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DEFINITIONS

ADMINISTRATIVE COSTS
Administrative expenses incurred to manage the health system, including, but not limited to provider relations and contracting; provider billing; provider sub-capitation administration provision; non-encounterable PBM fees (e.g., pharmacy network management, pharmacy discount negotiating, drug utilization review, coordination of specialty drugs, pharmacy claims processing, pharmacy call center operations, etc.); quality improvement activities; accounting; information technology services; processing and investigating grievances and appeals; legal services, which includes legal representation of the Contractor at administrative hearings; planning; program development; program evaluation; personnel management; staff development and training; provider auditing and monitoring; utilization review and quality assurance. Administrative costs do not include expenses incurred for the direct provision of health care services, including case management, or integrated health care services.

ADULT GROUP AT OR BELOW 106% FPL (Formerly TWG Non-Med): Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL). Also referred to as: Adults $\leq$106%

ADULT GROUP AT OR ABOVE 106% FPL (Formerly Newly Eligible Adults): Adults aged 19-64, without Medicare, with income above 106% through 133% of the FPL. Also referred to as: Adults > 106%

AFFILIATE: See Related Party Transactions.

AHCCCS: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM. A State agency, as described in A.R.S. Title 36, Chapter 29, which is responsible for the provision of hospitalization and medical care to members through contracts with Contractors. AHCCCS is Arizona’s Medicaid program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program.

AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM): The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov.

ALTERNATIVE PAYMENT MODEL (APM) (formerly Value Based Purchasing)
A model which aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality. APM strategies for this initiative may include any combination of Primary Care Incentives, Performance-Based Contracts, Bundled/Episode Payments, Shared Savings, Shared Risk and Capitation + Performance-Based Contracts purchasing strategies as defined in ACOM 306 and 307.

CAPITATION: Payment to a Contractor by AHCCCS, of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.
CARE MANAGEMENT
Care Management is a group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery. See also AMPM 1000.

CASE MANAGEMENT
Case Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes.

CONTRACTOR: An organization or entity that has a prepaid capitated contract with the AHCCCS administration pursuant to A.R.S. §36-2904 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.

DAY: Calendar day unless otherwise specified.

DURABLE MEDICAL EQUIPMENT: An item or appliance that is not an orthotic or prosthetic and that is: designed for a medical purpose, is generally not useful to a person in the absence of an illness or injury, can withstand repeated use, and is generally reusable by others.

EMERGENCY MEDICAL CONDITION: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

EMERGENCY SERVICES: Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

ENROLLMENT: The process by which an eligible person becomes a member of a Contractor’s plan.

FEE-FOR-SERVICE: A method of payment to registered providers on an amount per service basis.

FQHC/RHC VISIT: Face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner
within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

HOME HEALTH: Health and supportive services provided in an AHCCCS member’s home. This service shall be provided under the direction of a physician to prevent hospitalization or institutionalization and may include nursing, therapies, supplies and home health aide services. It shall be provided on a part-time or intermittent basis.

INCURRED BUT NOT REPORTED CLAIMS (IBNR): Incurred but not reported liability for services rendered for which claims have not been received.

INPATIENT: A patient who is provided with room, board, and general nursing services in a hospital setting and is expected to occupy a bed and remain at least overnight.

OUTPATIENT: A patient who is not confined overnight in a health care institution.

PRIMARY CARE PHYSICIAN (PCP) PARITY: The Patient Protection and Affordable Care Act (ACA) requires that the Contractor pay qualified primary care providers (and other providers specified in ACA) fees that are no less than the Medicare fee schedule in effect for calendar years 2013 and 2014, or the fee schedule rate that would result from applying the 2009 Medicare conversion factor, whichever is greater, for certain services designated by specific Current Procedural Terminology (CPT) codes.

PHARMACY: An establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist, who is registered pursuant to A.R.S. Title 32, Chapter 18.

PHYSICIAN SERVICES: Services provided within the scope of the practice of medicine or osteopathy, as defined by State law, or under the personal supervision of an individual, licensed under State law to practice medicine or osteopathy. Physician services exclude those services routinely performed and not directly related to the medical care of the individual patient.

PRIOR PERIOD COVERAGE (PPC): The period of time, prior to the member’s enrollment, during which a member is eligible for covered services. The time frame is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article1.

PROVIDER: Any person or entity who contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.
RECEIVED BUT UNPAID CLAIMS (RBUC): Claims that have been received by the Contractor but have not been paid. A claim is considered received the day it is physically received at the Contractor.

REINSURANCE: A risk-sharing program provided by AHCCCS to the contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.

RELATED PARTY TRANSACTIONS: Transactions with a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. “Related parties” or “Affiliates” include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

STATE ONLY TRANSPLANT MEMBERS: Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income may become eligible for one of two extended eligibility options as specified in A.R.S. 36-2907.10 and A.R.S. 36-2907.11.

SUPPLEMENTAL SECURITY INCOME (SSI): Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind, or disabled and have household income levels at or below 100% of the FPL.

SUB-CAPITATION: A fixed premium paid by a Contractor to a provider of health care services with which the Contractor has a contract. The provider is at risk for the designated services.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF): A Federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It replaced Aid to Families with Dependent Children (AFDC).

THIRD PARTY: An individual, entity, or program that is, or may be, liable to pay all, or part of, the medical cost of injury, disease, or disability of an AHCCCS applicant or member as defined in R9-22-1001.
1.00 GENERAL INFORMATION

1.01 Purpose and Objective of the Guide

The purpose of the AHCCCS Financial Reporting Guide for Acute Contractors (Guide) is to set forth the monthly, quarterly, and annual reporting requirements for acute care Contractors. The primary objective of the Guide is to establish consistency and uniformity in reporting. This Guide is neither intended to limit the scope of audit procedures to be performed during the Contractor’s annual certified audit, nor to replace the independent Certified Public Accountant’s judgment as to the work to be performed. It is instead intended to define certain additional procedures and analysis to be performed and reported on by the applicable Contractor management on a periodic basis and by the independent Certified Public Accountants on an annual basis.

The contract with AHCCCS requires that Contractors furnish information from their records relating to the performance under the contract. Certain financial and statistical data are outlined in the contract as minimum reporting requirements. AHCCCS has developed a standard set of forms to be used to satisfy the financial reporting requirements as well as guidelines and minimum reporting requirements for the annual audited financial statements. This guide is intended to outline these requirements and also provide examples of required reports in the Appendix to the guide. This guide is not intended nor should it be construed as an all-inclusive manual. The format and content of the required reports are subject to change. Questions regarding the content or format of a report are to be directed to the Contractors’ assigned Financial Consultant.

Contractors are required to utilize the most recent Financial Statement Reporting Template provided by the Division of Health Care Management (DHCM) for submission of all required quarterly and annual reports.

If the Contractor is a Medicare Advantage Plan licensed through the Department of Insurance, quarterly reporting to AHCCCS is required for informational purposes only. AHCCCS will accept a copy of the NAIC filing submitted to the Arizona Department of Insurance (DOI). AHCCCS acknowledges that the quarter ending 12/31/xx filing to DOI is due 90 days after quarter end and thus is due to AHCCCS at the same time it is filed with DOI. If the Contractor is a Medicare Advantage Plan certified by AHCCCS, then the Contractor shall use the applicable AHCCCS Financial Reporting Guide and the related report template (the E-6 series, Profitability by GSA is not required) for quarterly reporting to AHCCCS.
1.02 Effective Dates and Reporting Time Frames

The provisions and requirements of this Guide are effective for reporting periods beginning October 1 of every contract year. As deemed necessary, amendments and/or updates to this Guide may be issued by AHCCCS.

Monthly reporting, when required, is due within 30 days of each month end, using either the Contractor’s internal financial statement format or the AHCCCS Reporting Guide format as determined by AHCCCS.

Quarterly reporting is due within 60 days of each quarter end, using the most recent AHCCCS Reporting Guide format.

A draft of the annual audited financial statements, supplemental schedules, and annual reconciliation are due within 90 days of the Contractor’s fiscal year end. AHCCCS must approve the Contractor’s draft audit prior to the Contractor’s auditors issuing the final audit report and financial statements. The final annual audited financial statements, annual reconciliation, management letter and all other annual financial reports are due within 120 days of the Contractor’s fiscal year end.

If a due date falls on a weekend or a State recognized holiday, reports will be due the following business day.

Extensions must be requested in writing and addressed to the Contractors’ assigned Financial Consultant. Requests must be submitted to AHCCCS at least five (5) business days prior to the due date and must include the reason for the extension and the revised submission date. Requests for extensions will be reviewed and acknowledged.

See Section 2.00 for a complete listing of monthly, quarterly, and annual filing requirements.

1.03 Sanctions

Failure to file with AHCCCS, accurate, timely, and complete financial statements and related deliverables may result in monetary penalties until such statements or deliverables are received by AHCCCS.

If a Contractor knowingly and willfully makes, or causes to be made, any false statement or misrepresentation of a material fact in any statement or disclosure filed pursuant to this policy, the Contractor may be fined pursuant to ACOM Policy 408.

AHCCCS may refuse to enter into a contract and may suspend or terminate an existing contract if the Contractor fails to disclose ownership or control information and related party transactions as required by AHCCCS policy.
2.00 FINANCIAL REPORTING REQUIREMENTS

The table on the following page represents the financial reporting requirements and the applicable due dates. Detailed descriptions of the required reports may be found in Section 3.00 and Section 4.00 of this Guide.
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<td>Parent Company Financial Statements (if applicable)</td>
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**Due Date:** 30 days after month end, 60 days after quarter end, 90 days after year end, 120 days after year end.
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<td>Related Party Transactions</td>
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* Required submissions **only** if audit adjustments have impacted amounts previously reported or Contractor revised financial statements subsequent to the 4th quarter reports submitted to AHCCCS. See Paragraph 4.16
3.00 INSTRUCTIONS FOR COMPLETION OF QUARTERLY AND ANNUAL REPORTING

3.01 General Instructions

All reports must be compiled using the accrual basis of accounting. The Contractor shall submit these forms electronically on or before the due date to AHCCCS via the Secured File Transfer Server (SFTS) using the Financial Statement Reporting Template provided by the Division of Health Care Management (DHCM). The sent date will be used as the receipt date for timeliness purposes. The electronic copy must contain the Reporting Guide Template in MS Excel including all supplemental schedules. The certification page needs to bear all signatures written or electronic and be inserted into the Excel template. If the contractor opts to use a written signature then the certification page will need to be submitted in PDF format and inserted into the Excel template. Any additional information needs to be submitted in MS Excel. Amounts reported to AHCCCS under this guide are to represent the AHCCCS acute care business independent of any other line of business in which the Contractor may be engaged. The financial statements must at least separate these lines of business in the form of additional supplemental schedules, if they are not separately presented in the financial statements themselves.

Draft annual audited financial statements and supplemental reports should be complete with all attachments and schedules and be as close to final as possible. There should be only minimal changes between the draft and final submissions. The draft and final audit report, audited financial statements and footnotes should be in accordance with GAAP or GASB. Footnotes and supplemental schedules should agree to amounts included in the audited financial statements.

Contractors should review the Sarbanes-Oxley Act and consider applying the best practices contained within the Act; including rotating at least the lead and reviewing partners of the audit firm every five (5) years.

Report line titles and columnar headings are detailed in the report specific paragraphs below. Utilize predefined categories or classifications before reporting an amount as "Other." For any material amounts included in the "Other" category, provide details and explanations in the footnotes regarding the content of the account(s). For this purpose, material is defined as an amount \( \geq 10\% \) of the total for each section. For example, if Other Income is reported and it is less than 10% of Total Revenues, no disclosure is necessary. However, if Other Income was 10% of Total Revenues, disclosure is necessary (see Paragraph 3.06 for Footnote Disclosure Requirements).

If information is not available or applicable, write "None," not applicable (N/A), or ":-0:-" in the space provided. When a Contractor changes any line item, for a prior quarter, the change must be reported one of two ways: one; submit corrected prior quarter report or two; record the change in the current quarter report.
3.02 Certification Statement

The purpose of the certification statement is to attest that the information submitted in the reports is current, complete, and accurate. The statement should include the Contractor name, Contractor identification number, quarter ended, preparer information, and Chief Executive Officer and Chief Financial Officer signatures, written or electronic. See Appendix A for an example of the Certification Statement.

3.03 Financial Statement Reporting Template Audit Report

The Financial Statement Reporting Template Audit Report lists the required audit criteria that must be passed prior to the submission of quarterly financial statements. If the audit check figures do not match, data should be corrected or an explanation should be provided in writing and submitted with the quarterly financial statement reporting package. See Appendix B for an example of this report.

3.04 Balance Sheet (Statement of Net Assets - governmental entities)

See Appendix C-1 for an example of this report.

**CURRENT ASSETS** are assets that are expected to be converted into cash or used or consumed within one year from the balance sheet date. Restricted assets for the performance bond, contracts, reserves, etc., are not to be included as current assets.

**A/C 10105 - Cash and Cash Equivalents**

Include: Cash and cash equivalents, available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.

Exclude: Restricted cash (and equivalents) and any cash (and equivalents) pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

**A/C 10110 - Short-term Investments**

Include: Investments that are readily marketable and that are expected to be redeemed or sold within one year of the balance sheet date.

Exclude: Investments maturing 90 days or less from the date of purchase and restricted securities. Also exclude investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.
A/C 10115 - **Capitation/Non-Title XIX/XXI Funding/Supplement/Risk Adjustment Receivable**

Include: Net amounts receivable from AHCCCS for capitation, Delivery Supplements, and risk adjustment as of the balance sheet date. See Capitation, Supplement, and Risk Adjustment Receivable Report (Paragraph 4.02) for required detail of this line item. Also include the Health Insurance Providers Fee revenues in this line.

A/C 10120 - **Reinsurance Receivable**

Include: Billed and unbilled reinsurance. See discussion of Reinsurance in Paragraph 5.02.

A/C 10125 - **Reconciliations/Settlements Receivable**

Include: Amounts receivable from AHCCCS for PPC, Prospective Tiered, Adults >106% and PCP Parity reconciliations/cost settlements. See Receivables/Payables Report (Paragraph 4.03) for required detail of this line item. This should equal only the sum of all receivable amounts listed on the Receivables/Payables Report (Paragraph 4.03). In addition, any settlement amounts due from AHCCCS relating to alternative payment model and access to professional services initiatives should be recorded in this account.

Exclude: Amounts due from providers relating to alternative payment model initiatives.

A/C 10130 - **Investment Income Receivable**

Include: Income earned but not yet received from cash equivalents, investments, on-balance sheet performance bonds, and short and long-term investments.

A/C 10135 - **Current Due from Affiliates/Other Funds**

Include: The net amount of receivables due from affiliates expected to be collected within one year of the balance sheet date. Note that only the net amount is reported. Therefore, there should not be a Due from and a Due to Affiliates concurrently. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due from affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

Exclude: Amounts due from affiliates resulting from medical claims payable, capitation payable or other medical expense related items and non-current amounts due from affiliates.

A/C 10140 - **Alternative Payment Model Receivable From Providers**

Include: Any amounts due from providers relating to alternative payment model initiatives between the Contractor and the provider.
**A/C 10145 - Other Current Assets**

Include: The total current portion of any assets (e.g. income taxes receivable) not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for in this line item, and should not be netted against the IBNRs. See Other Assets Report (Paragraph 4.04) for required detail of this line item.

**OTHER ASSETS**

**A/C 10205 - General Performance Bond**

Include: All cash and investments pledged to meet the AHCCCS performance bond requirement.

Exclude: Surety bonds or letters of credit that do not represent actual assets of the Contractor.

**A/C 10210 - Restricted Cash and Other Assets**

Include: Cash, securities, receivables, etc., whose use is restricted.

Exclude: Cash and/or investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

**A/C 10215 - Long-term Investments**

Include: Investments that are expected to be held longer than one year.

Exclude: Investments pledged by the Contractor to satisfy the AHCCCS performance bond requirement.

**A/C 10220 - Non-current Due from Affiliates/Other Funds**

Include: The net amount of receivables due from affiliates not expected to be collected within one year of the balance sheet date. Note that only the net amount is reported. Non-current Due from affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

Exclude: Amounts due from affiliates resulting from medical claims payable, capitation payable or other medical expense related items and current amounts due from affiliates.

**A/C 10225 - Other Non-Current Assets**

Include: The total non-current portion of any assets not accounted for elsewhere on the balance sheet including any non-current portion of Alternative Payment Model Initiatives. See Other Assets Report (Paragraph 4.04) for required detail of this line item.

**PROPERTY AND EQUIPMENT** consists of fixed assets including land, buildings, leasehold improvements, furniture, equipment, etc.
A/C 10305 - Land  
Include: Real estate owned by the Contractor.

A/C 10310 - Buildings  
Include: Buildings owned by the Contractor, including buildings under a capital lease, and improvements to buildings owned by the Contractor.

Exclude: Improvements made to leased or rented buildings or offices.

A/C 10315 - Leasehold Improvements  
Include: Capital improvements to facilities not owned by the Contractor.

A/C 10320 - Furniture and Equipment  
Include: Medical equipment, office equipment, data processing hardware, and software (where permitted), and furniture owned by the Contractor, as well as similar assets held under capital leases.

A/C 10325 - Other Property and Equipment  
Include: All other fixed assets not falling under one of the other specific fixed asset categories.

A/C 10330 - Accumulated Depreciation and Amortization  
Include: The total of all depreciation and amortization accounts relating to the various fixed asset accounts.

CURRENT LIABILITIES consists of obligations whose liquidation is reasonably expected to occur within one year from the balance sheet date.

A/C 20105 - Accounts Payable  
Include: Amounts due to creditors for the acquisition of goods and services (trade and administrative vendors) on a credit basis.

Exclude: Amounts due to providers related to the delivery of health care services.

A/C 20110 - Accrued Administrative Expenses  
Include: Accrued expenses and management fees and any other amounts, estimated as of the balance sheet date (i.e., payroll, taxes). Also include accrued interest payable on debts.

A/C 20115 - Payable to Providers  
Include: Net amounts owed to providers for monthly capitation.

Exclude: Capitation amounts payable to AHCCCS as a result of an overpayment. (This amount should be reported in A/C 20145 - Other Current Liabilities.)
**A/C 20120 - Medical Claims Payable**

Include: The total will include the total of reported but unpaid claims (RBUCs) and incurred but not reported claims (IBNRs). See the discussion on Medical Claims Liability in Paragraph 5.01.

**A/C 20125 - Reconciliations/Settlements Payable**

Include: Amounts payable to AHCCCS for PPC, Prospective Tiered, Adults >106% and PCP Parity reconciliations/cost settlements. See Receivables/Payables Report (Paragraph 4.03) for required detail of this line item. This should equal only the sum of all payable amounts detailed on the Receivables/Payables Report (Paragraph 4.03). In addition, any settlement amounts due to AHCCCS relating to alternative payment model and access to professional services initiatives should be recorded in this account.

Exclude: Amounts due to providers relating to alternative payment model initiatives.

**A/C 20130 - Alternative Payment Model Payable to Providers**

Include: Current portion of payable amounts due to providers relating to alternative payment model initiatives.

**A/C 20135 - Current Portion of Long-term Debt**

Include: The total current portion from the detail listed in the Long-term Debt Report (Other than Affiliates) which will include the principal amount on loans, notes, and capital lease obligations due within one year of the balance sheet date. See Long-Term Debt (Other than Affiliates) Report, Paragraph 4.08.

Exclude: Long-term portion of, and accrued interest on loans, notes, and capital lease obligations.

**A/C 20140 - Current Due to Affiliates/Other Funds**

Include: The net amount of payables due to affiliates expected to be paid within one year of the balance sheet date. Note only the net amount is reported. Therefore, there should not be a Due from and a Due to Affiliates concurrently. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

Exclude: Amounts due to affiliates resulting from medical claims payable, capitation payable, or other medical expense related items and non-current amounts due to affiliates.
**A/C 20145 - Other Current Liabilities**

Include: The total current portion from the detail listed in the Other Liabilities Report, which will include those current liabilities not specifically identified elsewhere (i.e., income taxes payable). See Other Liabilities Report, Paragraph 4.05. Also include the current portion of the Health Insurance Providers Fee liability in this line.

**OTHER LIABILITIES** are those obligations whose liquidation is not reasonably expected to occur within one year of the date of the balance sheet.

**A/C 20205 - Non-current Portion of Long-term Debt**

Include: The total non-current portion from the detail listed in the Long-term Debt report which will include the long-term portion of principal on loans, notes, and capital lease obligations. See Long-Term Debt (Other than Affiliates) Report (Paragraph 4.08) for required detail of this line item.

Exclude: Current portion of, and accrued interest on loans, notes, and capital lease obligations.

**A/C 20210 - Non-current Due to Affiliates/Other Funds**

Include: The net amount of payables due to affiliates not expected to be paid within one year of the balance sheet date. Note that only the net amount is reported. All related party transactions that are not conducted in the normal course of business require written prior approval from AHCCCS. Due to affiliate amounts should be described in the notes to the financial statements. See Paragraph 3.06 - #10.

Exclude: Amounts due to affiliates resulting from medical claims payable, capitation payable, or other medical expense related items and current amounts due to affiliates.

**A/C 20215 - Other Non-current Liabilities**

Include: The total non-current portion of Other Liabilities, which will include those non-current liabilities not specifically identified elsewhere. Non-current portion of Alternative Payment Model Initiatives should be reported on this line. See Other Liabilities Report (Paragraph 4.05) for required detail of this line item. Also include the non-current portion of the Health Insurance Providers Fee liability in this line.

**EQUITY/NET ASSETS** includes preferred stock, common stock, treasury stock, additional paid-in capital, contributed capital, and retained earnings/fund balance.

**A/C 30105 - Preferred Stock**

Include the total par value of Preferred Stock, or in the case of no-par shares, the stated or liquidation value.
**A/C 30110 - Common Stock**  
Include the total par value of Common Stock, or in the case of no-par shares, the stated value.

**A/C 30115 - Treasury Stock**  
Include the amount of Treasury Stock reported using the Par Value or Cost Method.

**A/C 30120 - Additional Paid-in Capital**  
Include amounts paid and contributed in excess of the par or stated value of shares issued. Also include adjustments from purchases and revaluations recorded in accordance with SFAS No. 141, Business Combinations and EITF 88-16, Basis in Leverage Buyout Transactions.

**A/C 30125 - Contributed Capital**  
Include donated capital to the Contractor. Describe the nature of the donation as well as any restrictions on this capital in the notes to financial statements.

**A/C 30130 - Restricted Net Assets**  
Include Net Assets restricted for any purpose.

**A/C 30135 - Reserved for Future Use**

**A/C 30140-1 Retained Earnings/Net Assets (Liabilities)**  
Include the undistributed and unappropriated amount of earned surplus. Beginning retained earnings balance for a new fiscal year should agree to the ending retained earnings balance from the previous fiscal year and should remain constant during the fiscal year.

- **30140-5** *Net Income/ (Loss) YTD* – must agree with the YTD Statement of Revenue and Expenses without rounding.
- **30140-10** *Unrealized Gains/ (Loss)* – report unrealized gains or losses in this line.
- **30140-15** *Transfer In/Out* – report amounts transferred in/out (Government Entities) and equity distributions in this line.
- **30140-20** *Reserved for Future Use*
3.05 Statement of Revenues and Expenses

See Appendix C-2 for an example of this report

REVENUES

A/C40105 - Prospective Capitation
Include: Revenue recognized on a prepaid basis from AHCCCS for provision of prospective health care services for AHCCCS eligible acute care members.

Exclude: All other capitation, such as CRS, DES/DDD, ALTCS, MAPD, and PPC.

A/C 40110 - PPC Capitation
Include: Revenue recognized from AHCCCS for the provision of prior period coverage health care services for AHCCCS eligible acute care members.

Exclude: All prospective, DES/DDD, or ALTCS capitation.

A/C 40115 - Alternative Payment Model Initiatives Reconciliation/Settlement
Include: Settlements from AHCCCS for Alternative Payment Model Initiatives previously Payment Reform Initiatives/Shared Savings Arrangements. The related balance sheet amounts should be recorded in A/C 10125 and/or A/C 20125.

A/C 40120 - Delivery Supplement
Include: Delivery supplement revenue earned as of the statement date.

A/C 40125 – Adults >106% Reconciliation Settlement
Include: Adults >106% reconciliation settlement amounts. Estimated reconciliation settlement amounts should be accrued in the period they are earned.

A/C 40130 - Prospective Tiered Reconciliation Settlement
Include: All prospective tiered reconciliation settlement amounts. Estimated prospective tiered reconciliation settlement amounts should be accrued in the period that they are earned. Any adjustments to prior contract years need to be disclosed on the Prior Contract Year Adjustment Report. See Prior Contract Year Adjustment Report (Paragraph 4.12) for the required detail on this item. Also, in the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements (Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

A/C 40140 - PPC Settlement
Include: Prior Period Coverage (PPC) reconciliation settlement amounts. Estimated PPC reconciliation settlement amounts should be accrued in
the period that they are earned. Any adjustments to prior contract years need to be disclosed on the Prior Contract Year Adjustment Report. See Prior Contract Year Adjustment Report (Paragraph 4.12) for the required detail on this item. Also, in the event that a Contractor determines no accrual is necessary, an explanation is required within the Footnote Disclosure Requirements (Paragraph 3.06) and must include the methodology used to determine no accrual was necessary.

**A/C 40145 - PCP Parity Cost Settlement**
Include: Cost-settlement payments from AHCCCS related to the PCP Parity payment program.

**A/C 40160 - Health Insurance Providers Fee Revenue**
Include: An accrual for the revenue that will be paid to the Contractor from AHCCCS to cover the Health Insurance Providers Fee.

**A/C 40305 - Investment Income**
Include: All investment income earned during the period. Interest income and interest expense should not be netted together.

**A/C 40310 - Other Income (Specify)**
Include: Revenue from sources not identified in the other revenue categories.

**EXPENSES** All expenses must be reported net of Medicare/TPL reimbursement and net of quick pay discounts.

**Hospitalization Expenses** include only those expenses for Inpatient hospital services.

**A/C 50105 - Hospital Inpatient**
Include: All contracted or fee for service expenses for hospital inpatient services, including room, board, and ancillary expenses.
Exclude: Any prior period coverage hospital expenses.

**A/C 50110 - Hospital Inpatient - Behavioral Health Services**
Include: All contracted or fee for service expenses for hospital inpatient services, including room, board, and ancillary expenses, for behavioral health services.

**A/C 50115 - PPC – Hospital Inpatient**
Include: All contracted or fee for service expenses related to prior period coverage hospital inpatient services.
Exclude: Prospective hospital inpatient expenses.
**Medical Compensation Expenses** include compensation paid for physician and non-physician services. Expenses should include all contracted, non-contracted, fee for service and sub-capitated expenses.

**A/C50205 - Primary Care Physician Services**
Include: Those expenses for primary care delivery and other practitioners, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This also includes urgent care facility expenses.

Exclude: Any prior period coverage medical compensation expenses. PCP Parity Enhanced Payment Expense.

**A/C 50210 - Behavioral Health Physician Services**
Include: Those expenses for physician services related to Behavioral Health services.

Exclude: The amounts related to the enhanced PCP parity payments, amounts related to the enhanced PCP parity should be reported under A/C 50235.

**A/C 50215 - Referral Physician Services**
Include: Those expenses for referral (specialist) physician services.

**A/C 50220 - PH FQHC/RHC Services**
Include: FQHC/RHC services should be recorded to this line if the services meet the definition of a visit or are incidental to the visit.

**A/C 50225 - Other Professional Services**
Include: All other professional services not specifically identified in one of the categories defined above.

**A/C 50230 - PPC – Physician Services**
Include: All expenses related to prior period coverage medical compensation services (i.e., PCP, referral physician, and other professional services).

Exclude: Prospective physician services expenses.

**A/C 50235 - PCP Parity Enhanced Payment Expense**
Include: Enhanced payment amount to a Physician, for example if the payment to the Physician is $20, $5 of which is for PCP Parity Enhanced Payment, the amount reported under A/C 50235 is $5, the remaining $15 is reported under A/C 50205.

**Other Medical Expenses** include services provided to members on an outpatient basis. Services include emergency services, pharmacy, lab, radiology, etc. Expenses should include all contracted, non-contracted, fee for service and sub-capitated expenses for these services.
A/C 50305 - Emergency Facility Services
Include: Those expenses relating to emergency room services provided on an outpatient basis.

A/C 50310-1 PH Pharmacy
Include: Pharmacy expenses incurred for outpatient services.
Exclude: Pharmacy expenses incurred for dental and PBM non-encounterable components.

A/C 50310-5 PH Pharmacy Rebates
Include: Amounts related to pharmacy rebates.

A/C 50315 - Laboratory, Radiology and Medical Imaging
Include: Pathology, Laboratory and radiology (medical imaging, x-ray) expenses incurred for outpatient services.

A/C 50320 - Outpatient Facility
Include: Outpatient facility expenses incurred for outpatient services.
Exclude: Physician expense for surgery (this should be included in A/C 50215 above).

A/C 50325 - Durable Medical Equipment
Include: Medical equipment, medical supplies, medical appliances and oxygen expenses incurred for outpatient services.

A/C 50330 - Dental
Include: Dental expenses incurred for outpatient services, including outpatient surgery, pharmacy, lab, and radiology specifically related to a dental diagnosis.

A/C 50335 - Transportation
Include: Transportation expenses incurred for inpatient and outpatient services, both emergency and non-emergency.

A/C 50340-00 Nursing Facility, Home Health Care
Include: Expenses relating to nursing facility (NF) and home health care including durable medical equipment expense incurred in a NF or home health care setting. Examples include: Intermediate Care Facility and Skilled Nursing Facility.

A/C 50345 - Therapies
Include: Expenses include rehabilitation therapies (occupational, physical, and speech) and respiratory therapy incurred for outpatient services.
**A/C 50350 - Alternative Payment Model Performance Based Payments to Providers**
Include: Expenses (disbursements/recoupments to/from providers) related to the Alternative Payment Model (APM) (formerly Value Based Purchasing) with providers as defined in the definition section of this guide. Expenses should be recorded in the period in which they occurred or were earned. The related balance sheet amounts should be recorded in A/C 10140, A/C 20130, and/or A/C 20215.

**A/C 50355-1 Behavioral Health Day Program**
Include: Medical, home and community expenses incurred for services provided to members in a Behavioral Health Day Program including supervised day program, therapeutic day program, and medical day program.

**A/C 50355-5 Behavioral Health Case Management Services**
Include: Case management expenses related to behavioral health services, including salaries, benefits, travel, and training expenses for the case manager(s), and case management supervisors.

**A/C 50355-10 Behavioral Health Crisis Intervention Services**
Include: Expenses incurred for Crisis Intervention Services provided to members including mobile, stabilization, and telephone.

**A/C 50355-15 Behavioral Health Rehabilitation Services**
Include: Expenses incurred for Rehabilitation Services provided to members including living skills training, Cognitive Rehab, Health Promotion, and Supported Employment Services.

**A/C 50355-20 Behavioral Health Residential Services**
Include: Expenses incurred for Residential Services provided to members including Level II and Level III Behavioral Health Residential Facility Room and Board.

**A/C 50355-25 All Other Behavioral Health Services**
Include: Miscellaneous support services incurred for All Other Behavioral Health Services provided to members. This includes personal care services, family support, peer support, home care training to home care client, unskilled respite care, and supported housing.

**A/C 50360 - PPC – Other Medical Expenses**
Include: Outpatient expenses incurred for services provided to members in the prior period coverage period.

**A/C 50370 - Other Medical Expenses**
Include: Outpatient expenses not specifically identified in one of the categories defined above.
A/C 70105 - Reinsurance
Include: Reinsurance earned, billed and unbilled, as of the statement date. See discussion in Paragraph 5.02.
NOTE: AHCCCS treats the reinsurance revenue account as a contra-expense account.

A/C 70205 - Third Party Liability
Include: Revenue from settlement of accident claims or other third party sources.
NOTE: AHCCCS treats the TPL revenue account as a contra-expense account.

NOTE: A/C’s 70105 and 70205 should be reported as negative numbers, to allow the Financial Statement Reporting Template to properly net the amounts out of medical expense.

Administrative Expenses are those costs associated with the overall management and operation of the Contractor. All administrative expenses must be allowable, reasonable and appropriately reported by funding source/risk group in the pre-defined administrative expense lines. Management fees must be separately identified and reported in the pre-defined administrative expense lines as well. In addition, management fees may not be increased without prior written approval from AHCCCS. Expenses related to the pre-defined administrative expense lines should not be reported under A/C 81405, Other Administrative Expenses.

A/C 80105 - Compensation
Include: All forms of compensation, including employee benefits and taxes, to administrative personnel. This includes medical director compensation, whether on salary or contract.

A/C 80205 - Occupancy
Include: Occupancy expenses incurred, such as rent and utilities, on facilities that are not used to deliver health care services to members.

A/C 80305 - Depreciation
Include: Depreciation on those assets that are not used to deliver health care services to members.

A/C 80405 - Care Management/Care Coordination
Include: Care Managers expenses incurred for activities performed as defined in Contract and AMPM 1020.

A/C 80505 – Professional and Outside Services
Include: Fees and expenses of professional consultants and others for general services such as accounting, auditing, actuarial and legal.

A/C 80605 – Office Supplies and Equipment
Include: Expenses for office supplies and equipment used for normal business operations.
A/C 80705 – Travel
Include: Expenses for transportation, meals, lodging and other travel-related expenses incurred by employees who are in travel status on official business.

A/C 80805 - Repair and Maintenance
Include: Expenses incurred to restore an asset to a previous operating condition or to keep an asset in its current operating condition.

A/C 80905 – Bank Service Charge
Include: Any charges and fees assessed by the bank.

A/C 81005 – Insurance
Include: Expenses related to insurance.

Exclude: Reinsurance premiums. Report these expenses under A/C 81605, Other Administrative Expenses.

A/C 81105 - Marketing
Include: Expenses related to any form of exchange whereby the intent is to promote or increase the membership of the Contractor.

A/C 81205 - Interest Expense
Include: Interest expense incurred on outstanding debt and interest paid to providers on late claims during the period. Interest income and interest expense should not be netted together.

A/C 81305 – Pharmacy Benefit Manager Expenses
Include: Expenses for pharmacy network management, pharmacy discount negotiating, drug utilization review, coordination of specialty drugs, pharmacy claims processing, pharmacy call center operations and other PBM-related costs.

A/C 83005 - Other Administrative Expenses
Include: Administrative expenses not specifically identified in the categories above.

A/C 89999 - Profit (Loss) from Non-Operating
Include: Gains and losses on sale of investments and fixed assets during the period and any other non-operating income or loss.

A/C 90105 - Income Taxes
Include: Provision for income taxes for the period, including taxes associated with the Health Insurance Providers Fee.
A/C 90205 - Premium Taxes
Include: Provision for premium taxes for the period.

A/C 90305 - Health Insurance Providers Fee
Include: Provision for Health Insurance Providers Fee for the period. In accordance with FASB 720-50-25-1, the liability related to the annual fee shall be estimated and recorded in full once the entity provides qualifying health insurance for health insurers in the applicable calendar year in which the fee is payable. The liability for the Health Insurance Providers Fee should be fully recognized by the end of the contract year. Therefore, Contractors should begin recognizing 1/9th of the liability in January.

Exclude: Taxes associated with the Health Insurance Providers Fee.

3.06 Footnote Disclosure Requirements

Footnote disclosures are required in order to supplement AHCCCS’ understanding of the financial statements and supplemental schedules. The following list represents minimum expected disclosures and is not intended to be all-inclusive. Disclosures required by GAAP or GASB should also be included. If the disclosure does not apply, indicate so by writing "None" or "Not Applicable (N/A)" next to the numbered footnote.

1) Organizational Structure:

Discuss the organization structure, location of its headquarters, and a brief summary of the operations of the Contractor.

2) Summary of Significant Accounting Policies:

Discuss accounting policies relating to significant balance sheet line items such as, but not limited to, cash and cash equivalents, investments and medical claims payable. Specifically, the medical claims payable policy should discuss the methodology used in calculating IBNR balances.

On an annual basis with the quarter ending December submission, or in the event of a change, discuss the expense allocation methodology by geographic service area, risk group and the inclusion of any new geographic service areas.

Discuss revenue and expense recognition policies for the following:
- Capitation revenue; Delivery Supplement revenue; Reconciliation Settlements
- Reinsurance revenue
- Other revenue
- Medical expenses
- Administrative expenses
- Alternative Payment Model Initiatives
- Health Insurance Providers Fee and related tax
• Federal and State Income Tax

Discuss any changes in accounting methodologies which have taken place during the current contract year.

3) Other Amounts:

Describe material amounts included in the "other" and "miscellaneous" categories in the Balance Sheet and Statement of Revenues and Expenses. Material amounts are considered greater than 10% of the related total category (i.e., assets, liabilities, revenues, and total other medical expenses). For administrative expenses, material amounts are considered to be greater than 5% of total administrative expenses.

4) Pledges/Assignments and Guarantees:

Describe any pledges, assignments, or collateralized assets and any guaranteed liabilities not disclosed on the balance sheet.

5) Performance Bond:

Disclose the method by which the Contractor satisfied the AHCCCS performance bond requirement for the quarter. This disclosure is required whether or not the amounts are included in the financial statements.

6) Material Adjustments:

Disclose and describe any material adjustments made during the current reporting period. Include those adjustments that may relate to a prior period, specifically IBNR adjustments, that affect the financial statements and provide detail for which period(s) the adjustment(s) relate.

7) Medical Claims Payable Analysis:

Explain large fluctuations and/or revisions in estimates and the factors that contributed to the change in the Medical Claims Payable balances from the prior quarter. Specifically, address changes of more than 10% (on per member per month basis). Explanations should detail the amount of the adjustments by quarter and by risk group.

8) Contingent Liabilities:

Provide details of any malpractice or other claims asserted against the Contractor, as well as the status of the case, potential financial exposure and expected resolution.
9) **Investments:**

Long-term investments that may be liquidated without significant penalty within 24 hours, which the Contractor would like treated as current assets for calculation of the current ratio, must be disclosed in the footnotes. Descriptions and amounts should be disclosed and should include indication of whether or not the investments are restricted or unrestricted. (Note that significant penalty in this instance is any penalty greater than 20%). Also disclose the amount of Unrealized Gains or Losses reported on the financial statements associated with these investments.

10) **Due from/to Affiliates (Current and Non-current):**

Describe, in detail, the composition of the due to/from affiliates including the name of the affiliate, a description of the affiliation, amount due to/from the affiliate and a description of any significant changes to the line item.

11) **Equity Activity:**

Disclose all activity in equity, other than net income or net loss.

12) **Non-Compliance with Financial Viability Standards and Performance Guidelines:**

Disclose any non-compliance with Financial Viability Standards and Performance Guidelines, the factors causing the non-compliance and the plan of action to resolve the issue(s), including specifying the expected month that the compliance will be evidenced in the financial statements. Please show the calculations in the footnote.

13) **Changes in Financial Statement Line Items:**

Describe changes in balance sheet asset items if the current or previous quarter amount is equal to or greater than +/-5% of the Total Assets for that quarter and if the change from the prior quarter amount is equal to or greater than +/-5%.

Describe changes in balance sheet liability line items if the current or previous quarter amount is equal to or greater than +/-5% of the Total Liabilities (for that quarter and if the change from the prior quarter is equal to or greater than +/-5%).

Describe changes in balance sheet Equity/Net Assets line items if the current or previous quarter amount is equal to or greater than +/-5% of the Equity/Net Assets for that quarter and if the change from the prior quarter amount is equal to or greater than +/-5%.

Balance Sheet changes should be calculated on a dollar basis.

Describe changes in Statement of Revenue and Expense items if the current or previous quarter amount is equal to or greater than +/-5% of Total Revenues and if the change from the prior quarter amount is equal to or greater than +/-5%.
The first quarter in a Contractor’s fiscal year should be compared to the fourth quarter in the previous fiscal year versus the final audit report.

The Statement of Revenue and Expense percentages will be calculated using two separate calculations.

The percentage change quarter over quarter for Statement of Revenue and Expense line items should be calculated using PMPM amounts.

When calculating the individual line item amount as a percent of Total Revenue use whole dollars.

The following example demonstrates that no explanation of variance is required.

<table>
<thead>
<tr>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Member Months</td>
</tr>
<tr>
<td>Total Revenue</td>
</tr>
<tr>
<td>Outpatient Facility Expense</td>
</tr>
</tbody>
</table>

| | QE03/31/xx | QE06/30/xx | PMPM% Change | % of Revenue |
| Outpatient Facility | $15,000 | $15,200 | 1% | 6% |

14) **Drug Rebates/Discounts**

Provide the amount of drug rebates or discounts received that the Contractor has recorded for the reporting period (A/C 50310). Indicate whether or not the drug rebates are either included in or excluded from the Lag Report for Medical Claims Payable.

In addition, provide a written statement confirming that rebates do not include drugs that are listed in the AHCCCS Rebate Program.

15) **Interest on Late Claims**

Report interest payments made to providers on late claims. This amount should tie to the interest as reported in the Claims Dashboard for the same reporting period.

16) **Accrued Sanctions**

Report any accrued sanctions assessed by AHCCCS, the year-to-date amount of the accrual and the Income Statement line item in which they are included.
17) **Provider Incentives**

Report the amount of provider incentives reported for the period. Indicate the Income Statement line number and risk group in the financial statements where these are reported.

18) **Alternative Payment Model Initiatives**

Report the total amounts by contract year (current year and previous two years) of any APM (formerly known as value based purchasing) arrangements included in the financial statements. The total amount per contract year should include actual dollars paid plus adjustments and accruals. Exclude amounts related to AHCCCS quality reconciliations.

19) **Non-Covered Services**

Report the type and amount of any non-covered service included in the financial statements. Indicate the line number and risk groups in the financial statements where these are reported.

20) **Risk Adjustment**

Provide the amount of risk adjustment for the reporting period. Indicate the line number on the Statement of Revenue and Expenses where these are reported and include the detail by risk group.

21) **Prior Contract Year / Period Adjustments**

Provide the amount reported on the Prior Contract Year Adjustments Schedule related to a prior contract year(s) and a detailed explanation for the adjustment(s).

Disclose and describe any material prior period adjustment(s) which is equal to or greater than 10% of total revenues or total expenses and is related to a prior quarter within the current contract year.

22) **Non-Capped Newborn Costs**

Where applicable, disclose all medical costs incurred in the quarter, for dates of services from the date of birth to the day before a tardy notification which are considered non-capped expenses.

23) **Premium Deficiency Reserve**

Include the cumulative amount of the reserve as well as the current quarter amount and all line items included in the current quarter entry.
24) **Medical Loss Ratio Components**

Additional reporting information will be provided.

25) **Access to Professional Services Initiative (APSI)**

Separately disclose APSI-related prospective and PPC revenue and expenditure amounts. Identify the expense lines in the Statement of Revenue and Expense Report where APSI is reported.

26) **Management Fees**

Disclose the quarterly amount expended for Management Fees and indicate whether the fee percentage increased during the quarter.
4.00 SUPPLEMENTAL REPORTS

See Appendix E for examples of supplemental reports.

4.01 Reserved for Future Use

This paragraph is reserved for future use.

4.02 Capitation, Supplement, and Risk Adjustment Receivables

List the amounts, by type, that are included in the Balance Sheet – A/C 10115. Amounts related to Capitation, Delivery Supplement and Risk Adjustment should be detailed out by contract year if applicable.

4.03 Receivables/Payables Report

List the amounts, by type, that are included in the Balance Sheet – A/C 10125 and A/C 20125. Amounts related to PPC, Prospective Tiered, Adults >106%, and PCP Parity reconciliations/cost settlements (both receivables and payables where applicable) should be detailed by contract year.

4.04 Other Assets Report

Include all other assets (current and non-current) in the appropriate categories provided. List all individual assets greater than 10% of total other assets separately and list the total of others not individually greater than 10%. The ending balances for current assets should agree to A/C 10145 and non-current assets to A/C 10225 of the Balance Sheet.

4.05 Other Liabilities Report

Include all other liabilities (current and non-current) in the appropriate categories provided. List all Alternative Payment Model (formerly known as Value Based Purchasing) Initiative amounts and individual liabilities greater than 10% of total other liabilities separately, and list the total of others not individually greater than 10%. The ending balances for current liabilities should agree to A/C 20145 and non-current liabilities to A/C 20215 of the Balance Sheet.

4.06 Alternative Payment Model Performance Based Payment Report

List the amounts that are included in the Balance Sheet – A/C 10140 and A/C 20130 and A/C 20215. Information should be detailed by provider and by contract year.
4.07 Lag Report for Medical Claims Payable

A claim liability is established when an event occurs that creates an obligation to pay benefits, but complete payment has not yet been made as of the reporting date. Lag Reports are used to track historical payment patterns and an integral part of the methodology to calculate the liability. If the Lag Report is not the primary methodology, the Contractor should use lag information as a validation test for accruals calculated using other methods. The instructions below apply to the Hospitalization Lag, Medical Compensation Lag, and Other Lag report in total.

The schedule is arranged with dates of service horizontally and quarter of payment vertically. Therefore, payments made during the current quarter for services rendered during the current quarter are reported on row 1, column 2, while payments made during the current quarter for services rendered in prior quarters are reported on row 1, columns 3 through 8. Do not include sub-capitation payments in this schedule.

Expense reported in the current period on the Lag Report should equal the expenses reported in the Statement of Revenues and Expenses less the expenses reported in the sub-capitated expense report by hospital, medical compensation, and other in total. The remaining balance on all Lag Reports should agree to the Medical Claims Payable total as reported on the Balance Sheet.

The schedule allows for the inclusion of an adjustment (e.g., for provider refunds, lag schedule adjustments) amount to the lag schedule. A general explanation of any adjustments should be included in the footnotes as well as additional detail if any adjustment is greater than 10% of total medical claims payable.

4.08 Long-term Debt (Other than Affiliates) Report

List all loans, notes payable and capital lease obligations by lender as well as by current and long-term portions of outstanding principle at the end of the quarter (exclude debt to affiliates, this is to be reported on the Due (to) from Affiliates line). The totals should equal the amounts reported on the Balance Sheet – A/C’s 20135 and 20205.

4.09 Analysis of Profitability by Risk Group Report

This report provides an analysis of revenues and expenses by GSA by major risk group classification. This report is also used in capitation rate setting. A report is to be completed for each GSA in which the Contractor operates, and in total. The instructions for the Statement of Revenues and Expenses are to be utilized in defining line items on this report. The sum totals of all line items for all counties should equal the Statement of Revenues and Expenses.
Investment Income and Total Administration expense are to be allocated to the risk groups.

4.10 Sub-capitated Expenses Report

This report is a summary of sub-capitation expenses, by risk group, by individual expense line item. Only list the accounts in this report that have sub-capitation expenses. Sub-capitated expenses SHOULD NOT be reported for A/C 50350 Alternative Payment Model Performance Based Payments to Providers. This information assists in calculating any reconciliation and is used in capitation rate setting. Effective for all Contractors with fiscal years ending on or subsequent to September 30, 2016, an Independent Auditor’s Attestation is required for the sub-capitated expenses report as part of the draft and final audit. For MLR calculation purposes, the portion of the sub-capitation payment that is explicitly attributable to the provision of administrative services by the provider should be excluded from the calculation of the MLR Report and reported in Footnote #24.

Exclude from sub-capitation expense, PCP Parity Enhanced Payments as reported under A/C 50235. For example if the payment to a sub-capitated Physician is $20, $5 of which is for PCP Parity Enhanced Payment, the amount reported on the Sub-capitated expense report is $15.

4.11 Block Purchases Expense Report

This report is a summary of block purchases expenses, by risk group, by individual expense line item. Only list amounts in this report for expenses that have block purchasing arrangements. This information assists in calculating any reconciliation and is used in capitation rate setting.

Exclude from block purchases expense, PCP Parity Enhanced Payments as reported under A/C 50235. For example if the block purchase payment to a Physician is $20, $5 of which is for PCP Parity Enhanced Payment, the amount reported on the block purchases expense report is $15.

4.12 Prior Contract Year Adjustment Schedules

This report is intended to be a summary of material adjustments that apply to prior contract years. Please list all balance sheet and income statement adjustments on the appropriate line. All IBNR and Reinsurance adjustments need to be broken out by AHCCCS contract year on this schedule. All other material adjustments need to be broken out if a financial statement line that is greater than 10% of total assets (for all assets), total liabilities (for all liabilities), or total revenue (for all revenue and expenses) and the change is greater than 10% over the previous quarter. The adjustments need to be broken out between the current AHCCCS contract year and previous AHCCCS contract years.
4.13 FQHC/RHC Member Months

List the quarterly member month information by category (i.e., Categorical by SSI, Categorical Linked Expansion, Federal Non-Categorical Linked Expansion, and Federal Non-Categorical Linked Conversion, SCHIP) for each FQHC/RHC. Effective October 1, 2009, Title XXI (Kids Care) member months should be reported in the appropriate column. Any member assigned to the FQHC/RHC on the 1st day of the month should be counted as one member month. Partial months will not be counted. Exclude State Only transplant member months. Please ensure to use the most current schedule Appendix E-9.

Contractors are responsible for maintaining a detailed listing, by month, of members receiving services. Listing should include member name, AHCCCS ID#, primary care physician, Provider Type code, FQHC/RHC assigned, FQHC/RHC AHCCCS Provider Id, rate code at date of service, and amounts paid. This list may be subject to AHCCCS review. The listing should not be submitted with the quarterly FQHC/RHC Report. It should be maintained internally and provided upon request.

4.14 Consolidated or Parent Company Financial Statements (if applicable)

Contractors that are a wholly owned subsidiary of another organization must submit quarterly unaudited financial information of the parent or sponsoring organization (balance sheet and statement of revenues and expenses only).

4.15 Related Party Transaction Reports

Related Party Transaction statements must be submitted to AHCCCS 120 days after year-end. See the AHCCCS website for links to the templates for these reports (https://www.azahcccs.gov/Resources/Contractor/Manuals/financialReporting.html).

4.16 Annual Reconciliation

In addition to the annual audited financial statements, a reconciliation of the Contractor’s final year-to-date quarterly financial statements to the draft annual audited statements must be submitted with the draft audited statements. This reconciliation schedule must also be submitted with the final audited statements. No new account classifications should be added, see your Financial Consultant for technical assistance.

Any footnotes or supplemental schedules that are impacted by draft or final audit adjustments must be resubmitted to agree to the audited amounts in the draft and final audit and resubmitted with these reports. See Appendix F for an example of the annual audit reconciliation report.
4.17 Parent Company Annual Audit Report (if applicable)

Contractors that are wholly owned subsidiaries must submit audited financial statements of the parent or sponsoring organization no later than 120 days after the parent company's fiscal year end.

5.00 ACCOUNTING AND REPORTING ISSUES

5.01 Medical Claims Liability (Including Claim Estimations RBUCs and IBNRs)

There are three primary components of claims expense:

- Paid claims,
- Received but unpaid claims (RBUCs). A claim is considered an RBUC immediately upon receipt by the Contractor and should be tracked as such. The processing status of an RBUC is either pended, in process or payable, and
- Incurred but not reported claims (IBNRs).

The first two components of claims expense are readily identifiable as part of the basic accounting systems utilized by the Contractors. Since these components, along with a well-established prior authorization and referral system, form the basis for estimation of IBNRs, it is important that Contractors have adequate claims accrual and payment systems. These systems must be capable of reporting claims on an incurred or date of service basis, have the capacity to highlight large outlier cases, possess sufficient internal controls to prevent and detect payment errors, and conform to regular payment patterns. Once IBNR estimates have been established, it is imperative that the Contractors continually monitor them with reference to paid claims.

Claims expense cannot be properly evaluated without adequate consideration of current trends and conditions. The following summarizes claims environment factors that should be considered:

- Changes in policy, practice, or coverage
- Fluctuations in enrollment by rate code category
- Expected inflationary trends
- Trends in claims lag time
- Trends in the length of hospital inpatient stay by rate code category
- Changes in rate code case mix
- Changes in contractual agreements

Elements of an IBNR System
IBNRs are difficult to estimate because the quantity of service and exact service cost are not always known until claims are actually received. Since medical claims are the major expenses incurred by AHCCCS Contractors, it is extremely important to
accurately identify costs for outstanding unbilled services. To accomplish this, a reliable claims system and a logical IBNR methodology are required.

Selection of the most appropriate system for estimating IBNR claims expense requires judgment based on a Contractor's own circumstances, characteristics, and the availability and reliability of various data sources. Using a primary estimation methodology, along with supplementary analysis, usually produces the most accurate IBNR estimates. Other common elements needed for a successful IBNR system are:

1. An IBNR system must function as part of the overall financial management and claims system. These systems combine to collect, analyze, and share claims data. They require effective referral, prior authorization, utilization review and discharge planning functions. Also, the Contractor must have a full accrual accounting system. Full accrual accounting systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to the Contractor’s members.

2. An effective IBNR system requires the development of reliable lag tables that identify the length of time between provision of service, receipt of claims, and processing and payment of claims by major provider type (hospital, medical compensation and other medical). Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficient, accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification, on a pro-forma basis, to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e., paid claims).

3. Accurate, complete, and timely claims data should be monitored, collected, compiled, and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e., prior authorization records). Prior authorization data together with claims data and other relevant information should be used to identify claims liabilities.

4. Claims data should also be segregated to permit analysis by major rate code, county, major provider, and category of service.

5. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine a Contractor’s IBNR methodology if applicable.

There are several different methods that may be used to determine the IBNR amount. Examples include, but are not limited to, Case Basis, Average Cost and Lag Tables (see below). The Contractor should employ the one that best meets its needs and
accurately estimates its IBNR. The IBNR methodology used by the Contractor must be evaluated by their independent Certified Public Accountant or actuary for reasonableness. A description of the process should also be included in the footnotes to the financial statements under the Summary of Significant Accounting Policies.

Case Basis Method
Accruals are based on estimates of individual claims/episodes. This method is generally used for those types of claims where the amount of the cost will be large, requiring prior authorization. The final estimated cost can be made after the services have been authorized by the Contractor. For example, if a Contractor knows how many hospital days were authorized for a certain time period, and can incorporate the contracted reimbursement arrangement(s) with the hospital(s), a reasonable estimate should be attainable. This is also the most common and can be the most accurate method for small and medium sized organizations.

Average Cost Method
As the name suggests, average costs of services are used to estimate total expense. The expenses estimated using average costs are then reduced by claims that have been paid or claims that have been received but are unpaid (RBUCs). There are two primary average cost methods which are discussed below. It is important to note that each method may be used by a Contractor to estimate different categories of IBNRs (i.e., hospitalization vs. all other medical).

Per Member Per Month (PMPM) Averages
Under this method the average costs are based on the population rate for each risk group over a given time period. The average cost may cover one or more service categories and is multiplied by the number of members in the specific population to estimate the total expense of the service category. Any claims paid and RBUCs for the service category are subtracted from the expense estimate which results in the IBNR liability estimate for that service category.

Per Diem or Per Service Averages
Averages for this method are of specific occurrences known by the Contractor at the time of the estimation. Therefore, it is first necessary to know how many hospital days, procedures or visits were authorized as of the date for which the IBNR is being estimated. Again, once the total expense has been estimated, the amount of related paid claims and RBUCs should be subtracted to get to the IBNR liability. This method is primarily used for hospitalization IBNRs as Contractors generally know the number of hospital days authorized at any given time.

If the Contractor is considering a method different from that previously described, a written description of the process must be submitted to AHCCCS for approval prior to its use.
5.02 Reinsurance

Reinsurance provides reimbursement to the Contractors when extraordinary costs associated with a member are incurred during a contract year. Specific deductible amounts and reimbursement rates are in the Acute Care Contract between AHCCCS and the Contractors.

Reinsurance receivable should include all expected reinsurance from AHCCCS, billed and unbilled.

5.03 Related Parties/Affiliates

AHCCCS monitors the existence of related party transactions in order to determine if any significant conflicts of interest exist in the Contractor's ability to meet AHCCCS objectives. A related party or affiliate may be defined as anyone who has the power to control or significantly influence the Contractor or be controlled or significantly influenced by the Contractor. Accordingly, subsidiaries, parent companies, sister companies, and entities accounted for by the equity method are considered related parties, as are principal owners, Board of Director members, management, and their immediate families, and other entities controlled or managed by any of the previously listed entities or persons, including management companies. Related party transactions include all transactions between the Contractor and such related parties, regardless of whether they are conducted in an arm's length manner or are not reflected in the accounting records (e.g., the provision of services without charge or guarantees of outstanding debt).

Transactions with related parties may or may not be in the normal course of business. In the normal course of business, there may be numerous routine and recurring transactions with parties who meet the definition of a related party. Although each party may be appropriately pursuing its respective best interest, transactions between them must be disclosed and reviewed for reasonableness.

5.04 Financial Viability Standards and Performance Guidelines

The Contractor must comply with the AHCCCS-established financial viability standards. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: Current Ratio; Equity per Member; Contract Year to Date Medical Expense Ratio; and the Contract Year to Date Administrative Cost Percentage. On an annual basis, AHCCCS will review the Medical Loss Ratio.

Sanctions may be imposed if the Contractor does not meet these financial viability standards. If a critical combination of the Financial Viability Standards is not met, or if the Contractor’s experience differs significantly from other Contractors, additional monitoring, such as monthly reporting, may be required.
FINANCIAL VIABILITY STANDARDS

**Current Ratio**
Current assets divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 24 hours without significant penalty (i.e., greater than 20%).

*Standard: At least 1.00*

If current assets include a receivable from a parent company, the parent company must have liquid assets that support the amount of the inter-company loan.

**Equity per Member**
Unrestricted equity, less on-balance sheet performance bond, divided by the number of members enrolled at the end of the period. For this calculation use members as reported on the first day of the month following the end of the quarter (i.e. for quarter ending March 31, xx use April 1st enrollment) at the following link: [https://www.azahcccs.gov/Resources/Reports/providerpopreport.html](https://www.azahcccs.gov/Resources/Reports/providerpopreport.html)

*Use report titled Enrollment by Health Plan by County.*

*Standard: At least $170 for Contractors with enrollment < 100,000
$115 for Contractors with enrollment of 100,000+*

Additional information regarding the Equity per Member requirement may be found in the *Performance Bond and Equity per Member Requirements* policy in the ACOM.

**Contract YTD Medical Expense Ratio**
Total medical expenses +TPL (line #70205) divided by the sum of total Prospective and PPC capitation (lines #40105 & 40110) + Alternative Payment Model Initiatives Reconciliation/Settlement (line #40115) + Delivery Supplement (line #40120) + Adults >106% (line #40125) + Prospective Tiered Recon Settlement (line #40130) + PPC Settlement (line #40140) + PCP Parity Cost Settlement (line #40145) - Reinsurance (line #70105) - less premium tax

*Standard: At least 85%
When calculated on a contract year-to-date basis*

**Contract YTD Administrative Cost Percentage**
Total administrative expenses divided by the sum of total Prospective and PPC and capitation (lines # 40105 & 40110) + Alternative Payment Model Initiatives Reconciliation/Settlement (line #40115) + Delivery Supplement (line #40120) + Adults >106% (line #40125) + Prospective Tiered Recon Settlement (line 
#40130) + PPC Settlement (line #40140) + PCP Parity Cost Settlement (line #40145) - Reinsurance (line #70105) less premium tax

*Standard: No more than 10%

*When calculated on a contract-year-to-date basis*

**Medical Loss Ratio**

The numerator includes Incurred Claims, Quality Improvement Expense and Fraud Prevention Activities. The denominator is Premium less Taxes and Fees. A credibility adjustment is added to the overall calculation. This calculation shall be performed annually in accordance with 42 C.F.R 438.8. The Contractor shall provide the required information as outlined in Exhibit 9 of its Contract with AHCCCS.

*Standard: At least 85%

*When calculated on a contract year end basis*
6.00 APPENDICES

**Appendix A:** Certification Statement
**Appendix B:** Financial Statement Reporting Template Audit Report
**Appendix C:** Financial Statements
**Appendix D:** Financial Statement Footnote Disclosures
**Appendix E:** Supplemental Reports
**Appendix F:** Audit Reconciliation Report
**Appendix G:** Related Party Transactions
**Appendix H:** Medical Loss Ratio Reporting Template, Certification and Instructions
7.00 EXHIBITS

Exhibit 1: Sample Footnotes for Quarterly Financial Reports

Paragraph 3.06
Quarter ended MM/DD/YYYY
Footnotes

1. ORGANIZATIONAL STRUCTURE
Organizational Structure
Company ABC (ABC) was established on October 1, 1982, as a division of Company XYZ Health Services Network (XYZ), an Arizona not-for-profit corporation.

Location of Headquarters
Company ABC is located at 123 Main Street in Phoenix, Arizona, and is contracted with AHCCCS to administer acute healthcare services to qualified residents in Maricopa, Pinal, Gila, Apache, Coconino, Mohave, Navajo, Pima, and Yavapai counties.

The Balance Sheet and Statement of Revenues and Expenses reflect only the financial condition and the results of operations of the services provided under the contract with the Arizona Health Care Cost Containment System (“AHCCCS”).

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES
Allocation Methodology for allocating medical expenses to each risk group and geographic service area
Company ABC uses several sources of information for allocating the revenues and expenses on the Profitability by Risk Group by Geographic Service Area Schedule. For capitation revenue and member months, the actual 820 files received by AHCCCS are utilized. For hospital expenses Company ABC utilizes a combination of paid claims and prior authorizations. Company ABC then uses a combination of provider contracts (for sub capitated arrangements), member months and actual paid claims data, updated quarterly for all other medical expense categories.

Cash and Cash Equivalents
The majority of the change between the prior and current quarter is due to the timing of the sweep transfer from the cash concentration account to the cash zero-balance account.

Short-term Investments
All short term investment can be converted to cash within 24 hours

Capitation Revenue
Capitation revenue is recognized when the AHCCCS administration provides information that a member is assigned to the Contractor program on membership rosters.
**Delivery Supplement Revenue**
Delivery supplement revenue is recognized upon a delivery of a child by a member during a prospective enrollment period assigned to the Contractor. This supplemental payment excludes those members who deliver in a prior period coverage time period.

**Prior Period Coverage Settlement**
Monthly, an amount estimated to be due to or due from AHCCCS for prior period coverage members is calculated and reported on the financial statements.

**Reinsurance Receivable**
Contractor reviews claims payments to determine claims that are eligible for reinsurance. These are reported on the financial statements in the amount expected to be collected from AHCCCS.

**Investment Income Receivable**
Income that is earned but not yet received is recognized in the month identified.

**Other Current Assets**
Current portion of fixed assets which are not captured elsewhere on the balance sheet. Any receivables from providers are accounted for on this line and are not netted against IBNRs.

**Long-term Investments**
Long-term Investments are those expected to be held longer than one year. Long-term investments listed in the Investments Report (Paragraph 4.01) are subject to prior approval from AHCCCSA. Currently, Contractor has no long-term securities.

**Property, Plant and Equipment**
Contractor has no Property, Plant, or Equipment.

**Administrative Expenses**
Administrative expenses are recognized monthly as incurred in accordance with Company ABC’s Cost Allocation Plan and as defined by AHCCCS. These costs are indirect cost as they are incurred for the common benefit of multiple direct program service activities and are grouped according to the nature of the cost.

**Medical Claims Payable**
Medical expenses payable are calculated monthly based on historical experience and are reviewed monthly by an outside actuary. Further information regarding the calculation of IBNR balances can be found in the Contractor IBNR policy. All medical expenses payable are reported net of Medicare.

**Received but Unprocessed Claims (RBUC’s)**
Medical claims are logged into the Contractor's claim system when received. Any claims in the claims department that haven't been logged at quarter end are summarized. An estimated amount due for these received but unprocessed claims is reported on the Medical Claims Payable report. Claims that have been processed but for which no check has been issued are also included as well as any unpaid pharmacy invoices for which an invoice has been received.
There are a number of claims for which the claim category (medical, hospital, other) is unknown. These claims are distributed among the different claim categories based on the total accrual for each category with adjustments made to this distribution as appropriate.

The RBUC lag for all unprocessed claims is based on the actual lag between date received and the end of the reporting period. The lag for unpaid pharmacy invoices and processed claims for which no check has been issued is assumed to be "current."

**Taxes**
The Company participates in a tax allocation agreement with Company XYZ and other members of an affiliated group for federal taxes. Within the Company, taxes are allocated to the Acute, Medicare and ALTCS lines of business using the Company’s estimated blended effective rate.

**Membership**
Members are included in the member month calculation for each month, or portion of a month they were enrolled with Contractor. Members who were enrolled less than a month are counted proportionally to the part of the month they were enrolled.

**Medical Expenses**
Medical expenses are accrued in the period that services are rendered and are based, in part, on estimates. The total amount of medical expenses recognized includes actual claims payments, capitation payments, and an estimated amount due for claims that have been received but haven't been processed and an estimated amount due for claims that have been incurred but have not been received. All medical expenses are reported net of Medicare.

**Changes in accounting methodologies**
In 2011, due to the potential change in rebate receipts, rebates were not recorded until rebates were actually received. In Q/E 3/31/12, rebates were accrued monthly based on historical data.

3. **OTHER AMOUNTS**

**Other Income**
The amounts reported for other income consists of the miscellaneous revenue.

**Miscellaneous Medical Expenses**
Non-physician medical expenses and optical expenses are included here.

**Other Administrative Expenses**

**Other Current Assets**
This includes short-term deferred taxes and expected third party liability revenue. These assets are depicted in the Other Assets Report.

**Other Non-Current Assets**
Other Non-Current Assets include Long-term deferred taxes.
Other Current Liabilities
This includes premium taxes due to the Department of Insurance, and estimated sanction accruals.

Other Non-Current Liabilities
There are no amounts for non-current liabilities reported.

4. PLEDGES AND ASSIGNMENTS AND GUARANTEES
Contractor has no pledges, assignments, or collateralized assets. There are also no guaranteed liabilities not disclosed on the balance sheet.

5. PERFORMANCE BOND
Method

Over or Under Funding
The performance bond substitute is the amount required by AHCCCS and is not over or under funded.

6. MATERIAL ADJUSTMENTS
An adjustment was made this quarter per the actuary's recommendations for balance sheet reserves. These adjustments occurred in the normal course of business for the Contractor.

7. MEDICAL CLAIMS PAYABLE ANALYSIS
A. Medical claims payable (A/C 20120) increased $11.6M, or 31.6% over prior quarter. Medical expenses payable are calculated monthly based on historical experience and are reviewed monthly by an outside actuary. Company ABC booked expense and related reserves for Maricopa County based on actuary's review. For inpatient expense, Company ABC recorded expense based on actual referral days expenses by tier by hospital. Company ABC has had enough historical data to calculate balance sheet reserves since May 2006. As such, March's income statement reflects any adjustments made to the reserves.

PMPM comparison quarter to quarter on medical claims payable:

<table>
<thead>
<tr>
<th>Dollar basis:</th>
<th>% Change from Prior Quarter</th>
<th>PMPM basis:</th>
<th>% Change from Prior Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td></td>
<td>21.7%</td>
<td>Inpatient</td>
</tr>
<tr>
<td>Medical Comp</td>
<td></td>
<td>23.4%</td>
<td>Medical Comp</td>
</tr>
<tr>
<td>Other Medical</td>
<td></td>
<td>34.3%</td>
<td>Other Medical</td>
</tr>
<tr>
<td>PPC Total</td>
<td></td>
<td>40.9%</td>
<td>PPC Total</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>31.6%</td>
<td>Total</td>
</tr>
</tbody>
</table>

B. With the beginning of the new contract year in October 2008 and Company ABC’s place in the auto-assign algorithm, the increased member months are driving the majority of the increases in the liabilities on the balance sheet. PPC member months increased 1,813, or 7.9% over prior quarter and prospective member months increased 22,087, or 18.5% over prior quarter. In total, member months increased 16.8% over prior quarter.
Member months increase comparison:

<table>
<thead>
<tr>
<th></th>
<th>Oct-08</th>
<th>Nov-08</th>
<th>Dec-08</th>
<th>Jan-09</th>
<th>Feb-09</th>
<th>Mar-09</th>
<th>Total QE 0812</th>
<th>Total QE 0903</th>
<th>Change from prior quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPC</td>
<td>8,390.1</td>
<td>6,608.1</td>
<td>8,023.1</td>
<td>7,189.8</td>
<td>8,325.8</td>
<td>9,318.8</td>
<td>23,021.3</td>
<td>24,834.4</td>
<td>1,813.1 7.9%</td>
</tr>
<tr>
<td>Prospective</td>
<td>37,135.9</td>
<td>39,744.7</td>
<td>42,290.8</td>
<td>44,307.6</td>
<td>46,813.8</td>
<td>50,096.7</td>
<td>141,131.4</td>
<td>141,218.1</td>
<td>22,086.7 18.5%</td>
</tr>
<tr>
<td>Total</td>
<td>45,526.0</td>
<td>46,352.8</td>
<td>50,324.0</td>
<td>51,497.4</td>
<td>55,139.7</td>
<td>59,415.5</td>
<td>164,152.7</td>
<td>166,052.5</td>
<td>23,899.8 16.8%</td>
</tr>
</tbody>
</table>

8. CONTINGENT LIABILITIES
In the opinion of management, no legal matters exist that would have a material adverse effect on the financial position of Contractor.

9. INVESTMENTS
Contractor has no long-term investments that the Contractor would like treated as current assets for calculation of the current ratio.

10. DUE FROM/TO AFFILIATES (CURRENT AND NON-CURRENT)
There is currently are no amounts due from or due to affiliates.

11. EQUITY ACTIVITY
There are no changes to equity other than the net income or net loss of the Contractor.

12. NON-COMPLIANCE WITH FINANCIAL VIABILITY STANDARDS AND PERFORMANCE GUIDELINES

FINANCIAL VIABILITY STANDARDS - Year to Date
Current Ratio
Insert calculation and indicate whether Contractor meets standard, if not explain.

Equity per Member
Insert calculation and indicate whether Contractor meets standard, if not explain.

PERFORMANCE GUIDELINES
Medical Expense Ratio
Insert calculation and indicate whether Contractor meets standard, if not explain.

Administrative Cost Percentage
Insert calculation and indicate whether Contractor meets standard, if not explain.

13. CHANGES IN FINANCIAL STATEMENT LINE ITEMS

Changes in Financial Statement Line items based on current standards as identified under Section 3.06 Footnote Disclosure Requirements:

A. Cash and cash equivalents (A/C 10105) increased by $17,526,336, or 50% from the previous reporting quarter. This is the result of increased capitation premiums received related to the new contract October 1, 2008 and the Contractor's place in the algorithm. Prospective member
months increased 18.6% and PPC member months increased by 7.9% over prior quarter. The capitation increases were offset by an increase in claims payment volume of $8,885,065 compared to prior quarter.

B. Capitation/Supplement/Reconciliation Receivable (A/C 10115) decreased by $2,065,466, or -19.2% from the previous reporting quarter. The premiums receivable decreased $291,726 due to month-end timing on capitation. PPC reconciliation receivables decreased by $787,563 over prior quarter. Tiered reconciliation receivables decreased by $988,327 in the current quarter due to normal reconciliation activity.

C. Total medical claims payable (A/C 20120) have increased by $11,580,697, or 31.6% over last quarter. Please refer to the detailed analysis in Footnote 7 above for the discussion of the changes within this line item.

D. Prospective Hospitalization IBNR increased by $2,525,000, or 21.75% over the previous quarter. While the claims paid out on average in the current quarter were $264K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in prospective member months in this quarter versus last quarter.

E. Prospective Physicians IBNRs increased by $900,000, or 23.4% over the previous quarter. While the claims paid out on average in the current quarter were $74K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in prospective member months in this quarter versus last quarter.

F. Prospective Other IBNRs increased by $2,627,697, or 34.3% over the previous quarter. While the claims paid out on average in the current quarter were $24K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in prospective member months in this quarter versus last quarter.

G. PPC IBNRs increased by $5,528,000, or 41% over the previous quarter. While the claims paid out on average in the current quarter were $294K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in prospective member months in this quarter versus last quarter.

H. Other current liabilities (A/C 20145) of $4,063,993 increased $1.9M, or 89% over prior quarter with the accrual of the anticipated adjustment for capitation risk scores of $1,854,171 and plan administration accrual of $79,109 in the current quarter.

I. Prospective capitation revenue (A/C 40105) increased $7,876,838, or 22.7% from previous quarter due to the increased member months over prior quarter. $6,444,236 of the total increase is due to the increase in prospective member months of 22,087 over the previous quarter to 141,218. The remainder of the increase is the result of a shift in member mix and as a result, the prospective capitation increased from $291.71 PMPM in the prior quarter to $301.92 PMPM in the current quarter.
J. PPC capitation revenue (A/C 40110) increased $3,807,328, or 27.5% from previous quarter due to the increased member months over prior quarter of 1,813 and a shift in member mix from TANF 1-13 to AHCCCS Care.

K. Delivery supplement revenue (A/C 40120) increased $343,003, or 21.42% from previous quarter due to the increased number of births received for the current quarter. There were 289 births in the current quarter compared to 238 births in the prior quarter.

Insert chart of births by quarter for past six quarters here

L. PPC Settlement revenue (A/C 40140) decreased by $676,653 over the previous quarter. While PPC member mix stayed consistent with prior quarter with the exception of TANF 1-13 and AHCCCS Care, the PPC settlement decreased from -$4.82 PMPM in the prior quarter to -$31.71 PMPM in the current quarter.

M. Inpatient expense (A/C 50105) increased by $1,548,254, or 12.2% from the previous quarter which was due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to the steady increase in prospective member months in this quarter versus last quarter. While the claims paid out on average in the current quarter was $264K higher each week than in previous quarter, the increase in IBNR is in anticipation of the claims that will be processed in the coming months due to the steady increase in prospective member months in this quarter versus last quarter. Prospective average length of stay increased from prior quarter of 3.42 to 3.79 this quarter and inpatient admits increased from 2,953 prior quarter to 3,282 for the current quarter. Inpatient days increased from 10,098 last quarter to 12,247 days for the current quarter.

N. Referral physician expense (A/C 50215) increased by $1,075,475, or 21.6% from the previous quarter which was due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to increased member months in this quarter versus last quarter.

O. Emergency care expenses (A/C 50305) increased by $185,771, or 6.4% from the previous quarter due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to the increase in member months in this quarter versus last quarter.

P. Pharmacy expenses (A/C 50310-1) increased by $1,125,956, or 49% from the previous quarter due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to the increase in member months in this quarter versus last quarter.

Q. PPC other expenses (A/C 50360) increased by 1,176,613, or 66.2% from previous quarter due to the increase in IBNR in anticipation of the claims that will be processed in the coming months due to the increase in member months in this quarter versus last quarter.
14. DRUG REBATES/DISCOUNTS
It is estimated that ABC will receive 2% of pharmacy costs as rebates. At quarter end, $151,631 is estimated to be received. ABC received $29,544.84 in month/year.

15. INTEREST ON LATE CLAIMS
ABC paid $1,407 in Month of Year relating to disputed claims from service date. ABC also paid $2,986 in Month and Year for claims from date of service 07/01/07 to 9/30/07.

16. ACCRUED SANCTIONS
ABC increased its accrual for sanctions by $250,000 during the quarter ended MM/DD/YYYY. These sanctions have not been finalized and are dependent on CYE 9/30/2011 and 9/30/2012 performance standard results. The expense related to these sanctions is included in A/C 83005. Total accrued sanctions of $2,200,000 are included on the balance sheet in A/C 20105.

17. PROVIDER INCENTIVES
ABC paid no provider incentives during the quarter ended MM/DD/YYYY.

18. ALTERNATIVE PAYMENT MODEL INITIATIVES

<table>
<thead>
<tr>
<th></th>
<th>APM Paid</th>
<th>Accruals</th>
<th>Adjustments</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYE18</td>
<td>$3,500,000</td>
<td>$3,000</td>
<td>$120,000</td>
<td>$3,623,000</td>
</tr>
<tr>
<td>CYE17</td>
<td>820,000</td>
<td>17,000</td>
<td>70,000</td>
<td>907,000</td>
</tr>
<tr>
<td>CYE16</td>
<td>340,000</td>
<td>-</td>
<td>32,000</td>
<td>372,000</td>
</tr>
<tr>
<td></td>
<td>$4,660,000</td>
<td>$20,000</td>
<td>$222,000</td>
<td>$4,902,000</td>
</tr>
</tbody>
</table>

19. NON-COVERED SERVICES
Non-covered services for claims paid from January to March 2009 and the line items they fall on are:

<table>
<thead>
<tr>
<th>Report Line</th>
<th>Risk Group Title</th>
<th>Risk Group Title</th>
<th>Risk Group Title</th>
<th>Total</th>
<th>Non-Covered Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>402 Hospital Inpt</td>
<td>9.60</td>
<td>580.00</td>
<td></td>
<td>589.60</td>
<td>Occupational &amp; Speech Therapy</td>
</tr>
<tr>
<td>410 Referral Physicians</td>
<td>162.00</td>
<td>78.00</td>
<td></td>
<td>240.00</td>
<td>X-Ray Analysis</td>
</tr>
<tr>
<td>422 Total Outpatient</td>
<td></td>
<td>(855.00)</td>
<td>(855.00)</td>
<td>(25.40)</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Total</td>
<td>9.60</td>
<td>742.00</td>
<td>(777.00)</td>
<td>(25.40)</td>
<td></td>
</tr>
</tbody>
</table>

20. RISK ADJUSTMENT
During the quarter, Company ABC accrued $4.5 million for risk adjustment for the year ending MM/DD/YYYY.

21. PRIOR CONTRACT YEAR / PERIOD ADJUSTMENTS
During the quarter, company ABC recorded an adjusting entry to Reinsurance revenues decreasing the revenues by a total of $1,500,000, of that amount $500,000 is related to the
current year with $1,000,000 adjusting revenues in the prior year due to encounters which did not adjudicate through to the reinsurance case within the 15 month timely filing deadline.

22. NON-CAPPED NEWBORN COSTS
During the quarter, Company ABC incurred $48,123 for newborn costs for 2 births for which capitation was not received.

23. PREMIUM DEFICIENCY RESERVE
During the quarter the Contractor recorded an increase to the Premium Deficiency Reserves in the amount of $2,500,000 to other current liabilities line A/C 20145 and other revenue line A/C 40310. Total Reserves equal $5,000,000.

24. MEDICAL LOSS RATIO
Additional Information will be provided

25. ACCESS TO PROFESSIONAL SERVICES INITIATIVE (APSI)
APSI-related prospective and PPC revenue and expenditure amounts for the quarter ended 3/31/XX.

<table>
<thead>
<tr>
<th>Revenue</th>
<th>APSI Rate</th>
<th>Member Months</th>
<th>APSI Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective</td>
<td>$ 7.56</td>
<td>64,723</td>
<td>$ 489,306.00</td>
</tr>
<tr>
<td>PPC</td>
<td>$ 0.17</td>
<td>487</td>
<td>$ 83.00</td>
</tr>
<tr>
<td>Total Revenue</td>
<td></td>
<td></td>
<td>$ 489,389.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditures</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician Services (A/C 50205)</td>
<td>$ 151,879.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Physician Services (A/C 50215)</td>
<td>$ 129,633.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Professional Services (A/C 502225)</td>
<td>$ 204,157.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$ 485,669.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Revenue over Expenditures</td>
<td>$ 3,720.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. MANAGEMENT FEES
During the quarter, Company ABC expended $5M on Management Fees. The Fee percentage of 5% did not increase during the quarter.