audits could lead to requests for reimbursement by the grantor agencies for costs disallowed under the terms of the awards. It is the opinion of management that all costs charged against state awards are allowable under the regulations of those programs.

Community Care, Inc. and Related Corporation

**Schedule of Grant Revenues and Expenditures by Funding Source
Year Ended December 31, 2023**

	Family Care, Family Care Partnership and PACE
<hr/>	
Revenue:	
Capitation revenue	\$ 771,720,661
Grants and reimbursements	1,324,588
Client pay portion	89,996,896
Total revenue	<u>863,042,145</u>
Expense:	
Wages and benefits	69,344,984
Other direct	752,480,245
Premium deficiency reserve	2,849,474
General, administrative, and occupancy	29,720,053
Total expenses	<u>854,394,756</u>
Excess revenues over expenses	<u>\$ 8,647,389</u>



RSM US LLP

Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards* and the *Wisconsin Department of Health Services Family Care Audit Guide*

Independent Auditor's Report

Board of Directors
Community Care, Inc.

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States and the *Wisconsin Department of Health Services (DHS) Family Care Audit Guide*, issued by the Wisconsin Department of Health Services, the consolidated financial statements of Community Care, Inc. and Related Corporation (the Organization) which comprise the consolidated statement of financial position as of December 31, 2023, the related consolidated statements of activities and cash flows for the year then ended, and the related notes to the consolidated financial statements, and have issued our report thereon dated May 1, 2024.

Report on Internal Control over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the Organization's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that have not been identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Organization's consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the consolidated financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that is required to be reported under *Government Auditing Standards* or the *DHS Family Care Audit Guide*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* and the *DHS Family Care Audit Guide* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

RSM US LLP

Minneapolis, Minnesota
May 1, 2024

**Report on Compliance for State Programs: Report on Internal Control Over Compliance; and
Report on Schedule of Expenditures of State Awards Required by Wisconsin Department of
Health Services Family Care Audit Guide**

Independent Auditor's Report

Board of Directors
Community Care, Inc.

Report on Compliance for Each State Program

Opinion on Each State Program

We have audited Community Care, Inc. (the Organization) compliance with the types of compliance requirements identified as subject to audit in the *DHS Family Care Audit Guide* that could have a direct and material effect on each of the Organization's state programs for the year ended December 31, 2023. The Organization's state programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, the Organization complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on its state programs for the year ended December 31, 2023.

Basis for Opinion for State Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS); the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States (Government Auditing Standards); and the audit requirements of *DHS Family Care Audit Guide*. Our responsibilities under those standards and the *DHS Family Care Audit Guide* are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of the Organization and to meet our other ethical responsibilities, in accordance with 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 opinion on compliance for the state program. Our audit does not provide a legal determination of the Organization's compliance with compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules and provisions of contracts or grant agreements applicable to the Organization's state programs.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on the Organization's compliance based on our audit. 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, *Government Auditing Standards*, and the *DHS Family Care Audit Guide* will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about the Organization's compliance with the requirements of each state program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards*, and the *DHS Family Care Audit Guide*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, 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 Organization's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of the Organization's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with GAAS, *Government Auditing Standards*, and the *DHS Family Care Audit Guide*, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Other Matters

The results of our auditing procedures disclosed two instances of noncompliance which are required to be reported in accordance with the *DHS Family Care Audit Guide*, and which are described in the accompanying schedule of findings and questioned costs as items 2023-001 and 2023-002. Our opinion on the state program is not modified with respect to these matters.

Government Auditing Standards requires the auditor to perform limited procedures on the Organization's response to the noncompliance finding identified in our compliance audit described in the accompanying schedule of findings and questioned costs. The Organization's response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the response.

Report on Internal Control Over Compliance

A deficiency in internal control over compliance exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a state program on a timely basis. *A material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a state program will not be prevented, or detected and corrected, on a timely basis. *A significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a state program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance. We consider the deficiencies in internal control over compliance described in the accompanying schedule of findings and questioned costs as items 2023-001 and 2023-002 to collectively be a significant deficiency.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

Government Auditing Standards requires the auditor to perform limited procedures on the Organization's response to the internal control over compliance findings identified in our compliance audit described in the accompanying schedule of findings and questioned costs. The Organization's response was not subjected to the other auditing procedures applied in the audit of compliance and, accordingly, we express no opinion on the responses.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the *DHS Family Care Audit Guide*. Accordingly, this report is not suitable for any other purpose.

RSM US LLP

Minneapolis, Minnesota
May 1, 2024

Community Care, Inc. and Related Corporation

**Schedule of Findings and Questioned Costs
Year Ended December 31, 2023**

Section I—Summary of Auditor’s Results

Financial Statements

Type of auditor’s report issued	Unmodified
Internal control over financial reporting:	
Material weakness(es) identified?	No
Significant deficiency or deficiencies identified?	None reported
Noncompliance material to financial statements noted?	No

State Awards

Type of auditor’s report issued	Unmodified
Internal control over state programs:	
Material weakness(es) identified?	No
Significant deficiency or deficiencies identified?	Yes
Any audit findings disclosed that are required to be reported in accordance with Managed Long-Term Care Audit Guide	Yes

Section II—Financial Statement Findings No matters were reported

Section III—State Award Findings and Questioned Costs

Finding 2023-001 – Denied Claims Not Denied Accurately

State Program: Family Care (FC), Family Care Partnership (FCP), and Program for All-inclusive Care of the Elderly (PACE)

Criteria: DHS Claims Audit Report for the Managed Long-Term Care Audit Guide for Family Care, Family Care Partnership and Program for All-inclusive Care for the Elderly (PACE) Managed Care Organizations requires units denied or rejected are verified. Units not paid or rejected are reviewed for accurate processing.

Condition: One out of 24 denied claims subject to testing was properly denied, but it was for the improper denial code.

Cause: Inadequate controls for selection of denial codes for denied claims.

Effect: Denied claim was denied for the wrong denial code reason.

Questioned costs: No

Context: The claim was denied properly, but the denial code used was for the wrong reasoning of denial.

Repeat finding? No

(Continued)

Community Care, Inc. and Related Corporation

Schedule of Findings and Questioned Costs (Continued)
Year Ended December 31, 2023

Recommendation: We recommend management internally audit denied claims for proper reasoning and incorporate additional internal controls around the claims review process.

Views of responsible officials of the auditee: The Organization's management agrees with the finding and the auditor's recommendation.

Finding 2023-002 – 2023 1st quarter Center for Medicare Services (CMS) fee schedule (#2805) not updated

State Program: Family Care (FC), Family Care Partnership (FCP), and Program for All-inclusive Care for the Elderly (PACE)

Criteria: DHS Claims Audit Report for the Managed Long-Term Care Audit Guide for Family Care, Family Care Partnership and Program for All-inclusive Care for the Elderly (PACE) Managed Care Organizations requires that the provider contract rate is verified and the claim is paid at the contract rate.

Condition: Two out of 85 claims tested for Pace and Partnership were not allowed and paid for at the proper rate.

Cause: There was a CMS conversion rate update that was not reflected in the CMS fee schedule within the claims system.

Effect: Certain physician claims for FCP and PACE were paid at an amount 2.5% less than the claims should have been paid at.

Questioned costs: No

Context: This affected certain physician claims of Medicare members for Community Care Health Plan and resulted in an approximate underpayment to providers of \$29,000.

Repeat finding? No

Recommendation: We recommend management review for any CMS fee schedule updates on a monthly basis to incorporate any changes that may be updated by CMS.

Views of responsible officials of the auditee: The Organization's management agrees with the finding and the auditor's recommendation.

(Continued)

Community Care, Inc. and Related Corporation

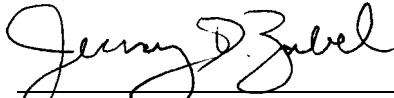
Schedule of Findings and Questioned Costs (Continued)
Year Ended December 31, 2023

Section IV—Other Issues

Does the auditor's report on the notes to the financial statements include disclosure with regard to substantial doubt as to the auditee's ability to continue as a going concern? No

Does the audit report show audit issues (i.e., material noncompliance, non-material noncompliance, questioned costs, material weakness, significant deficiency, management letter comment, excess revenue or excess reserve) related to grants/contracts with the Wisconsin Department of Health Services? Yes

Was a management letter or other document conveying audit comments issued as a result of this audit? Yes



Jeremy Zabel, Partner

Date of report: May 1, 2024

Community Care, Inc. and Related Corporation

Summary Schedule of Prior Year (2022) Findings and Questioned Costs Year Ended December 31, 2023

Finding 2022-001 – Denied Claims Not Timely Adjudicated

State Program: Family Care (FC), Family Care Partnership (FCP), and Program for All-inclusive Care for the Elderly (PACE)

Criteria: DHS Claims Audit Report for the Managed Long-Term Care Audit Guide for Family Care, Family Care Partnership and Program for All-inclusive Care for the Elderly (PACE) Managed Care Organizations requires units not paid or rejected be reviewed for accurate processing. MCOs shall adjudicate and transmit the remittance advice with payment for clean claims within one hundred eighty (180) calendar days of receipt.

Condition: Two out of nine denied claims subject to testing were denied and claims were not re-processed within the 180-day requirement.

Cause: Lack of monitoring of timely adjudication of denied claims.

Effect: Denied claims were not timely adjudicated resulting in delayed payments to the respective providers.

Questioned costs: No

Context: Two denied claims totaling \$285, out of nine denied claims tested totaling \$1,721, were denied and not timely adjudicated resulting in delayed payments to the respective providers.

Repeat finding? No

Recommendation: We recommend management internally audit denied claims for timely adjudication and incorporate additional internal controls around the claims review process.

Views of responsible officials of the auditee: The Organization's management agrees with the finding and the auditor's recommendation.

Corrective action taken: The Claims Department is reviewing all claims denied for the same reason as one of the claims cited above. Claims denied for all other reasons, including the second claim cited above, are being included in the audits conducted by the Internal Audit Department. The Internal Audit Department of Community Care is conducting quarterly audits of denied claims that began in the second quarter of 2023. The Claims department has shown marked improvement with the implementation of the new claims manager and the department is staying fully staffed.



April 22, 2024

Finding 2023-001 Denied Claims Not Denied Accurately

Context: One claim tested out of 24 for Pace and Partnership was properly denied, but it was denied for the improper denial code.

Recommendation: We recommend management internally audit denied claims for proper reasoning and incorporate additional internal controls around the claims review process.

Management Action Plan:

Claims Auditor/Analyst

The position of Claims Auditor/Analyst was recently filled within the Claims Department. This position will be responsible for auditing samples of:

- Paid Claims
- Denied Claims including reason codes
- Updated fee schedules

Status: In process. The new Claims Auditor recently started at Community Care and is in the process of learning the specifics of claims processing. It is anticipated that the auditing process will be fully functional within the next six months.

Finding 2023-002 2023 1st quarter Center for Medicare Services (CMS) fee schedule (#2805) not updated

Context: Two out of 85 claims tested for Pace and Partnership were not allowed and paid for at the proper rate due to a conversion rate update that was not reflected in the CMS fee schedule within the claims system. This affected the physician billing only for Community Care Health Plan and resulted in an approximate underpayment to providers of \$29,000.

Recommendation: We recommend management review for any CMS fee schedule updates on a monthly basis to incorporate any changes that may be updated by CMS.

Management Action Plan:

Claims Auditor/Analyst

The position of Claims Auditor/Analyst position will be responsible for auditing samples of:

- Paid Claims
- Denied Claims
- Updated fee schedules



Status: In process. The new Claims Auditor recently started at Community Care and is in the process of learning the specifics of claims processing. It is anticipated that the auditing process will be fully functional within the next six months.

Additional Controls surrounding application of new fee schedules

CMS fee schedules are updated through a process residing outside of the Claims Department. Additional controls will be implemented around the process of applying new fee schedules.

These include:

- Recording date fee schedule was available
- Recording date fee schedule was applied
- Notification to Claims department of new fee schedule

Status: In process. Controls are being developed. Implementation is expected by June 30, 2024.

Contact: Christy Smith, CFO
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