

GENERAL INFORMATION, DEFINITION, AND INSTRUCTION

If there are any differences between the reporting form instructions and the Knox-Keene Health Care Service Plan Act of 1975 (“Act”) and Title 28, California Code of Regulations (“Regulations”), the Act or Regulations will take precedence.

GENERAL

For filing Health Care Service Plan Financial Report of Affairs and Conditions:

1. Filing Dates (as of 6/30/02), all health plans are required to file financial statements electronically:

Annual: Required to be filed electronically within 120 days after the close of the fiscal year.

Annual Audited: Required to be filed electronically within 120 days after the close of the fiscal year.

Quarterly: Required to be filed electronically within 45 days after the close of the quarter.

Monthly: Required to be filed electronically within 30 days after the close of the month.

2. All Health Plans are required to submit an Electronic Filing Signature Verification Form (“Agreement”). Once the Department of Managed Health Care (“Department”) accepts this Agreement, the user id and password to the web portal is sent to the Plan. If there are any changes to the information in the Agreement, a new Agreement must be submitted to the Department. The Electronic Filing Signature Verification Form can be downloaded from the Department’s web site at:

http://www.hmohelp.ca.gov/healthPlans/rep/rep_fin_submit.aspx

Please send the Agreement to:

ATTN: Licensing Administration
Verification Form
Department of Managed Health Care
Division of Licensing
980 9th Street, Suite 500 Sacramento, CA 95814

Review the checklist on Page (25) to determine which Reports, Interrogatories, Schedules, Notes to Financial Statements and Supplemental Information are required to be submitted to the Department.

3. If additional supporting statements or schedules are added in connection with answering interrogatories or providing information on the financial statement, the addition should be properly keyed to the item being answered (Example – Interrogatories, #23” “Current Assets, #9”).

4. Any items that cannot be readily classified under one of the printed items must be reported with an identifying title in the appropriate schedule for each applicable page or section thereof entitled “DETAILS OF WRITE-INS AGGREGATED AT ITEM.” If additional lines are needed, see #3.

5. The fields “**Included**” and “**Excluded**” are for TNE purposes and should be filled in accordingly. Amounts to be included in TNE should be in the “**Included**” column.

6. If this report does not contain the information asked for in the reporting forms or is not prepared in accordance with these instructions, it will be rejected.

7. Whenever it appears in this report, the term “affiliate” of a person is a person controlled by, under common control with, or controlling such person (see subsections (c) and (d) of Rule 1300.45).
 8. Before information can be entered in the reporting forms, a dialogue box may appear (depending on your settings). You will be asked to disable or enable the macros. Click on the ENABLE MACROS button to ensure that the spreadsheet functions properly.
 9. Report all amounts in thousands or whole dollars ONLY. Health Plans may elect to report in thousands or whole dollar amounts to the nearer thousand or dollar or through truncation of digits below a thousand or a dollar (Examples: \$602,543.52 may be reported as \$603 (in 000’s) or \$602,544 by rounding or \$602 (in 000’s) or \$602,543 by truncation). If the plan reports in thousands, Box 4, on the cover page must be checked.
 10. The workbook is locked and sheets cannot be added or deleted. To add additional spreadsheets or documents attach them concurrently after uploading financial statements.
- Once the reporting forms (Document can not be open at the time of upload) have been uploaded via the Department’s financial web portal at <https://wps0.dmhc.ca.gov/secure/login/> it will go through a series of checks. If the reporting form passes our initial checks, it will be uploaded to the Department’s database. The monitoring examiner will review the filing. Any additional reporting forms and attachments, for the same period, will be revisions to the previous reporting form submitted. Your revised submission will replace your previous submission. Therefore, please ensure that the reporting forms and ALL attachments (i.e. Notes to Financial Statements, Supplemental Schedules) are uploaded.
- If the reporting form does not pass our initial checks, the plan will immediately receive a message from our SQL server listing the problem(s) with the reporting forms. Once the Plan makes the necessary changes, the reporting form and all attachments must be submitted again.
11. All financial information submitted via the financial web portal will be posted to the Department’s web site. Please note: if the Plan wants Schedule L, in the annual filing, to remain confidential, the Plan is required to request confidential treatment pursuant to California Code of Regulations Title 28, Section 1007.
 12. If you have questions regarding the financial statement reporting forms or electronic filing process (for financial statements), please email at healthplanreporting@dmhc.ca.gov
 13. Plans can now send messages directly to the reviewing examiner through the financial portal. (Click on messages once signed in)
 14. A history of all uploads will now be available that displays: The status of the filing, who submitted the filing and when it was submitted.
 15. Profiles can be created and changed as needed under the “Health Plan Profile” tab.

16. Error messages will no longer be e-mailed after submission-If an error exists the system will automatically display an error message dialogue box, prompting the uses to correct the issues.

ACTUARIAL CERTIFICATION

The reporting entity is not required to submit the actuarial certification unless they meet Rule 1300.77.2(d) of Title 28. According to Rule 1300.77.2(d), if a plan uses an actuarial estimate to calculate incurred and unreported claims, the actuarial estimate must be supported by an actuarial certification.

If the reporting entity is filing an actuarial certification, then Schedule I “Analysis of Total Medical Liability to Actual Claims Paid” is not required to be submitted to the Department.

The reporting entity should use the following guidelines if an actuarial certification is submitted to the Department:

- (1) There is to be included on or attached to Page 1 of the annual statement, the statement of a qualified health maintenance organization actuary setting forth his or her opinion relating to loss reserves, provision for experience rating refunds, and any other actuarial items. “Qualified health maintenance organization actuary,” as used herein means a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation, or a person who otherwise has demonstrated his competency in such actuarial evaluation to the satisfaction of the Director.
- (2) Such a statement of opinion must consist of a paragraph identifying the actuary; a scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the actuary’s work (see Sections 5-7 below); and an opinion paragraph expressing his or her opinion with respect to such subjects (see sections 810 below). One or more additional paragraphs may be needed in individual cases if the actuary considers it necessary to state a qualification of his or her opinion or to explain some aspect of the annual statement, which is not already sufficiently explained in the annual statement.
- (3) The opening paragraph should generally indicate the actuary’s relationship to the organization.

For an actuary who is an employee of the organization, the opening paragraph of the opinion should contain a sentence such as:

“I (name and title of actuary), am an officer (employee) of (named organization) and a member of the American Academy of Actuaries.”

For a consulting actuary, the opening paragraph of the opinion should contain a sentence such as: “I, (name and title of consultant), am associated with the firm of (name of firm). I am a member of the American Academy of Actuaries and have been retained by the (name of organization) with regard to loss reserves, actuarial liabilities and related items.”

For a person other than a member of the American Academy of Actuaries, the opening paragraph of the opinion should contain a sentence such as:

“I, (name and title), am an officer (employee) of (name of organization) and I [have competency in actuarial valuations for organizations of this kind] or: [am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind] or:
“I, (name and title of consultant), am associated with the firm (name of firm). I [have competency in actuarial valuations for organizations of this kind] or: [am recognized by the American Academy of Actuaries as qualified to perform actuarial valuations for organizations of this kind] and have been retained by the (name of organization) with regard to such valuation.”

- (4) The following are examples, for illustrative purposes, of language, which in typical circumstances would be included in the remainder of the statement of opinion. The illustrative language should be modified as needed to meet the circumstances of a particular case, and the actuary should in any case, use language that clearly expresses his or her professional judgment.
- (5) The scope paragraph should contain a sentence such as the following:

“I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities, and related items listed below, as shown in the annual statement of the organization as prepared for filings with regulatory officials, as of December 31, 200_.

The paragraph should list those items and amounts with respect to which the actuary is expressing an opinion. The list should include but not necessarily be limited to:

- (i) Claims Unpaid (Reported and Unreported)
- (ii) Provision for deferred maternity benefits
- (iii) Other actuarial liabilities; and
- (iv) Premium items, such as receivables, due and unpaid, unearned, and paid in advance as they may relate to actuarial items.

(6) If the actuary has examined the underlying records and/or summaries, the scope paragraph should also include a sentence such as the following:

“My examination included such review of the assumptions and methods used and of the underlying basic records and/or summaries and such tests and calculations as I considered necessary.”

(7) If the actuary has not examined the underlying records and/or summaries, but has relied upon those prepared by the organization, the scope paragraph should include a sentence such as one of the following:

- (i) “I relied upon the records and/or summaries prepared by the responsible officers or employees of the organization. In other respects, my examination included such review of the assumptions and methods used and such tests of the calculations as I considered necessary.”
- (ii) “I relied upon (name of firm) for the accuracy of the underlying records and/or summaries. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.”

(8) The opinion paragraph should include a sentence, which covers at least the points listed in the following illustration:

“In my opinion, the amounts carried in the balance sheet on account of the items identified above:

- (i) Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,
- (ii) Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the Statement was prepared,
- (iii) Meet the requirements of the laws of (state of domicile),
- (iv) Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements,
- (v) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end,
- (vi) Include appropriate provision for all actuarial items which ought to be established.”

(9) If there has been any material change in the assumptions and/or methods from those previously employed, that change should be described in the statement of opinion by inserting a phrase such as:

“A material change in assumption (and/or methods) was made during the past year but such change accords with accepted actuarial standards.” A brief description of the change should follow.

The adoption of new coverage requiring underlying assumptions, which differ from assumptions used for prior coverage, is not a change in assumption within the meaning of this paragraph.

(10) If the actuary is unable to form an opinion, he or she should refuse to issue a statement of opinion. If the opinion is adverse or qualified, the actuary should issue an adverse or qualified opinion explicitly stating the reason(s) for such opinion.

(11) If the actuary does not express an opinion as to the accuracy and completeness of underlying listings or summaries used in his evaluation, there should be included on or attached to Page 1 of the statement blank the statement of an organization officer or accounting firm who prepared such underlying data similar to the following:

“I (name of officer of the organization), (title of officer), of (name and address of organization)(or accounting firm), hereby affirm that the listings and summaries of data prepared for and submitted to (name of actuary) were prepared under my direction and, to the best of my knowledge and belief, are accurate and complete.

“Signature”

REPORT #1 – BALANCE SHEET

PURPOSE:

The balance sheet reports the assets, liabilities, and stockholders' equity of the reporting entity at a specific date.

Column

1A. **Included:** Enter the current information for the entity which is included in the TNE calculation. For example, if the financial statements are for the year ended December 31, 2007, the information at December 31, 2007 should be entered in this column. If the financial statements are for the quarter or month ended March 31, 2007, the information at March 31, 2007 should be entered in this column.

1B. **Excluded:** Enter the current information for the entity which is excluded from the TNE calculation. In general, receivables from officers, directors and affiliates and intangible assets will be excluded from the TNE calculation. Example of items that are not to be used in the calculation of TNE are: Goodwill, going concern value, organizational expense, starting-up costs; receivables from officers, directors, owners, or affiliates which are not fully secured unless they are for goods or services arising in the ordinary course of business which are payable on the same terms as similar transactions with non-affiliates and which are not past due. Also, long term prepayments of deferred charges and non-returnable deposits are example of Excluded items. In addition for Plans filing consolidated financial statements, financial information for non regulated business will be excluded from TNE calculation.

2. **Current period:** no entry needed, calculated automatically.

PART A – BALANCE SHEET ASSETS

Line:

1. **Cash and Cash Equivalents** – Cash in the bank or on hand, available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase. Do not include restricted cash. Provide detail in Schedule A-1.
2. **Short-Term Investments** – Readily saleable investments acquired with temporarily unneeded cash. Do not include restricted securities. Provide detail in Schedule B.
3. **Premiums Receivable – Net** – Gross amounts collectible from groups or individuals who receive services from the reporting entity, less the amount accrued for premiums determined to be uncollectible for the period. This should not include fee-for-service. Provide detail in Schedule C.
4. **Interest Receivable** – Interest earned on investments but not received.
5. **Shared Risk Receivable** (for Limited License Plans Only) – Gross amounts collectible for the reporting entity's share in shared risk pools, less the amount accrued for receivables determined to be uncollectible during the period. Provide detail in Schedule D.
6. **Other Health Care Receivables – Net** – Gross amounts collectible from other sources (i.e., fee-for-service, COB, copayments, subrogation, non-affiliated provider receivables, advances to providers, etc.), less the amount accrued for receivables determined to be uncollectible during the period. Provide detail in Schedule D.
7. **Prepaid Expenses** – Future expenses paid in advance, i.e., unexpired insurance.
8. **Secured Affiliate Receivables – Current** – Any secured current accounts receivable from parent, subsidiary, and/or affiliates. For purposes of these reports, "Secured Affiliate Receivables – Current" are obligations that are fully secured by tangible collateral, other than by securities of the plan or an affiliate, with equity of at least 110 percent of the amount owing. This includes short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the

same terms as equivalent transactions with non-affiliates and which are not past due. Secured Affiliate Receivables – Current must be filed and approved by the Department of Managed Health Care for inclusion in the Tangible Net Equity Calculation. [Rule 1300.76(e)](Provide detail in Schedule D).

9. **Unsecured Affiliate Receivables – Current** – Any unsecured short-term (60 days or less) current accounts receivable from parent, subsidiary, and/or affiliates—must be excluded in the Tangible Net Equity Calculation unless determined to be in the normal course of business. [Rule 1300.76(e)] (Provide detail in Schedule D.)
10. **Aggregate Write-ins for Current Assets** – The total of the write-ins listed in schedule “Details of Write-ins Aggregated at Item 10 for Current Assets.” This line is linked from Report #1, Part A, Line 1031. Show restricted and non-restricted current assets, including inventories, and other items that are not included in the other Current Asset categories. The restricted current assets must also be reported on Schedule A-2.
11. **Total Current Assets** – Total of the above categories (Lines 1 thru 10).
12. **Restricted Assets** – Enter non-current restricted assets including statutory insolvency requirements. Provide detail in Schedule A-2.
13. **Long-Term Investments** – Long-term investments intended to be held for a period longer than twelve months. Provide detail in Schedule B.
14. **Intangible Assets and Goodwill – Net** – Assets of no physical substance; may include patents, copyrights, licenses, franchises. Provide gross amount, less amortization.
15. **Secured Affiliate Receivables – Long Term** – Any secured non-current (long-term, more than 60 days) accounts receivable from parent, subsidiary, and/or affiliates. For purposes of these reports, “Secured Affiliate Receivables – Long Term” are obligations that are fully secured by tangible collateral, other than by securities of the plan or an affiliate, with equity of at least 110 percent of the amount owing. Secured Affiliate Receivables – Long Term must be filed and approved by the Department of Managed Health Care for inclusion in the Tangible Net Equity Calculation. [Rule 1300.76(e)] (Provide detail in Schedule D)
16. **Unsecured Affiliate Receivables – Past Due** - Any unsecured non-current accounts receivable that is past due from parent, subsidiary, and/or affiliates—must be excluded in the Tangible Net Equity Calculation. [Rule 1300.76(e)].
17. **Aggregate Write-ins for Other Assets** – The total of the write-ins listed in schedule “Details of Write-ins Aggregated at Item 17 for Other Assets.” This line is linked to Report #1, Part A, Line 1731. Show non-current assets not included in the Other Assets categories.
18. **Total Other Assets** – Total of the above categories (Lines 12 thru 17).
19. **Land, Building and Improvements** – Include real estate and buildings owned by the reporting entity and improvements made to the reporting entity owned buildings. Provide detail in Schedule E.
20. **Furniture and Equipment** – Includes medical equipment, office equipment and furniture owned by the reporting entity. These items should be net of depreciation. Provide detail on Schedule E.
21. **Computer Equipment – Net** – Includes computer hardware and software owned by the entity. These items should be net of depreciation. Provide detail on Schedule E.
22. **Leasehold Improvements – Net** – Improvements to facilities not owned by the reporting entity. Provide gross amount, less amortization.

23. **Construction in Progress** – Buildings or improvements in progress or under construction. These items will be capitalized upon completion or utilization. Provide detail on Schedule E.
24. **Software Development** – Includes qualifying computer software costs incurred during the application development stage. Provide detail on Schedule E.
25. **Aggregate Write-ins for Other Equipment** –The total of the write-ins listed in schedule “Details of Write-ins Aggregated at Item 25 for Other Equipment.” This line is linked to Report #1, Part A, Line 2531. Include automobiles, fixtures, and other fixed assets not reported in Property and Equipment categories.
26. **Total Property and Equipment – Net** – Total of Property and Equipment categories, less accumulated depreciation (Lines 19 thru 25).
27. **Total Assets** – Total of Current Assets, Other Assets, and Net Property and Equipment (Lines 11, 18, and 26).

PART B – BALANCE SHEET LIABILITIES AND NET WORTH

Column

2. **CONTRACTING** – Those Liability Categories not included in Column 3.

3. **NON-CONTRACTING** – Liability Categories resulting from unpaid uncovered expenditures (see below), the outstanding indebtedness of loans that are not specifically subordinated to uncovered expenses or guaranteed by the sponsoring organization and all other monetary obligations that are not similarly subordinated or guaranteed. (Applies to Lines 3 through 7 only).

Uncovered Expenditures – the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency. These are expenditures for health care services for which the reporting entity is at risk. They will vary in type and amount, depending on the arrangements of the reporting entity. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services for which a provider has agreed not to bill the enrollee even when the provider is not paid by the reporting entity, or for services that are guaranteed, insured, or assumed by a person or organization other than the reporting entity.

4. **TOTAL** – Total of Contracting and Non-Contracting Columns.

Current Period: Enter the current information for the entity. For example, if the financial statements are for the year ended December 31, 2007, the information at December 31, 2007 should be entered in this column. If the financial statements are for the quarter or month ended March 31, 2007, the information at March 31, 2007 should be entered in this column.

Line:

1. **Trade Accounts Payable** – Amounts due to creditors for the acquisition of goods and services (trade and vendors rather than health care providers) on a credit basis. Provide detail on Schedule F.
2. **Capitation Payable** – Amounts due to capitated providers (i.e. medical groups/IPAs, ancillary, and hospitals) for medical services rendered to enrollees of the reporting entity.
3. **Claims Payable (Reported)** – Claims received and not adjudicated (not paid or denied). Refer to Rule 1300.77.4 (Items 1-4) for items to include in this section. Provide detail on Schedule G.
4. **Incurred But Not Reported Claims** – Incurred but not reported (IBNR) is an estimate for claims that have been incurred as of the date of statement preparation for which the reporting entity is responsible but has not yet determined the specific amount of liability (Schedule G, Section I, Column 2, Row 5).
5. **POS Claims Payable (Reported)** – Point-of-Service claims that are received and not adjudicated (not paid or denied). Refer to Rule 1300.77.4 (Items 1-4) for items to include in this section. Provide detail on Schedule G. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]
6. **POS Incurred But Not Reported Claims** – An estimate for point-of-service claims (include both in-network and out-of-network) that have been incurred as of the date of statement preparation for which the reporting entity is responsible but has not yet determined the specific amount of liability. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]
7. **Other Medical Liability** – Amounts due to plans/providers for withholds, shared risk pools, etc.
8. **Unearned Premiums** – Income received or booked in advance of the period to which it applies. A liability exists to render service in the future.

9. **Loans and Notes Payable – Current** – The principal amount on loans due within one year. Provide detail in Schedule J.
10. **Amounts Due to Affiliates – Current** – Any payable amount to an affiliate as defined in Line 7 of the General Instructions. This includes all loans, notes payable, and intercompany balances. Provide detail on Schedule J.
11. **Aggregate Write-ins for Current Liabilities** – The total of the write-ins listed in schedule “Details of Write-ins Aggregated at Item 11 for Current Liabilities.” This Line is linked to the total from Report #1, Part B, Line 1131. Show current liabilities not included in other current liability categories; include accrued payroll and taxes.
12. **Total Current Liabilities** – Total of Current Liability Categories (Lines 1 thru 11).
13. **Loans and Notes Payable (Not Subordinated)** – Loans and notes signed by the reporting entity, not including current portion payable. Include federal loans. Provide detail on Schedule J.
14. **Loans and Notes Payable (Subordinated)** – Loans and notes that are subordinated. The reporting entity must have an approved subordination agreement filed with the Department of Managed Health Care, in order to include in the Tangible Net Equity Calculation. [Rule 1300.76]. Provide detail on Schedule J.
15. **Accrued Subordinated Interest Payable** – Enter the accrued interest due on the subordinated loan and/or notes. The reporting entity must have an approved subordination agreement filed with the Department of Managed Health Care, in order to include in the Tangible Net Equity Calculation. [Rule 1300.76].
16. **Amounts Due to Affiliates – Long Term** – Non-Current amounts payable to an affiliate as defined in Line 7 of the General Instructions. This includes all loans, notes payable, and intercompany balances. Provide detail on Schedule J.
17. **Aggregate Write-ins for Other Liabilities** – Enter the total of the write-ins listed in schedule “Details of Write-ins Aggregated at Item 17 for Other Liabilities.” This Line is linked to the total from Report #1, Part B, Line 1731. Show other liabilities of long-term nature.
18. **Total Other Liabilities** – Total of Other Liability Categories (Lines 13 thru 17).
19. **Total Liabilities** – Total of Current Liabilities and Other Liabilities (Lines 12 and 18).
20. **Common Stock** - The amount should equal the par value per share multiplied by the number of issued shares or in the case of no-par shares, the total stated value.

Authorized common stock is the number of shares that the state has authorized a company to issue. Outstanding common stock is the number of authorized shares that have been issued and are presently held by stockholders (excluding treasury stock).

Issued common stock is the cumulative total number of authorized shares that have been issued and are outstanding. The number of issued shares includes treasury stock.

Treasury stock is the company’s own shares that have been issued, fully paid, and reacquired by the issuing company but not cancelled. Treasury stock is included in issued capital stock but is not part of outstanding stock.

21. **Preferred Stock** – This amount should equal the par value per share multiplied by the number of issued shares, or in the case of no-par shares, the total stated or liquidation value.

22. **Paid In Surplus** – This Line should be the gross amount of paid in and contributed surplus without reduction for commissions or other expenses in connection with such transactions, but reduced by a distribution declared and paid as a return of such surplus. Also, the amount reflects the amounts paid and contributed in excess of the par or stated values of shares issued.
23. **Contributed Capital** – Capital donated to the reporting entity. Describe the nature of donation as well as any restrictions on this capital in the **Notes to Financial Statements**.
24. **Retained Earnings (Deficit)/Fund Balance** – Cumulative earnings or deficit from operations, net of reserves and restricted funds.
25. **Aggregate Write-ins for Other Net Worth Items** – Enter the total of the write-ins listed in schedule “Details of Write-ins Aggregated at Item 25 for Other Net Worth Items.” This Line is linked to the total from Report #1, Part B, Line 2531.
26. **Total Net Worth** – Total of Net Worth Categories (Lines 20 thru 25).
27. **Total Liabilities and Net Worth** – Total of Total Liabilities and Net Worth (Line 19 and Line 26).

REPORT #2 STATEMENT OF REVENUES, EXPENSES, AND NET WORTH

PURPOSE: The income statement summarizes the results of the reporting entity's operation for a given time period by disclosing revenues earned and expenses incurred.

Column

Year-to-Date (ANNUAL): Enter annual information for the past twelve months. For example, if the fiscal year ended December 31, 2007, the entity would report information for the year January 1, 2007 through December 31, 2007 in this column.

1. Current Period (QUARTERLY OR MONTHLY): Enter information for the current period. For example, if the quarter ended December 31, 2007, the entity would report information for October 1, 2007 through December 31, 2007. If the financial statements are for the month ended November 30, 2007, the information for the period November 1, 2007 through November 30, 2007 would be reported.

2. Year-to-Date (QUARTERLY OR MONTHLY): Enter year-to-date information. For example, if the fiscal year end is December 31, 2007 and the entity is currently reporting for the quarter ended September 30, 2007, the year-to-date information would be reported January 1, 2007 through September 30, 2007. If the financial statements are for the month ended November 30, 2007 (and the entity's fiscal year ends December 31, 2007), the year-to-date information would be reported January 1, 2007 through November 30, 2007.

REVENUES

Line:

1. **Premium (Commercial)** – Revenue recognized on a prepaid basis from individual and groups for provision of specified range of health services over a defined period of time, normally one month. (Report POS premiums on Line 7) If advance payments are made to the reporting entity for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability (Report #1, Part B, Liabilities, Unearned Premiums).
2. **Capitation** – Revenue from an HMO or health care service plan as compensation for providing health care services to enrollees of the reporting entity.
3. **Co-payments, COB, Subrogation** – Revenue recognized by the reporting entity for co-payments, COB, or subrogation.
4. **Title XVIII - Medicare** – Revenue resulting from an arrangement between the reporting entity and the Health Care Financing Administration (HCFA), for services to a Medicare beneficiary. Include revenues for Medicare Cost and Risk contracts.
5. **Title XIX – Medicaid** – Includes revenue resulting from an arrangement between the reporting entity and a Medicaid State agency for services to a Medicaid beneficiary. The reporting entity, for a fee, agrees to cover the full medical costs of Medicaid subscribers. **PLUS: All other revenues from other governmental and public programs (I.E Healthy Families, Healthy Kids, AIM, IHSS revenues). A separate schedule can be attached to the financials statements separating out each line of business as an attachment.**
6. **Fee-For-Service** – Revenue that is recognized by the reporting entity for provision of health services to non-enrollees and services provided to enrollees that are excluded from their prepaid benefit packages.

7. **POS Premiums** – Revenue recognized by the reporting entity for the provision of health care services to enrollees that are enrolled in a point of service plan. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]
8. **Interest** – Interest earned from all sources.
9. **Risk Pool Revenue** (for Limited License Plans Only) – Report revenue earned from risk-sharing contracts. The reporting entity may have contracts that contain certain shared-risk provision whereby the reporting entity can earn additional incentive revenue based upon the utilization of services by the reporting entity’s enrollees.
10. **Aggregate Write-ins for Other Revenue** –The total of the write-ins listed in schedule “Details of Write-ins Aggregated at Item 10 for Other Revenue.” This Line is linked to the total from Report #2, Line 1031. Show revenue from sources not covered in the other Revenue accounts, such as recovery of bad debts or gain on sale of capital assets, etc.
11. **Total Revenue** – Total of the above revenue accounts (Lines 1 thru 10). Calculated automatically.

MEDICAL AND HOSPITAL EXPENSES

12. **Inpatient Services – Capitated** – Capitation costs incurred by the reporting entity for the costs of routine and ancillary services to enrollees, while confined to an acute care hospital.
13. **Inpatient Services – Per Diem** – Per diem costs incurred by the reporting entity for costs of routine and ancillary services to enrollees, while confined to an acute care hospital. “Per diem” is defined as a flat rate payment for each day of an enrollee’s hospital stay.
14. **Inpatient Services – Fee-For-Service/Case Rate** – Fees incurred by the reporting entity on a fee-for-service basis for the costs of routine and ancillary services to enrollees, while confined to an acute care hospital.
 - Routine hospital service includes regular room and board (including intensive care units, coronary care units, and other special inpatient hospital units), dietary and nursing services, medical surgical supplies, medical social services, and the use of certain equipment and facilities for which the provider does not customarily make a separate charge.
 - Ancillary services may also include laboratory, radiology, drugs, delivery room and physical therapy services. Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.
 - Include in the cost of utilizing skilled nursing and intermediate care facilities. Skilled nursing facilities are primarily engaged in providing skilled nursing care and related services for enrollees who require medical or nursing care or rehabilitation services.
 - Intermediate care facilities are for enrollees who do not require the degree of care and treatment which a hospital or skilled nursing care facility provides, but do require care and services above the level of room and board.
15. **Primary Professional Services – Capitated** – Capitation costs incurred by the reporting entity to primary care physicians, dentists, or other professionals, for the delivery of medical services.

Full Service Plans: Report expenses for physician services provided under contractual arrangement to the reporting entity. Include capitation payments paid by the reporting entity to physicians for delivery of medical services. Also, include the cost (salaries, including fringe benefits) associated with operating staff model facilities. Do not include expenses for services provided by other medical

professionals (Line 17). For example, if a reporting entity offers medical and dental coverage, the expenses for the delivery of medical services would be reported on Line 15 and the delivery of dental services would be reported on Line 17.

Specialized Plans: Report expenses for services provided under contractual arrangement to the reporting entity. Include capitation payments paid by the reporting entity to dentists or other professionals for delivery of medical services. Also, include the cost (salaries, including fringe benefits) associated with operating staff model facilities.

16. **Primary Professional Services – Non-Capitated** – Costs incurred by the reporting entity, on a fee-for-service basis, for the delivery of medical services. Include referrals by capitated providers for which the reporting entity is at risk (do not include expenses for medical personnel time devoted to administrative tasks).
17. **Other Medical Professional Services – Capitated** – Capitated costs incurred by the reporting entity for other medical professional services.
18. **Other Medical Professional Services – Non-Capitated** – Fees incurred by the reporting entity to providers on a fee-for-service basis for other medical professional services.

Other Medical Professional Services – Compensation, including fringe benefits, paid by the reporting entity to providers engaged in the delivery of medical services and to personnel engaged in activities in direct support of the provision of medical services. This includes dentists, psychologists, optometrists, podiatrists, extenders, nurses, clinical personnel such as ambulance drivers, technicians, paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and medical record clerks.
19. **Non-Contracted Emergency Room and Out-of-Area Expense** – Expenses for non-contracted health delivery services including emergency room costs incurred by enrollees for which the reporting entity is responsible. This includes out-of-area service costs for emergency physician and hospital services.
20. **POS Out-Of-Network** – Report out-of-network expenses that were provided to enrollees in the point-of-service plan. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]
21. **Pharmacy Expense - Capitated** – Capitated costs incurred by the reporting entity for providing prescription drugs to enrollees.
22. **Pharmacy Expense – Fee-For-Service** – Fees incurred by the reporting entity for providing prescription drugs on a fee-for-service basis.
23. **Aggregate Write-ins for Other Capitated Medical and Hospital Expenses** –The total amount for write-ins listed in schedule “Details of Write-ins Aggregated at Line 23 for Other Capitated Medical and Hospital Expenses.” This Line is linked to the total from Report #2, Line 2331. Include the costs directly associated with the delivery of medical services under a reporting entity arrangement which are not appropriately assignable to the medical expense category defined above; e.g., costs of medical supplies, medical administration expenses, malpractice insurance, etc.
24. **Aggregate Write-ins for Other Non-Capitated Medical and Hospital Expenses** –The total amount for write-ins listed in schedule “Details of Write-ins Aggregated at Line 24 for Other Non-Capitated Medical and Hospital Expenses.” This Line is linked to the total from Report #2, Line 2431.
25. **Total Medical and Hospital Expenses** – Total of the above medical and hospital accounts (Lines 12 thru 24).

ADMINISTRATION - Costs associated with the overall management and operation of the reporting entity including the following components:

26. **Compensation** – All expenses for administrative services including compensation and fringe benefits for personnel time devoted to or in direct support of administration. Do not include marketing expenses.
27. **Interest Expense** – Report interest on loans, incurred during the period.
28. **Occupancy, Depreciation, and Amortization** – Expenses associated with administrative services which include the costs of occupancy to the reporting entity which are directly associated with the reporting entity administration. These include the costs of using a facility, fire and theft insurance, utilities, maintenance, lease, etc. Do not include expenses for marketing in this category.
29. **Management Fees** – Report all expenses associated with services provided by non-affiliates. Do not include expenses for services provided by affiliates under management services agreements (Line 31).
30. **Marketing** – Expenses directly related to marketing activities including advertising, printing, marketing representative compensation and fringe benefits, commissions, broker fees, travel, occupancy, and other expenses allocated to the marketing activity.
31. **Affiliate Administration Services** - Expenses associated with services provided by affiliates under management services agreements.
32. **Aggregate Write-ins for Other Administration Expenses** –The total of the write-ins listed in schedule “Details of Write-ins Aggregated at Item 32 for Other Administration Expenses.” This Line is the total from Report #2, Line 3231. Show costs, which are not appropriately assignable to the other Administration Expenses, categories. According to Rule 1300.78, administrative costs are costs, which arise out of the operation of the plan as such, excluding direct and overhead costs incurred in the furnishing of health care services, which would be ordinarily incurred in the provision of such services whether or not through the plan. Refer to Section 1300.78 for items to include in this section.
33. **Total Administration** – Total of the above administration accounts (Lines 26 thru 32).
34. **Total Expenses** – Total of Medical, Hospital, and Administration Expenses (Line 25 and Line 33).
35. **Income (Loss)** – Excess or deficiency of total revenues over total expenses (Line 11 less Line 34).
36. **Extraordinary Item** – A nonrecurring gain or loss that meets the following criteria:
 - The event must be unusual; that is, it should be highly abnormal and unrelated to, or only incidentally related to, the ordinary activities of the entity;
 - The event must occur infrequently; that is, it should be of a type that would not reasonably be expected to recur in the foreseeable future.
 - The following gains and losses are specifically not extraordinary:
 - i. Write-down or write-off of accounts receivable, inventory, or intangible assets.
 - ii. Gains or losses from changes in the value of foreign currency.
 - iii. Gains or losses on disposal of a segment of a business.
 - iv. Gains or losses from the disposal of fixed assets.

v. Effects of a strike.

vi. Adjustments of accruals on long-term contracts.

(Describe in detail the reasons for the extraordinary item in the Notes to Financial Statements).

37. **Provision for Taxes** – State and federal taxes for period.

38. **Net Income (Loss)** – Excess or deficiency of total revenues over total expenses adjusted for extraordinary items and federal and state taxes (Line 35 minus Line 36 minus 37).

NET WORTH

39. Net Worth Beginning of Period

40. Audit Adjustments – Adjustments between the 4th quarter and the annual filing.

41. Increase (Decrease) in Common Stock

42. Increase (Decrease) in Preferred Stock

43. Increase (Decrease) in Paid In Surplus.

44. Increase (Decrease) in Contributed Capital

45. Increase (Decrease) in Retained Earnings

46. Net Income (Loss): Report #2, linked to Line 38.

47. Dividends to Stockholders

48. Aggregate Write-ins for Changes in Retained Earnings: The total amount of the write-ins listed in “Details of Write-ins Aggregated at Item 48 for Changes in Retained Earnings.” This Line is linked to the total from Report #2, Line 4831.

49. Aggregate Write-ins for Changes in Other Net Worth Items: Report #1, Part B. Show items not covered in the Other Net Worth categories. The total amount of the write-ins listed in “Details of Write-ins Aggregated at Item 49 for Changes of Other Net Worth Items.” This Line is linked to the total from Report #2, Line 4931.

50. Net Worth End of Period: Total of Net Worth Accounts (Lines 39 thru 49). This Line should equal Report #1, Part B, Line 26, Column 4.

REPORT #3 - STATEMENT OF CASH FLOWS (Direct Method)

Effective January 1, 2003, all plans are required to file the Statement of Cash Flows using the direct method.

PURPOSE:

This report provides information about the amount of net cash provided or used by the reporting entity during a period from operating activities, investing activities, and financing activities. This statement indicates the net effect of these cash flows on the reporting entity's cash and cash equivalents. A reconciliation of beginning and ending cash and cash equivalents is included in this statement.

STATEMENT OF CASH FLOWS - DIRECT METHOD

Lines:

1-10 12-17 19-25 30-38: Use information from Report #1 and Report #2 current and prior periods to complete these sections.

Line 11: **Net Cash Provided (Used) by Operating Activities:** Total of Lines 1 thru 10.

Line 18: **Net Cash Provided (Used) by Investing Activities:** Total of Lines 12 thru 17.

Line 26: **Net Cash Provided (Used) by financing Activities:** Total of Lines 19 thru 25.

Line 27: **Net Increase (Decrease) in Cash:** Total of Lines 11, 18, and 26.

Line 28: **Cash and Cash Equivalents at the Beginning of Period:** Beginning balance must tie to the ending balance, (Line 29: Cash and Cash Equivalents at the End of Period), of the prior period (month to month, quarter to quarter, year to year).

Line 29: **Cash and Cash Equivalents at the End of Period:** Total of Lines 27 and 28.

Line 32: **Decrease (Increase) in Receivables:** Include all receivables [Premiums, Shared Risk (for limited license plans only), Interest and Other Health Care].

Line 34: **Decrease (Increase) in Affiliate Receivables:** Include Secured and Unsecured Receivables

Line 38: **Aggregate Write-Ins for Adjustments to Net Income:** This Line is the total from Report #3, Line 3831.

Line 39: **Total Adjustments:** Total of Lines 31 thru 38.

Line 40: **Net Cash Provided (Used) by Operating Activities:** Line 30 plus Line 39.

REPORT #4: ENROLLMENT AND UTILIZATION TABLE

PURPOSE: The report shows the number of enrollees enrolled by product type and utilization statistics for the reporting entity.

Column

1. Source of Enrollment – Type of enrollment:

- Large Group Commercial - Number of enrollees that are covered by a large employer group contract.
- Medicare Risk - List an enrollee as a Medicare enrollee if payment for care is received under contract with the Centers for Medicare & Medicaid Services (CMS). Include enrollees that have supplemental coverage (from the reporting entity) to their individual Medicare coverage.
- Medicare Supplement - Also known as “Medigap,” refers to Medicare beneficiaries who are covered under various private supplemental health insurance plans.
- Medi-Cal Risk - List enrollee as a Medi-Cal enrollee if payment for care is received under contract with a Medicaid State Agency.
- Individual - List enrollees where the individual subscriber contracts directly with the reporting entity.
- Point of Service-Individual - Individual subscribers that are enrolled in a contract with the reporting entity where the reporting entity assumes the financial risk for both in-network and out-of-network coverage or service. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]
- Point of Service-Small Group - Enrollees covered under a small employer group that are enrolled in a contract with the reporting entity where the reporting entity assumes the financial risk for both in-network and out-of-network coverage or service. See Section 1357 of the Act for the definition of small group. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]
- Point-of-Service-Large Group - Enrollees covered under a large employer group that are enrolled in a contract with the reporting entity where the reporting entity assumes the financial risk for both in-network and out-of-network coverage or service. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]
- Small Group Commercial - Number of enrollees that are covered by a small employer group contracts. See Section 1357 of the Act for the definition of small group.
- Healthy Families - Number of enrollees that are covered by the Healthy Families Program
- AIM - Number of enrollees that are covered by the Access for Infant and Mothers Program.
- Medicare Cost - List an enrollee as a Medicare enrollee, other than Medicare Advantage, if payment for care is received under contract with the Centers for Medicare & Medicaid Services (CMS).
- ASO - List enrollees that are covered through an administrative services organization.
- PPO Individual - List individual subscribers that are covered by a preferred provider organization.
- PPO Small Group - List enrollees that are covered by a preferred provider organization under a small employer group contract. See Section 1357 of the Act for the definition of small group.
- PPO Large Group - List enrollees that are covered by a preferred provider organization under a large employer group contract.
- Aggregate Contracted from Other Plans – Number of enrollees received from contracts with other Knox-Keene licensed health plans.
- Aggregate Other Source of Enrollment - List any other source of enrollment that is not listed above (i.e., report enrollees that are eligible for both Medicare and Medicaid and do not include them on Lines 2 and 3).
- Total Membership - Total of all sources of enrollment. Grandfathered enrollees should be included in this number.

2. Total Enrollees at End of Previous Period – An enrollee is an individual who has been enrolled as a subscriber or an eligible dependent of a subscriber and for whom the reporting entity has accepted the

responsibility for the provision of basic health services as may be contracted for. This column shows enrollees at the end of the previous reporting period (whether month, quarter or year).

3. **Additions During Period** – Show number of enrollees added during the period.
4. **Termination During Period** – Show number of enrollees that are disenrolled during the period.
5. **Total Enrollees at End of Period** – Column 2 added to Column 3 less Column 4.
6. **Grandfathered Enrollees** – Enrollees that meet the definition of Section 1251 of the Patient Protection and Affordable Care Act. The enrollees fitting this definition are included as part of Column 5.
7. **Cumulative Enrollee Months for Period** – For the purpose of this report, an enrollee month is equivalent to one enrollee for whom the reporting entity has recognized premium revenue for one month. Where the revenue is recognized for only part of a month (or other relevant time period) for a given individual, a pro-rated partial enrollee month may be counted. Accumulate enrollee months for the period.

- 8-10. **Ambulatory Encounters** – The ambulatory encounters experienced by the total membership during the time period. “Ambulatory encounters” are further defined as follows: Ambulatory Services: Health services provided to enrollees who are not confined to a health care institution. Ambulatory services are often referred to as “outpatient” services, distinct from “inpatient” services.

Encounter: A face-to-face contact between the reporting entity, an enrollee, and a provider of health care service who exercise independent judgment in the care and provision of health service(s) to the enrollee. The term “independent” is used synonymously with self-reliance, to distinguish between providers who assume major responsibility for the care of individual enrollees and all other personnel who assist in providing that care (Encounter excludes immunization).

All utilization for the reporting entity total membership is to be reported whether or not the reporting entity bears financial responsibility for the service, except for the enrollee’s discretionary use of services if the reporting entity does not arrange or finance these services. For example, Medicare days and C.O.B. (Coordination of Benefits) days should be reported, as the reporting entity may bear financial responsibility or arrange these services while cosmetic surgery paid for and arranged by the enrollee need not be reported. If the reporting entity is unable to provide enrollment or utilization information in the exact format requested, similar statistics could be supplied with differences noted in the notes to financial statements.

8. **Physician** – The number of enrollee ambulatory encounters for the period provided by physicians only.
9. **Non-Physician** – The total number of enrollee ambulatory encounters for the period provided by non-physician medical personnel.
10. **Total** – The total of columns 8 and 9.
11. **Total Patient Days Incurred** – The number of hospital patient days that the reporting entity may ultimately be responsible for.

Patient Day: A patient day is a period of service rendered an inpatient with the day of discharge being counted only when the patient was admitted on the same day. Newborns whose inpatient stay is concurrent with the mother’s stay should not be counted separately from the mother’s patient days. Newborns whose inpatient stay is longer than the mother’s should be counted as separate patient days for the period beginning with the discharge of the mother.

12. **Annualized Hospital Days/1000** – Multiply the total hospital days in the period by 12,000, then divide the result by the cumulative member months. [(Column 11)/(Column 7) * 12,000 = Days /1000]
13. **Average Length of Stay** – Divide the total number of hospital days by the number of admissions. [(Column 11)/Admissions = Average Length of Stay]

INSTRUCTIONS FOR SUPPORTING SCHEDULES

- **Schedule A-1 Cash:** List all accounts reported for Report #1, Part A, Line 1 and all accounts reported on Report #1, Part A, Line 12
- **Schedule B – Investments:** List short-term investments in total and long-term investments in total, or provide detailed information on individual investments and valuation.
- **Schedule C Premiums Receivables (Other than Affiliates):** List accounts with balances greater than 5% of gross Premiums Receivable (Report #1, Part A, Line 3) and indicate amount reported for Allowance for Doubtful Accounts. Group the total of all other premiums receivable and enter the total on the Line titled “Aggregate Accounts Not Individually Listed.”
- **Schedule D – Health Care Receivables & Amounts due from Parent, Affiliates, & Subsidiaries:** List accounts for Health Care Receivables & Receivables due from Parent, Affiliates, & Subsidiaries with balances greater than 10% of gross receivables. These amounts should not be offset against corresponding liabilities. Include loans and advances to participating hospitals and providers and rebates from pharmaceutical companies. Group the total of all other receivables and enter the total on the Line titled “Aggregate Accounts Not Individually Listed.” Affiliate receivables reported at “net” against payables for the same entity must have a written Right of Offset agreement in place to document the enforceability of a setoff arrangement and it is to be filed and approved by the Department of Managed Health Care. Without a written Right of Offset, an affiliate receivable and an intercompany payable are to be recorded at “gross” and the receivable is to be deducted from TNE if it is not in the normal course of business and/or it is past due over 60 days.
- **Schedule E Property and Equipment:** Provide detail for property and equipment as reported on Report #1, Part A, Lines 19 through 25.
- **Schedule F – Accounts Payable:** List creditors with account balances greater than 5% of total trade accounts payable. Group the total of all accounts payable and enter the total on the Line titled “Aggregate Accounts Not Individually Listed-Due.”
- **Schedule G (Section I) Unpaid Claims Analysis:** – Provide an analysis of unpaid claims by claim type. Refer to Report #1, Part B, Lines 3 through 7 to complete this Section. Please note that the plan will need to analyze Line 7 to determine if there is any unpaid claim activity to report in this Section.
- **Schedule G (Section II) Analysis of Claims Unpaid – Previous Year:** Provide detail on unpaid claims for the previous year. This section measures the adequacy of prior year claim reserves by comparing the actual amount paid and any outstanding reserves in the current year on prior year claims against the reserves previously established. **FILE WITH ANNUAL REPORT ONLY.**
- **Schedule G (Section III) Inventory of Claims to be Processed:** – Provide information regarding the number of claims waiting to be processed. See following example on how to complete the schedule:

The plan’s fiscal year-end will end on June 30, 2007. Their first quarterly filing on the new forms will be for the quarter ended March 31, 2007. Schedule G, Section III:

1 Month	2 Beg. Bal	3 Add.	4 Deduct	5 Deduct	6 Add/Deduct	7 End Bal.
March 2007	^^	**	**	**	**	“
Feb2007	^^	**	**	**	**	“
Jan 2007	^^	**	**	**	**	“

(^^) Ending balance from previous month (**) Monthly totals (“) Amount equals Schedule H, Column #6

The quarter and year ended June 30, 2007 will be:

1 Month	2 Beg. Bal	3 Add.	4 Deduct	5 Deduct	6 Add/Deduct	7 End Bal.
Jun-07	^^	**	**	**	**	"
May-07	^^	**	**	**	**	"
Apr-07	^^	**	**	**	**	"
Mar-07	^^	**	**	**	**	"

FOR SPECIALIZED HEALTH PLANS ONLY: If a specialized health plan pays less than 25% of their total health care costs on a fee-for-service basis, Schedule G (Section III) is not required to be filed.

- **Schedule H – Aging of All Claims (in Dollars):** Age all claims on hand at the end of each month. The date received should be used to age the claims.

FOR SPECIALIZED HEALTH PLANS ONLY: If a specialized health plan pays less than 25% of their total health care costs on a fee-for-service basis, Schedule H is not required to be filed.

- **Schedule I – Analysis of Total Medical Liability to Actual Claims Paid:** The purpose of this schedule is to test the entity's lag schedules and verify the accruals for total claims liability. Provide information on a quarterly basis. The reporting entity may provide an actuarial certification in lieu of Schedule I. See following example on how to complete the schedule. Example:

The Plan's fiscal year ends June 30, 2007:

Reported Accrual				
1	2	3	4	5
Quarter Ending Date	Total Medical Liability*	Amount Paid-To-Date	Difference - Column (2-3)	Outstanding Liability (Based on plan's lag table)
June 2007	##	XXX		**
March 2007	##	^^	(Col 2-3)	**
Dec 2006	##	^^	(Col2-3)	**
Sept 2006	##	^^	(Col2-3)	**
June 2006	##	^^	(Col2-3)	**
Mar 2006	##	^^	(Col2-3)	**
Dec 2005	##	^^	(Col2-3)	**
Sept 2005	##	^^	(Col 2-3)	**

* Should tie to Report #1, Part B, Column 4, Lines 3 through 7.

(##) Amount reported for total medical liability in Report #1, Part B.

(^^)=

Qtr Ending	Amounts paid between:	For Dates of Service:
Mar-07	4/1/07 - 6/30/07	3/31/07 and prior
Dec-06	1/1/07-6/30/07	12/31/2006 and prior
Sep-06	10/1/06 – 6/30/07	9/30/06 and prior
Jun-06	7/1/06 – 6/30/07	6/30/06 and prior
Mar-06	4/1/06 –6/30/07	3/31/06 and prior
Dec-05	1/1/06 – 6/30/07	12/31/05 and prior
Sep-05	10/1/05 – 6/30/07	9/30/05 and prior

(**) Based on the plan's lag table(s), enter the amount of outstanding liability.

FOR SPECIALIZED HEALTH PLANS ONLY: If a specialized health plan pays less than 25% of their total health care costs on a fee-for-service basis, Schedule I is not required to be filed.

- **Schedule J - Loans and Notes Payable (Including Affiliates):** List all amounts of loans and notes payable, including those to affiliates, with balances greater than 10% of gross payables.
- **Schedule K – Summary of HMO Transactions with any Affiliates:** This schedule should be prepared on an accrual basis notwithstanding the column headings. If the HMOs and Parent, Subsidiaries or Affiliates is both a payor and a recipient of amounts in any category, the net of these amounts should be reported on one Line. Amounts of transactions that result in an increase in surplus should be shown as positive figures; and, transactions that result in a decrease in surplus should be reported enclosed in parentheses.

Column

1. **Federal ID Number:** Provide the Federal ID number.
2. **Names of HMOs and Parent, Subsidiaries or Affiliates:** Enter name. Each company will be represented by a single Line, which will contain the net amount of all transactions.
3. **Shareholder Dividends:** Include total amount of shareholder dividends.
4. **Capital Contributions:** Provide total amount of capital contributions. Include: Surplus notes.
5. **Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments:** Include: Total amount of purchases, sales or exchanges of loans, securities, real estate, mortgage loans or other investments.
6. **Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliates:** Exclude: contingent liabilities. Contingent liabilities are to be disclosed in the Notes to Financial Statements.
7. **Management Agreements and Service Contracts:**
Include: All revenues/expenditures under management agreements, service contracts, etc., except for amounts under
 - GAAP cost sharing arrangements.
 - All income tax amounts resulting from intercompany tax-sharing arrangements. Contracts for services provided by the insurer or purchased by the insurer from other affiliates.

- All compensation under agreements with affiliated brokers and reinsurance intermediaries.
 - Exclude: Any amounts reportable in Column 8.
8. **Income/ (Disbursements) Incurred Under Reinsurance Agreements:** Include: Experience rating refunds. Insurers who participate in a pooling agreement with affiliated insurers should be indicated with a “P” in this column. Exclude pooling agreement amounts. List the pooling percentage and the name of each insurer in each pool in the **FOOTNOTES**.
9. **Any Other Material Activity not in the Ordinary Course of the Insurer’s HMO Business:** Include: Inter-company loans, to the extent that these loans are not repaid at the end of the year.

Exclude: Those transactions that of a routine nature (i.e., the purchase of insurance coverage and cost allocation transactions that are based upon generally accepted principles of accounting).

10. **Total:** Enter the total amount reported in amounts reported in columns 3 to 9

- **Schedule L – Analysis of Operations by Lines of Business** – This report will provide detailed information regarding Enrollment, Revenues and Expenses, and Total Medical Liabilities by Line of Business. Please refer to the instructions for the Balance Sheet, Report #1, Part B (Liabilities and Net Worth) and the Statement of Revenues and Expenses for instructions and Line item descriptions for this Report.

Column 2 – **Total** - The amounts reported in this column must agree with amounts reported in (Report #2, Column 1).

Column 3 – **Commercial** – Business that provides for medical coverage including hospital, surgical, and major medical.

Include: Business that provides for medical coverage including hospital, surgical, major medical.

Exclude: Medicare (Title XVIII), Medicaid (Title XIX), Point-of-Service (POS), Dental Only, Vision Only, Administrative services only (ASO), administrative services contracts (ASC), or other non-underwritten business.

Column 4 – **Individual Group** – Report in accordance with Article 3.1 of the KKA, Section 1357 “definitions.”

Column 5 – **Small Employer Group** – Report in accordance with Article 3.1 of the KKA, Section 1357 “definitions.”

Column 6 – **Title XVIII (Medicare)** – Contracts with Health Care Financing Administration (HCFA) to provide services that are paid a pre-determined monthly amount per member based on a total estimated budget.

Include: Business where the managed care organization charges a premium and agrees to cover the full medical costs of Medicare subscribers.

Exclude: Commercial business, Medicaid (Title XIX), Point-of-Service (POS), Dental Only, Vision Only, Administrative services only (ASO), administrative service contracts (ASC), or other non-underwritten business.

Column 7 – **Title XIX (Medicaid)** – Those members enrolled under a prepaid contract between the reporting entity and the appropriate state agency administering medical assistance under a state plan approved under Title XIX of the Social Security Act where that agency agrees to pay part or all of the member.

Include: Business where managed care organization charges a premium and agrees to cover the full medical costs of Medicaid subscribers.

Exclude: Commercial business, Medicare (Title XVIII), Point-of-Service (POS), Dental Only, Vision Only, Administrative services only (ASO), administrative services contracts (ASC), or other non-underwritten business.

Column 8 – **POS** – A type of health plan allowing the covered member to choose to receive a service from participating or non-participating provider, with different benefit levels associated with the use of participating providers. [Refers to POS plan contracts pursuant to Article 5.6 of the Knox Keene Act]

Include: Business that provides for medical coverage including hospital, surgical, major medical.

Exclude: Commercial business, Medicare (Title XVIII), Medicaid (Title XIX), Dental Only, Vision Only, Administrative services only (ASO), administrative services contracts (ASC), or other non-underwritten business.

Column 9 – **Dental Only** – An entity providing Dental coverage in addition to health coverage.

Include: Policies providing for dental only coverage issued as stand alone dental or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

Exclude: Commercial business, Medicare (Title XVIII), Medicaid (Title XIX), Point-of-Service (POS), Vision Only, Administrative services only (ASO), administrative services contracts (ASC), or other non-underwritten business.

Column 10 – **Vision** – An entity providing Vision coverage in addition to health coverage provided by the health care company.

Include: Policies providing for vision only coverage issued as stand alone vision or as a rider to a medical policy that is not related to the medical policy through deductibles or out-of-pocket limits.

Exclude: Commercial business, Medicare (Title XVIII), Medicaid (Title XIX), Point-of-Service (POS), Dental Only, Administrative services only (ASO), administrative services contracts (ASC), or other non-underwritten business.

Column 11 - **Healthy Families** – Contracts with Healthy Families program to provide health, dental, and vision coverage to children (under 19) who do not have insurance and do not qualify for free Medi-Cal.

Column 12 – **Administrative Services Contract (ASC)**

Include: Business where the reporting entity provides services to a third party self insured group and where the reporting entity advances its own funds in payment of claims and issues its own membership card or other identifying document and use of their provider networks to the members of the group.

Column 11 – **Other**

Include: A company that is engaged in one or more insurance businesses, other than health business (e.g., workers' compensation) or that maintains a corporate account that cannot be reported in Columns 2 through 9 of the Analysis of Operations by lines of business shall add the amounts for each additional line of business or corporate account and shall enter the total in Column 10 (Other). Similar action should be taken where applicable in supporting exhibits.

INSTRUCTIONS FOR SUPPLEMENTAL INFORMATION PURSUANT TO RULES

1300.84.06, 1300.84.2 AND SECTIONS 1374.67 AND 1374.68

PURPOSE: This report requires disclosure of supplemental information to demonstrate compliance with the specific requirements of Rule 1300.84.06(b), 1300.84.2 and Sections 1374.67 and 1374.68. If any item is not applicable to your operations, then please enter “NA”. If additional room is needed, use overflow page 29.

- A. Provide a written explanation of the method of calculating the provision for incurred and unreported claims.
- B. Provide the name of the debtor, nature of the relationship, nature of receivable, the amount and the terms for each accounts and notes receivable from officers, directors, owners or affiliates for the period of the financial statements reported. The “terms” should indicate the type of settlement, such as “Settled Monthly”.
- C. Provide the donor’s name, affiliation with reporting entity, the valuation method used to value the donated materials or services, and the amount for any donated materials or services received for the period of the financial statements reported.
- D. Provide the creditor's name, affiliation with reporting entity, a summary of how the obligation arose, and the amount for any forgiven debt or obligations during the period of the financial statements reported.
- E. Definitions that apply to the calculation of the plan's tangible net equity in accordance with Rule 1300.76:

Subordinated debt and related accrued interest must be filed and approved by the DMHC prior to including it in the TNE calculation. Any operating cost assistance or direct loan made to a plan by the United States Center for Medicare and Medicaid Services pursuant to Public Law 93-222, as amended, may be treated as a subordinated loan, notwithstanding any express terms thereof to the contrary. [Reference to Line 14 and 15 of Report #1—Part B: Liabilities and Net Worth]

Unsecured receivables-both “current” and “past due” are excluded in calculating tangible net equity, unless determined to be in the normal course of business and not past due. “Past due” portion of receivable to be excluded for tangible net equity calculation is any receivable over 60 days old. [Reference to Line 9 and 16 of Report #1—Part A: Assets]

F. Percentage of administrative costs to revenue obtained from subscribers and enrollees is calculated for the year to date for compliance with Section 1378 and Rule 1300.78(b).

Line 22: Revenue from subscribers and enrollees equals the sum of Line 1 to 5 plus Line 7 and Line 9 of the Year-to Date of Report #2: Revenue, Expenses and Net Worth.

Line 23: Administrative Costs equals Line 33 less Line 10 of the Year-to-Date of Report #2: Revenue, Expenses and Net Worth.

Line 24: Percentage is calculated as Line 22 divided by Line 23.

G. Percentage of health care expenses for noncontracting providers to determine compliance with Section 1377 and Rule 1300.77, as follows:

Line 25: Total amount of health care services incurred for the immediately preceding six-month period is calculated from Lines 19 and 20 from the Current Period of Report #2: Revenue, Expenses and Net Worth for the current quarter plus the prior quarter.

Line 26: Total costs for health care for the immediately preceding six months is calculated from Line 25 from the Current Period of Report #2: Revenue, Expenses and Net Worth for the current quarter plus the prior quarter.

Line 27: Percentage is calculated as Line 25 divided by Line 26. If the percentage calculated is less than 10%, then leave Line 29 to Line 34 blank. If the percentage calculated exceeds 10%, the following information shall be provided for the period being reported:

Line 28: The amount of health care expenses incurred for Noncontracting providers or direct reimbursement to subscribers and enrollees, when Line 27 exceeds 10%, determined as follows:

Line 29: Amount of all claims for non-contracting provider services received for reimbursement but not yet processed.

Line 30: Amount of all claims for non-contracting provider services denied for reimbursement during the previous 45 days.

Line 31: Amount of all claims for non-contracting provider services approved for reimbursement but not yet paid.

Line 32: An estimate of the amount of claims for non-contracting provider services incurred, but not reported.

Line 33: Calculation of compliance with Section 1377(a) as determined in accordance with such section and Rule 1300.77(b), as follows:

Line 34: Cash & cash equivalents maintained on deposit with Department in the form of a restricted deposit and assigned to the Department pursuant to Section 1377(a) (1) (A).

Line 35: Total liability for noncontracting provider claims equals the sum of Lines 29 to 32.

Line 36: Calculation of required cash & cash equivalents equals 120% of Line 35.

Line 37: Deposit required is equal to Line 36 and is the amount required to be restricted and assigned to the Department pursuant to Section 1377(a)(1)(A).

Line 38: Excess (deficient) reserves are the difference between Line 34 and Line 37. If this line is positive, then deposit is in excess of required amount. If this line is negative, then deposit is deficient and requires that an additional restricted deposit be assigned to the Department for this amount.

H. Point of Service (POS) Health Care Service Plan Contract limitations pursuant to Section 1374.67 [If POS product does not apply, leave Lines 39 to 57 blank].

Percentage of premium revenue earned from POS plan contracts for compliance with Section 1374.67(a) as follows:

Line 39: Premium revenue for POS contracts as reported on Line 7 for the Current Period of Report #2: Revenue, Expenses and Net Worth.

Line 40: Total premium revenue earned for the current quarter for the **sum of Lines 1 through 5 plus Line 7** for the Current Period of Report #2: Revenue, Expenses and Net Worth.

Line 41: Percentage is calculated by dividing Line 39 by Line 40. Resulting percentage is **not** to exceed 50 percent.

I. Percentage of total health care expenditures incurred for enrollees for out-of-network services for POS enrollees for compliance with Section 1374.67(b) as follows:

Line 42: Total health care expenditures for out-of-network services for POS enrollees as reported on Line 20 for the Current Period of Report #2: Revenue, Expenses and Net Worth.

Line 43: Total health care expenditures as reported on Line 25 for the Current Period of Report #2: Revenue, Expenses and Net Worth.

Line 44: Percentage is calculated by dividing Line 42 by Line 43. Resulting percentage is **not** to exceed 20 percent.

Line 45: Enter the total number of **enrollees** that are enrolled in POS contract pursuant to Article 5.6 of the Knox Keene Act for the period reported. This enrollment number is to agree with POS enrollment reported on Report #4 line 6, column 5.

Line 46: Enter the number of **Physician ambulatory encounters** for POS enrollees for the period reported. The number of encounters is to agree with POS encounters reported on Report #4 line 6, column 7.

Line 47: Enter the number of **Non-Physician ambulatory encounters** for POS enrollees for the period reported. The number of encounters is to agree with POS encounters reported on Report #4 line 6, column 8.

Line 48: Total ambulatory encounters (total of lines 46 and 47). This total is to agree with POS total encounters reported on Report #4 line 6, column 9.

Line 49: Enter the total **Patient Days** incurred for POS enrollees. This total is to agree with POS total patient days reported on Report #4 line 6, column 10.

Line 50: Enter the **Annualized Hospital Days** per 1000 for POS enrollees. This total is to agree with POS annualized hospital days reported on Report #4 line 6, column 11.

Line 51: Enter the **Average Length of Stay** for POS enrollees. This total is to agree with POS average length of stay reported on Report #4 line 6, column 12.

Line 52: Compliance with restricted deposit requirement of Section 1374.68(a) as follows:

Line 53: Current monthly claims payable for out-of-network coverage or services provided under Point-of-Service Contracts equals amount reported on Line 5 of Report #1---Part B: Liabilities and Net Worth.

Line 54: Current monthly incurred but not reported claims balance for out-of-network coverage or services provided under Point-of-Service contracts equals amount reported on Line 6 of Report #1---Part B: Liabilities and Net Worth.

Line 55: Total claims payable plus incurred but not reported balance for out-of-network coverage or services provided under POS contracts equals the sum of Line 46 and Line 47.

Line 56: Total equals 120 percent of Line 48 to determine amount of deposit required pursuant to Section 1374.68(a) (2).

Line 57: Required deposit is the greater of Line 49 or \$200,000 and this amount is to be restricted and assigned to the Department pursuant to Section 1374.68(a).

LIST OF FORMS REQUIRED TO BE FILED

	Annual Reporting Form	Quarterly Reporting Form	Quarterly Reporting Form*	Monthly Reporting Form
Jurat Page	X	X	X	X
Supplemental Information	X	X	X	X
Report #1, Part A: Assets	X	X	X	X
Report #1, Part B: Liabilities	X	X	X	X
Report #2: Revenue, Expenses, and Net Worth	X	X	X	X
Report #3: Statement of Cash Flows	X	X	X	X
Report #4: Enrollment and Utilization Table	X	X	X	X
Schedule A-1: Cash	X		X	
Schedule A-2: Restricted Assets	X		X	
Schedule B: Investments	X			
Schedule C: Premiums Receivable (Other than Affiliates)	X		X	
Schedule D: Health Care Receivables & Amounts Due from Parent, Subsidiaries, and Affiliates	X	X	X	
Schedule E: Property & Equipment – Net	X			
Schedule F: Accounts Payable	X		X	
Schedule G: Section I – Unpaid Claims	X	X	X	
Section II – Analysis of Claims Paid (Previous Year)	X			
Section III – Inventory of Claims to be Processed	X	X	X	
Schedule H: Aging of all Claims	X	X	X	
Schedule I: Analysis of Total Medical Liability to Actual Claims Paid	X [^]	X [^]	X [^]	
Schedule J: Loans and Notes Payable (Including Affiliates)	X			
Schedule K: Summary of HMO's Transactions with Affiliates	X			
Schedule L: Analysis of Operations by Lines of Business	X			
Notes to Financial Statements	X	X	X	X
Overflow Page for Write-Ins	X	X	X	
TNE Calculation	X	X	X	X
General Interrogatories	X			

* The Plan will be required to file the forms if the Plan is TNE deficient or is notified by the Department to file the forms.

[^] The Plan may submit an actuarial certification in lieu of Schedule I.

NOTE: If a specialized health plan pays less than 25% of their total health care costs on a fee-for-service basis, Schedules G (Section III), H, and I are not required to be filed.