Amending schedules to reflect Ohio Department of Insurance comments and NAIC data validation notification.

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ANNUAL STATEMENT

FOR THE YEAR ENDING DECEMBER 31, 2015

OF THE CONDITION AND AFFAIRS OF THE

HealthSpan Integrated Care

NAIC Group Code 00000 (Current Period), 00000 (Prior Period) NAIC Company Code 95204 Employer's ID Number 34-0922268

Organized under the Laws of Ohio, State of Domicile or Port of Entry Ohio

Country of Domicile United States

Licensed as business type: Life, Accident & Health [ ] Property/Casualty [ ] Hospital, Medical & Dental Service or Indemnity [ ]

Dental Service Corporation [ ] Vision Service Corporation [ ] Health Maintenance Organization [ ]

Other [ ] Is HMO, Federally Qualified? Yes [X] No [ ]

Incorporated/Organized 03/29/1962 Commenced Business 10/27/1976

Statutory Home Office 1001 Lakeside Ave. Suite 1200 (Street and Number), Cleveland, OH, US 44114-1153 (City or Town, State, Country and Zip Code)

Main Administrative Office 1001 Lakeside Ave. Suite 1200 (Street and Number)

Cleveland, OH, US 44114-1153 (City or Town, State, Country and Zip Code) 216-621-5600 (Area Code) (Telephone Number)

Mail Address 1001 Lakeside Ave. Suite 1200 (Street and Number or P.O. Box), Cleveland, OH, US 44114-1153 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 1001 Lakeside Ave. Suite 1200 (Street and Number)

Cleveland, OH, US 44114-1153 (City or Town, State, Country and Zip Code), 216-621-5600 (Area Code) (Telephone Number) (Extension)

Internet Web Site Address Healthspan.org

Statutory Statement Contact Felicia Browning (Name), 216-479-5510 (Area Code) (Telephone Number) (Extension)

Felicia.browning@mercy.com (E-Mail Address) (Fax Number)

OFFICERS

Name	Title	Name	Title
Allan Greenberg #	President	Dave Nowiski	Treasurer

OTHER OFFICERS

DIRECTORS OR TRUSTEES

Jeffrey J Copeland	Robert Campbell	William Franks	Allan Calonge
Walid Sidani MD			

State of .....Ohio.....

County of .....Cuyahoga.....

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The officers of this reporting entity, being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC *Annual Statement Instructions* and *Accounting Practices* and *Procedures* manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Allan Greenberg President	Dave Nowiski Treasurer	

Subscribed and sworn to before me this

_____ day of _____, _____

a. Is this an original filing? Yes [ ] No [X]

b. If no:

1. State the amendment number 2
2. Date filed 07/13/2016
3. Number of pages attached

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefit Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Net premium income	360,173,360	196,974,630	0	0	0	36,590,247	126,608,483	0	0	0
2. Change in unearned premium reserves and reserve for rate credit	0									
3. Fee-for-service (net of $ medical expenses)	0									XXX
4. Risk revenue	0									XXX
5. Aggregate write-ins for other health care related revenues	71,639	0	0	0	0	0	0	0	71,639	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	360,244,999	196,974,630	0	0	0	36,590,247	126,608,483	0	71,639	0
8. Hospital/medical benefits	204,041,859	122,855,190				22,106,051	59,080,618			XXX
9. Other professional services	13,000,794	7,827,879				1,408,516	3,764,399			XXX
10. Outside referrals	0	0				0				XXX
11. Emergency room and out-of-area	16,588,934	9,988,326				1,797,258	4,803,350			XXX
12. Prescription drugs	73,396,842	39,272,007				7,788,231	26,336,604			XXX
13. Aggregate write-ins for other hospital and medical	55,422,729	33,370,456	0	0	0	6,004,541	16,047,732	0	0	XXX
14. Incentive pool, withhold adjustments and bonus amounts	0									XXX
15. Subtotal (Lines 8 to 14)	362,451,158	213,313,858	0	0	0	39,104,597	110,032,703	0	0	XXX
16. Net reinsurance recoveries	4,794,275	4,214,995				0	579,280			XXX
17. Total hospital and medical (Lines 15 minus 16)	357,656,883	209,098,863	0	0	0	39,104,597	109,453,423	0	0	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
19. Claims adjustment expenses including $ 5,133,825 cost containment expenses	10,978,215	6,840,529				919,186	3,218,500			
20. General administrative expenses	78,670,650	51,563,050				6,728,352	20,379,248			
21. Increase in reserves for accident and health contracts	84,426,836	61,357,468				9,426,437	13,642,931			XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23. Total underwriting deductions (Lines 17 to 22)	531,732,584	328,859,910	0	0	0	56,178,572	146,694,102	0	0	0
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	(171,487,585)	(131,885,280)	0	0	0	(19,588,325)	(20,085,619)	0	71,639	0
DETAILS OF WRITE-INS										
0501. Other	71,639								71,639	XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 5 above)	71,639	0	0	0	0	0	0	0	71,639	XXX
0601. Other-Health Care Revenue (admin services)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301. Care Delivery Expense	52,120,300	31,382,038				5,646,753	15,091,509			XXX
1302. Community Service	3,302,429	1,988,418				357,788	956,223			XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 through 1303 plus 1398) (Line 13 above)	55,422,729	33,370,456	0	0	0	6,004,541	16,047,732	0	0	XXX

1. Summary of Significant Accounting Policies and Going Concern

a. Accounting Practices

The accompanying statutory financial statements of HealthSpan Integrated Care ("HealthSpan or the Company") have been prepared in conformity with the National Association of Insurance Commissioners' ("NAIC") *Accounting Practices and Procedures* manual, ("NAIC SAP"), the NAIC Annual Statement Instructions, and other accounting practices as prescribed or permitted by the State of Ohio – Ohio Department of Insurance (ODI). There were no reported differences to net income, statutory surplus, or risk based capital for specific practices, prescribed or permitted by the State of Ohio, that deviate from NAIC SSAP in the reported periods.

		State of Domicile	2015	2014
	NET INCOME		**(in thousands)**	**(in thousands)**
(1)	HealthSpan state basis (page 4, Line 32, Columns 2 & 3)	OH	$ (217,563)	$ (53,345)
(2)	State Prescribed Practices that increase / (decrease) NAIC SAP:	OH	-	-
(3)	State Permitted Practices that increase / (decrease) NAIC SAP:	OH	-	-
(4)	NAIC SAP (1-2-3=4)	OH	$ (217,563)	$ (53,345)
	SURPLUS			
(5)	HealthSpan state basis (page 3, Line 33, Columns 3 & 4)	OH	$ 36,678	$ 53,795
(6)	State Prescribed Practices that increase / (decrease) NAIC SAP:	OH	-	-
(7)	State Permitted Practices that increase / (decrease) NAIC SAP:	OH	-	-
(8)	NAIC SAP (5-6-7=8)	OH	$ 36,678	$ 53,795

b. Use of Management Estimates

The preparation of the statutory financial statements in conformity with NAIC SAP, the NAIC Annual Statement Instructions, and other accounting practices as prescribed or permitted by the ODI requires management to make estimates and assumptions that affect the reported amounts. The estimated fair value of investments; Medicare revenue accruals; Medicare payables and reserves; the reserves for unpaid claims and claims adjustment expense; the premium deficiency reserves; legal liabilities; real estate, property, and equipment impairment and useful lives; and investment impairments represent significant estimates. Actual results could differ materially from those estimates. No significant changes from the 2015 annual statement

1. Summary of Significant Accounting Policies and Going Concern (continued)

c. Accounting Policies

1. Short Term Investments

Cash and short-term investments include interest-bearing deposits purchased with an original or remaining maturity of twelve months or less. Cash and investments that are restricted by contractual or regulatory requirements are classified as bonds and other invested assets and excluded from cash and short-term investments.

Receivables and payables for securities represent current amounts for unsettled securities purchases or sales.

2. Bonds and Amortization

Bonds and other invested assets include money market funds, U.S. Treasury and government-sponsored agencies, loan-backed and or structured securities, industrial and miscellaneous bonds and all other government bonds. Recognized gains and losses are recorded on the specific identification basis. Interest income is included in net investment and other income.

Bonds are reported in accordance with NAIC Annual Statement Instructions (Statement Value). Accordingly, bonds that are designated highest quality, NAIC Designation 1 and 2, are reported at amortized cost using the effective interest method, and bonds that are classified as NAIC Designation 3 or lower are reported at lower of amortized cost or fair value.

Adjustments are made prospectively and repayment assumptions are obtained from a third party vendor data source for loan-backed and/or structured securities. The amortization method used is the scientific method.

Investments are regularly reviewed for impairment and a charge is recognized when the fair value is below cost basis and is judged to be other-than-temporary. Impairment is included in recognized losses. In its review of assets for impairment that is deemed other-than-temporary, management generally follows the following guidelines:

- Substantially all investments are managed by outside investment managers who do not need the Company's management pre-approval for sales, therefore substantially all declines in value below amortized cost are recognized as impairments that are other-than-temporary.

- For other securities, losses are recognized for known matters, such as bankruptcies, regardless of ownership period, and investments that have been continuously below book value for an extended period of time are evaluated for impairment that is other-than-temporary.

The Company's investment transactions are recorded on a trade-date basis.

1. Summary of Significant Accounting Policies and Going Concern (continued)

1. Accounting Policies (continued)

3. Common Stock – Not applicable.

4. Preferred Stock – Not applicable.

5. Valuation Mortgage Loans – Not applicable.

6. Loan Backed Securities – Not applicable.

7. Investment in Subsidiaries – Not applicable.

8. Investment in Joint Ventures – Not applicable.

9. Accounting for Derivatives – Not applicable.

10. Premium Deficiency Calculation

Premium deficiency reserve and the related expenses are recognized when it is probable that expected future health care and maintenance costs under a group of existing insurance contracts will exceed anticipated future premiums, current reserves and anticipated future reinsurance recoveries over the insurance contract period. The Company projects future premiums and losses using historical results to help determine future performance for both prepayments and claims. An estimated expense factor is then applied, and the result is discounted using a rate of return. This net present value, less any existing reserves, is recorded as a premium deficiency. Expected investment income and interest expense are included in the calculation of premium deficiency reserves, as appropriate. The premium deficiency reserve was $84.4 million and $0 at December 31, 2015 and 2014, respectively, and was actuarially determined. Given the inherent variability of the premium deficiency reserve estimate, the actual liability could differ significant from the calculated amount.

11. Estimating Losses and Claims Adjustment Expenses

The cost of health care services is recognized in the period in which services are provided. Reserves for unpaid claims and claims adjustment expense consist of unpaid health care expenses, which include an estimate of the cost of services provided to HealthSpan's members by third-party providers that have been incurred but not reported. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims and other relevant data. Estimates are monitored and reviewed, and, as settlements are made or estimates are revised, adjustments are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of paid claims is dependent on future developments, management is of the opinion that the reserves for unpaid claims and claims adjustment expense are adequate to cover such claims.

1. Summary of Significant Accounting Policies and Going Concern (continued)

c. Accounting Policies (continued)

11. Estimating Losses and Claims Adjustment Expenses (continue)

Amounts due to the Physician Group are included in the reserves for unpaid claims and consist primarily of unpaid medical expenses owed to the Physician Group for medical services provided to HealthSpan members. The cost of medical services, including an estimate of claims incurred but not reported, is recognized by HealthSpan in the period in which services are provided and is reflected as a component of medical and hospital services expenses.

12. Capitalization Policy

Real estate, property, and equipment, which include land, buildings, and equipment, are stated at cost less accumulated depreciation and amortization. Interest is capitalized on facilities construction in progress and is added to the cost of the underlying asset, in accordance with SSAP No. 44, Capitalization of Interest. Depreciation begins when the project is substantially complete and ready for its intended use. Buildings and equipment are depreciated on a straight- line basis over the estimated useful lives of the various classes of assets, generally ranging from 3 to 33 years.

Maintenance and repairs are expensed as incurred. Major improvements that increase the estimated useful life of an asset are capitalized. Upon the sale or retirement of assets, recorded cost and related accumulated depreciation are removed from the accounts, and any gain or loss on disposal is reflected in operations.

In accordance with SSAP No. 73, Health Care Delivery Assets – Supplies, Pharmaceuticals and Surgical Supplies, Durable Medical Equipment, Furniture, Medical Equipment and Fixtures, and Leasehold Improvements in Health Care Facilities, pharmaceutical inventory, as well as medical center furniture, fixtures, and equipment used in the direct delivery of care, are included in property and equipment. Pharmaceutical inventory is included in the furniture and equipment category.

Pharmaceutical inventory is not subject to depreciation. Medical center furniture, fixtures, and equipment used in the direct delivery of care are depreciated over their estimated useful lives but for a period not to exceed three years.

For the years ended December 31, 2015 and 2014, depreciation and amortization expense was $8.9 million and $11.7 million, respectively.

Management evaluates alternatives for delivering services that may affect the current and future utilization of existing and planned assets and could result in an adjustment to the carrying values of such land, buildings, and equipment in the future. Management evaluates and records impairment losses, where applicable, based on expected utilization, projected cash flows, and recoverable values. For the year ended December 31, 2015, the Company recorded $45.5 million of impairment expense.

1. Summary of Significant Accounting Policies and Going Concern (continued)

c. Accounting Policies (continued)

13. Pharmaceutical Rebate Methodology

The Company accounts for pharmaceutical rebate receivables in accordance with SSAP No. 84, Certain Health Care Receivables and Receivables under Government Insured Plans (SSAP No. 84). The admitted receivable balances as of December 31, 2015 and 2014 are $4.4 million and $1.5 million, respectively, are included in health care receivables on the balance sheets. These are comprised of estimated pharmacy rebates for the current quarter as reported in the financial statements plus the pharmacy rebates invoiced/confirmed for the preceding quarter.

14. Reserves for Claims Unpaid and Unpaid Claims Adjustment Expenses

The cost of health care services is recognized in the period in which services are provided. Reserves for unpaid claims and claims adjustment expense consists of unpaid health care expenses, which include an estimate of the cost of services provided to HealthSpan's members by third-party providers that have been incurred but not reported. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims and other relevant data. Estimates are monitored and reviewed and, as settlements are made or estimates are revised, adjustments are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. While the ultimate amount of paid claims is dependent on future developments, management is of the opinion that the reserves for unpaid claims and claims adjustment expense are adequate to cover such claims. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated.

HealthSpan Physicians (Physician Group) provides or arranges hospital and medical services for HealthSpan members. Payments from HealthSpan constitute substantially all of the revenues for the Physician Group. Payments to the Physician Group represent a substantial portion of the expenses for medical services reported in the Company's statutory financial statements. The Physician Group is a fully owned subsidiary of HealthSpan Partners (HSP). Because the Physician Group is not controlled by HealthSpan, its operations are not included in the statutory financial statements.

Amounts due to the Physician Group are prepaid monthly on a per-member per-month capitation fee. The capitation amount is reflected in claims expense. Unpaid claims consist primarily of unpaid medical expenses owed to outside providers for the medical services provided to HealthSpan members. The cost of medical services, including an estimate of claims incurred but not reported, is recognized by Health Span in the period in which services are provided and is reflected as a component of medical and hospital expenses**.**

15. Cost Allocations

For reporting lines of business activity, expenses are allocated based on utilization and experience.

1. Summary of Significant Accounting Policies and Going Concern (continued)

c. Accounting Policies (continued)

16. Revenue Recognition

Net premium revenue includes premiums from employer groups, individuals, and Medicare. Net premium revenue is recognized over the period in which the members are entitled to health care services. The majority of HealthSpan's Medicare cost contract revenue is paid based on cost, with interim payments using pre-established rates, and final settlement after the end of the year. Estimates of the final settlement of the cost report are recorded by HealthSpan. At December 31, 2015 and 2014, in connection with HealthSpan's Medicare cost contract, HealthSpan recorded allowances and reserves for revenue adjustments in the amount of $11.2 million and $18.0 million, respectively, of which approximately $9.0 million and $10.0 million, respectively is recorded as Medicare payables and reserves. The remaining amounts are recorded as a reduction in health care and other receivables. Medicare cost contract revenue decreased by approximately $0.1 million and increased $5.2 million for the years ended December 31, 2015 and 2014, respectively; due to prior-year retrospective adjustments.

In addition, Medicare benefits include a voluntary prescription drug benefit (Part D). Revenue for Part D include capitated payments made from Medicare adjusted for health risk factor scores. Related accruals are recognized monthly based on cumulative experience and membership data. Part D revenue is finalized after all data is submitted to Medicare and the final settlement is made after the end of the year.

Medicare cost revenue and Medicare Part D revenue are subject to governmental audits and potential payment adjustments. The Centers for Medicare & Medicaid Services performs coding audits to validate the supporting documentation maintained by HealthSpan.

HealthSpan receives prospective payments from the government for the Catastrophic Reinsurance Subsidy and the Low-Income Member Cost Sharing Subsidy related to the Company's offering of Medicare Part D drug coverage. Reinsurance payments are funds paid by the government for a portion of the catastrophic coverage-level claims. The Low-Income Member Cost Sharing Subsidy is for all or a portion of the deductible, the coinsurance, and the co-payment amounts for low-income beneficiaries. The payments made for claims are recorded against the prospective payments and could result in either a net receivable or payable. The net receivable or payable is recorded as health care and other receivables – net or premiums received in advance.

Estimates of retrospective adjustments resulting from coding audits, cost reports, and other contractual adjustments are recorded in the time period in which members are entitled to health care services. Actual retrospective adjustments may differ from initial estimates.

Premiums collected in advance are deferred and recorded as premiums received in advance. Revenue is adjusted to reflect estimates of collectability, including retrospective membership adjustment trends and economic conditions. Revenue and related receivables are exclusive of charity care. Revenue derived under contracts with governmental payers is subject to audit and potential retrospective adjustments.

1. Summary of Significant Accounting Policies and Going Concern (continued)

   d. Going Concern

      On February 29, 2016 the Company submitted and ODI subsequently approved a major modification filing for the "Market Withdrawal and Novation of Government Programs Business." In March of 2016, HealthSpan entered into an agreement with an unrelated party to sell the insured membership and administrative services of the Company and transition the membership to buyer. Effective January 1, 2017, the Company will cease operating all lines of business.

      HealthSpan Partners is the parent company of HealthSpan Integrated Care. HealthSpan Partners has an agreement with its Parent CHP Mercy Health for financial support necessary to enable the Company, through at least a year from the date of issuance of these financial statements, to meet operating requirements, obligations and commitments as and when they become due, through advances, capital contributions or other means.

2. Accounting Changes and Corrections of Errors

   In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, Revenue from Contracts with Customers (Topic 606), to clarify revenue recognition principles. This guidance is intended to improve disclosure requirements and enhance the comparability of revenue recognition practices. Improved disclosures under the amended guidance relate to the nature, amount, timing and uncertainty of revenue that is recognized from contracts with customers. This guidance will be required to be applied retrospectively (either fully or on a modified approach). Although this guidance was originally expected to be effective for reporting periods beginning after December 15, 2016, the FASB issued ASU 2015-14 Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date, to delay the effective date of ASU 2014-09 by one year (to reporting periods beginning after December 15, 2017) with early adoption permitted as of the original effective date. HealthSpan is currently evaluating the impact that ASU 2014-09 will have on its statutory- basis financial statements.

   In February 2016, the FASB issued ASU 2016-02, Leases (Topic 842). The guidance in ASU 2016-02 supersedes the lease recognition requirements in ASC Topic 840, Leases. ASU 2016-02 requires an entity to recognize assets and liabilities arising from a lease for both financing and operating leases, along with additional qualitative and quantitative disclosures. ASU 2016-02 is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. HealthSpan is currently evaluating the impact that ASU 2016-02 will have on its statutory-basis financial statements.

3. Business Combinations and Goodwill

    a. Statutory Purchase Method – Not applicable.

    b. Statutory Merger – Not applicable.

    c. Assumption Reinsurance – Not applicable.

    d. Impairment Loss

        For the years ended December 31 2015 and 2014, HealthSpan reported goodwill impairment of $5.7 million and $0.

4. Discontinued Operations – Not applicable

5. Investments

    a. Mortgage Loans

        For the years ended December 31, 2015 and 2014, HealthSpan had no investments in mortgage loans.

    b. Debt Restructuring

        For the years ended December 31, 2015 and 2014, HealthSpan had no investments in restructured debt.

    c. Reverse Mortgages

        For the years ended December 31, 2015 and 2014, HealthSpan had no investments in reverse mortgages.

    d. Loan Backed Securities

        For the years ended December 31, 2015 and 2014, HealthSpan had no investments in loan backed securities.

    e. Repurchase Agreements and Securities Lending Transactions

        For the years ended December 31, 2015 and 2014, HealthSpan was not a party to repurchase agreements or securities lending transactions.

5. Investments (continued)

f. Real Estate

As of December 31, 2015, certain real estate properties occupied by HealthSpan were determined to have indicators of impairment as a result of continuing operating losses and the future strategic plan of HealthSpan as determined by Mercy Health. As a result of the analysis prepared by management, it was determined that certain real estate properties occupied by HealthSpan were in fact impaired and the real estate properties occupied by HealthSpan were adjusted to their fair value. Management determined the fair value of the real estate properties occupied by HealthSpan using a market valuation methodology using inputs such as real estate appraisals and offers to purchase from third parties. This determination of fair value is consistent with a Level 2 measurement under the fair value hierarchy.

The company recorded $34.8 million of real estate impairment and is included in the total amount of Net Realized Capital Gains (Losses) in the statement of revenue and expenses.

g. Investments in Low-Income Housing Tax Credits

For the years ended December 31, 2015 and 2014, HealthSpan had no investments in low-income housing credits.

h. Restricted Assets

HealthSpan is required to keep investments on deposit in the State of Ohio, where it is licensed. At December 31, 2015 and December 31, 2014, $404 thousand and $406 thousand, respectively, in long-term U.S. Treasury notes were restricted to satisfy the state's regulatory requirements.

i. Working Capital Finance Investments

For the years ended December 31, 2015 and 2014, HealthSpan had no working capital finance investments.

j. Offsetting and Netting of Assets and Liabilities

For the years ended December 31, 2015 and 2014, HealthSpan had no offsetting of derivative, repurchase, or securities borrowing and lending assets or liabilities.

k. Structured Notes

For the years ended December 31, 2015 and 2014, HealthSpan had no structured notes.

6. Joint ventures, Partnerships and Limited Liability Companies –Not applicable.

7. Investment Income

All investment income due and accrued is admitted at December 31, 2015 and 2014.

8. Derivative Instruments – Not applicable

9. Income Taxes

HealthSpan Integrated Care (HealthSpan) is a not-for-profit corporation, exempt from federal and state income taxes.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

HealthSpan Partners (HSP) is the sole corporate member of HealthSpan. HSP is a distinct, secular, and tax-exempt organization with the primary objective of developing provider networks and insurance products. HSP is a partner organization of Mercy Health, and is included in the consolidated financial statements of Mercy Health, who is the ultimate controlling party of HealthSpan. Mercy Health is a Catholic health organization, supervising market delivery systems consisting of hospitals, nursing homes, and other organizations providing health-related services.

The amount due from (due to) from affiliates at December 31, 2015 and 2014, is primarily related to capitation paid to and medical services received from the Physician Group and general expenses and claims paid by HealthSpan Partners and Mercy Health on behalf of HealthSpan. The Company does not provide other parties with guarantees.

The Physician Group, a subsidiary of HSP, provides medical services to HealthSpan's members. During 2015 and 2014, HealthSpan incurred expenses of $77.3 million and $68.1 million for hospital and medical services provided or arranged by the Physician Group. HealthSpan incurs expenses for information technology, treasury, general management, administrative support, accounting, and accounts payable processing services provided by Mercy Health. For the year ended December 31, 2015 and 2014, HealthSpan incurred expenses of $48.1 million and $9.7 million for services provided by Mercy Health

At December 31, 2015 2014, related party and affiliate balances were as follows (in thousands):

	12/31/2015	12/31/2014
Mercy Health	$ 2,134	$ (157,161)
HealthSpan Partners	(7,689)	(57,364)
HealthSpan Physicians	30,360	-
HealthSpan Inc.	(227)	-
	$ 24,578	$ (214,525)

During the years ended December 31, 2015 and 2014, the Company had no amount deducted from its asset value or its parent's asset value due to their affiliation. Additionally, the Company had no investments in subsidiary, controlled or affiliated entities in 2015 or 2014.

HealthSpan received contributed surplus of $202.8 million from HSP in 2015 ($0 in 2014).

11. Debt

As December 31, 2015 and 2014, HealthSpan does not have an agreement with the Federal Home Loan Bank or other third party lenders.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and other Postretirement Benefit Plans

Mercy Health administers defined contribution plans for eligible employees of HealthSpan. Employer contributions and costs are based on a percentage of covered employees' eligible compensation. For the year ended December 31, 2015 and 2014, plan expense was $3.1 million and $3.3 million, respectively. No significant changes from the 2015 annual statement.

13. Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

HealthSpan is a nonprofit, charitable corporation and does not issue stock. HealthSpan Partners (HSP) is the sole corporate member of HealthSpan and no individual or entity has any ownership interest in HealthSpan. HealthSpan and HSP share certain corporate officers.

For the years ended December 31, 2015 and 2014, the Company paid no dividends. In accordance with the Ohio Revised Code, HealthSpan must receive approval from the ODI to pay a dividend or distribution during 2015 which, when combined with dividends or distributions paid within the preceding 12 months exceeds the greater of either (a) 10% of HealthSpan's statutory capital and surplus at December 31, 2015 or (b) HealthSpan's net gain from operations on a statutory basis for the year ended December 31, 2015.

At December 31, 2015 and December 31, 2014, HealthSpan held no stock for special purpose and is not a mutual reciprocal.

As of December 31, 2015 and 2014, HealthSpan has reclassified $3.6 and $4.5 million from unassigned funds to special surplus, representing the Company's estimated Annual Fee on Health Insurers for the year ended December 31, 2015 and 2014, respectively.

No portion of surplus is represented by cumulative unrealized gains or losses.

Unassigned surplus was reduced by $9.7 million at December 31, 2015 and $7.4 million for the year ended December 31, 2014 for nonadmitted assets.

HealthSpan did not undergo any quasi-reorganization in the years ended December 31, 2015 or 2014.

14. Liabilities, Contingencies and Assessments

a. As of December 31, 2015 and 2014, HealthSpan was not a guarantor, and had no commitments to a subsidiary, controlled or affiliated entity.

b. As of December 31, 2015 and 2014, HealthSpan had no guaranty fund or other assessments.

c. As of December 31, 2015 HealthSpan had no gain contingencies that could have a material effect on the financial statements.

d. For the years ended December 31, 2015 and 2014, HealthSpan paid the following amounts in the reporting periods to settle claims related extra contractual obligations or bad faith claims stemming from lawsuits (in thousands):

	2015	2014
Claims related ECO and bad faith losses paid	$ -	$ -

The number of claims where amounts were paid to settle claims related extra contractual obligations or bad faith claims resulting from lawsuits during the reporting period were:

	0-25 Claims	25-50 Claims	51-100 Claims	101-500 Claims	More than 500 Claims
2015	**X**				
2014	**X**				

The claim count information above is disclosed per claim.

e. HealthSpan is involved in various legal proceedings arising in the ordinary course of business operations. Such litigation proceedings include: administrative litigation, employment litigation, breach of contract and other commercial and tort litigation, consistent with the health care industry.

In the opinion of management, based upon current facts and circumstances, the resolution of these matters is not expected to have a material adverse effect on the financial position or results of operations of HealthSpan. Where appropriate, reserves have been established in accordance with SSAP No. 5R, Liabilities, Contingencies, and Impairment of Assets. The outcome of litigation and other legal and regulatory matters is inherently uncertain, however, and it is possible that one or more of the legal or regulatory matters currently pending or threatened could have a material adverse effect.

15. Leases

a. Lessee Operating Leases

1. HealthSpan leases primarily office space, medical facilities and equipment under various operating leases that expire through 2018. Certain leases contain rent escalation clauses and renewal options for additional periods.

Total operating lease expense for all operating leases except those with terms of a month or less that were not renewed was (in thousands):

	2015	2014
Minimum Rentals	$ 2,163	$ 2,316
Contingent Rentals	-	-
Less Sublease Rentals	-	-
	$ 2,163	$ 2,316

2. At December 31, 2015, minimum aggregate commitments under noncancelable operating leases extending beyond one year were as follows (in thousands):

Year Ending December 31	Operating Leases
2016	$ 1,596
2017	839
2018	14
2019	-
Thereafter	-
	$ 2,449

3. HealthSpan is not involved in any material sales-leaseback transactions.

b. Lessor Leases

1. Leasing is not a material part of HealthSpan's activities in terms of revenue, net income, or assets.

16. Information About Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments With Concentrations of Credit Risk

a. Financial instruments that potentially subject HealthSpan to concentrations of credit risk consist primarily of investment securities and accounts receivable. All investments in securities are managed within guidelines established by HealthSpan's management, which, as a matter of policy and procedure, limit the amounts that may be invested in each type of security, with any one issuer, and in various credit quality classifications. Concentrations of credit risk with respect to accounts receivable is limited due to the large number of payers comprising HealthSpan's customer base. Accordingly, HealthSpan does not believe any significant concentration of off-balance sheet or credit risk existed at December 31, 2015 or December 31, 2014.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

    a. Transfers of Receivables Reported as Sales – Not applicable.

    b. Transfer and Servicing of Financial Assets – Not applicable.

    c. Wash Sales – Not applicable.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

    a. ASO Plans – Not applicable.

    b. ASC Plans – Not applicable.

    c. Medicare or Similarly Structured Cost Based Reimbursement Contract

        1. Revenue from HealthSpan's Medicare Cost Reimbursement Contract (Medicare Cost Contract) consisted of 61.0 million and $74.7 million for medical and hospital related services for years ended 2015 and 2014, respectively, and $3.9 million and $4.7 million for administrative expenses for years ended 2015 and 2014, respectively.
        2. As of December 31, 2015 and 2014, HealthSpan has no net receivables from Medicare with an account balance greater than $10,000 or 10% of HealthSpan's receivables from the Medicare Cost Contract.
        3. The majority of Health Plan's Medicare revenues are paid based on cost, with interim payments using pre-established rates, and the final settlement is made after the end of the year. Estimates of final settlements of the cost report are recorded by Health Plan. At December 31, 2015 and 2014, in connection with HealthSpan's Medicare cost contract, HealthSpan recorded allowances and reserves for adjustments of recorded revenues in the amount of $11.2 million and $18 million, respectively.

19. Direct Premium Written / Produced by Managing General Agents / Third Party Administrators

    HealthSpan does not have direct premiums written/produced my managing general agents or third party administrators during the reporting periods.

20. Fair Value Measurements

HealthSpan has no nonfinancial assets or liabilities that are required to be measured and reported at fair value on a recurring basis. Fair value is defined as the price that would be received to sell an asset or transfer a liability in an orderly transaction between market participants at the measurement date. HealthSpan's financial assets carried at fair value have been classified, for disclosure purposes, based on a hierarchy that prioritizes inputs to valuation techniques used to measure fair value into three levels.

- Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities.
- Level 2 – Inputs include quoted prices for similar assets or liabilities in active markets, quoted prices from those willing to trade in markets that are not active, or other inputs that are observable or can be corroborated by market data for the term of the instrument. Such inputs include market interest rates and volatilities, spreads, and yield curves.
- Level 3 – Certain inputs are unobservable (supported by little or no market activity) and significant to the fair value measurement.

Investments, as discussed in the *Investments* note, are reported at lower of amortized cost or fair value, with impairment recorded if amortized cost is greater than fair value. The fair values of investments are based on quoted market prices, if available, or estimated using quoted market prices for similar investments. If listed prices or quotes are not available, fair value is based upon other observable inputs or models that primarily use market-based or independently sourced market parameters as inputs. In addition to market information, models also incorporate transaction details such as maturity. Fair value adjustments, including credit, liquidity, and other factors are included, as appropriate, to arrive at a fair value measurement.

Investments at statement value and estimated fair value at December 31, 2015 (in thousands).

Asset Description	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3
U.S Treasury Bonds	$ 13,982	$ 13,994	$ -	$ 13,982	$ -
Industrial and miscellaneous Bonds	12,943	13,117		12,943	
Total Investments	$ 26,925	$ 27,111	$ -	$ 26,925	$ -

Investments at statement value and estimated fair value at December 31, 2014 (in thousands).

Asset Description	Aggregate Fair Value	Admitted Assets	Level 1	Level 2	Level 3
U.S Treasury Bonds	$ 14,618	$ 14,530	$ -	$ 14,618	$ -
Industrial and miscellaneous Bonds	13,173	13,184		13,173	
Total Investments	$ 27,791	$ 27,714	$ -	$ 27,791	$ -

There were no transfers between Level 1, 2, and 3 during 2015 or 2014.

21. Other Items
    a. Extraordinary Items – Not applicable.
    b. Troubled Debt Restructuring – Not applicable.
    c. Other Disclosure and Unusual Items – Not applicable.
    d. Business Interruption Insurance Recoveries – Not applicable.
    e. State Transferrable and Non-transferrable Tax Credits – Not applicable.
    f. Subprime Mortgage Related Risk Exposure – Not applicable.
    g. Retained Assets – Not applicable.

22. Subsequent Events

Subsequent events have been considered through February 29, 2016 for the statutory statements issued on February 29, 2016.

In the fourth quarter of 2015, HealthSpan Partners (HSP) made the decision to exit the care delivery operations of HealthSpan Physicians and dissolve the associated medical group effective March 31, 2016. Additionally, during March of 2016 HealthSpan Integrated Care will close its retail pharmacy operations that operated in the medical facilities. The land and medical facilities used in the care delivery operations are owned by HSIC and recorded as Real Estate in the Statement of Assets. In the 2015 financial statements, HSIC recorded an impairment loss of $36.9 million to write the real estate down to its fair market value.

Effective February 29, 2016, HSP and HealthSpan executed an agreement with an independent third-party buyer (the Buyer) to sell its insured membership and administrative services to the Buyer and transition the insured membership to Buyer during 2016. Effective January 1, 2017, HealthSpan will cease operating all lines of business.

In accordance with paragraph 8 of Statement of Statutory Accounting Principles No. 72, the Ohio Department of Insurance approved the Company's request to record the subsequent receipt of $12MM of contributed capital as surplus effective December 31, 2015.

Section 9010 of the Affordable Care Act requires health insurance issuers to pay an annual Health Insurance Fee (HIF) based on net written premiums, beginning in 2014. The HIF is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the HIF becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The Company recognizes the annual fee for the current calendar year in full on January 1. The Company also reclassifies from unassigned surplus to special surplus an amount equal to its estimated fee for the following calendar year. This amount is recognized ratably throughout the current calendar year.

The Company was subject to the HIF in 2015 and 2014. As of December 31, 2015, the Company has written health insurance subject to the HIF, expects to conduct health insurance business in 2016, and estimates its portion of the HIF payable on September 30, 2016 to be approximately $3.6 million. This amount is reflected in special surplus in the statutory basis balance sheets and statements of changes in capital and surplus. Total Adjusted Capital ("TAC") and Authorized Control Level ("ACL") were $36,678 and $9,816, respectively, as of December 31, 2015. Had the assessment, based upon 2015 premiums written, been accrued on December 31, 2015, TAC would have been reduced to $33,053, which

would have reduced risk-based capital (RBC) by approximately 10% as of December 31, 2015. Reporting the 2016 HIF as of December 31, 2015 would not have triggered an RBC action level.

On January 1, 2016 and 2015, the Company recorded estimated liabilities and corresponding expense related to the ACA Health Insurer Fee in the amount of $3.6 million and $4.5, respectively. The estimates were based on $189.4 million and $217.1 million of assessable premiums written in 2015 and 2014, respectively and the estimates are included special surplus at December 31, 2015 and 2014. The Company paid $3.6 million and $3.2 million respectively, for the Health Insurer Fee which are included in general and administrative expenses on the accompanying Statements of Operations.

	Current Year (thousands)	Prior Year (thousands)
Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the federal Afforable Care Act (YES)/(NO)	Yes	
ACA fee assessment payable for the upcoming year	$ 3,625	$ 4,514
ACA fee assessment paid	$ 3,625	$ 3,195
Premium written subject to ACA 9010 assessment	$ 189,377	$ 189,059
Total adjusted capital before surplus adjustment (Five-Year Historical Line 14)	$ 36,678	$ 53,795
Total adjusted capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	$ 33,053	$ 49,281
Authorized Control Level (Five-Year Historickal Line 15)	$ 9,823	$ 10,624
Would reporting the ACA assessment as of December 31, 2015 have triggered an RBC action level (YES/NO)	NO	

23. Reinsurance

During 2015 and 2014, HealthSpan held a reinsurance contract with Preferred Professional Insurance Company (PPIC) to protect itself against high-cost, catastrophic claims exposure for its comprehensive line of business. The reinsurance is a non-proportional per risk excess of loss agreement whereby HealthSpan retains the first $300 thousand and $550 thousand of loss per Medicare Advantage and Commercial member, respectively. Additionally, HealthSpan agrees to a 10% coinsurance rate for claims exceeding the retention. The reinsurance contract does not relieve HealthSpan of its primary obligation to pay member claims. In 2015 and 2014, HealthSpan ceded premium of $1.8 million and $2.0 million on $216.0 million and $249.0 million of direct premium, respectively. Additionally, HealthSpan has recorded $2.2 million and $1.5 million of reinsurance recoveries related to this contract as a reduction of claims expense for the years ending December 31, 2015 and 2014, respectively.

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the company or by any representative, officer, trustee, or director of the company?

Yes ( ) No (X)

(2) Have any policies issued by the company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Section 2 – Ceded Reinsurance Report – Part A

(1) Does the company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credit?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 – Ceded Reinsurance Report – Part B

(1) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the company may consider the current or anticipated experience of the business reinsured in making this estimate.

None

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the company as of the effective date of the agreement?

Yes ( ) No (X)

B. Uncollectible Reinsurance

HealthSpan has not written off any uncollectible reinsurance during the reporting periods.

C. Commutation of Ceded Reinsurance

HealthSpan has not commuted any ceded reinsurance during the reporting periods.

D. Certified Reinsurer Rating Downgraded or Status Subject to Revocation

HealthSpan has not ceded insurance to a certified reinsurer whose rating has been downgraded or was subject to revocation during the reporting periods.

24. Retrospectively Rated Contracts

The ACA established risk sharing programs, known as risk adjustment, reinsurance, and risk corridors, to protect health insurers against the incurrence of high claims which may occur as a result of the guarantee issue rules of the ACA. Two of the programs, reinsurance and risk corridors, are temporary and conclude in 2016. The risk adjustment program is permanent.

The risk adjustment program shifts risk by transferring funds to individual and small group plans that report high risk based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool, and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. The Company's estimate of amounts receivable and/or payable under the risk adjustment program is based on our estimate of both our own and the state average risk scores. The amount estimated to be paid in 2016 to the risk adjustment program for 2015 is $12.4 million as of December 31, 2015 (as of December 31, 2014, the risk adjustment reserve was $0). HealthSpan paid $13.2 million for risk adjustment during 2015 for the 2014 assessments, which is reflected as a change in estimate within premium revenue. HealthSpan has recorded contributions to the risk adjustment program as assessments, which are included on the statement of admitted assets, liabilities, capital, and surplus.

The risk corridor program limits issuer gains and losses for qualified health plans in the individual and small markets by comparing allowable medical costs to a target amount, each defined/prescribed by Department of Health and Human Services (HHS), and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to HealthSpan or require HealthSpan to refund HHS a portion of the premiums we received. HHS guidance provides that risk corridor collections over the life of the three year program will first be applied to any shortfalls from previous benefit years before application to current year obligations. For the 2014 plan year HealthSpan has an unrecorded receivable $1.2 million, which was received 2015 and will be recorded in the fiscal year 2016 statutory-basis financial statements. No risk corridor liability is anticipated for 2015.

The reinsurance program requires HealthSpan to make reinsurance contributions for calendar years 2014 through 2016 to HHS based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the ACA in the individual commercial market will be eligible for recoveries if individual claims exceed a specified threshold. Accordingly, plan contributions are recorded as premium reductions and recoveries are recorded as a reduction of claim

expense. For group members, the ACA reinsurance program is accounted for as an assessment because claims incurred for group members are not eligible for recovery under the program.

For individual members, who may incur high claim costs eligible for reimbursement, the ACA reinsurance program is accounted for as reinsurance. Accordingly, plan contributions are recorded as premium reductions and recoveries are recorded as a reduction of claim expense. For group members, the ACA reinsurance program is accounted for as an assessment because claims incurred for group members are not eligible for recovery under the program.

The following table summarizes the medical loss ratio rebates required pursuant to the Public Health Service Act.

	1 Individual	2 Small Group Employer	3 Large Group Employer	4 Other Categories with Rebates	5 Total
Prior Reporting Year					
(1) Medical loss ratio rebates incurred	$ -	$ -	$ -	$ -	$ -
(2) Medical loss ratio rebates paid	-	-	-	-	-
(3) Medical loss ratio rebates unpaid	-	-	-	-	-
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	-
Current Reporting Year -to-Date					
(7) Medical loss ratio rebates incurred	$ -	$ -	$ -	$ -	$ -
(8) Medical loss ratio rebates paid	-	-	-	-	-
(9) Medical loss ratio rebates unpaid	-	-	-	-	-
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebates unpaid net of reinsurance	XXX	XXX	XXX	XXX	-

The following table summarizes the impacts of the risk sharing provisions of the ACA on admitted assets, liabilities and revenue of HealthSpan for the years ended December 31 (*in thousands*):

a. Permanent ACA Risk Adjustment Program	2015	2014
Assets		
1. Premium adjustments receivable due to ACA Risk Adjustment	$ -	$ -
Liabilities		
2. Risk Adjustment user fees payable for ACA Risk Adjustment	$ 12	$ 14
3. Premium adjustments payable due to ACA Risk Adjustment	$ -	$ -
Operations (Revenue & Expense)		
4. Reported as revenue in premium for accident and health contracts (written / collected) due to ACA Risk Adjustment	$ -	$ -
5. Reported in expenses as ACA Risk Adjustment user fees (incurred/paid)	$ 12	$ 14
b. Transitional ACA Reinsurance		
Assets		
1. Amount recoverable for claims paid due to ACA Reinsurance	$ 2,822	$ 2,109
2. Amounts recoverable for claims unpaid due to ACA Reinsurance (Contra Liability)	$ -	$ -
3. amounts receivable relating to uninsured plans for contributions for ACA	$ -	$ -
Liabilities		
4. Liabilities for contributions payable due to ACA Reinsurance -not reported as ceded premium	$ 2,269	$ 3,308
5. Ceded reinsurance premiums payable Due to ACA Reinsurance	$ 326	$ 463
6. Liabilities for amounts held under uninsured plans contributions for ACA	$ -	$ -
Operations (Revenue & Expense)		
7. Ceded reinsurance premiums due to ACA Reinsurance	$ 326	$ 463
8. Reinsurance recoveries (income statement) due to ACA reinsurance payments or expected payments	$ 2,965	$ 2,630
9. ACA Reinsurance contributions -not reported as ceded premium	$ -	$ 3,308
c. Temporary ACA Risk Corridors Program		
Assets		
1. Accrued retrospective premium due to ACA Risk Corridors	$ -	$ -
Liabilities		
2. Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors	$ -	$ -
Operations		
3. Effect of ACA Risk Corridors on net premium income (paid/received)	$ -	$ -
4. Effect of ACA Risk Corridors on change in reserves for rate credits	$ -	$ -

The following table summarizes a roll-forward of 2014 ACA risk-sharing provisions for the asset and liability balances, along with the reasons for adjustments to 2014 balances (in thousands):

	Accrued prior year on business written before December 31 of the prior year		Received or paid as of the current year on business written before December 31 of the prior year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior year accrued less payments col (1-3)	Prior year accrued less payments col (2-4)	To prior year balances	To prior year balances		Cumulative balance from prior years Col (1-3+7)	Cumulative balance from prior years Col (2-4+8)
	1 Receivable	2 (Payable)	3 Receivable	4 (Payable)	5 Receivable	6 (Payable)	7 Receivable	8 (Payable)	Ref	9 Receivable	10 (Payable)
a. Permanent ACA Risk Adjustment Program											
1. Premium adjustment receivable	-	-	-	-	-	-	-	-	A	-	-
2. Premium adjustment (payable)	-	-	-	(13,188)	-	13,188	-	(13,188)	B	-	-
3. Subtotal ACA Permanent Risk Adjustment Program	-	-	-	(13,188)	-	13,188	-	(13,188)		-	-
b. Transitional ACA Permanent Risk											
1. Amounts recoverable for claims paid	2,109	-	2,960	-	(851)	-	851	-	C	-	-
2. Amounts recoverable for claims unpaid (contra liability)	521	-	-	-	521	-	(521)	-	D	-	-
3. Amounts receivable relating to uninsured plans	-	-	-	-	-	-	-	-	E	-	-
4. liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium	-	3,308	-	3,308	-	-	-	-	F	-	-
5. Ceded reinsurance premiums payable	-	(463)	-	(438)	-	(25)	-	25	G	-	-
6. Liability for amounts held under uninsured plans	-	-	-	-	-	-	-	-	H	-	-
7. Subtotal ACA transitional reinsurance program	2,630	2,845	2,960	2,870	(330)	(25)	330	25		-	-
c. Temporary ACA risk corridor program											
1. Accrued retrospective premium	-	-	1,213	-	(1,213)	-	1,213	-	I	-	-
2. Reserve for rate credits or policy experience rating refunds	-	-	-	-	-	-	-	-	J	-	-
3. Subtotal ACA risk corridors program	-	-	1,213	-	(1,213)	-	1,213	-		-	-
d. Total for ACA risk Sharing Provisions	2,630	2,845	4,173	(10,318)	(1,543)	13,163	1,543	(13,163)		-	-

Explanation of Adjustments

A. Not applicable
B. Prior year estimate was less than actual.
C. Prior year estimate was less than actual.
D. Prior year estimate was less than actual.
E. Not applicable
F. Not applicable
G. Prior year estimate was greater than actual.
H. Not applicable
I. Prior year estimate was less than actual.
J. Not applicable

25. Change in Incurred Claims and Claim Adjustment Expenses

Unpaid claims and claims adjustment expense includes both reported and unreported medical claims. Unpaid claims incurred but not reported represent an estimate of claims incurred for or on behalf of HealthSpan's members that had not yet been reported to HealthSpan. Unpaid claims are based on a number of factors, including hospital admission data and prior claims experience, as well as claims processing patterns; adjustments, if necessary, are made to medical expense in the period the actual claims costs are ultimately determined.

Claims adjustment expense represents costs incurred related to the claim settlement process, such as costs to record, process, and adjust claims. These expenses are calculated using a percentage of current medical costs, which is based on historical cost experience.

For the years ended December 31, activity in the reserves for unpaid claims was as follows (*in thousands*):

	2015	2014
Claims Payable:		
Balance beginning of period	$ 40,997	$ 78,725
Incurred Claims:		
Insured Events of Current Year	$ 364,965	$ 411,578
Increase (decrease) insured events of prior year	(2,474)	(3,454)
Total incurred claims	$ 362,491	$ 408,124
Paymet of claims:		
Claims incurred in prior years	$ 38,475	$ 75,386
Claims incurred in current year	336,518	370,466
Total claims paid	$ 374,993	$ 445,852
Balance end of the period	$ 28,495	$ 40,997

26. Intercompany Pooling Arrangements

HealthSpan has no intercompany pooling arrangements.

27. Structured Settlements

Not applicable for health entities.

28. Health Care Receivables

a. Pharmaceutical Rebate Receivables

The Company accounts for pharmaceutical rebate receivables in accordance with SSAP No. 84, *Certain Health Care Receivables and Receivables under Government Insured Plans (SSAP No. 84)*. The admitted receivable balances as of December 31, 2015 and 2014 are $4.4 million and $1.5 million, respectively, are included in health care receivables on the balance sheets. These are comprised of estimated pharmacy rebates for the current quarter as reported in the financial statements plus the pharmacy rebates invoiced/confirmed for the preceding quarter. Additional details are included in the table below:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Biled or Othewise Confirmed	Actual Rebates received Within 90 Days of Billing	Actual Rebates received Within 91 to 180 Days of Billing	Actual Rebates received More Than 180 Days of Billing
12/31/2015	$ 4,363	$ 4,363	$ 1,259	$ -	$ -
9/30/2015	3,728	3,728	929	561	-
6/30/2015	3,021	3,021	1,705	-	-
3/31/2015	3,454	3,454	735	589	-
12/31/2014	1,467	1,467	1,190	887	-
9/30/2014	3,675	3,675	515	-	-
6/30/2014	2,585	2,585	398	-	-
3/31/2014	1,085	1,085	-	-	-
12/31/2013	-	-	-	-	-
9/30/2013	-	-	-	-	-
6/30/2013	-	-	-	-	-
3/31/2013	-	-	-	-	-

b. Not applicable

29. Participating Policies

HealthSpan has no participating policies

30. Premium Deficiency Reserves

Premium deficiency reserve and the related expenses are recognized when it is probable that expected future health care and maintenance costs under a group of existing insurance contracts will exceed anticipated future premiums, current reserves and anticipated future reinsurance recoveries over the insurance contract period. The Company projects future premiums and losses using historical results to help determine future performance for both prepayments and claims. An estimated expense factor is then applied, and the result is discounted using a rate of return. This net present value, less any existing reserves, is recorded as a premium deficiency. Expected investment income and interest expense are included in the calculation of premium deficiency reserves, as appropriate. The premium deficiency reserve was $84.4 million and $0 at December 31, 2015 and 2014, respectively, and was actuarially determined. Given the inherent variability of the premium deficiency reserve estimate, the actual liability could differ significant from the calculated amount.

31. Anticipated Salvage and Subrogation

HealthSpan had no salvage and subrogation included in as a reduction of loss reserves for the years ended December 31, 2015 and 2014, respectively.

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories

State, Etc.	1 Active Status	Direct Business Only							
		2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Plan Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/ Casualty Premiums	8 Total Columns 2 Through 7	9 Deposit-Type Contracts
1. Alabama AL								0	0
2. Alaska AK								0	0
3. Arizona AZ								0	0
4. Arkansas AR								0	0
5. California CA								0	0
6. Colorado CO								0	0
7. Connecticut CT								0	0
8. Delaware DE								0	0
9. District of Columbia DC								0	0
10. Florida FL								0	0
11. Georgia GA								0	0
12. Hawaii HI								0	0
13. Idaho ID								0	0
14. Illinois IL								0	0
15. Indiana IN								0	0
16. Iowa IA								0	0
17. Kansas KS								0	0
18. Kentucky KY								0	0
19. Louisiana LA								0	0
20. Maine ME								0	0
21. Maryland MD								0	0
22. Massachusetts MA								0	0
23. Michigan MI								0	0
24. Minnesota MN								0	0
25. Mississippi MS								0	0
26. Missouri MO								0	0
27. Montana MT								0	0
28. Nebraska NE								0	0
29. Nevada NV								0	0
30. New Hampshire NH								0	0
31. New Jersey NJ								0	0
32. New Mexico NM								0	0
33. New York NY								0	0
34. North Carolina NC								0	0
35. North Dakota ND								0	0
36. Ohio OH	L	198,770,517	126,694,933		36,785,513			362,250,963	0
37. Oklahoma OK								0	0
38. Oregon OR								0	0
39. Pennsylvania PA								0	0
40. Rhode Island RI								0	0
41. South Carolina SC								0	0
42. South Dakota SD								0	0
43. Tennessee TN								0	0
44. Texas TX								0	0
45. Utah UT								0	0
46. Vermont VT								0	0
47. Virginia VA								0	0
48. Washington WA								0	0
49. West Virginia WV								0	0
50. Wisconsin WI								0	0
51. Wyoming WY								0	0
52. American Samoa AS								0	0
53. Guam GU								0	0
54. Puerto Rico PR								0	0
55. U.S. Virgin Islands VI								0	0
56. Northern Mariana Islands MP								0	0
57. Canada CAN								0	0
58. Aggregate other alien OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal	XXX	198,770,517	126,694,933	0	36,785,513	0	0	362,250,963	0
60. Reporting entity contributions for Employee Benefit Plans	XXX							0	
61. Total (Direct Business)	(a) 1	198,770,517	126,694,933	0	36,785,513	0	0	362,250,963	0
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998) (Line 58 above)	XXX	0	0	0	0	0	0	0	0

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

Explanation of basis of allocation by states, premiums by state, etc. All premiums were earned in the State of Ohio

(a) Insert the number of L responses except for Canada and other Alien.