# IN THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT, IN AND FOR LEON COUNTY, FLORIDA 

State of Florida, ex rel., the
Department of Financial Services of
the State of Florida,
Relator,
v.

CASE NO: $\qquad$
Universal Health Care Insurance
Company, Inc.,
Respondent,

## THE FLORIDA DEPARTMENT OF FINANCIAL SERVICES' APPLICATION FOR ORDER TO SHOW CAUSE, INJUNCTION, AND NOTICE OF AUTOMATIC STAY FOR PURPOSES OF LIQUIDATION

The Florida Department of Financial Services (hereinafter "Department") hereby applies to this Court pursuant to Sections 631.031 and 631.061 , Florida Statutes, for the entry of an Order to Show Cause, Injunction, and Notice of Automatic Stay on the appointment of the Department as Receiver of Universal Health Care Insurance Company, Inc. ("Respondent" or "UHCIC") for purposes of liquidation. In support of its Application, the Department states:

1. This Court has jurisdiction pursuant to Section 631.021(1), Florida Statutes, and venue is proper pursuant to Section 631.021(2), Florida Statutes.
2. Respondent is a corporation authorized pursuant to the Florida Insurance Code to transact business in the State of Florida as a domestic life and health insurer since May 26, 2006. Respondent's principal place of business is located at 100 Central Avenue, Suite 200, St. Petersburg, Florida 33701.
3. Universal Health Care Group, Inc. ("UHCG") is the sole owner of Universal Health Care, Inc. ("UHC"), a Health Maintenance Organization, and Universal Health Care Insurance Company, Inc. ("UHCIC"), an insurance company. UHCG also owns American Managed Care ("AMC") which is the management company and third party administrator for UHC and UHCIC. AMC employs the corporate officers and the majority of the employees of both UHC and UHCIC. UHCG, UHC and UHCIC have identical corporate officers.
4. Section 631.021(3), Florida Statutes, provides that a delinquency proceeding pursuant to Chapter 631, Florida Statutes, constitutes the sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving a Florida domiciled insurer.
5. Sections 631.031 and 631.061 , Florida Statutes, empower the Department to apply to this Court for an order directing it to liquidate a domestic insurer upon the existence of any of the grounds specified in Sections 631.051 and 631.061, Florida Statutes. Further, Section 631.025(2), Florida Statutes, authorizes the Department to initiate delinquency proceedings against any insurer if the statutory grounds are present as to that insurer.
6. Pursuant to Section 631.031(1), Florida Statutes, by letter dated February 1, 2013, Kevin McCarty, Commissioner of the Office of Insurance Regulation, advised Florida's Chief Financial Officer, Jeff Atwater, that the Office of Insurance Regulation (the "Office") concluded grounds existed for the initiation of delinquency proceedings against Respondent. A copy of the letter is attached as Exhibit "A."
7. Based on the documentation received from the Office, the Department has determined that grounds for Respondent's liquidation exist pursuant to Section 631.051(1), Florida Statutes, in that Respondent is impaired or insolvent. The basis for the determination is summarized as follows:
A. On January 15, 2013, Respondent requested that Center for Medicare and Medicaid Services ("CMS") allow the company to implement enrollment capacity limits on Respondent T's Network PFFS (Contract No. H8090), Non-Network PFFS (Contract No. H5820), and PPO (Contract No. H5096). A copy of the letter from Akshay Desai to CMS is attached as Exhibit "B." On January 17, 2013, Respondent again requested that CMS allow the company to implement enrollment capacity limits, and requested that the decision be expedited. By its own admission, Respondent stated that the reason for this request is that the company "has reason to believe that Universal is financially impaired." A copy of the e-mail from Francoise Trotman, Respondent's Chief Compliance Officer, is attached as Exhibit "C."
B. The Office has determined that Respondent is operating in an unsound financial condition.
i. The Office has concerns over the company recording retrospective management fees as receivables from AMC. AMC does not have the ability to pay such receivables. AMC has filed multiple insolvent financial statements, most recently September 30, 2012. A copy of American Managed Care, LLC's Quarterly Report is attached as Exhibit "D." As of December 31, 2012, Respondent shows this asset as non-
admitted. the March 31, 2012, and June 30, 2012, financial statements. A copy of Universal Health Care Insurance Company, Inc.'s Monthly Statement for the month ending December 31, 2012, is attached as Exhibit "E."
ii. Section 624.4095, Florida Statutes, limits an insurer's ratio of annual net written accident and health premium to surplus as to policyholders to a maximum of 4:1 and annual gross written accident and health premium to a maximum of 10:1. Respondent has a history, beginning in 2007, of noncompliance with one or both of the accident and health writing ratios. This ratio measures the insurance company's cushion of capital and surplus available to absorb losses resulting from unexpected variances from expected operating results, and is an important indicator of financial solvency. Respondent's violations of Section 624.4095, Florida Statutes, has resulted in Corrective Action Plans, Consent Orders and a Consent Order For Public Administrative Supervision And Contingent Order Of Liquidation since Respondent s licensure during 2006. Respondent's writing ratios remain out of compliance today.
iii. As of December 31, 2012, by their own admission, Respondent has a deficit of capital and surplus of approximately $\$ 4$ million. A
copy of Universal Health Care Capital Plan is attached as Exhibit "F."
C. Two other states in which Respondent operates have issued Consent Orders stating that Respondent shall not enroll any new customers in that state, due to Respondent's unsound financial condition.
i. The Georgia Office of Insurance issued a Consent Order dated November 15, 2012, stating that Respondent "shall cease writing new business" in the State of Georgia. A copy of the Consent Order is attached as Exhibit "G."
ii. The Ohio Department of Insurance issued a Consent Order dated December 18, 2012, affirming that Respondent "will not solicit, issue, or otherwise write any new policies or contracts of insurance, nor shall it assume any new risk in the State of Ohio". A copy of the Consent Order is attached as Exhibit "H."
8. In addition, the Department has determined that grounds for Respondent's liquidation exist under Section 631.051(3), Florida Statutes, in that Respondent is found by the Department to be in such condition, as to render its further transaction of insurance hazardous to its policyholders, creditors, stockholders, or the public. The basis for this determination is summarized as follows:
A. Respondent has a pattern of mismanagement, which has resulted in Respondent operating in such a condition as to render its further transaction of
insurance hazardous to its policyholders, creditors, stockholders, and the public. This pattern of mismanagement includes the following:
i. There has been frequent turnover in the position of Chief Financial Officer. Respondent has had five Chief Financial Officers within a period of six years. Respondent was without a Chief Financial Officer between May 2011 and October 2012.
ii. The Report on Significant Deficiencies in Internal Controls that accompanied the 2011 audited financial statements included a list of issues that the auditor considered material weakness involving internal control over financial reporting. A copy of the letter listing the issues is attached as Exhibit "I."
iii. The claim system is compromised and previous attempts to convert to a new claim system have been unsuccessful. A copy of the letter from Jennan Enterprises regarding the conversion of the claims system is attached as Exhibit " J ."
B. The Office has determined that Respondent is engaging in methods or practices which render the continuance of business hazardous to the public or insureds.
i. During 2012, UHCG entered into a credit agreement with Bank United for a total of $\$ 60$ million. On three separate occasions since October 29, 2012, Bank United has notified UHCG of certain events of default. These events include an allegation that the financial statements provided at the time
the Credit Agreement was entered into were incorrect, false, and/or misleading. Copies of the three letters from Bank United to Universal Health Care Group, Inc., are attached collectively as Exhibit "K." UHCG, UHC and Respondent have identical corporate officers.
ii. The Office has concluded that some of UHC's assets, as reported on previously filed financial statements, have been materially overstated, causing UHC to be in worse financial condition than its filed financial statements make it appear.
iii. Respondent has had multiple adverse findings related to the financial condition of Respondent, which includes material financial adjustments made to the 2011 annual statement, the March 31, 2012, and June 30, 2012, financial statements. A copy of Universal Health Care Insurance Company, Inc.'s Annual Statement for the year ending December 31, 2011, is attached as Exhibit "L."
iv. The Office has concluded that several receivables reported on Respondent's previous financial statements will not be able to be collected.
v. Management of Respondent has filed misleading financial statements and has omitted an entry of material amounts on the books of the insurer. See Exhibit "M."
vi. The Office believes that there will be future problems with insurer solvency because of a lack of access to additional capital. A copy of the affidavit of Toma L. Wilkerson, Director of Life \& Health Financial Oversight, Office of Insurance Regulation, is attached as Exhibit "N."
vii. Further, although UHCG, the parent company of Respondent, has entered into a Letter Agreement with America's $1^{\text {st }}$ Choice Holdings of Florida, LLC, for the purchase of UHCG and all its affiliated health plans, including Respondent, completion of the transaction detailed within the letter agreement is subject to governmental and regulatory approval. Regulatory Approval is questionable at this time. A copy of the Letter Agreement is attached as Exhibit "O."
9. Section 631.041(1), Florida Statutes, provides that the Department's Application for an Order to Show Cause operates as an automatic stay of certain actions. Notice of the automatic stay should be contained within the Order to Show Cause. However, the Court order should provide that regulatory actions against Respondent by any regulatory body shall not be stayed. Section 631.041(3) and 63.041(4), Florida Statutes, authorize this Court to enter certain injunctions to preserve the remaining assets of the insurer.
10. It is in the best interest of Respondent, its creditors and insureds that the relief requested in this Application be granted.

WHEREFORE, the Florida Department of Financial Services respectfully
moves this Court for an Order:
A. Directing Respondent to appear before this Court on a short day certain and show good cause, if any, as to why the Department should not be appointed Receiver of Respondent for purposes of liquidation under the provisions of Chapter 631, Florida Statutes.
B. Requiring Respondent to file a written response along with any defenses it may have to the Department's allegations no later than twenty (20) days after the service of any Order to Show Cause issued by this Court and at least fifteen (15) days prior to hearing.
C. Directing that in order to protect the interests of policyholders, creditors, and the public generally, pending the adjudication of this matter and to protect and preserve the assets, books, and records of Respondent pending hearing on the Department's petition pursuant to Section 631.041(3) and 631.041(4), Florida Statutes, all persons, firms, corporations, associations and Respondent's affiliates as defined by Section 631.011, Florida Statutes, all persons, and all other persons or entities within the jurisdiction of this Court, including, but not limited to, Respondent and its officers, directors, stockholders, trustees, members, agents, and employees to be enjoined and restrained from removing, destroying, or otherwise disposing of any documents, books, records, or assets of Respondent (or pertaining to Respondent), from doing, through acts of commission or omission, or permitting to be done any action which might waste or otherwise dispose of the books, records, including but not limited to electronic records, and assets of, or directly or indirectly relating to, the Respondent; from denying the Department access to the books, records, and assets of, or directly or indirectly
relating to, the Respondent; from in any manner interfering with the Department or the conduct of these proceedings, from the removal, concealment or other disposition of the property, books, records, and accounts of, or directly or indirectly relating to, the Respondent; from commencement or prosecution of any actions against the Respondent, or the obtaining of preferences, judgments, writs of attachment or execution against Respondent or its property or assets. However, regulatory actions against Respondent by any regulatory body should not be stayed or enjoined;
D. Directing the Department be given authorization to conduct, at its discretion, either an investigation authorized by Section 631.391, Florida Statutes, of Respondent and its affiliates, as defined above, to uncover and make fully available to the Court the true state of Respondent's financial affairs. In furtherance of this investigation, Respondent and its parent corporation, its subsidiaries and affiliates, should be required to make all books, documents, accounts, records, and affairs, which either belong to or pertain to the Respondent, wherever located, available for full, free and unhindered inspection and examination by the Department during normal business hours (8:00a.m. to 5:00p.m.), Monday through Friday, from the date of this Order. This investigation should include a full and complete examination of any and all reviews, compilations, audits or any other work of whatever nature performed by any accounting firm to include all work papers, on behalf of, related to or in any way cónnected with Respondent, its affiliates and/or Respondent's corporate structure and affiliations. Respondent and its affiliates should be ordered and enjoined to cooperate with the Department to the fullest extent required by Section 631.391, Florida Statutes. Such cooperation should include, but not be limited to, the taking of oral testimony under oath
of Respondent's officers, directors, managers, trustees, agents, adjusters, employees, or independent contractor of Respondent, its affiliates and any other person who possesses any executive authority over, or who exercises any control over, any segment of the affairs of Respondent in both their official , representative and individual capacities and the production of all documents that are calculated to disclose the true state of Respondent's affairs.
E. Directing that any officer, director, manager, trustee, agent, accountants, adjuster, employee, or independent contractor of Respondent and any other person who possess any executive authority over, or who exercises any control over, any segment of the affairs of Respondent to fully cooperate with the Department as required by Section 631.391, Florida Statutes, and as set out in the preceding paragraph.
F. Directing that the failure of Respondent and its affiliates and all other persons or entities within the jurisdiction of this Court, to cooperate with the Department's investigations as required by Section 631.391, Florida Statutes, and that failure to comply with any Order to Show Cause issued by this Court shall result in the immediate entry of an order of liquidation.
G. Giving notice of the automatic stay provisions of Section 631.041(1), Florida Statutes.
H. Directing the Officers and Directors of Respondent to comply with the provisions of Section 626.9541(1)(w), Florida Statutes; and
I. Granting such other relief as the Court deems appropriate.

AND FURTHER, at hearing or on consent of Respondent, if this Court determines that a receiver should be appointed, the Department moves this Court for entry of its Order of Liquidation that is substantially similar to the one that is attached to this Application as Exhibit "P".

RESPECTFULLY SUBMITTED on this day 4 th of February, 2013.


Florida Bar No. 139408
ROBERT V. ELIAS,
CHIEF ATTORNEY
Florida Bar No. 530107
TIMOTHY L. NEWHALL
DEPUTY CHIEF ATTORNEY
Florida Bar No. 391255
JODY E. COLLINS
SENIOR ATTORNEY
Florida Bar No. 500445
Florida Department of Financial Services
Division of Rehabilitation and Liquidation
2020 Capital Circle SE, Suite 310
Tallahassee, Florida 32301
(850) 413-4414 - Telephone
(850) 413-3992 - Facsimile

Financial Services Commission

RJCK SCOTT GOVERNOR

JEFF ATWATER CHIEF FINANCLAL OFFICER

## KEVIN M. MCCARTY

COMMTSSIONER

February 1,2013
The Honorable Jeff Atwater
Chief Financial Officer
Department of Financial Services
The Capitol, PL-11
Tallahassee, FL 32399
Re: Universal Health Care Insurance Company, Inc.

## Dear Chief Financial Officer Atwater:

Please be advised that the Office of Insurance Regulation (hereinafter referred to as the "Office") has determined that one or more grounds exist for the initiation of delinquency proceedings, pursuant to Chapter 631, Florida Statutes, against Universal Health Care Insurance Company, Inc. (hereinafter referred to as "UHCIC"), and that delinquency proceedings must be initiated. UHCIC is a domestic life and health insurer licensed in the State of Florida, and is currently selling Medicare Advantage business. As specified in Section 631.051, Florida Statutes, the grounds that allow for a petition for an order appointing the Department of Financial Services (hereinafter referred to as the "Department") as receiver include:
(1) The company is impaired or insolvent.

The Office finds for the reasons set forth in the attached documents that UHCIC is impaired or insolvent.
(2) The company is found by the Office to be in such condition or is using or has been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its policyholders, creditors, stockholders, or the public.

UHCIC's impairment or insolvency poses a serious danger to the financial safety of the policyholders, subscribers, claimants, creditors and citizens of the State of Florida.
(3) The company has been the victim of embezzlement, wrongful sequestration, conversion, diversion, or encumbering of its assets; forgery or fraud affecting it; or other illegal conduct in, by, or with respect to it, which if established would threaten its solvency; or that the Office has reasonable cause to so believe any of the foregoing has occurred or may occur;

The Office has concluded, for the reasons set forth in the attached documents, that UHCIC has filed incorrect, false, and/or misleading financial statements.

The Office has determined that UHCIC is currently impaired, insolvent, or about to become insolvent. As such, I am advising you of that determination so that delinquency proceedings can be initiated by the Division of Rehabilitation and Liquidation. The following documents are attached in support of such determination:

Exhibit 1 - Affidavit of Toma Wilkerson, Director Life \& Health Financial Oversight, with Exhibits.

As always, the Office stands ready to provide any additional information or assistance the Department needs in order for this matter to proceed as expeditiously as possible. Thank you for your attention to this matter.

cc: PK Jameson, General Counsel
Department of Financial Services
Sha'Ron James, Division Director
Division of Rehabilitation and Liquidation
Department of Financial Services

100 Central Avenue, Sulte 200, St, Peterslburg, FL 33701 • phome 1-866-690-4842 - fax 1-727-822-3556 , med wwwunivic.com

January 15, 2013

Ms. Shirley Fuquay
Account Manager
Department of Health \& Human Services
Centers for Medicare \& Medicaid Services
61. Forsyth St., Sulte 4T20

Atlanta, Georgla 30303-8909

Re: Universal Health Care Insurance Company, Inc.
Contract No: H8098, H5820 and H5098
Unlversal Health Gare, Inc.
Contract No: H5404
Request to Specify Plan Capacity Limit

Dear Ms. Fuquay:

In its letter to the Centers for Medicare and Medicald ("CMS") dated January 14, 2013, Universal Health Care Group ("Universal") requests to implement plan capacity Ilmits for Universal Insurance Company, Inc. ("UHCIC") and Universal Health Care, Inc. ( ${ }^{\prime \prime}$ UHC") in keeping with the provisions stated at 42 CFR 422.60 (b) (2), (3). Unlversal expects that this capacity limit will ensure that neither UHCIC nor UHC will accept any new enrollments during the effective period of the capacity limit.

This decision pertains to UHCIC'S Network PFFS (Contract No. H8098), Non-Network PFFS (Contract No. H5820) and PPO (Contract No. H5096) and UHC's HMO contract (Contract No. H5404).
Speciflcally Universal would like to speclfy the following capacity limits per contract:
H8 0808 - 14,106
H5820-20,659
H5096-2,705
HS404-38,193

Please nate that specified plan limits are based on the plan's current membership enrolled as of Januare 15, 2013.


Piease also note that thils decision does NOT affect the subsidiaries of Unlversal Health Care Group inc, Universal HMO of Texạs, Inc. and Universal Health Care of Nevada, Inc.

If you have any questions or need addiltional information, please do not hesitate to contact Francolse Trotman, Chilef Compliance Officer at 727-456-6585 or at frotman@unlyhc.com.

> Sincerelv, Aundonan
> Akshay Desai, M.D., MPH
> President \& CEO
CL. Office of Insurance Regulation
Clarisse Owens Centers for Medicare and Medicaid Services (CMS/CM)
encl

## Kennedy, Ray

From:<br>Sent:<br>To:<br>Subject:<br>Wilkerson, Toma<br>Thursday, January 17, 2013 4:40 PM<br>Schoenecker, Catharine; Threadgill, Dennis; Johns, Paul; Struk, Christopher; Reglat, Valerie; Davis, Heather; Kennedy, Ray; Davis, LaTasha; Davis, Rebecca<br>Fw: Universal's Request - Enrollment Capacity Limits

From: Francoise Trotman [mailto:FTrotman@univhc.com]
Sent: Thursday, January 17, 2013 04:12 PM
To: Fuquay, Shirley (CMS/CMHPO) (SHIRLEY.FUQUAY@cms.hhs,gov) <SHIRLEY.FUQUAY@cms.hhs,gov>
Cc: Wilkerson, Toma; Akshay Desai, M.D., M.P.H. <adesal@unlvhc,com>; miltchell@sostrategy.com
[mitchell@sostrategr.com](mailto:mitchell@sostrategr.com)
Subject: Re: Universal's Request - Enrollment Capacity Limits
Ms. Fuquay,
On January 15, 2013 Universal Health Care ("UHC") requested that CMS allow the plan to implement enroliment capacity limits on the following contracts: H8090, H5820, H5096 and H5404. The Universal management team is requesting that CMS assist with expediting its decision. The company has assessed its financial acumen and has reason to believe that Universal is financially impaired. We believe that expediting this matter allows the company, CMS and the State to protect our existing members and avoid risk to any new Medicare beneficiaries through continued enrollment.

Thank you,
Francolse Trotman
Chief Compliance Officer

Haalh Cem Qrous
Universal Health Care
100 Central Avenue, Sulte 200
St. Petersburg, FL 33701
Offlce: 727-456-6585
Fax: 727-329-0745
FTrotman@univhc.com
httpi//www. univhc.com
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EXHIBIT "C"

ATTESTATION 8TATEMENT


PPIGERS / DiRECTORS / MEMERR

| Chtor Excaulvo Onlicer | Akshary h, Doach M.O. |
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14 day of Novernber , 2012

## Office of Insurance Regulation Specialty Product Administration

FLORIDA COMPANY CODE:
45271

## QUARTERLY REPORT

 OF THEFEDERAL EMPLOYER IDENTIFICATION NUMBER:

AMERICAN MANAGED CARE, LLC
(Insurance Administrator)

TO THE
OFFICE OF INSURANCE REGULATION
OF THE
STATE OF FLORIDA
Specialty Product Administration
200 East Gaines Street
Tallahassee, FL 32399-0331

FOR THE QUARTER ENDED
September 30, 2012

DUE 45 DAYS AFTER THE END OF EACH QUARTER

## GENERAL INFORMATION AND INSTRUCTIONS

1. Financial statements must be prepared in accordance with generally accepted accounting principles and as prescribed in the Florida Statutes.
2. The Balance Sheet and Statement of Income must be prepared based on year-end amounts.
3. All tems used in this report will have their general meaning except where specific statutory language applies under the applicable provisions of the Florida Insurance Code.
4. This form is submitted electronically. Adobe Reader version 7.0 .5 or higher is required. If you do not have that version, please upgrade at http://www, adobe.com prior to downloading any forms.
5. When you downloaded this report, you were assigned a session key. This session key has an expiration date that was also assigned prior to downloading this form. Please make sure you save or submit prior to this expiration date or all work up until the last save will be lost.

This session will expire on: 11/14/2012 11:30:00 PM Eastern Time
6. To assist you In completing this form click both "Highlight Fields" and "Highlight Required Fields" in the upper right hand corner of the report page. This will highlight the fields where you may enter data.
7. The report form will calculate all totals and pre-populate fields based upon your responses. Data cannot be entered into the total and pre-populated fields.
8. Please enter all numeric fields with numbers only (no commas, dashes, dollar signs, etc.). Unanswered questions and blank lines on schedules will not be accepted. If no answers or entries are to be made, enter " $0^{\circ}$ on all lines asking for a numeric response and "None" or "N/A" on all lines requesting a non-numeric response. Additionally, certain Schedules and Exhibits provide the option "Check if $N / A$ " if the information requested is not applicable to your company.
9. Line descriptions may not be altered or added. When in doubt where to place an item, show the item in an appropriate "Other" line and include a supplemental schedule describing the items listed in the "Other" category. Any item which is of an extraordinary nature should also be entered on an appropriate "Other" line.
10. "Save" or "Submit" buttons are provided on the last page of this report. Hit the ALT+s keys to go to the last page. By clicking the Save button, all data entered on the form will be saved to our website. It is strongly recommended that you save your data perlodically as you fill in this form. You will receive a confirmation message once the data is successfully saved.
11. When you either save or submit the form, all data is checked for completeness; you will be notified if errors have occurred. When submitting data, you will be asked to correct these validation errors. Once the form is successfully submitted, the form becomes read-only. To update information after submission, an amended form must be flled through REFS.
12. If additional explanations, supporting statements or schedules are added or are necessary, the additions should be properly cross-referenced to the item being answered. This additional information should be in electronic format (l.e. Word, Excel, PDF, etc) or, if in paper format, scanned in as a PDF, and should be attached and uploaded to the filing as a Miscellaneous Document through REFS.

13 When you have completed a form and selected "Submit Final," your report form is uploaded as a "Completed" document to your Component List; this does not submit the report to the Office of Insurance Regulation. Upon completion of all required items, the "Begin Submission Process" button (bottom right of the screen) will activate. You must select and complete the "Begin Submission Process" to successfully submit your entire filing to OIR.
14. Please print, sign and upload a PDF version of the Jurat/Attestation Statement (see next page) under the corresponding component in REFS. If yoü do nōt have a component so named, pleäse üplōā a signed PDF under the Miscellaneous Documents component.

## ATTESTATION STATEMENT



Under penaities of perjury, I declare that I have read the Annual Report of the $\quad$ American Maneged Care, LLC
and that the facts stated in It are true.
(name of llcensee)
Nowember of $\quad$ Preskenvowner

## baLANCE SHEET

| Current Assets: | Current Period |
| :---: | :---: |
| 1. Cash \& Cash Equivalents | \$540,905 |
| 2. Investments | \$100 |
| 3. Accounts Receivable - Trade, Net |  |
| 4. Notes Recelvable |  |
| 5. Prepaid Expenses | \$3,458,650 |
| 6. Deferred Income Taxes |  |
| 7. Other (Identify) See Upload Page | \$31,529,937 |
| 8. Total Current Assets (Sum of Lines 1 through 7) | \$36,529,692 |
| 9. Long-Term Investments | \$420,475 |
| Property \& Equipment: |  |
| 10. Land |  |
| 11. Buildings | - |
| 12. Furniture, Fixtures, \& Equipment | \$4,024,680 |
| 13. Leasehold Improvements | \$8,575 |
| 14. Other (Identify) See Upload Page | \$18,050,444 |
| 15. Total Cost of Property \& Equipment (Sum of Lines 10 through 14) | \$22,083,699 |
| 16. Accumulated Depreciation | \$10,133,964 ) |
| 17. Net Property \& Equipment (Line 15 less Line 16) | \$11,949,735 |
| Intangible Assets: |  |
| 18. Goodwill |  |
| 19. Other (Identify) |  |
| 20. Total Intangible Assets (Sum of Lines 18 and 19) |  |
| Other Assets: |  |
| 21. Notes Receivable |  |
| 22. Due from Affilates \& Other Related Parties (Upload Schedule via REFS) | \$85,392 |
| 23. Deferred Income Taxes |  |
| 24. Other (Identify) Deposits | \$27,082 |
| 25. Total Other Assets (Sum of Lines 21 through 24) | \$112,474 |
| 26. Total Assets (Sum of Lines 8, 9, 17, 20 and 25) | \$48,012,276 |

## BALANCE SHEET

(Continued)

| Current Liabilities: | Current Period |
| :---: | :---: |
| 27. Notes Payable |  |
| 28. Current Portion of Long Term Debt |  |
| 29. Accounts Payable | \$5,944,472 |
| 30. Accrued Expenses | \$8,320,142 |
| 31. Deferred Revenue |  |
| 32. Deferred Income Taxes |  |
| 33. Other (ldentify) See Upload Page | \$34,818,083 |
| 34. Total Current Llablities (Sum of Lines 27 through 33) | : \$49,082,897 |
| Other Llablities: |  |
| 35. Long-Term Debt, Net of Current Portion |  |
| 36. Due to Affiliates Or Other Related Parties (Upload Schedule via REFS) |  |
| 37. Deferred Revenue |  |
| 38. Deferred Income Taxes | \$117.806 |
| 39. Other (Identify) See Upload Page | \$972,771 |
| 40. Total Other Llabilities (Sum of Lines 35 through 39) | \$1,090,677 |
| 41. Total Liabilities (Sum of Lines 34 and 40) | \$50,173,274 |
| Equity: |  |
| 42. Common Stock |  |
| 43. Additional Paid In Capital | \$27,206,896 |
| 44. Preferred Stock |  |
| 45. Retained Earnings (Deficit) | $(\$ 29,368,201)$ |
| 46. Less Cost of Treasury Stock | $1$ |
| 47. Other (Identify) Unrealized gains on Investments, net of tax | \$307 |
| 48. Total Equity (Sum of Lines 42 through 47 . Must be the same as the amounts reported on Page 7, Line 5.) | (\$2,160,988) |
| 49. Total Liabilities and Equity (Sum of Lines 41 and 48) | \$48,012,276 |

## STATEMENT OF INCOME

| Revenues: | Current Period Year-to-Date |
| :---: | :---: |
| 1. Commissions \& Administrative Fees | \$59,452,312 |
| 2. Investment Income | $(\$ 64,207)$ |
| 3. Other (Identify) |  |
| 4. Total Revenues (Sum of Lines 1 through 3) | \$59,388,106 |
| Operating Expenses: |  |
| 5. Salaries, Wages, Contract Labor, \& Commissions | \$36,493,788 |
| 6. Payroll Taxes | \$3,358,007 |
| 7. Employee Benefits | \$3,338,371 |
| 8. Consulting \& Professional Fees | \$20,337,720 |
| 9. Directors' Fees \& Expenses |  |
| 10. Advertising, Marketing \& Promotion | (\$70,251) |
| 11. Depreciation \& Amortization | \$2,749,850 |
| 12. Dues \& Subscriptions | \$99,190 |
| 13. Entertainment \& Promotion | \$260,295 |
| 14. Equipment | (\$1,097) |
| 15. Insurance | \$65,505 |
| 16. Miscellaneous |  |
| 17. Office, Printing \& Postage | \$4,666,376 |
| 18. Rent | \$2,368,118 |
| 19. Repairs \& Maintenance | \$196,279 |
| 20. Taxes \& Licenses | \$504,292 |
| 21. Telephone \& Utilities | \$1,967,334 |
| 22. Travel | \$662,714 |
| 23. Other (Upload Schedule via REFS) | (\$9,530,358) |
| 24. Total Operating Expenses (Sum of Lines 5 through 23) | \$67,464,133 |
| 25. Revenues Less Operating Expenses (Line 4 less Line 24) | $(\$ 8,076,028)$ |
| 26. Other Income or Gain, (Expense) or (Loss) (Upload Schedule via REFS) |  |
| 27. Income before Income Taxes (Sum of Line 25 and Line 26) | (\$8,076,028) |
| 28. Provision for Income Taxes | \$55 |
| 29. Net Income (Loss) (Line 27 less Line 28) | (\$8,076,083) |

## STATEMENT OF CHANGES IN OWNERS EQUITY

|  |  | Current Period | Last Year |
| :---: | :---: | :---: | :---: |
| 1. | Balance of owners equity, Beginning of Year | $(\$ 790,925)$ | \$3,016,824 |
| 2. | Net income (loss) as reported on Page 6, Line 29 | (\$8,076,083) | (\$21,420,155) |
| 3. | Other increases (decreases) in equity (Upload detailed schedule via REFS) | \$6,706,010 | \$22,612,406 |
| 4. | Dividends \& other equity distributions to owners | $(\ldots)$ | ( \$5,000,000 ) |
| 6. | Balance of owners equity, Perlod End (Line 1 plus Lines 2 \& 3 minus Line 4. Must be the same amount as those reported on Page 5, Line 48.) | (\$2,160,998) | (\$790,925) |

## SCHEDULE OF INSURERS - SUMMARY

|  |  | Florida Only | $\frac{2}{\text { Other States }}$ |
| :---: | :---: | :---: | :---: |
| 1. | How many insured or self-insured programs, funds, or plans in Florida and in states other than Florida are administered by the administrator? | 2 | 3 |
| 2. | How many carriers provide insurance coverage for the programs, funds, or plans referred to in Question 1 above? | 2 | 3 |
| 3. | For the year covered by this report, what was the total amount of funds handled by the administrator for the programs, funds, or plans referred to in Question 1 above? | \$564,172,406 | \$474,886,165 |
| 4. | How many residents of Florida, and residents of states other than Florida, are insured by insured or self-insured programs. funds, or plans administered by the administrator? | 121,883 | 72,528 |

## SCHEDULE OF INSURERS - FLORIDA ONLY

For each insurer (including any self-insured plan) which, during the period covered by this report, provided or offered to provide insurance coverage to Florida residents and for which the administrator acted as an insurance administrator, list below, with respect to those insurers and insureds, the insurer's complete, unabbreviated name, the number of such insureds, the total premiums collected or collectible, and the total claims paid or payable by the administrator. Upload additional pages as needed (via REFS), and enter the totals from all such pages on Line 13. Enter the totals for all insurers on Line 14.

|  | Complete, Unabbrevlated Name of Insurer or Self-Insured Plan | $\begin{gathered} 1 \\ \text { Number of } \\ \text { Florida Insureds } \end{gathered}$ | $\begin{gathered} 2 \\ \text { Total Florida } \\ \text { Premiums } \end{gathered}$ | $\begin{gathered} 3 \\ \text { Total Florida } \\ \text { Claims } \end{gathered}$ |
| :---: | :---: | :---: | :---: | :---: |
| 1 | Universal Health Care | 118,046 | \$535,168,341 | \$446,675,899 |
| 2 | Universal Health Care Insurance Company | 3,837 | \$29,004,065 | \$27,733,997 |
| 3 |  | - |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |
| 6 |  |  |  |  |
| 7 |  |  |  |  |
| 8 |  |  | $\because$ |  |
| 9 | $\therefore$ |  |  |  |
| 10 |  |  |  |  |
| 11 |  |  |  |  |
| 12 |  |  |  |  |
| 13 | Enter totals from Attached Schedules |  |  |  |
| 14 | TOTAL for all Insurers | 121,883 | \$564,172,406 | \$474,409,896 |

Company Name: AMERICAN MANAGED CARE, LLC
LUST OF OFFICERS/DIRECTORS AND KEY PERSONNEL
 provided. If requifed biographical information has not been previously submitted on those checked, please refer to the instructions provided at hitp:ifunco.floir.com/site Documents/OfficeDirector.pdf.

|  | Marne | Poaltionftile | Residence Address | Chy | Statel Prov. | $\begin{gathered} \text { Zp/Postal } \\ \text { Code } \end{gathered}$ | Dete of Brith | \% | New |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Alshay M. Desai, |  | President, CEO | 1841 Brightwater Bhd NE | St. Petersburg | FL | 33704 | 01/28/1958 | 0 | $\Sigma$ |
| Sendip I. Pated |  | Secretary, General Counsel, CAO | 1850 Peters Place | Cloarwater | FL | 33784 | 11/2019968 | 0 | ᄃ |
| Steven J. Schaefer |  | Treasurer | 1809 Tanstone Plac | Brandon | FL | 33510 | 0202/1957 | 0 | ᄃ |
| Deepak Desal |  | Chief Strategy Officer | 3943 Bayshore BNd NE | St Petersturg | FL | ${ }^{33708}$ | 09/2711958 | 0 | [ |
|  |  |  |  |  |  |  |  |  | $\Gamma$ |
|  |  |  |  |  |  |  |  |  | [ |
|  |  |  |  |  |  |  |  |  | $\Gamma$ |
|  |  |  |  |  |  |  |  |  | $\Gamma$ |
|  |  |  | . |  |  |  |  |  | $\Gamma$ |
|  |  |  |  |  |  |  |  |  | $\Gamma$ |
|  |  |  |  |  |  |  |  |  | $\Gamma$ |
|  |  |  |  |  |  |  |  |  | [ |

Company Name: AMERICAN MANAGED CARE, LLC
LIST OF COMPANIES
Complete the following for all companies and affiliates holding at least $10 \%$ Imterest in the operations of the provider. State the percentage owned. If such company has been added to this list during this report .
period, place a check in the "New' column provided. period, place a check in the "New" column provided.

Page 10 of 11

## SAVĖ/SUBMIT PAGE

Save - Use this button to save your data to our server. It is strongly recommended that you save your data periodically as you fill in this form. You can still save your data even if you have validation errors appear below.

Submit Final - Use this button if you have entered all the required information and want to submit this data to our server. If you have validation errors, they must be corrected before being able to submit the form data. Once you successfully submit the form data, you can no longer make changes.

The session key will expire an: 11/14/2012 11:30:00 PM Eastern Time




# QUARTERLY STATEMENT 

AS OF DECEMBER 31, 2012
OF THE CONDITION AND AFFAIRS OF THE
Universal Health Care Insurance Co., Inc.



The officers of thls reporting entity being duly swom, each degose and say that they are the described officers of eaid reporting entity, end that on the reporting period stated above, alf of the hereln described assets were the absolute property of the esid reporting entity, free and ciear from amy liens or claims theraon, excapt as herain stated, end that this statement, together with related extubits, schedules and explanations therein contained, annexed or refarred to, is a full and true statement of all the assets and liabsilies and of the condtion and affalrs of the aald reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have bean completed in accordance with the NAIC Annusi Statoment instructions and Accounting Practices and Procadures manual excapt to the extent thet (1) state law may differ, or, (2) that atate ules or reguiations require differances in reporting not related to accounting practices and procedures, according to the best of their information, benowledge and beriot, respectively. Furthermore, the scope of this athestation by the described officers also includes the relsted comesponding electronic filing wth the NAlC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing mery be requested by various regulators in lieu of or in addilion to the enclosed statement.


a. Is this an original fling? Yes $[x \mid$ ith $[$ ]
a. is this an original Eling? Yes [ $x$ ith [ ]

1. State the amendment number
2. Dale flied
3. Number of pages attached


STATEMENT AS OF DECEMBER 31, 2012 OF THE Universal Heaith Care Insurance Co., Inc.


LIABILITIES, CAPITAL AND SURPLUS


STATEMENT OF REVENUE AND EXPENSES


STATEMENT OF REVENUE AND EXPENSES (Continued)

|  | Current Year To Date | Prior Year To Date | 3 Prior Year Ended Decermber 31 |
| :---: | :---: | :---: | :---: |
| CAPITAL \& SURPLUS ACCOUNT |  |  |  |
|  | $\cdots$ | ......55,515,958 | - .-....55,515,958 |
|  | $\cdots$ | $\cdots-. . .-(5,211,325)$ | -...... $515,332,304$ ) |
| 35. Change in valuation basis of aggregate policy and claim reserves ............... | .................. 0 | $\cdots$ | $\cdots$ |
| 36. Change in net unrealzed capital galns (lasses) less capital gains tax of \$ .......................... 0 | $\cdots$ |  | -1.-.... 195057 |
| 37. Change in not unrealized forrign exctrange capital.gain or (loss)... | $\cdots$ |  | - |
| 38. Change in net deferred income tax ..... | .-..........35,302 | -................. 0 |  |
| 39. Change in monadmitted assets ....................... | ....- $14,953,611)$ | $\cdots$ | $\ldots$ |
| 40. Change in unauthorized reinsurance ...-...-.-. | -....-.....0 | ,.-.............. 0 | $\ldots . . . . . . . . . . . . . . . .$. |
| 41. Change in treasury stock ...---- | $\cdots-10$ | $\cdots$ | $\square \cdots$ |
| 42. Change in aurpius notes | .....i1,150,209 | 0 |  |
| 42. Change in surplis | ...... $1,150,200$ |  | 10 |
|  | - $-\cdots$. | .................. 0 | $1-0$ |
| 44. Cepital Changes: |  |  |  |
| 44.1 Paid in | $\cdots$ | - .-.............00 | $\cdots$ |
| 44.2 Transferred from surpius (Stook Dividend) .......... |  | $\cdots$ | $\cdots$ |
| 44.9 Transterred to cirplus .................................................... | $\cdots$ | $\cdots-\cdots$ | $\cdots$ |
| 45. Surplus edjustmenta: |  |  | । |
| 45.1 Paid in . | .-....10,650,000 | .............---. 0 | $1-0$ |
| 45.2 Traniterred to capital (Stock Dimidend) ............................... |  | -................ 0 | : |
| 45.3 Trangrerted from captal ................................. | 0 | $\cdots \cdots \cdots$ | - -1. |
| 46. Dividends to stockholders | $\cdots$ | …a............ O |  |
| 47. Aggregate wite-ina for gains or (losses) in surplus ........................ | $\cdots$ | - $-\cdots$ - -1. | $\cdots . . .-)^{-1 . . . . . . . . . ~} 0$ |
| 48. Net change in captal and surpius (Unes 34 Lo 47) ................... | $\ldots . . . .19,833,445)$ | .-..... $(4,977,975)$ | $(18,936,630)$ |
| 49. Capital and aurplus end of reporting period (Line 33 plus 48) | 16,745.883 | 50,537,983 | 36,579,328 |
| DETALS OF WRTEEHS |  |  |  |
| 4701. | $\ldots$ | $\ldots$ | $\cdots 0$ |
| 4702. ................... |  | $\cdots$ | $\square \square_{0}$ |
|  |  | $\ldots$ - | $1-0$ |
|  |  |  | $\cdots$ |
| 4799. Totaks, fines 4701 through 4703 dus 4798) (Line 47 above) | 0 | 0 | 0 |

CASH FLOW

STATEMENT AS OF DECEMBER 31, 2012 OF THE Universal Health Care Insurance Co., Inc.
EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION


STATEMENT AS OF DECEMBER 31, 2012 OF THE Universal Health Care Insurance Co., Inc.
SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS


## OVERFLOW PAGE FOR WRITE-INS

MQ002 Additional Agoregate Lines for Page 02 Une 25.

|  | Assets | $2$ <br> Nonadmitted Assets | 3 Nel Admitted Assets (Cols. 1-2) | 4 Decamber 31 Prior Year Net Admitted Assets |
| :---: | :---: | :---: | :---: | :---: |
|  | - $-. . . . . . . . . . .82,594 ~$ | -...................... 0 | --.......-82,594 | Ad.....-.......-...... 0 |
|  |  | $\cdots$ |  |  |
| 2597. Summary of remaining write-ins for Line 25 from Page 02 | 82,594 | 0 | 82,594 | 0 |

#  

100 Central Avenue, Suite 200, St. Petersburg, FL 33701 • phone 1-866-690-4842 • fax 1-727-822-3556 • web www.univhc.com

February 1, 2013

Re: Universal Health Care Capital Plan

Toma,
As an addendum to the company's December 2012 financial package, we are submitting a brief write-up of our plan to bridge the capital hole.

As you can see from the financials, UHC has a capital deficit of $\$ 45,878,854$ as of $12 / 31 / 12$.
We have signed a binding letter of agreement with America's $1^{\text {sl }}$ Choice Holdings of Florida, LLC stating that they plan to infuse $\$ 30$ million dollars of capital into UHC once they acquire the company. The company is attaching a signed copy of the letter of agreement. In addition, the company has signed a term sheet with the Centene Corporation for the sale of our Medicaid and Nursing Home Diversion membership. We expect the sale to generate approximately $\$ 15$ million dollars in additional capital that would be used to further bridge the capital dcficit in UHC. We have attached the term sheet with Centene Corporation. Also, based on our January 2013 revenue, we expect the Minimum Capital and Surplus Requirement in UHC to drop by an additional $\$ 4$ million. The sum of these pieces will suffice the capital deficiency you see in our December filings. Additionally, we are including a signed letter of interest from iStar Financial Inc. to purchase our corporate office in St. Petersburg, FL for the amount of $\$ 21,250,000$. We are continuing to work through the details with iStar and will update you on our discussions.

You will also see on the December financials that UHCIC has a capital deficit (at 250\% RBC) of $\$ 4,354,333$ as of $12 / 31 / 12$.

The binding letter of agreement with America's $1^{\text {st }}$ Choice Holdings states they will infuse $\$ 15$ million of capital into UHCIC upon closing which will bring us into compliance with our capital requirements.

In addition, to the above capital fixes it is also important to recognize the improvement in the underlying business that has occurred since 2012. We have improved our contract rates with our largest provider, HCA. We started monitoring provider utilization, billing patterns, and rates at a micro level, leading to numerous contract changes, and changes in provider behavior. We expect to see the full impact of these changes in 2013. Also, our 2013 bids and benefits are more financially sound. We are seeing some of the results of this already; UHC and UHCIC plan revenue are up significantly on a PMPM basis when compared to 2012. We have already taken many steps, including the reduction of headcount, reduction in marketing expenses, and reduction in outsourcing to reduce our SG\&A costs due to the decrease in membership. We expect the UHC and UHCIC blocks of business to run profitably in 2013.

I look forward to discussing these exciting activities when we meet next time.
Yours Truly,

## Amdesai.

Dr. Akshay Desai

Attachments:

1. The Letter of Agreement with America's $1^{\text {st }}$ Choice Holdings
2. Signed Letter of Interest from inStar Financial Inc.
3. Executed Term Sheet from Centene Corporation

## OFFICE OF COMMISSIONER OF INSURANCE

## STATE OF GEORGIA



## CONSENT ORDER

The Commissioner of Insurance of the State of Georgia (the "Commissioner"), pursuant to the authority of the Georgia Insurance Code, and Universal Health Care Insurance Company, Inc. ("Univergal Health Care") hereby agree to the following Pindings of Fact and Order:

## FINDINGS OF FACT

## 1.

Universal Health Care is an insurer domiciled in the State of Florida.
2.

On August 28, 2006, the Commissioner and Univarsal Health Care entered into a consent order which granted Universal Health Care a certificate of authority, number 2006124, to do business as a Life, Accident and Sickness insurer subject to specifically enumerated conditions.
3.

In 2011, Universal Health Care received premiums totaling \$513,888,262. \$178, 104,212 of those premium dollars were received on behalf of Oeorgia consumers.

4,
For the year ending December 31, 2011, Universal Health Care reported a net loss of $\$ 27,028,701$.


EXHIBIT "G"

Consent Order
Case No. 11010368
Page 2
5.

For the six month period ending June 30, 2012, Universal Health Care reported a net loss of $\$ 22,131,415$.

## Order

Based upon the foregoing, IT IS HEREBY ORDERED AND AGREED YO BY UNIVERSAL HEALTH CARE that from the date this Consent Order is signed by the Commissioner, Universal Health Care shall cease writing new business. Universal Health Care may renew business and may cover those customers who have already enrolled in the current open enrollment period, but Universal Health Care shall not enroll any new customers after the date the Commissioner signs this Consent Order. Such restrictions shall remain in effect until such time as the Commissioner, by order, lifts this Consent Order.

## IT IS FURTHER ORDERED AND AGREED TO BY UNIVERSAL HEALTH CARE

 that nothing in this Consent Order precludes the Commissioner from taking further actions as the Commissioner deems appropriate and nothing in this Consent Order shall be deemed to waive any grounds for commencing further legal proceedings against Universal Health Care.SO ORDERED this __ 15 th day of _Novemher__ 2012.


## Consent Order

Case No. 11010368
Page 3
Note: If you are an Individual with a disability and wish to acquire this document in an alternative format, please contact the Office of the Commissioner of Insurance, Two Martin Luther King, Jr. Driye, Atlanta, Georgia 30334; Telephone. No. (404) 656-2082.

## Consent Order

Case No. 11010368
Page 4

## CONSENTED TO BY:

Universal Health Care Insurance Company, Inc.
Audesain.
President, Universal Health Care Insurance Company, Inc.

Sworn to and subscribed before me this 14 day of NDEHPER, 2012.

## SpJPJt

Notary Public - State of FroploA My Commission Expires: $10 / 27 / 14$

# STATE OF OHIO <br> DEPARTMENT OF INSURANCE <br> 50 W . Town Street, Third Floor, Suite 300 <br> Columbus, Ohio 43215 

| IN THE MATTER OF | $:$ |  |
| :--- | :--- | :--- |
| UNIVERSAL HEALTH CARE | $:$ | CONSENT ORDER |
| INSURANCE COMPANY, INC. | $:$ |  |
| (NAIC NO. 12577) | $:$ |  |

Universal Health Care Insurance Company, Inc. ("Company") is a Florida domiciled life insurance company with its main administrative offices located in St. Petersburg, Florida.

On May 13, 2010, the Company obtained a Certificate of Authority ("COA") to conduct the business of life and health insurance in the State of Ohio. The Company's exclusive line of business is Medicare Advantage insurance.

The Company appears to be in violation of Ohio Revised Code ("R.C.") Section $3903.71(\mathrm{E})(3)$ based on the fact that the Company reported a net loss, including but not limited to net unrealized capital gains or losses, change in non-admitted assets, and the payment of cash dividends, of $\$ 28,706,939$, which is greater than $50 \%$ of its $\$ 41,113,362$ of surplus for the twelve months ended September 30, 2012, in excess of the $\$ 2.5$ million minimum capital and surplus required by R.C. Sections 3909.02 and 3907.05 , which condition violates Ohio Administrative Code ("O.A.C.") Section 3901-3-04(C)(1)(e); Hazardous Financial Condition Standards.

The Company appears to be in violation of R.C. Section 3903.71(E)(3) based on the fact that the Company reported a net loss excluding net realized capital gains and losses of $\$ 25,473,772$, which is greater than $20 \%$ of its $\$ 41,113,362$ of surplus for the twelve months ended September 30, 2012, in excess of the $\$ 2.5$ million minimum capital and surplus required by R.C. Sections 3909.02 and 3907.05 , which condition violates O.A.C. Section 3901-3-04(C)(1)(g), Hazardous Financial Condition Standards.

To resolve this matter, the Director and the Company hereby agree to the following:

1. The Company affirms that it will not solicit, issue, or otherwise write any new policies, or contracts of insurance, nor shall it assume any new risk in the State of Ohio after the date of this Consent Order.
2. The Company agrees that it shall continue to file its required financial statements, and pay all applicable fees and taxes that are required to be paid in order to otherwise maintain its COA. The Company also agrees to service_any_existing-policies-or-contracts-of-insurance-issued-to persons

STATE OF OHIO<br>DEPARTMENT OF INSURANCE<br>50 W. Town Street, Third Floor, Suite 300<br>Columbus, Ohio 43215

## IN THE MATTER OF <br> UNIVERSAL HEALTH CARE <br> : INSURANCE COMPANY, INC. <br> (NAIC NO. 12577) <br> CONSENT ORDER <br> : <br> : <br> AIC NO. 1257 :

Universal Health Care Insurance Company, Inc. ("Company") is a Florida domiciled life insurance company with its main administrative offices located in St. Petersburg, Florida.

On May 13, 2010, the Company obtained a Certificate of Authority ("COA") to conduct the business of life and health insurance in the State of Ohio. The Company's exclusive line of business is Medicare Advantage insurance.

The Company appears to be in violation of Ohio Revised Code ("R.C.') Section $3903.71(\mathrm{E})(3)$ based on the fact that the Company reported a net loss, including but not limited to net unrealized capital gains or losses, change in non-admitted assets, and the payment of cash dividends, of $\$ 28,706,939$, which is greater than $50 \%$ of its $\$ 41,113,362$ of surplus for the twelve months ended September 30, 2012, in excess of the $\$ 2.5$ million minimum capital and surplus required by R.C. Sections 3909.02 and 3907.05 , which condition violates Ohio Administrative Code ("O.A.C.") Section 3901-3-04(C)(1)(e), Hazardous Financial Condition Standards.

The Company appears to be in violation of R.C. Section 3903.71(E)(3) based on the fact that the Company reported a net loss excluding net realized capital gains and losses of $\$ 25,473,772$, which is greater than $20 \%$ of its $\$ 41,113,362$ of surplus for the twelve months ended September 30, 2012, in excess of the $\$ 2.5$ million minimum capital and surplus required by R.C. Sections 3909.02 and 3907.05 , which condition violates O.A.C. Section 3901-3-04(C)(1)(g), Hazardous Financial Condition Standards.

To resolve this matter, the Dircctor and the Company hereby agree to the following:

1. The Company affirms that it will not solicit, issue, or otherwise write any new policies, or contracts of insurance, nor shall it assume any new risk in the State of Ohio after the date of this Consent Order.
2. The Company agrees that it shall continue to file its required financial statements, and pay all applicable fees and taxes that are required to be paid in order to otherwise maintain its COA. The Company also agrees to service any_existing policies or-contracts-of-insurance-issued-to-persons

residing in Ohio and it is specifically authorized to continue to adjust, administer, and pay claims in Ohio.
3. The Company having been advised of its right to a hearing and its right to appeal an Order of the Director pursuant to R.C. Chapter 119, hereby waives its right to a hearing and an appeal of an Order arising from a hearing, and any appeal of this Consent Order.
4. The Company waives any and all causes of action, claims or rights, known or unknown, which it has or may have against the Director or any of her employees, agents, consultants, or officials of the Ohio Department of Insurance in their individual and official capacities as a result of any acts or omissions, in connection with this matter which may have occurred prior to the date of this Consent Order.
5. The Company agrees that if it fails to comply with the terms of this Consent Order, such failure shall constitute an additional and separate ground for the non-renewal, suspension, or revocation of its COA to conduct the business of insurance in the State of Ohio, provided however that such action shall be subject to all the requirements of R.C. Chapter 119. The Director reserves the right to initiate administrative and judicial proceedings, or take any other action permitted by law.
6. If the Company requests to resume writing or assuming any new business in the State of Ohio, the Department will consider releasing the Company from the terms and conditions contained in this Consent Order under terms acceptable to the Department. Any request must be in writing, submitted to the Department and should include, at a minimum, a plan of business operations.
7. The Department shall continue its surveillance and analysis of the financial condition of the Company while this Consent Order is in effect.
8. The Consent Order shall be entered in the Journal of the Ohio Department of Insurance.

## UNIVERSAL HEALTH CARE

 INSURANCE COMPANY, INC.

Title: $\qquad$
Date: $12 / \mathrm{mef} / 2$

OHIO DEPARTMENT OF INSURANCE


Date: $\qquad$

In planning and performing our audit of the statutory-basis financial statements of Universal Health Care Insurance Company, Inc. (the Company) as of and for the year ended December 31, 2011, in accordance with auditing standards generally accepted in the United Statas, we considered its internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the statutory-basis financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be significant deficiencies or material weaknesses and therefore, there can be no assurance that all deficiencies, significant deficiencles, or material weaknesses have been identified. However, as discussed below, we identified certain deficiencies in internal control that we consider to be material weaknesses.

A deficiency in internal control exists when the design or oparation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or combination of deficiencies, in intemal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

During our audit, we noted the following matter involving internal control over financial reporting and its operation that we consider to be a material weakness as of December 312011.

## FInancial Statement Close Process

The financial statement close process is defined as the process where the results of various transactions are summarized, reviewed, consolidated, edited and created into a variety of management financial reports. The boundaries of this process begin with the preparation of the preliminary trial balance and end with the preparation of the financial statements and related disclosures and analyses. The process Includes closing the general ledger and preparing the trial balances and any consolidation entries, accumulating the posting of journal entries, drafting the financial stataments and disclosures, and preparing management's discussion and analysis.

Several of the Company's processes that are integral parts of the financial statement close process were found to be deficient during the course of our audit. As a result, approximately forty entries have been proposed by either Company personnel or our audit team. Additionally, we noted that the financial statement close process had not been formally completed when we began our year-end audit fieldwork in late February 2012. We also note that the Company's accrual for medical claims payable wes not finalized untll the middle of March 2012 and a complete draft of the statutory-basis financial statements was not available until May 2012.

There should be a formal process in place in order to ensure that financial statements are generated appropriately and timely. This should include, but not be limited to, the following:

- A process to ensure all expenses incurred during the period are accrued as of the monthend date
- A process to ensure that premiums and other health care receivables are recognized correctly as they are earned and that proper cut-off is achieved from period to period
- A process to Improve the tracking of claim overpayments
- A process to corisider the effects of subsequent claims payments on the liability for medical and pharmacy claims payable
- A formal process to review key financial information by employees that are not resporisible for the preparation of such financial information
- A re-evaluation of the information technology and accounting resource capability in response to an increase in the complexity, nature, volume of transactions, and growth of the entity over the past two years

We recommend management review its current procedures for key processes within the financial statement close process and determine the appropriateness for those processes for preventing or detecting and correcting material misstatements, preparing reliable, accurate monthly and annual reporting and ensuring such processes are consistent with leading practices in the industry. The Company should consider computer, computer-dependent and manual controls that affect such processes as well as the adequacy of the Company's current information system to provide the necessary information.

This communication is intended solely for the information and use of the audit committee, board of directors, management, others within the organization and the State of Florlda Department of Financial Services Office of Insurance Regulation to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these speclfied parties.

## Emot + Young LLP

June 1, 2012

To : . Kerby Baden, EIC
From: Jenny L Jeffers IS Specialist
Subject: • Documentation of Data Analysis
Date: December 10, 2012

Jennan Enterprises, LLC was contracted with Invotex Group on behalf of the state of Florida Office of Insurance Regulation to review the claims system and integrity of the claims data as a part of a targeted Financial and Market Conduct examination of Universal Health Group. The companies were scheduled to convert the Fortuna System, which has been implemented at the companies since 2006, to the QNXT system by Trizetto.

An initial visit was performed by Lisa Marteney of Jennan Enterprises, LLC and a report generated on October 24, 2012. In this report and associated meeting notes, it was stated that:

- Jason Mitchell stated that during the last year, between $\mathbf{3}$ and 4 million dollars has been invested in Universal's infrastructure. Changes to the infrastructure include new servers, more storage systems, rebuilt switches, addltional fiber optic lines, rebuilt circuits, upgraded internet lines and becoming more virtualized. A tremendous investment in money and resources has been made to upgrade Universal's infrastructure.
- Currently the load percentages are where Universal likes to see them - except for storage, which is currently running at $65 \%$ of capacity. Jason stated that additional storage will be added in the near future.
- Jason Mitchell stated that over the last 18 months, IT has grown approximately 35\%. Jason, Deby and a lot of the new IT team have had the opportunity to work together at WellCare. Jason also stated that IT is utilizing quite a few contractors. They have added two new positions. Director of IT Security and a Sr. IT Auditor
- Jason stated that the current plan is to have the conversion from the Fortuna claim system to the Trizetto claim system complete by the June/suly 2013 time frame.
- Jason stated that anything "relevant" from the Fortuna system will be moved to the new TriZetto system. All data from the Fortuna system will be maintained in the Operational Data Store (ODS). All new data will be held here also. This will allow for easier reporting and auditing. The Fortuna system will also be maintained and running for audit purposes.
- Jason stated that one reason for the change from the current Fortuna claim system to the TriZetto claim system is that TriZetto has the capacity to handle the Company's growth. TriZetto will be hosted in their Denver facility, Jason does not want any critical systems to be run out of the Universal Healthcare facility. Jason stated that Universal does not have the data center layout, environmental controls or the capacity to handle supporting all of the critical systems. It appears from review of the Statement of Work contracts between TriZetto and Universal that the claim capacity issues that Universal has been plagued with in the past should be taken care of by the new Trizetto claim system. The company has entered into a 10 year contract with Trizetto.
- Jason stated that the original target date for completion of the conversion from the fortuna claim system to the TriZetto claim system was before open enrollment. Open eriroliment begins
on October $15^{\text {th }}$ and runs for 45 days. On the $1^{\text {st }}$ of September, a meeting was held and it was decided that instead of rushing the conversion process, the process would stop for now and resume in the January/February 2013 timeframe. Jason stated that the new date for all testing and the conversion to be complete is the June/July 2013 time frame.

Following the review of Ms. Marteney's report and interview notes from her interview with Jason Mitchell, VP of Technology and Deby McCourt, Director of IT and the processing of the claims data provided by the company for the selection of samples, a discussion was held with the EIC and Jenny Jeffers, IT Lead on the project. Questions were raised regarding:

- The expenditure of funds for upgrade of the systems in spite of the conversion to QNXT and the hosting of all processes by Trizetto
- The curtailment of the conversion project on September 1, 2012 when it was further stated by Jason Mitchell that no surprises were noted during the conversion
- The difficulty experienced in interpreting the claims data to determine fully and partially denied claims as well as the issues noted during the claim sample review
- . Difficulty encountered in the attempt to determine the percentages of denied claims for each company and line of business

It was decided that a second onsite visit - this time by Jenny Jeffers, Lead IS Specialist was needed to determine the actual reason for curtailing the conversion as well as to further discuss the quality of the data going into the new system. This visit occurred on November 20, 2012.

Additional interviews were conducted with:

- Jason Mitchell, VP of Technology - overview of conversion project and discussion of project delay
- Shalendra Dhanasar, Sr. Data Analyst - data quality overview
- Bryan Richardson, Sr. Director Provlder Services
- Travis Johnson, Sr. Director Enrollment Operations
- Melissa Johnson, Sr. Manager of Claims
- Debra Wingo, Manager of Diversion
- Linda Shoenfelt, VP Operations

The primary discussion for the meetings of the day focused on the data quality prior to the initial conversion attempt and during the period under review as well as the efforts by the company to clean up the data and continue with the conversion. One primary concern was the basis for the decision to curtail the conversion project.
In the discussion with Jason Mitchell, he explained that the conversion was stopped September 1, 2012 when it was discovered that the data from the Fortuna system needed a lot more cleanup before the conversion would work appropriately. This was detected during the UAT (User Acceptance Training). The conversion was not working. IT presented the case to upper management that the data was not converting appropriately due to multiple issues with the source data (the issues are explained in more detail in the discussion with Bryan Richardson). Mr. Mitchell felt that if the conversion was completed and the new system was implemented prior to open enrollment, serious consequences would ensue. Therefore, the decision was made to "beef up" the Fortuna system to accommodate any growth resulting from the open enrollment process. Infrastructure was expanded and changes were made to the Fortuna system, both of which were at near capacity. The contracts with Fortuna (Indus/E4E) were extended more than once (as evidenced by the contracts with Indus provided and reviewed by the IS -

Specialist). New rates were negotiated and the current expectation is to have the new system up and running by summer of 2013 - the dates are specified in the Indus (E4E) contracts - see Attachment 1.

The original conversion project was driven by two major company needs:

- The need for sufficient capacity to accommodate the growth of the company
- The end of the service contract with Indus (E4E) for providing both software support and TPA services
The project team (no dedicated team was established, rather all IT personnel and available business personnel were a part of the team) was given a March 30, 2012 deadline for completing the conversion project. The contract with Trizetto was not signed until December of 2011. The contracts provided for review did not include the completed signature blocks and dates signed, however the date stamps were present on the documents. See Attachments 2a-2d. The original negotiations were occurring during October 2011 and that is when the work began on the conversion planning. The size of project and amount of data to be converted made the target date virtually impossible to achieve. Therefore, the project plan was modified to minimize the work required. One of the items that were de-emphasized was the scrubbing of data prior to performing the conversion. Rather, emphasis was on mapping the data from Fortuna to QNXT (Trizetto product). There were field mismatches (fields in Fortuna that were not in QNXT and fields that were in QNXT that were not in Fortuna). These situations were handled utilizing user defined fields in QNXT to accommodate needed information in Fortuna that was not in QNXT and in developing ODS (Operational Data Store) which would contain information from both systems. The project plan for the development of the ODS system was provided and reviewed - See Attachment 3. Data that was not in Fortuna was minimal according to the company; but to enhance the data and provide some normalization, a contract was developed with Enclarity to do data improvement on the provider data and signed on 12/2/2011 - See Attachment 4. Fees are addressed on page 9 of this document. Discussion with Bryan Richardson indicated that the Enclarity process did not improve the data quality as expected. HHI Consulting was utilized to assist in the Project Charter development and conversion project plan - See Attachment 5.

A conversation was held with Linda Shoenfelt, Project Manager of the conversion project. Linda was hired from WellCare and had assisted in the implementation of Facets at that company. She noted that she came in at the contract negotiation stage of the game and assisted with the development of the Statements of Work (SOWs) and Service Level Agreements (SLAs). She further indicated that she worked with the outside Project manager from HHI Consulting - specialized in QNXT conversions. A Gap analysis was performed and it was discovered that ZNXT and MedHOK (Medical House of Knowledge software for encounters) would provide the needed functionality. QNXT is a medical services admin system that is specifically written for government medical system processing. The concept of groups is not the emphasis, but rather the members. Some issues were noted - for example that encounters were not being loaded. Solutions were developed for gaps as much as possible with the short time frame. See Attachment 6. Personnel were working around the clock to attempt to achieve the implementation deadline. The company had grown very fast before the infrastructure was ready for the growth. Finally, after 4 mapping attempts and failed testing, the entire team together decided not to go live. This was not until September 2012.

The result of the conversion not being completed in March, 2012 was the requirement for the management of UHCG to negotiate extensions with Indus (E4E) for maintenance and TPA services to their contract which had been signed initially.in. October, 2006...The. IS. Specialist asked if-Fortuna-was a commercial package or written for UHCG. The response was that it is a commercial package but was
developed with advice from UHCG and they were the primary client. It was stated that one impetus for the shọt conversion project period was disagreement between UHCG management and Indus management. Thus, the differences had to be worked out to allow the company to continue to process business on the old system. Additionally, the infrastructure had to be enhanced at UHCG to allow for adequate capacity and some changes were required for the Fortuna system to handle increased capacity that may arise from open enrollment. The contract amendments were reviewed and changes in prices and dates of renegotiation-See Attachment 7. The amendments show the renegotiations at dates specifled in the description of the conversion target and modified target dates and the current contract is scheduled to end in March 31, 2013. This is an issue in light of the current conversion date being July - September 2013. It was noted that the run out charge was significantly greater for the contract amendment in March 2011. This could have been a contributing factor in the disagreement between the two companies.

## The initial conversion project failed due to two major issues:

- The time allocated for the project created an unattainable goal, therefore important steps were not carried out.
- The data that has not been in good shape since the inception of the Fortuna system (October 2006) and was not appropriately cleaned up and corrected prior to the conversion.

The company is to be commended for curtailing the implementation and go live with the new product prior to open enrollment for 2013. This avoided what the company called a certain flasco with the acceptance of new members and new plans.
The IS Specialist requested interviews with Bryan Richardson, Sr. Director of Provider Services and Travis Johnson, Sr. Director of Enrollment Services to discuss issues they are working on with the data. These meetings were to gain a better understanding of the data issues other than the claims data that was provided to the IS Specialist for the selection of samples.
Bryan Richardson came to the company from WellCare and has been with the company since June 2012. He noted large data discrepancies and verified that due to the time restraints, insufficient data cleanup and normalization had been done on the provider data prior to the initial conversion attempt. The mapping efforts did not take into account the differences in data relationships in the two systems such as the Line of Business and Plan relationships. The group is an entity for providers in QNXT and the affiliation concept is used whereas this concept had not been applied in Fortuna. Roles would change of a specific group and changes were not appropriately made. Processors were allowed to enter a new provider record if the appropriate address was not found. There were not checks to make sure that the appropriate record did not exist. This resulted in multiple records for many providers - one provider was found to have 5300 records associated with his provider number - 13 locations were valid for the group. There was no QA or really way to find the errors. Bryan's cleanup efforts began following the Enclarity cleanup work, which he stated was not productive. The data was too bad for the Enclarity process to clean up - they did however add the NPI (National Provider Identifler) numbers to the provider records. This fact indicates that the company did not have NPI numbers (which are required for all providers for Medicare and Medicaid) for all providers prior to this effort. The issues with the provider data could have led to incorrect payment of claims, inability to identify duplicate claims submitted and inappropriate pricing of claims prior to the major cleanup effort that is now being conducted at the company. Bryan Richardson hired temps to manually make corrections to much of the data. IT personnel have looked at the original logic for converting provider data and have redone or reworked it to be correct. Bryan is currently reviewing the mapping for correctness. He has created design templates for each type of provider. QNXT pays claims well according to Bryan but does not do
the best job on providers. Therefore $U I$ fixes had to be added to the scope. MedHOK will be used to fill the gaps between needed functionality and the functionality provided by QNXT. Bryan stated that he hopes to do the final provider conversion in mid to late December. One major concern is being able to provide correct and complete provider directory information. There is currently no Trizetto help but they will need to be re-engaged. The project is over budget for both time and cost - The IS Specialist requested a budget to actual comparison - not provided.

A conversation was held with Shalendra Dhansar, Sr. Data Analyst to discuss the issues with the data. He explained that 6 years ago Fortuna was a small package and that the company had little growth for the flrst few years. In 2007, there was a dramatic increase in PFFS enrollment from 20,000-66,000 members in 1 week. Due to CMS compliance requirements, the company had to enter the new members onto the system within a short period of time. Thus these members were entered manually resulting in a "flasco". PFFS indicates any doctor any time with slack requirements at that time. This was the source of many of the data errors - hand entry and no editing in the system at that time. In 2008 and 2009 CMS began requiring NPI (National Provider Identifler) and clamped down on restrictions. In entering the address for both members and providers, there were no data checks allowing incorrect addresses, cities, counties and states to be entered. Incorrect addresses can result in communicatlons with members being misdirected and incorrect data entry can result in inappropriate denial of claims due to apparent ineligibility. These issues were possible with the data at UHCG. IN 2010 the growth began to. slow down and the company began to set up for HEDIS (Healthcare Effectiveness Data and Information Set) and decided to strive for 5 star data. The data has been much improved between 2010 and the present according to Shalendra. The IS Specialist. followed up on the member data and asked to speak to the head of enrollment.

A new person has also been brought over on March 26, 2012 from WellCare to handle enrollment. Travls Johnson is very experienced in SQL which is the database that Fortuna utilizes. The cleanup process for the enrollment data is being done outside of the master database. The goal is to clean up 36 years of experience in enrollment data. QNXT utilizes AEM (Automated Enrollment Management) to handle enrollment. It was discovered that the interface did not accomplish all of the functionality required by the company. They now have an In house process for eligibility handling. Travis has increased the enrollment team from 25-30 people to 65 currently including 22 phone service team number increase. Roles and responsibilities have been added and assigned. There is a team doing member reconciliation between CMS and the company. When there is a reject from CMS a root cause is found by the Quality Team. This team is also handling complaints. The SOW (Statement of Work) for Trizetto and project plan were re-done to reflect all changes from regulatory agencies. Trizetto is taking over the processing functions that are currently being performed by E4E/Indus/Fortuna. There were no SLAs (Service Level Agreements) in the past but they are being incorporated into the Trizetto contract.

The original observation and one of the reasons for the second on site visit resulted from the difficulty experienced in interpreting the data provided for the selection of denied claim samples. The IS Specialist noted the apparent high occurrence of denied claims. Verification of the method of identifying totally denied claims and partially denied claims resulted in discussions with Shalendra Dhansar, Sr Data Analyst. The answers were not clearly defined and often Melissa Johnson, Sr. Claims Manager was brought into the conversation. The data provided was not consistent. Denials were noted In different ways in different data. Rather than having a relational database with denial reasons in a related table, the data had fields numbered - denial reason 1, 2, etc. The fields were not named to reasonably reflect the data in them and the data was not consistent or complete. Some records were found in the claims header records but there were no detail records matching the header records. . Some claims indicated no payment but there were records matching those claim numbers in the check file. No
explanation was available for these occurrences. Another improvement was that prior to 2010 anyone could request a change by E4E which kept thing changing unnecessarily. That has been changed and change requests have a defined path.
A conversation was requested with Melissa Johnson, who came to the company from WellCare the end of May, 2012. She noted that there were no management tools in place as she had expected. Her impression is that the data is there somewhere but is hard to get to. In some cases fields have been used for other things. The IS Specialist had run some querles to determine percentages of denied claims. It was determined that no reliance could be placed on the results due to difficulties with data consistency. Melissa was asked by the EIC to create a denied claim report showing percentages. During the onsite discussion, she was working on perfecting her queries to take all of the differences in the meaning of denied into consideration. IPAs and capitated services which should have been excluded in the remark field (open text). She was working on the Iterations of the query to be able to produce an accurate denial report (a basic management tool) from the current data. When asked about the new system, Melissa stated that the prior managers who have now left the company had seen the system but she has not seen the new system. Most first pass processing is performed in India by Indus (E4E) with some of the reconsiderations being worked at the St Petersburg location. Weekly audit meetings are held with the claims processing units in India and daily inventory is reviewed.

Debra Wingo discussed Diversion claims with the IS Specialist and the EIC. She explained that this is a pilot program in Florida and that the company has put in a bid to provide services for multiple counties. The new program will be called MLTC. The company submitted a bid on 8 of the 11 counties where the LOB will be offered. QNXT does not have the required conflguration to handle Diversion. The current Diversion data indicated that $95 \%$ of the claims were denied. This was not correct but is an example of the data quality and completeness associated with the claims data for diversion. A system will need to be found or developed to handle Diversion members, providers and claims in the future.

In summary, the following observations have been made:

- The data of the company has been unsatisfactory for several years. An initiative is currently in place to improve the quality and completeness of the data for providers, members and claims. Claims data and processing is dependent on provider and member data. Therefore, claims processing could have been compromised over the last years due to the inadequacy of the provider and member data.
- The company has spent a large amount of money to date on infrastructure upgrades, changes to Fortuna to increase capacity, consultants to improve data and conversion efforts that have not been successful. The comparison of the conversion budget to actual comparison has not been provided so it is not possible to quantify how much over budget and over hours the project is. Additionally, infrastructure will be outsourced for the hosting of QNXT once the conversion is complete.
- There are several functions that cannot be performed in QNXT which are essential for the business to run, for example, provider tracking, enrollment and diversion processing. Additional software has been purchased to accommodate these functions.
- The current contract for claims processing and maintenance of Fortuna is scheduled to be terminated in March of 2013 and the project plan indicates that the conversion will be completed in-July-September-of-2013--This implies that an additional renewal-will-probably be required.
- The company has brought in new personnel to perform data cleanup, mapping and conversion. This should bring a more positive result to the new conversion process.
- It was stated that storage is currently at $65 \%$ which is high when growth is anticipated, however, the infrastructure will be outsourced to Trizetto once the conversion is complete.

The IS Specialist strongly recommends that the state follow the progress of the conversion and new processing implementation as weil as the implementation of the ODS (Operational Data Store).

## BankUnitted

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Senior Vice President, Commercial Banking Tol (305) 6984113 E-mall: cklank(ophankuniledicom - BankUnited

October 29, 2012

Universal Health Care Group, Inc.
American Managed Care, LLC
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Saint Petersburg, FL 33701
Attn: General Counsel
Facsimile: ( 727 )-456-7873
Email: spatel@univhc.com

## VLA EMAIL, FEDERAL EXPRESS OVERNIGHT AND FACSMMILE

Re: Notice of Default Under Credit Agreement Among Universal Health Care Group. Inc.. as Borrower ("Universal"). American Managed Care, LLC, as Cuarantor Thereto, Dated April 6,2012 (the "Credit Agreement")
Dear Mr. Patel:
The purpose of this letter is to inform you that the Administrative Agent and all required lenders under the Credit Agreement have determined that Events of Default exist under
the Credit Agreement.

At the time the Credit Agreement was entered into, Universal provided BankUnited and the lending parties with the unaudited consolidated and consolidating financial statements of itself and its subsidiaries for the period ending December 31, 2011. Universal then provided its audited financial statements for the year ending December 31, 2011 on July 31, 2012. The audited financial statements differ materially from those provided at the time of closing and indicate a loss from operations of $\$ 43,898,539$ and a loss before income taxes of $\$ 46,168,814$. To say the least, this is an extreme and material change to the financial statements provided at the time of closing. At no time were the Administrative Agent or other lenders informed of this change until the audited financial statements were received. In addition, upon requesting an extension to provide the audited financial statements by July 31, 2012, Universal and AMC represented that they were not aware of any Events of Default.

It is the position of the required lenders that Events of Default exist under Section 7.1 of the Credit Agreement, which include without limitation:

1. 7.1(b) Misrepresentations - that the financial statements provided were incorrect at the time of closing, and that Universal and AMC falsely stated under the Waiver Agreement dated May 29, 2012 there were no Events of-Default-under-the-Credit
2. 7.1(c) Covenant Default-that Universal breached its affirmative covenant under Section 5.7 (i) to promptly inform the Administrative Agent of any development or event which could reasonably be expected to have a material adverse effect.

In furtherance of the foregoing, Section 3.1 of the Credit Agreement provides that the unaudited statements delivered for the period ending $12 / 31 / 11$ were prepared in accordance with GAAP, fairly presented in all material respects the financial condition of Universal and its subsidiaries, and disclosed all material indebtedncss and other liabilities, direct or contingent. Section 3.2 of the Credit Agreement provides that gince December 31, 2011 there had been no development or event which has or could reasonably be expected to have a material adverse effect. Section 3.22 of the Credit Agreement provides that all factual information proviously furmished or hereinafter furnished on behalf of Universal will be true and accurate in all material respects and not incomplete by omitting to state any material fact necessary to make such information not misleading.

Although the required lenders have determined that one or more Events of Default exist, and are hereby placing you on notice of such defaults, the required lenders have chosen not to exercise their remedies at this time pending further discussions and negotiations among the parties. Nothing contained herein constitutes a waiver of any rights of the required lenders which may be exercised at any time. Notwithstanding the foregoing, you are also hereby notified that the lenders have a perfected security interest in Universal's general intangibles, which include, among other things, the entirety of any tax refund (the "Tax Refind") that is currently due and owing to Universal.

While we are aware that Universal, AMC and their regulated subsidiaries are parties to a Tax Sharing Agreement and file their tax returns on a consolidated basis, the law clearly provides that, under circumstances similar to those at issue here, the filing entity that is entitled to receive the proceeds of a tax refund has an ownership interest in such funds, with all other entities within the enterprise holding a potential claim in their capacity as creditors. See, e,g., BankUnited Financial Services, Inc, v. FDIC (In re Bankunited Financial Corporation), 462 B.R. 885 (Bankr. S.D. Fla. 2011).

In accordance with the foregoing, you are hereby notified that any restructuring proposal presented by Universal and AMC must consider the lenders' secured interest in the Tax Refund and that immediately upon receipt of the Tax Refind, it must be placed in an escrow account at BankUnited and remain there pending the instruction of the required lenders. Further, please be advised that any attempt to place additional debt on the real estate or to compromise the rights of the lenders with respect to the Tax Refund without the prior express consent of the required lenders, including through a transfer of any portion of those funds to any of the regulatory subsidiaries, would constitute a breach of the Credit Agreement and would be mot with immediate legal action against Universal, AMC and their respective fiduciaries. Please be further advised that any effort to sell, transfer, lease or otherwise dispose of the real estate, or assets generally, is flatly prohibited under Section 6.4(a) of the Credit Agreement, which, among other things, disallows transfers of property or assets exceeding $\$ 500,000$ as set forth in Section 6.4(a)(vi) and, further, restricts all transfers during the existence of an Event of Default.
2. 7.1(c) Covenant Default-that Universal breached its affinmative covenant under Section 5.7(i) to promptly inform the Administrative Agent of any development or event which could reasonably be expected to have a material adverse effect.

In furtherance of the foregoing, Section 3.1 of the Credit Agreement provides that the unaudited statements delivered for the period ending $12 / 31 / 11$ were prepared in accordance with GAAP, fairly presented in all material respects the financial condition of Universal and its subsidiaries, and disclosed all material indebtedness and other liabilities, direct or contingent. Section 3.2 of the Credit Agreement provides that since December 31, 2011 there had been no development or event which has or could reasonably be expected to have a material adverse effect. Section 3.22 of the Credit Agreement provides that all factual information previously furnished or hereinafter fumished on behalf of Universal will be true and accurate in all material respects and not incomplete by omitting to state any material fact necessary to make such information not misleading.

Although the required lenders have determined that one or more Events of Default exist, and are hereby placing you on notice of such defaults, the required lenders have chosen not to exercise their remedies at this time pending further discussions and negotiations among the parties. Nothing contained herein constitutes a waiver of any rights of the required lenders which may be exercised at any time. Notwithstanding the foregoing, you are also hereby notified that the lenders have a perfected security interest in Universal's general intangibles, which include, among other things, the entirety of any tax refund (the "Tax Refind") that is currently due and owing to Universal.

While we are aware that Universal, AMC and their regulated subsidiaries are parties to a Tax Sharing Agreement and file their tax returns on a consolidated basis, the law clearly provides that, under circumstances similar to those at issue here, the filing entity that is entitled to receive the proceeds of a tax refund has an ownership interest in such funds, with all other entities within the enterprise holding a potential claim in their capacity as creditors. See, e.g., BankUnited Financial Services, Inc. v. FDIC (In re Bankunited Financial Corporation), 462 B.R. 885 (Bankr. S.D. Fla. 2011).

In accordance with the foregoing, you are hereby notified that any restructuring proposal presented by Universal and AMC must consider the lenders' secured interest in the Tax Refund and that immediately upon receipt of the Tax Refund, it must be placed in an escrow account at BankUnited and remain there pending the instruction of the required lenders. Further, please be advised that any attempt to place additional debt on the real estate or to compromise the rights of the lenders with respect to the Tax Refund without the prior express consent of the required lenders, including through a transfer of any portion of those funds to any of the regulatory subsidiaries, would constitute a breach of the Credit Agreement and would be met with immediate legal action against Universal, AMC and their respective fiduciaries. Please be further advised that any effort to sell, transfer, lease or otherwise dispose of the real estate, or assets generally, is flatly prohibited under Section 6.4(a) of the Credit Agreement, which, among other things, disallows transfers of property or assets exceeding $\$ 500,000$ as set forth in Section 6.4(a)(vi) and, further, restricts all transfers during the existence of an Event of Default.

Please be advised that the statements set forth in this letter are made without prejudice concerning additional facts which may become known and as to any other remedies possessed by the lenders, all of which are reserved.

Sincerely,
BANKUNITED, N.A. as Administrative Agent

Charles Klenk, Sehiof:Vice President

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7765 NW 148ih Sireet
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Charles J. Klenk
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E-mally chankoterakuitedicom

## - BankUnited

Noveuber 14; 2012
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American Managed Care, LLC
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OVERNIGHT AND FACSIMILE
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> Re: Supplemental Notice of Default Under Credit Agreement Among Universal Health Care Group, Inc, as Borrower (Cniversal"), American Managed Care LC. Qs Guarantor (GMC") BankUnited, N.A. as Administrative Aren, and theLender Parties Thereto. Dated April 6,2012 (the "Credit Agreement")

## Dear Mr Patel:

The purpose of this letter is to (i) respond to that certain Notice of Reservation of Rights, dated October 31, 2012 (the "Reservation of Rights"), issued by Universal and AMC to the Adninilstrative Agent; (ii) inform you that the Administrative Agent and all Required Lenders have determined that additional Events of Default exist under the Credit Agreement beyond those previlously identified int the Notice of Defaulf, dated October 29, 2012, issued by the Administrative Agent to Universal and AMC (the "Initial Notice of Default"); and (iil) to notify you that the Administrative Agent and all Required Lenders have elected to exercise certain of their remedies under Section 72 of the Credit Agreement including, but not limited to, the immediate termination of all Commitments under the Credit Agreement, as discussed below.

## 1. THERESERVATION OFRIGHTS

As you are aware, the Initial Notice of Default provided by the Administrative Agent, which is Incorporated herein by referenoe, states that Events of Default exist under Section 7.1(b) of the Credit Agreement as a result of incorrect, false and/or misleading statements contained (i) in the unaudited consolidated and consolidating finanoial statement of Universal and its subsidiartes for the period ending Decentiber 31, 2011 (the "Unaudited Financial Statements"), which was provided to the Administrative Agent and Lenders prior to (and in furtherance of) the closing of the Credit Agreement, and (ii) in the Waiver Agreement, dated May 29, 2012, whiol sought an extension for Universal to

Any caplalized term not otherwise defined herein shall have the meaning ascribed to süch term in the Credit Agreement.

EXHIBIT

provide audited financial statements and, in the same document, incorrectly stated that there were no Events of Default under the Credit Agreement. The Initial Notice of Default also explains that an Event of Default exists under Section 7.1(c) of the Credit Agreement as a result of Universal's failare to promptly inform the Administrative Agent of substantial losses and revisions to the Unaudited Financial Statements which could reásonably be expected to have a Material Adverse Effect.

Specifically, as set forth in the Initial Notice of Default, the audited financial statements that were provided by Universal to the Administrative Agent, dated July 31, 2012 (the Audited Einanicial Statements"), materially differed from the Unaudited Financial Statements provided in anticipation of closing by, among other things, indicating a loss before fincome taxes of $\$ 46,168,814$ (as opposed to a proft of $\$ 16,044,851$ ) and a net loss of $\$ 29,002,958$ (as opposed to net income of $\$ 10,761,982$ ). Despite the magnitude of the foregoing revisions, which reflect a downward adjustment to EBITDA of $\$ 62$ million and the request for an extension to provide the Audited Financial Statements, Universal failed to provide the Administrative Agent or the Lenders with any notice of the foregoing material changes until the Audited Financial Statements were finalized and, in the interim, affirmatively tepresented that it was not aware of any Events of Default.

We have revewed the Reservation of Rights, wherein Universal and AMC conclude that there bave been no Events of Default under either Section 7.1(b)(1) or Seation 7.1(c)(i) of the Credit Agreement. For the reasons set forth below, the Administrative Agent and the Required Lenders reject the conclusions set forth in the Reservation of Rights and restate that the foregoing Events of Default are ongoing.

## A. Misrepresentations

In the Reservation of Rights, you have argued that incorrect statements containied in the Untaidited Fíriancial Statements do not violate Section 7.1(b)(i) of the Credit Agreement for two primary teasons. Each argument is addressed below in turn.

First, you submit that statements contained in the Unaudited Financial Statements were not lincorrect, false or misleading "on or as of the date made or deemed made" and, as such, do ndt technically violate Section 7.1(b)(i) of the Credit Agreement. In response, the Adruinistrative Agent and Required Lenders state that the sheer scope and extent of the material changes reflected in the delayed Audited Financial Statements irrefutably establish that the results initially reflected in the Unaudited Financial Statements-which, among other things, overstated EBITDA by more than $\$ 62$ millionn-and, by extension, the representations and warratities provided under Sections 3.1 (a) of the Credit Agreement (Financial Condition), were incorrect, false and misfeading as of the date made. In declaring an Event of Default, Section 7.1(b)(i) of the Credit Agreement does notrequire an opinion as to whether misrepresentations are the result of negligence, gross negligence, or intentional fraud and, accordingly, no such qualification is provided here. However, If the misrepresentations are intentional and wero made for the purpose of inducing the Lenders to enter into the Credit Agreement there is the potential for additional and/or personal liability that will have to be evaluated, We are speccifically reserving our rights in that regard upon completion of such further determination:
tepresents and warrants that there shall be "no development or event which has had or could reasonably be expected to have a Material Adverse Effect," including as may be shown fiom the dute of the delivery of the Audited Financial Statements. This representation, which is ongoing, is "deemed made" as of the date of the Audited Finanoilal Statements, and is also incorrect, false and misleading as the Audited Financial Statements clearly reflect the existence of a Material Adverse Effect and, thus, constitute ant additional Event of Default under Section 7.1(b) of the Credit Agreement.

Second, you have argued that the changes reflected in the Audited Financial Statements do not constitute a default because they reflect revisions that you submit are "generally consideded immaterial" pursuant to Generally Accepted Auditing Standards, because they ate less than $5 \%$ in cettain selected categories, This argument is also unpersuasive. As an initial matter, the statement that, "as a matter of custom and practice in the accounting Industry Revisions of less than $5 \%$ are generally considered immaterial" is misleading and inapplicable heres While a "rule of thumb" regarding adjustments of less than $5 \%$ to net ficome (a category that is not discussed anywhere in your Reservation of Rights) is used wifhin the accounting industry as one of many indicators of materiality, commentators, including the Securities and Exchange Commission and the Financial Accounting Standards Board have stressed that "exclusive reliance on this or any percentage or numerical threshold has no basis in the accounting literature or the law." SEC Staft Accounting Bulletin: No. 99, 64. Fed Reg 45150 (1999) (emphasis added). Thus, the proper measure of materiality, as stated by the Financial Accounting Standards Board and echoed by the SEC is as follows:

The omission or misstatement of an item in a finaricial report is material if, in the light of surrounding circumstances, the magnitude of the ftem is such that it is probable that the judgment of a reasonable person relying upon the report would have been changed or influenced by the inclusion or coirection of the tem."

See id (quoting FASB; Statement of Financial Accounting Concepts No. 2, Qualitative Characteristics of Accounting Information, 132 (1980)).

Based on the foregoing, the Administrative Agent and Required Lenders have concluded that the misstatements contained in the Unaudited Financial Statement were material and would have changed or influenced their judgment, including as a result of the following:

- Chauge in Claims Incurred but Not Reponted ("IBNR"): The Audited Financial Statements reflect an increase of more than $\$ 51$ million in IBNR. This chiange represents a $40.2 \%$ increase to the amount previously reported in the Unaudited Financial Statements, i.e., $\$ 128,354,077$.
- Changein EBITDA; As noted above, EBITDA was decreased from a proft of $\$ 16,044,851$ to a loss of $\$ 46,168,814$.
- Change in Net Income: Similarly, as a result of corrections reflected in the Audited Financial Statements, previously disclosed net mome of $\$ 10,761,982$ was revised to reflect a net loss of $\$ 29,002,958$. Taken together or Independently, both the changes to EBITDA and Net lncome easily surpass
the miniscule $5 \%$ threshold identified in the Reservation of Rights as being indicative of materiality, both as a result of the sheer size of the adjustments and the resulting shifts from profits to deep losses.
- Change in Cash: In your reservation of rights you note that the reduction of het cash and cash equivalents, which went from $\$ 169.3$ million (unaudited) compared to $\$ 167.3$ million (audited) was less than $2 \%$ and, thus, presumably immaterial. Your analysis fails to note, however-consistent with the FASB's insistence on considering "surrounding oircumstances"-that, as revised, the company's cash, which was previously sufficient to cover IBNR of $\$ 128,354,077$ (unaudited) and provide stability to its regulated businosses and HMO members; is now no longer sufficient to cover its actually disclosed IBNR of $\$ 180,008,155$ (audited).

The essence of the Credit Agreement is that it is a credit facility secured by the ongoing opertational retiurtis of the underlying business. As such, misrepresentations regarding avallable cash flow, net income and Minimum Statutory Capital Requirenents drastically misrepresent the ongoing business value that is the essential security for repayment of the loans Given these surrounding oircumstances the misrepresentationis and the delay in disclosing the true financial condition of the companies was extremely material

## B. Covenant Defaults

In the Initial Nötice of Default, we stated that an Event of Default existed under Section 71(0)(1) of the Credit Agreement for failure to "promptly" give notice to the Administrative Agent of any "development or event which could reasonably be expected to have a Material Adverse Effect" as required under the affirmative covenant set forth in Section $5.7(1)$ of the Credit Agreement. Specifically, Universal and AMC not only failed to provide notice of the material adverse effects reflected in the Audited Financial Statements prior to the submission of such statements, and despite an extension to the repoiting deadine set forth in the Credit Agreement, but affirmatively represented that no Event of Default existed in connection with their request for an extension to the reporting requirement in the Waiver Agreement. You have raised three arguments to suggest that the foregoing does not constitute an Event of Default. We will address each in tum.

First, you have argued that the changes captured in the Audited Finiancial Statements are not material: For all of the reasons already set forth above, including, among other things, (i) the $\$ 62$ million downward revision to EBITDA, (ii) the change from profit to loss, and (iii) the lack of sufficient cash to meet the needs of the Regulated Subsidlaries' HMO members, the Administrative Agent and the Required Lenders reject your conclusion regarding the immaterial nature of the changes reflected in the Audited Financial Statemonts.

Second, you have stated that the Audited Financial Statements were provided in accordance with the deadine set forth in the Waiver Agreement. This position, however, ignores the plain language of Section $5.7(\mathrm{i})$, whioh imposes a disclosure obligation "promptly" after the discovery of any development "which could" (not "would") areasonably be expected to have a Material-Adverse-Effect ${ }^{\text {² }}$ It is our-position-that, when the possibility of a Material Adverse Effect exists- such as the lack of sufficient cash to meet regulatory requirements or the needs of HMO members-Section 5.7 (i) requires
more than disclosure at the very last possible day for the submission of a financial staternent with no prior waming of its ominous contents.

Third, you have stated that any potential failure to disclose a Material Adverse Effect was "cured"upon the disclosure of the Audited Financial Statements. This statement ignores the ffect that Section $7.1(\mathrm{c})$ (i) of the Credit Agreement, which governs failures to disclose Matential Adverse Effects under Section 5.7(i), is not subject to cure and allows for an immediate Event of Default to be declared upon discovery. As such, a violation of Section ${ }^{3}$ (o)(i) requires express waiver by the Administrative Agent with the approval of the Required Lenders:

For all of the reasons set forth above, we reaffirm that the Events of Default identified in the Irifial Notice of Default continue to exist.

## 11. ADDITIONAL EVENTS OR DEFAULT

The Administrative Agent and the Required Lenders have determined that the following Events of Default, including as previously identified in the Initial Notice of Default, are currently ongoing under the Credit Agreement:

- Misrepresentation under Section 7.il(b): As prevously noted in tha Initial Notice of Default and further disoussed herein, the Credit Parties have made representations and wairanties under the Credit.Agreement that were incorrect, false and/or misloading as prohibited under the Credit Agreement. Specifically; as clarified by the corrections sel forth in the Audited Financial Statements, the following representations and warranties under the Credit Agreement weite lincorrect, false and/or misleading: Section 3.1(a) (Financial Condition); Section 3.2 (No Material Adverse Effect); Section 3.17(c) (Solvency); Section 3.22 (Accuracy and Completeness of Information); Section 3.32(a) (Compliance with Health Care Laws and Insurance Regulations). Additonally, the Solvency Certificate required under Section 4.1(f), as supplied in connection with closing, has also proven to be incorrect, false:and/or misleading
- Misrepresentation under Section 7l(b): In the Initial Notice of Default, we clearly stated that the Tax Refund (as defined in the Initial Notice of Default) is a general intangible that constitutes the Lenders' Collateral and should be placed in escrow pending instrictions from the Administrative Agent and the Required Lenders, In the Reservation of Rights, you have expressly and anticipatorily repudiated the obligation to preserve this Collateral and stated that you intend to use the Tax Refund to satisfy minimum statutory sapital requirements. As a result of the foregoing, you have also rendered the representation contained in Section 9.1 incorrect, fallse and misleading, as that provision prohibits the release of Collateral without, among other things, the written consent of all of the Lenders.
- Misrepresentation under Section 7,1(b): As reflected in the revised disolosires provided on October 10, 2012, it is clear that the amount of Combined Minimum Statutory Capital calculated as of the last day of the fiscal quarter ending June 30, 2012 for Universal Health Care Insurance Company, Inc.
("UHCIC") was actually less than 1.30 times the Minimum Statutory Capital and did not comply with the requirements of Section 5.9(d) of the Credit Agreement. Accordingly, the report provided for June 30, 2012, together with the covenant compliance certificate that accompanied that report, was incorrect, false and misleading.
- Covenant Default under Section 7.1(c)(i): As previously noted in the Initial Notice of Default and further discussed herein, the Credit Parties have failed to comply with the affirmative covenant set forth in Section 5.7(i) of the Credit Agreement, which requires "prompt" notice of any event "development or event which could reasonably be expected to have a Material Adverse Effect:"
- Coveniant Default under Section 7.1(c)(i): Combined Minimum Statutory Capital calcuilated as of the last day of the fiscal quarter ending June 30, 2012 (as reflected in the revised disclosures provided on October 10, 2012) for UHCIC is less than 1.30 times the Minimum Statutory Capital and, thus, does not comply with the requirements of Section 5.9(d) of the Credit Agreement.

While all of the foregoing is troubling it bears stressing that the failure to comply with the Conbined Minimum Statutory Capital requirement is of particular concern for additional reasons. Specifically, it is our understanding that the existence of minimum statutory capital requirements (as imposed on the Regulated Subsidiaries and reflected in the Credit Agreement)-and the failure and/orinability to abide by those requirementscreates the potential for events that will have a direct and adverse effect on patients, particularly when providers beijeve that they will not be paid for services rendered. Given thi hatare of the Credit Parties' business, there is significant concern that the lack of dequate capital at UHCIC will not only adversely impact that entity in the near term, but will ultimately Impact the more than 180;000 Medicare and Medicaid members of United Health Care, Ino ("UHC").

## IMELECTIONOFREMEDIES

Based on all of the Events of Default identified herein and in the Initial Notice of Default, and in accordance with the termis of Section 7.2 of the Credit Agreement, the Administrative Agent and the Required Lenders declare that the Cornmitments are hereby immediately terminated. Additionally, pursuant to and in accondance with Section 2.7(b) of the Credit Agreement, the Administrative Agent and the Required Lenders declare that the principal of and, to the extent permitted by law, interest on the Loans and any other amounts owing under the Credit Agreement or under the other Credit Documents shall automatically bear Interest, at a per annum rate which is equal to the Default Rate.

The Administrative Agent and the Lenders reserve the right to exercise such other rights and remedies as provided under the Credit Agreement, the Credit Documents and under applicable law, induding the right of acceleration.

Pleasegovern yourself accordingly.

## Sincerely,

BANKUNITED, N.A.
as Administrative Agent

By: Charles J. KuentosyP

December 3, 2012

Uniyersal Health Care Group, Inc.
American Managed Care, LLC
100 Central Avenues Suite 200
Sátint Retersburg; FL 33701
Attm: Deepak Desal, Chief Strategy Officer
Facsimile (727) 497-5737
Emaile ddesal@univhacom

VA EMAIL, FEDERAL EXPRESS OVERNIGHT AND FACSIMLLE

Universal Health Care Group, Inc.

American Managed Care, LLC
100 Central Avenue, Suite 200
Saint Petersburg, FL 33701
Atni: Alec Mahmood, CFO
Email: amahmood@univhc:com

Re: Second Supplemental Notice of Default Under Credit Agreement Among Universal Health Care Group, Thc. as Borrower (Universaly American Managed Care, LLC, as Guarantor ("AMC") BankUnited, N.A. as Administrative Agent, and the Lender Parties Thereto, Dated April 6, 2012 (the Ctedit Agreement")

Doar Messrs Desal anơ Mahmood:
The purpose of this letter is to inform you that the Administrative Agent ${ }^{2}$ and all Required Lenders have determined that additional Events of Default exist under the Credit Agrement beyond those previousily identified in the (i) Notice of Default (the "Initial Notice of Default") and (ii) Supplemental Notice of Default (the "Supplemental Notice of Default"), which were issued by the Administrative Agent to Universal and AMC on October 29, 2012 and November 14, 2012, respectively.

## I. ADDITIONAL EVENTS OF DEEAULT

On November 20,2012 , the Administrative Agent received Universal's Officer's Compliance Certifioate (the "Compliance Certificate"), which reflects certain financial information for the fiscal quarter ended September 30, 2012, as contemplated under the Credit Agreement. In the Compliance Certificate Universal specifically acknowledges that it is currenty not in compliance with the following financial covenants contalned in Section 5.9 of the Credit Agreement: Fixed Charge Coverage Ratio (Section 5.9(b)), Consolidated Combined Ratio. (Section 59(c)), Combined Minimum Statutory Capital (Section $5.9(\mathrm{~d})$ ), and Tangible Net Worth (Section $59(\mathrm{e})$ ). As you know; the failure to comply with any one of the foregoing financial covenants constitutes an Event of Default

Any capitalized term not otherwise defined herein shall have the meaning ascrlbed to such term in the Credif Agreement
under Section 7.1 (c)(i) of the Credit Agreement, which can only be cured by express waiver fiom the Administrative Agent with the approval of the Required Lenders.

In addition to the foregoing, the Compliance Certificate also states that Universal is in compliance with the Tötal Leverage Ratio imposed under Section 59(a) of the Credit Agreement. This is inaccurate. The calculation of Total Leverage Ratio, as such term is deflined In the: Credit Agreement, is the ratio of Consolidated Funded Debt to Consolidated EBITDA and, pursuant to Section 1.3 (a) of the Credit Agreemient, must be calculated in accordance with GAAP. In the Compliance Certificate, the denominator in the calculation, which is Consolidated EBITDA, was calculated without regard for the fact that the number was negative. Thus, Universal's Total Leverage Ratio calculation treats a lo's of $\$ 37$ million as indistinguishable from a profit of $\$ 37$ million to conclude that the ratlo is compliant despite the fact that it is stated as a negative number. Universal does not have negative debty which is what is implied by this calculation. Any such conclusion Is contradicted by both logic and the rules of GAAP, which prohibit the use of a negative Total Leverage Ratio. The most obvious reason for this, as exemplified by Unifersal's calculation is that the ratio you have stated as a negative 1.08 is far better (Leie closer to zeto, it a loss of $\$ 37$ million) than the ratio that would have resulted if the company had positive Consolidated EBITDA of even one dollar (i, e, 40;878,242 to 1.00). Based on: the foregoing and the disclosures in the Compliance Certificate, the Administrative Agent and the Required Lenders have additionally determined that Universal is not in compliance with the Total Levarage Ratio requirement set forth in Section 5:9(a) of the Credit Agreementit, which constitutes an additional Event of Default under Sections 7.1(b) and 7.1(c)(i) of the Credit Agreement, which require express waiver by the Administrative Agent with the approval of the Required Lendets.

In addilion to the Events of Default reflected in the Compliance Certificate, the Administrative Agent and Required Lenders have deternined that Universal has also bretched the negative covenant contained in Section 6,4(a) of the Credit AgreementWhoh generally prohibits the transfer of certain assets-by down streaning o tax refund of approximately $\$ 11$ million (the "Tax Refund") to its affiliate Universal Health Care Insurarce Company, Inc, ("UHCIC'). Although Universal was repeatedly warned (including in both the linitial and Supplemental Notice of Default) that any transfer of the Tax Refund would violate the Credit Agreement, the transfer was nevertheless purposefully and imptoperly effectuated. Accordingly, the transfer of the Tax Refund to UHCIC constitutes an intentional breach of the Credit Agreement, violates Section 6.4(a), and results in an additional Event of Default under Section 7.1(c)(i) of the Credit Agreement.

Notwithstanding the foregoing, it is our understanding that the Tax Refund was transferred to UHCIC in exchange for a note to Universal from UHCIC (the "UHCIC Note"). Please be advised that the Lenders have receíved a pledge of all "Statutory Notes" under the Credit Agreement, which include the UHCIC Note as a "subordinated surplus promissory note issued by a Regulated Subsidiary to a Credit Party." Accordingly the UHCIC Note constitutes the Lenders' collateral and must be immediately allonged to the Administrative Agent.

The Administrative Agent and the Lenders have not elected to pursue additional remedies beyond those already set forth in the Supplemental Notice of Default and those referred to above; but reserve the right to exercise such other tights and remedies as provided under the Credit Agreement, the Credit Documents and under applicable law, Including: the right of acceleration.

Please be further advised that upon information and belief; the Credit Patties have suggested that the real property owned by Universal might be transferred to UHCIC to make up statutory capital shortális. Such a transfer would be in direct volatom of Section 6:4 of the Credit Agreement without the express written consent of the Administrative Agent and the Required Lenders and such consent is not granted at this time.

Please govern yourself accordingly.
Sincerely:
BANKUNITED, NA as Administrative Agent



ANNUAL STATEMENT

## FOR THE YEAR ENDING DECEMBER 31, 2041

OF THE CONDITON ANO AFFARS OF THE:
Unlveraal Henlth Care Inaurance Co. Inc.


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STATEMENT OF REVENUE AND EXPENSES (Continued)


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PART 3 - ANALY8IS OF EXPEN8ES



EXHIBIT OF NET INVESTMENT INCOME


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ANNUAL sTATEMENT FOR THE YEAR 2011 OF THE Universal Health Care Insurance Co., Inc.

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| 17. Amoume recevabit rimitiod to uninured pime ... |  |  |  |
|  | 0 |  |  |
| 48.2Not invened tex emen | $\underline{0}$ |  |  |
| 19. Ormunty tunde reavabis oc on depout. | $\square$ |  |  |
| 2a. Eiocrowle data proemenng equipment and sonwera. |  |  |  |
|  |  |  |  |
|  |  | - |  |
|  |  | - |  |
|  | -.3,870,804 | .3.800.240 | -(246,400) |
|  | -183,000 | 259.758 | -56,078 |
|  |  |  |  |
| Protered Cowl Accounte (1) inve 12 to 255 . | -.4,194.500 | -4,044,183 | - |
|  |  |  | 0 |
|  | 4,196,900 | 4,034, 60 |  |
| Pexall OF Whiteme |  |  |  |
| 1401. |  |  |  |
| 4102 |  |  |  |
| \$403. |  |  |  |
|  |  | 0 | 0 |
|  | 0 | 0 | 0 |
| 2501. Prepoid Expenses- | -57.194 | .280, 807 | - 151,515 |
| 2502. 4ceconts Recoivetia. | -125,087 | -30,591 | _(9,939) |
| 2503. |  |  |  |
|  |  |  |  |
|  | 103,000 | 29.785 | 50.889 |



## ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE UnNorsal Heath Care insurance Co., Inc.

## NOTES TO FINANCIAL STATEMENTS

Univecral Heath Cure Insurance Company Inc.
Notes to Finnncial Statements for the year ended December 31, 2011

## 1A. Sumrory of Sirnificant Accounting Policiet.

The accompanying rtatotory-banis financial otatements bave been prepared in conformity with the otatutory accounting practices preacribed or permitted by the State of Flotida Department of Finaneial Services, Office of Insurace Begulation (OIR). which practicen difter from U.S. generally accepted accounting principles (GAAP).
 (NAIC), aq well as rato law, rognlations, and general administrative rules. Permitted atatutory aceounting practices encompans all accounting practices not eo prescribed. Tho Compmy has no permitted atatutory accounting prectices. Tho mose significmut variances from (AAAP aso as follows:

Invermants: Investments in bonds are reported at amortized cont or fair valum based on- hesir National Associntion of
 hold-to-martasity, trading, or avaifablo for aalo. Hold-so-maturity fixed investments would be reported at amortized coast, and trading and available-for-sale fixed-maturity investments would be reportod at fair valise with unrealized grins and losses reported in operstions for those designated as trading and a a weparate ecmponent of other comprehensive income for thoso demgated ar available-for-mele. Foir vatue for statutory parpoasa in based on the pricen publiubed by tho Secaritior Valuation OASce of the NAIC (SVO), if available, wherear fir value for GAAP is based on quoted market prices.

All ainglo-chna min noulti-class mostgage-bactred and asect-backed securities (o.g, CMOn) aro adjunted for the effiects of changes in prepeyment anenmpriose on tho rolated accretion of diseount or emostizstion of premium of auch recuritise vaing either the retrompective or prospective methods. If it is detenuined that a decline in fhir vahse is other-than-temporary, the cons
 purchased or reteined, that reprevent benpficial jutrests in tecuritized astets (a.g. CMO, CBO, CDO, CLO, MBS, and ABS vecrinties), other than high-quality securitios, are adjusted using the prospective metbod whem there is a changpe in estimated flturs cash flowe. If it is deterraiped that a decline in fir vilue ir other-than-semporary, the cont basis of the security in written down to fair valuo. If high-credi-quality securities ere adjurted, the retrospective method is med

Nonadnitted assefs: Certain mesets desigated an "nonadmitted," principally fleniture and equipnent certain amonots receivitic, and other assete not opecifically identified as an adouitted asset with tho NAIC Accounting Practicos and Procedures Mannal, are exchuded from the accomparying atatutory-basie balnocs sheets and are charged directly to unasignad supphe. Under GAAP, such anets would be included in tho balance sheta to the extent that those ansere aro not impaired. Tha balnnces of nonadenitied assots aro an followa:

| Non Admitted Assets | December 31, 2011 |  | Ducember 31,2010 |  |
| :---: | :---: | :---: | :---: | :---: |
| Pharmasy Rebate Recelvable. | 5 | 2,446,514 | \$ | 2,122,947 |
| Acounte Recelvable |  | 1,556,266 |  | 1,449,517 |
| Reingurance Recolvable |  | 134,934 |  | 59,730 |
| Propaid Recolvable |  | 57,194 |  | 208,807 |
| Total Non Admlited Assets | \$ | 4,194,908 | S | 3,840,504 |

Refnsurnmes: Any reinaurance balances dearned to be uncoliectible are writen off through a charge to operations. Under GAAP, en allownico for mmounts deemed uncollectiblo world be enablished through a charge to operationn. Cinims lisbilitian ceded to reinumes have been reported as reductions of tho related rescrven rather than as arseda, at would be required under GAAP.
 statutary-basin, if approved by the ORR. Under GAAP, such motes payable are reconded as liabilitiet (neo Note 13).

Dpforned income farav: Defirred tax assets aro limited to: (1) the amount of federal income taxca paid in prior yean that can be recovered through lass carry becke for existing tempotary difienences that rovereo by the end of fbe subwequent calondar year, plins (2) the lesser of the remaining gross defered tax asectsexpected to be realized within oae year of the balance aleet dsts of $10 \%$ of net worth exchuding any net dofented tax meners, electronic data procesaing (EDP) equipment and operating softwaro, and any net positive goodwill, plus (3) the amount of remaining grous deforred tex ansets thet can be offiet eqpinst oxisting gross deferred lan liabilities. Any remaining doferied tax assefs are nonadmitted, Deferned taxes do not includo amovnts for ofte taves. Pumuant to Statement of Statutory Accouncing Principles (SSAP) No. 10R, paragruph 10.e, the Company may clect to admit additional deferred tax asects. Tho election is subject to certain capital mad sorphs requirements. If clected, the above is modified as follows (a) the canry back period for ( 1 ) above is modiffed to reflect avaibablo lows eary bucks for both ordinary and capital lowsea to be the carry back time frame conresponding with the ans bax loms carry buck pavisions, not to oxceed threa years; (b) the period of roalization and ths percentago of capital and supplus mentioaed in (2) above, are increased to three years and 15\%, respectivoly. Under GAAP, ateto incomo laxee ere included in the compoutation of deforred theses, s doferred lax asset in recorded for the anount of grow deferred tex alsert expected to be realized in all futuro years, and a valuation allowance in eatablinhed for deferred tax asseta not realizable.

Slatemont of cash flows: Cash, cash equivalents, and short-termin irvestovents in the statements of cach flows reprasent cach and inventhent balances wilh initial mishritios of one yotr or low: Utder GAAP; the correaponding caption includes cabla and investments with initial marurities of three month or less.

The effectr of the foregoing variances from GAAP on the accompanying watutory-basis financial statentente have not been determined, but are presumed to bo material.

## ANNUAL STATENENT FOR THE YEAR 2011 OF THE Unlverad Health Core Insurance Co., Inc.

## NOTES TO FINANCIAL STATEMENTS

## B. Use of Fitimater

The presentation of the finncial statements in confonmity with statutory accounting principlet requiren managemeat to makn astimutea and anmmptions that affect reported amounts of assota and linbilitics and dinclovures of contingeat asacts and linbilitios at the date of tha financial statemente and the reported rovemues and eapenses during the reportiag period Significant accounta ihnt aso bargaly deternined buped on minnagement's entimafos and assumptiona inchude IBNR clains payablo, scerved phannowy reimbumement due CMS, preminma receivable dwo fom CMS related to retro-premium adjustments and ribl-aharing adjustrmentr; and unallocnted preminum received from CMS included in upenrned premiuma. Actanl renults conld differ fram thove estimates, and those differencea could bo miterial. Such eximates and asmumptions could chenge in the fature an more information becomea known, which could impact the amounts reported herein

## C. Simnificent Accourting Policied

Univeral Health Care lmourance Company, Inc. (UHCIC' or "the Company") is a Florida domiciled insurance company and a wholty owned mebeidiary of Universel Health Care Group, Inc ("Gropp"). The Company was incorpornted on May 25, 2006 and formed ts a health insurance company that operates a Medicare Advantage Privato Fee for Service pien. The Company commonsced rovenne generating activitien in January 2007.

Tha Company has a contrict with tho Departmont of Henth and Human Services, Centers for Medicere \& Medicaid Servicen (CMIS) to provide healin eare services to Medicaro enrollees in the atates of Alabam, Arizons, Alkamma, Foridh, Georgin, Mlinoig, Indinm, Lauisisina, Marylead, Missiasippi, Missouri, Novade, Now Jeney, New Yort, North Carolin, Ohio, Ohtahome, Pennoyivania, South Carolina, South Daispta, Texis, Utah and Virginia, as well as tho Dialrict of Cohumbia. This coatract accounted for 100\% of the Company's rovemsea in 2011. CMS awarded the Company the contenct forr the period beginning Jenuary 1, 2007 and ending December 31, 2007 and has renowed the contract through December 31, 2011. The coatract provides for anmul axtenaions aubiect to agreement and approwal by both partiea

Inyestmenta
Inventoments in bonds, canh, cask equivalionta, and phort-derm invertments aro stated at vilues prescribed by the NAIC. as followa:
Investmenta are seported at amortized cost or fair valma based on thoir NAIC rating. Boade not baciced by otber loans aro pincipatily stated of amortized cost using the inderest method

Singlo-chass and multi-class mortgngo-backed and asett-bucked securitios are vaked at aroorticed cost uping the intenest method inchuding antiripated prepayments. Propayment asmuphiods aro obtained from dealer nurveys or internal or thindparty extimates and are bssed on the current intersst rate and economic environment. The prospective adjuatment method is ueed to value ath auch excuritita.
 one year or less whea parchneed including finds meindained under statulary requiremente (deporita), and consint of moncy mintes and certificates of deponit funds regintered with tho NAIC.

Investmenta in common stoches are denignated as avilable for sele and aso mported at frir valuo with unsealized gains or losses reported not of tazas in other charges in capital and surghus.

Realized capital gains and loases ano detennined using the specific identification basis. Changes in the admitted anset carrying amounath of boads are credited ox charged directly to unascigned muplus.

The firirvilue of an asset is the amonot at which that ascet could bo bought or pold in a current transaction between willing partios, that is, other than in a forced or liquidation eala. The firir value of a liabihity is the amount at which that liability conld bo eetiled in e current hansection between williag partien, that is, other than in a forced or liquidation settement.

Fair valuen are based on quoted nurket prices when available. When quoted market prices are not rivailabla, fair valuo is generally estimuted using discountod cash flow analyses, ineorporating current market inputs for similar finucial inutruments with comparabto temms and credit quality. In inatances where there is little or no morket activity for the samo or timilar hartrumertes, the Company eatimates fair viluo using methods, modele, and assumptions that management beliovee madee participsate woald vee to determine a current trensaction price. Thewe valuation techniquas involve some lovel of management estimetion and judgment, which becomer significant with increasingly complex instruncents or pricing modele. Where appropriata, adjustments afo included to reflect the rifi inherent in a particular methodoloyy, model or input ued.

Financial assets canried at fiair vaho aro clasgified, for dirclosure purpowes, based on a hierarchy defined by the Fair Vahe Meararements Disclognre Topic of the Finencial Accounting Standerds Boprdy Accounting Standards Codification (FASB ASC).
 matets and liabilitied (Level 1) and tho lowort ranking to fhir values detenmined using methodologies and modela with unobservable inpusta (Lovel 3). An meselte or a linbility's clastification is based on the lowert level input forat in aignificnat to its measurement. The lovela of the ohir valuo hierarchy are as follown:

Lovel 1 - Values are vandjumted quoted prices for identical assets and lisbilitios in active maskels accomiblo at tho measurement date.
Lavel 2 - Inpula inchude quoted prices for similar absets or liabilities in active markets, quoted pricen from thow willing to trado in marketa that art got active, or othar inpate that are observablo or can bo corroborated by merbet data for the term of the inatrument. Such ingule includo murket inderest rates and voletitities, cpretads, and yiold curves. ....... .
Law 3 - Certain inputs aro unobservable (arpported by fittle or no market activity) and significant to the fair valuo measurement. Unobservablo inputs reflect the Company's best estimuto of what hypothetical marfet participanta would use to determino a transaction price for the asset or liability at the reporting data.

## NOTES TO FINANCIAL STATEMENTS

At December 31, 2011 the Company's investments are ail classified as Loval 2 insinnuuenth.
Minimpm Conituland Surphas Repuicementa
Persuant to Section $624,408(1 a)$ of Florida Statuten, the Company is required to maintain a minimum aurplua sot lese than the greater of $\$ 1,500,000$, or $4 \%$ of total linbilities phas $6 \%$ of liabilitics relative to healh insureace. Pursuant to Section $624.4095(1)$ and 4(c) of Florida Statates, the Company is ntoo required to mantaio an ratio of actual or jrojected annual premiums, an defined, to current or projected surplus as to policy bolders, as defingd, of yot mone than $10: 1$ for groes writtea premiums or $4: 1$ for net written premiums. For purposes of this requirement, manul or projected premituns are limited to $80 \%$ for health insuranca companies meh ath the Company. By Conoont Order filed Jamary 5,2011 , the FL. OR granted perminsion for the Company to opermto at a ratio of grost actiual or projected anounal preminms io current minplua as to policy holdens of not more than 16:1, oxceeding the required ratias purgunat to Section $62.4095(1)$ and $4(c)$ of Flocida Statures. As a condition to this approval, the Company agreed to (1) samintain at all times complinace with tho rato limitation of nes actual or projected armual preminms to curren eurphas as to policy holders of $4: 1$ and RBC of $250 \%$ of the suthorized coatrol tevol; (2) maintain compliance with minimum capital and aruphus requirmmente dafined by Section 624.408, Floride Statutes; (3) elect a $75 \%$ attachnneur poiat quota-sharo reinsurance for 2011; (4) limit Medicuse enrollees for the 2011 plm year, and (5) defer any recquent to pay dividonde until after the September 30, 2011 quartecty statement is filed with tho ORR. Additionally, according to the Stale of Georgis Consent Onder dated Anguat 28, 2006, the Compery munt atso mainenin capital and amphas of not leas than $250 \%$ of the authorized control loval riat based capital. As of December 31. 2011, the Company's enpital and surplos of $\$ 45,059,196 \mathrm{mot}$ the reapective lovela preseribed by the stasatess and rognlatory sequirementa described above.

## Reconsition of Preminn Revenuo and Medical Expervesa

The Company gerienlly receives premiuma in advance of providing ervices, and recognizes premium revenve during the period in which the Company is obligated to provide services to ite membere Preminnus are billed monthly for coverage in tho following month and ere recognived st rovempe in the month for which inarrace coverage is provided. Accordingiy, the portion of premiums applicable to funtre periods is included in the accompanying atatulory-basia brinneo sbeets as premiums received in advanced and in sccounite payablo and aecrued expenses.

The Compars reconciites the memhership in its administrative syatem to the earollment data provided by CMS. There are timing differconcer between tho addition of a member to the Conmpmy't administrative syatem and the approval, or accrotion, of the smember by CNS. Additionilly, the monthly paymenth from CMS include adjustmenta to reflect changee in membership at a recuih of fẹtrosetive terminations, additions or other changea. Current period membership, not premiums, and claims expeoso are adjonted to reflect retrometive changes in memberthip.

Premivin and other heath curo recrivablea consiot of premiums duo from fideral agencies and membert baved on enrolled memberthip and other related hatith eare plan receivables. On an ongoing basi, management ortimatea the amorant of premiuna billinge that may eot bo folly collectinle bared on historical trends and other factora. Amounts deemed umeollectible are written off aprinat promium revenue in the period the determination is mada.
 adjustment model, which emportionts premiums peid according to helfh diagnosen. The rink adjuetroent moded usen health ritius indicators; or riak scoros to improve the sccuracy of payment. The CMS risk adjugtment model poys mane for mombers with increasing heath noverity. Under this risk adjustronen mothodalogy, dinguosis data from inpatient and ambulatory treatment vettinga are usid by CMS to calculate tha riks-adjusted promium payment to the Company. The monthly rini-ddjunted premium per menaber in determined by CMS baned od normalized riak acoror of each member from tha prior year. Anmully, CMS provides the updated rick scores to tho Company and rovises premium rates prospectively, beginning with the July reavithace for current plan year members. CMS will alco calculato tho retroactive refjustments to premium related to tho rovised riak ucores for the carrent year for current plan year members and for the prior year for prior plan year members.

All healith benefit organizations masat capture, collect, and aubmit the necesary diagnoair code information to CNS within preacribed desditnes. Aceordingly, the Company collects, captures, and aubmita the neceasary and available diagnatis data to CMS within prescribed dendinet for its HMO plim. The Company entiuntes changet in CMS premiuma related to rovenive edjuatruents based upon the diagnosir data submittod to CMS and witimately accepted by CMS. Riek sooste tere updated anavally by CMS, and the Compenty reconciles the data to eatimated amount recorded by tho Company with any adjuanuentis reconded in premium reveruse:

Modical expenser consist of clain payments, capitation pryments, and phamacy costo, net of reboten, as well as entimates of future payments of claims provided for servicen rendered prior to the end of the reporting period Cepitation puyments roproseak manthly conarictual feee diaborsed to phynicinas and other providert otho are remponsiblo for percviding modical cero to members. Phamacy costs (including Medicare Part D conts) represent payments for members' prencription drug benofin, net of rebetes from deug mamuactureriL Rebates are recogrized when the rebutes are eamed aecording to tho contractual arrangements with the rempective vendorn.

Premiums the Comppany payn to reinsurens aro reported an medical expencen and related reimsunace recoveries are reported as reductions of medical expenses.

Mediell claime liability repreenta tho Companry's paynuent responsibility for mervices that have been rendered by medical service providens to mermbers. There conts heve not been setled as of the balance aheet dates. Tho liability consits of medieal chims reforted by the medical servico peoviders sa well as an wetuarially determined estimato of claims that have been incuarted but not yet reported (IBNR) by the medical service providers.

Due to the mumerous factors influencing this linbility, the Company dovelops an estimato bared upen genernally accepted scturoial projection methodologies vaing cinim oubmission and paynent pattens nad cont trends. Deviationa, whether positive or nepative, between achual experience and estimates shed to establivat the liability nre recorded in the period of claina pryment on a conaintent

## NOTES TO FINANCIAL STATEMENTS

basis. Tho Compary continulally monitors the reaconableness of tho assumptions used in prior entimntes by comparison with actual claim patterns and considers thin information in fubure eatimstes.

Medical and other benofits paid can also be nignificantly impacted by outcomes from coust decisions, interpretations by regulatory authoritios, and logivativo changer invalving henlth caro mathers. As a rasult, amounts ultinntely paid my diffor from initial entimaten that did not consider such outcomes, interpretationa, and changea.

## Medicuro Pat D

The Compang't Medicare Adventage plen offers prescription drug benofis under Part D of the Medicare fiedeal health inturance program to tadividiale oligible for benafios under Part A or Part B. As such, tho Conpany receives additional premium and cont reimbursement conyponents.

For qualifying low-ineoms status (IIS), mernbers, CNS payt the Conypary for anome or all of the LIS memberg monthily preminum The CMS payment is dependent upon a member's income lovel, which is determined by tho Social Security Adrainistration. Lownincoms premium in recognized over the contratt poriod and reported as preminm reveruac Additionally, for qualifying Lis members, CMS will reimbnome the Company for all or a partion of tho IIS membeits deductiblo, coimauranco, and co-paynuent amount obove the out-of-pociet threshold for low-incomo benoficieries. Low-income cost-abrinig arbidies are poid by CNMS prompectively ia a fired amount per mernber per monih, and are determined based upon tho plan year bid rubmitted to CMS. After tho close of the ampuap plan year, CMS reconcilex nctual experience to low-incoute cont sharing oubsidier paid to the pim and any differencei are setted between CNM and the Company.

The Company also receives pryments from CMS for catastrophic peinsurance for membens of its Medicase Advantage plan. CNS mentes prospective monthly cataitrophic reinsonnce paymente to the Company beced on extimated average reinsurance pryments to othar Medicato Advantidge-Premerigtion Drug plang that provido Part D benefita. Ather the clowo of the armal plan year, CMB secomilea setual enpericice compnred to catatophic seinnmanco aubaidien paid to the Compary aod any differeacea aro settled betwrea CMS and tho Compary.

Low-ibcomo cont abaring and canstrophic reinsurance subbidies roprosent fuading from CNE for which the Compeny assumes no risk sod emountim peceived from CMS are reported net of paynunts of the netral prescription drus costs related to the low-incomo cost sharing and catatrophic reingurnace in the accompanying stabtory-basis balance eheets. The Company doet not recognize premium revenme or mediel claime expense for this activity.

Medicase Peat D activity remulted in a payable from CMS of \$291,140 at December 31. 2011, which iv inchuded in amounta receivable relating to noninsured plans in the socompanying statulory-basis balance aboeth. Actumi amount of Medicare Part $D$ rolated aneta and liabilitien could differ mutarinily from amomite reconded.

## Accrued Loss Adjustment Bxpente

Claino processing expenses for unpaid claims, inchuding clnims IRNR, aro ncerved baned cal optimated expenses noceasary to procen ruch clems.

## Adyertising Erpenge

Marketing and advertiving costs are expensed as incured. For the year eaded December 31, 2011, the Company incrived \$348,380 of advertising expenva.

## IncomeToxces

On September 27.2007, the Compeny elected to memorialize its tan-sharing erragement by participating in sa Intercomptany Tax Sharing Agreement (the Agreement) with Grouy, Univeral Health Cace, Ine. (HHC), and American Marmged Care, LLC (AMC). UHC and AMC aro entities owned $100 \%$ by Group. Beginniag with the 2007 tux year. Group bas filed a concolifinted federal tax refurn that inchudes the operations of the Company, Group, UHC, and ANC. On May 27, 2009, the Agreement was amended to inchude praticipntion by Univernal FMO of Tosas, Inc. (UHMOT). UHMOT was incopporated during the yoar cuded Deceuber 31, 2009 and is wholly ownod by Group. The Company obtained final approval of the nmensied Aypremeeat Aom the OR in October 2009. On July 27, 2010, the Agreemont was amended to include particippation by Univeril Health Care of Nevadu, Inc. (IFHCNV). UHCNV was incorporated during the year ended December 31, 2010, and is wholly owned by Group. The Company obtained fimal approval of the amended Agreement from tho ORR in Marct 2011.

Under terms of the Agreenent, each company shall be responsible for and ehall reinoburne Group for its separsady calculated chero of the consolidated tax benefit or expense. Further, per the Agreement, each company shall pay prompliy to, or be reimburted fiom, Group, on a quaterify basia not later than the due date for tho extimated quertorly payment of taxea, ita share of auch payment, estimited in the eame mamer as specified above. Any finnl adjustmenta to payments shall be made following the preparation of the consolidated federal income tax return.

## 2. Accomaning Chandes nit Correctiont of Frome

N/A
3. Burineas Combintiony and Gooduil

## 4. Diecontinged Operations <br> N/A

ANHUAL BTATENENT FOR THE YEAR 2011 OF THE Univaraal Health Care Enaurance Co., Ine.

## NOTES TO FINANCIAL STATEMENTS


#### Abstract

5. Invertment

A-D. N/A E. Repurchase Agreements andor Securities Lending Transactions:

The Company entered into a sweqp repurchase agreement with a financial services institution to increass its roturs on irverted aspeta. Tho transactiona iovalve the transfer of eccosse cush to in regulated fimancial institution that is collaterslized by secwitiea. On ths nant businase day, the transferred caph, along with any inkersest thereon, is trannferted back to the Company and tho collateralized securities aro retarnad. The arrangement metar the requirement to bo socounted for as secured borrowings. Tho Company zequires that at all times, cecurities obtained as collateral are rufficient to fund substantialty all of the cost of purchaning replacement sssess. At of December 31, 2011, amounts ontatanding under repurchase agreemuents of $\$ 8,285,087$ are clavified as canh in the accompanying statement of aseots. Ae of December 31, 2011, cecuritien with a fair mudiot vilue of approzimately $\$ 8,450,800$ were held as collateral under this agreement.


F-G.NA
6. Ipint Yentures. Pernemhipasid Limited Liobility Companies

N/A
7. Inivelment frome

N/A
8. Dexivative Indtomentaz

N/A
9. Yncome Taxea


NOTES TO FINANCIAL STATEMENTS


## 10. Information Conceming Pareat.Subaidiurios and Affliates

A - C. All outatanding theror of the Company are owned by Group, an insurnance holding compnny incorperated in the State of Delaware with operations bused in Floride. On Febraty 14, 2011. Group entesed into a $\$ 37,500,000$ term-lonn end a $\$ 2,500,000$ unfunded rovolving credit agreement which placed additional nuinionum atatutory capital requirementa an itts mbsidjaries, inchuding UHCIC. Under the credit agreement, the Comptany must maintsin marplus and cepital equal to or greater than $\mathbf{1 2 5 \%}$ of the Statutory minimum. Group pledged $100 \%$ of its equity intorest in UHCIC as security under the credit agreement.

Surplus notas payable, nolated party:
The Compuny, han recorded $\$ 18,250,000$ in-surplus-noter payable to ite parent; Group; at Decemberv 31,-2011-(4e8 niota 13). The terms of the surphus notes payable specify that principal and interest is payable only upon the prior spproval of FL, ORR The notes
 atud received FL ORR epproval for payment of intereat. As of the year ended December 31. 2010. Note wh's principal and intereat of $\$ 66,000,000$ and $\$ 4,295,202$, sespectively had been paid in fill. The Company paid down Note 6 it in tho total ateount of

## NOTES TO FINANCIAL STATEMENTS

$\$ 2,750,000$ an July 14, 2010. During the period from May 23, 2006 (date of inception) through December 31, 2011, UHCIC did pot obtain approval from FL OR for the Surphas Notas \#1, W2 and \#3; therefore UHCIC bas not recorded accrued interceat and intretel expeaso of $\$ 4,963,230$ rolated to thow noten.

## Dthdend paymmt

N/A

## Other molthanships:

The Company has a numagement agreament with American Manged Cra, LLC (AMC), effective through May 31, 2012 and automatically renowed in one year. termas, whereby AMC providea supervinory and namagements servicon, performs apecific functions and contratt servicest to ad performos certhin payroll functions for the Company. AMC is owned $100 \%$ by Group. Bffectivo December 1, 2010, fees puraupant to this agreement war sot at $9.0 \%$ of the total collected preninums on a monblaly bavis as approved by FL ORR on November 5, 2010. Effective Jemary 1, 2011. for compenuation for services rendered, the Company thall pay AMC a percecotago of boes collected premiums on a monithly besin. The amount shall very, as matually agreed between AMC and the Courpeny, but undes no circumatrance ahant the porcenkso of collected premiums paid to AMC Eeveced $9 \%$, without obtrining prior approval fram the FL, OIR. Further, no amounts paid by the Company shall renult in the Company being out of
 $\$ 35,213,868$ for the period firan Jaouary 1,2011 through Decenber 31, 2011.
 Univenul Feath Care, Inc (UHC), Univeral HMO of Toxis, Ioc. (UHMOT), Univessal Hoalh Care or Nevada, Inc. (UHCNV) and AMC, companies undes common control by Group, at well se Group itsolf. The Company also paye for end is reimburred by UHCC. UHMGOT, UHCNV and AMC for carthin expenditurea. At December 31, 2011, to Compary owed UHC $\$ 30,747$ and was owed $\$ 25,153$ fom AMC. All ancound will be cettled per terms of the Compmy's interconpany trantactions policy which requires the puyment to be mado within 30 doys.

## E. N/A

F. The Compmy han a management agreement with AMC, effective through May 31, 2012 and automatically renowed, wheneby AMC provides mpawisory and manngement rervices, perfonms specific fanctions and contract nervicee to and performe certain payroll fanctions for the Coulpany. AMC in owned $100 \%$ by Group

In eddition, tho Company msinfrins a provider agreement with American Family \& Geriatric Care (AFGC), which is owned 100\% by a majosity athreholder of Group. Amonnts paid to AFGC under the provider agreement for the yeer ended December 31, 2011 were $\$ 2,271,190$.

## G. -L. N/A

Under the Company's tax aharing agreenunt, \$5,B79,729, included in current federal and foreign income tar recoverable in the sccompanying Statemant of Assels. Liabilitise, Capital ond Surples, is dus to tho Company from Group and will be betiled per terms of tho interccrappary trensections policy.
11. Dshat

NA
 Benofit Phana
N/A


1. UFCLC has $10,000,000$ eberes of $\$ 1.00$ per valuo common stock aulhorived, $2,500,100$ shares insued and ourtanding as of Decensber 31, 2011.
2. NVA
3. Prior approval in needed by Floride OIR for dividend paymenta to Gsoup and may not bo presented for approval until atter the funo 30. 2011 quarterly totements aro filed
4. NA
5. Within the limitations of(3) above, there aro no restrictione placed on the portion of company profite that may be paid as ondimary dividends to stockholders.
6. N/A
7.N/A
7. N/A
8. N/A
9. The portion of unasgigned fimads (ourphus) represented ty cumulative unrealized gnins and lowses is 2-64,893. 11. Plense see table as followe:

|  | Dite Ismod | $\begin{aligned} & \text { Reterant } \\ & \text { Rnte } \end{aligned}$ | $\begin{aligned} & \text { Par Vitue } \\ & \text { (Face } \\ & \text { Arvant of } \\ & \text { Note) } \end{aligned}$ | Cuxylat <br> Nole | Principal mad/or Internat Peld Churept yey |  | $\begin{aligned} & \text { Uavperoved } \\ & \text { Primerpal undtor } \end{aligned}$ intratis |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| $\begin{aligned} & \text { 8x pint } \\ & \text { Notay } \end{aligned}$ | 12298006 | 3.18\% | Strogepan | \$8000000 | 0 | 0 |  | Deat ofurity |
| 8urphus |  |  | , | Sencoun | 0 | 0 | 22,003,333 | NA |
|  | 01/132007 | 5.0\% | \$2009000 | \$70000009 | 0. | 0 | . 5 Spl.g4. | N/A--......... |
| $\begin{aligned} & \text { 8urfan } \\ & \text { Noxatis } \end{aligned}$ | 02929607 | 5.0\% | \$11.000,000 | \$ 3 250000 | 0 | 12750.000 | 22467.952 | - |

12. N/A
13. N/A

NOTES TO FINANCIAL STATEMENTS


Henn canecainale

| Quarter | Estimated Rx Rebater as Reported on Finmacial Statements | Rx Rebates as Billed or Otherwise Confirmed | Actual <br> Rebates <br> Received <br> withia 90 <br> dayt of <br> Billing | Achual Rebates Received within 91 to 180 Days of biling | Actual <br> Rebatas Received More Than 180 Day: After Biding |
| :---: | :---: | :---: | :---: | :---: | :---: |
| 3/31/2009 | 5929,951 | \$929,951 | \$ | \$ | \$929.951 |
| 6/3072009 | 977,292 | 977.292 |  | - | 977,292 |
| 9/30/2009 | 1,015,385 | 1,015,385 | - | 899,703 | 115,682 |
| 12131/2009 | 887.585 | 887,585 | - | - | 887,585 |
| 3/31/2010 | 653,467 | 653.467 | - | 56,875 | 596,592 |
| 6/30/2010 | 1,319,378 | 1,319,378 | - | 1,319,378 |  |
| 9/30/2010 | 1,021,724 | 1,021,724 | 144.746 | 876,978 |  |

ANNUAL STATEMENT FOR THE YEAR 2011 OF THE Univerall Heath Care Insurance Co., Inc.
NOTES TO FINANCIAL STATEMENTS

| $12 / 31 / 2010$ | $1,248,839$ | $1,248,839$ | 92,048 | 921,625 | 235,166 |
| ---: | ---: | ---: | ---: | ---: | ---: |
| $3 / 31 / 2011$ | 1,685901 | $1,685,901$ | - | $1,655,901$ | - |
| 63012011 | $2,148,552$ | $2,148,552$ | 354,189 | $1,545,081$ | 249,282 |
| $9 / 30 / 2011$ | $1,873,665$ | $1,873,665$ | - | $1,601,843$ | - |
| $12 / 31 / 2011$ | $2,174,692$ | $2,174,692$ | - | - | - |

## 29. Participgting Policies N/A

30. Preminin Daficiency Reseryen

NA

## 31. Anticipated Salvage and Subtogntion

 N/A
## GENERAL INTERROGATORIES

PART 4 －COMMON INTERROGATORIE8

## GENERAL

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## GENERAL INTERROGATORIES






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## GENERAL INTERROGATORIES




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## GENERAL INTERROGATORIES

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## GENERAL INTERROGATORIES

## PART 2 - HEALTH INTERROGATORES



FIVE - YEAR HISTORICAL DATA


ANNUAL STATENENT FOR THE YEAR 2011 OF THE Universal Health Care Insurance Co, inc.
SCHEDULE T-PREMIUMS AND OTHER CONSIDERATIONS

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ANNUAL 8TATEMENT FOR THE YEAR $20 t 1$ OF THE Univarsel Health Care Inaurance Co., Inc.
ASSETS


ANNUAL ETATEMENT FOR THE YEAR 2011 OF THE Unlveraat Health Care Inaurance Co., Inc.
LIABILITIES, CAPITAL AND SURPLUS


STATEMENT OF REVENUE AND EXPENSES


## STATEMENT OF REVENUE AND EXPENSES (Continued)

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| :---: | :---: | :---: | :---: |
| CAPTMAL SURPRUS ACCOUNT |  |  |  |
| 34. Ceplana and aurplus prior reporting year $\qquad$ 55,515,950 <br>  $\square$ <br> - |  |  | -65,404.200 |
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ANNUAL STATEMENT FOR THE YEAR 2011 OF THE Universal Health Casp Insurance Con inc.


ANNUAL 8TATEMENT FOR THE YEAR 2014 OF THE Univareal Health Care insurance Co., inc.
UNDERWRITING AND INVESTMENT EXHIBIT
PART 3 - ANALY818 OF EXPEN8E8


## NOTES TO FINANCIAL STATEMENTS

Univenal Health Care Inpriance Company Inc.
Notea to Financial Statementa fors the year ended Decoumber 31, 2011

## 1A. Sumunry of Simificant Accousting Policiea

The accompanying statutory-besis fmenciat atatements have been prepared in conformity with the statotory accountiag practicea prencribed or permitted by tha State of Floside Department of Financial Services, Office of Insurance Rogulation (ORR). which psacticen diffor from U.S. gemerally accepted aceounting principles (GAAP).

Preacolbed atatutary acecunting practices inelude a variety of probications of tho National Association of Insuranse Commisuionem (NASC), as wall as stato lawh rogplations, and general adminintrative rulea. Pemitted ntatutory accounting practices encompass all acecounting practires not so prescribed. The Compary has no permitted atatutory actounting practicen The mare significent varimest from GAAP are an follows:
hrwanmons: Leventencots in bonda are reported at amortized cost or fair valuo baned on their Nationn Astociation of Inamance Commissionera (NAIC) rating. For GAAP, aich fuxed maturity invertments would be dosiguated at purchose as hold-to-maturity, traiding or avilablo for calo. Hald-to-maturity fixed investments would be reported at amortized cont, and treding and availshlo-for-salo fixed-matarity investments would bo reparted at fair valuo with urrealized gaine and losers reported in operations fin those derigunted as trading and as a separate component of other comprehensivo income for those designated ar avaiabie-for-alle. Fair valuo for atatupory gurposea is based on the prices pablished by the Securitien Vahuation Office of tho NAIC (SVO), if availabio, wherear fair vahu for GAAP is based on qnoted market prices.

All aingle-chas and multi-clapt mortgage-becked and matet-backed securities (ag., CMOs) are adjusted for the effects of changes in prepayment asmumptions on the relited aceretion of discoont or anointization of premium of such securities using cither tho retrespective ar prospective melhods. If it is determined that a dechine in fair value is othenthar-temporary, the coent banis of the security is written down to the vadiscounted estimeted foture cash gown. For GAAP purposes, nif recurivies, purchesed or retained, that represent beneflicial intereatr in mecuritized nasets (e,g., CMO, CBO, CDO, CLO, MBS, and ABS recuritieg), ofthor than high-quality wectrides, aro adjuated using the prospective metbod when thero is it chango in catimated
 written down to fir valuo. $\mathbf{I}$ high-credib-quality cecuritios are adjuated, the rotroepective metiod is used
 reccivablo, and other asects not speciffelly identified an an adocitted asser with tho NAIC Aceonnting Practices and Procedures Manual, are anchuded from the accompanying atatutory-basis balanco sheets and are charged directly to unasigned muphus. Under GAAP, mech amets would be included in the balenco checes to the extest that those assets are not impaired. The balnnces of nonadmitted aseets are as followa:

| Non Admltted Assets | December 31, 2091 | December 31, 2010 |
| :---: | :---: | :---: |
| Pharmacy Robute Recolvabie | \$ 2446,514 | \$ 2,122.947 |
| Accounts Recelvable | 1,556,266 | 1,449,517 |
| Relinsurance Recolvable | 134,934 | 59,230 |
| Prepald Recelvable | 57,194 | 208,807 |
| Total Non Admitted Assets | \$ 4,194,908 | \$ 3,840,501 |

Refnsurance: Any reinsurance balances deemed to be nacollectible are written off through a chargo to operationa. Under GAAP. an allowtice for amounts deemed uncollectible would be entrblished through a charge to operationa. Chims liabilitios ceded to reinanrens have been zeported as reductions of the related reserves raliber then as assets, as would be required under GAAP.

Sorphw nohy payable: Notes payable isened by tho Company to selated partien are clastified an cayital and auplos on a statutory-basis, if approved by tho OIR Under GAAP, ureb notes payablo are recorded as linbilitien (see Note 13).

Dafirred moone faxay: Deferred tax anots ars limited to; (1) the aprount of federal income tanos paid in prior yearl that can bo recovered turough loss carry backy for exieting tempornry differences that reverso by the end of the mibrequent calendar year. phus (2) the lesser of tho remaining grose doferred tax axsets oxpected to be redized within one year of the balance sheet. date or $10 \%$ of net worth exeluding any net deferred tax astots, electronic data processing (EDP) equipment and operating coftware, and any net positive goodovill, plus (3) tho emownt of remsining grose deforred tax ansets that can be offret agninst existing grome doforred tan tiabilities. Any remnining doferred tax assets are noondmitted. Doferred tazes do not includs emonala for state taxes. Puratant to Statement of Statutory Accounting Principles (SSAP) No 10R, paragraph 10es, the Company nosy elect to admit additional deferred tex aseets. The election is subject to certain capital sud murglua requirements. If etected, the above is modified as follows ( $A$ ) the carry back period for (1) above is modified to refleet avitsble kom cury beeky for both ondinary and capital losses to be the cany back time frome comespanding with the IRS tax lose carry back provimions, not to oxceed three years; (b) the period of realization aid the percentage of capital and anpplua mentioned in (2) above, aro increased to three yearn and $15 \%$, reapectivaly. Under GAAP. atato incomp taver are inchnded in the computation of doferred taces, $x$ defersed tax anset is recondad for the mmonnt of aross doferred tux amots expected to be realized in all fitture years, and a vahuation allownere is entablished for deferred tax assots not realizablo.

Shatoment of carh flows: Cach, cush equivilents, and ahort-tem invectments in the statements of eash flowe represent cash and investment. bal moee, with initiol muturitiss of ono.year or less. Under. GAAP, the corresponding caption inchudes cash and investmente with initial maturities of three months or lesa

The efficts of the foregoing variances from GAAP on the accompanying statatory-batis financial statements have not been determined, but are presumed to be materinl

## ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Univereat Heafth Care ineurance Co., Inc.

## NOTES TO FINANCIAL STATEMENTS

## B. UractFatimater

The presentation of the financial statements in conformity with natutory nccomanting primciplet requiret managenuent to matioo estimutes and asumptions that affect reported amounts of assels and liabilitise nad disclosures of contimgent sogets and linbilitiea at the daty of the fimancial statements and the reported revemues and expenses during the reporting poriod. Significant eccounte thet are largety determined based on managernents estimates and assumptions inchudo IBNR claima payablo, acenved pharmiey reionbursement dwo CMS, pemiums receivable due from CMS related to retro-pecunium adjustmente and riak-gharing adjustmaents: and upaliocented prominms received from CMS inchuded in unenrsed promium Actual results could differ from those estimates, and thooo dififerences could be material. Such estimates nod assumptions could change in the fature as more information becomes known, phich could impact the amornts reported berein

## C. Signiftcart Accounting Policiea

Univensal Henth Care lusurnce Company, Inc. (UHCIC" os "the Company") is a Florida domiciled inmance company and a wholly owned subsidiary of Universal Flealth Care Group, Inc. (Giroup"). The Company was incoporated an May 25, 2006 and formed as a health innusance company that operates a Medicare Advantage Private Feo for Service plan. The Company commonced reveme generating activities in Jamuary 2007.

Tho Coupany has a contract with the Department of Health nad Humon Services, Centers for Modicars \& Medicaid Servicet (CMS) to provide health eare services to Medicare enrollees in the statas of Alabams, Atizons, Athaneas, Florida, Georgia, Ilinois, Iodisna, Lomisiana, Maryiand, Mirrinsippi, Missouri, Nevadh, Now Jessoy, New York, North Carolim, Ohio, Othehoms, Peangylvanis, South Caroling, Socit Dekota, Texas, Utah and Virginis, as well as tha Dintrict of Columhia. This contract eccounted for $100 \%$ of the Company's revenues in 2011. CMS awarded the Company the contract for the period beginning Jenury 1. 2007 and euding December 31, 2007 and hay renowed the contract through December 31, 2011. Tho contract provides for annal exdemsions aubject to agreement and approval by both partice.

## Thyertmenta

Invenments in boods, cash, casb equivalenth, mod ahont-term investmende are stated at values prescribed by the NAIC, an follows:
Investments are reported at amortized cost or fair value based on their NAIC rating. Bonde not backed by other founa are principally mated at amortized cont uniag tho intereat method

Singlo-clasi and multi-cinss martgago-backed and asset-backed securitias aro valued at amoctized cost using the inlerest method inchudiag apticipated prepayments. Prepayment aspmpaptions are obtained fromi dealer survoys or internal or thirdparty estinnalea and aso based can the cursent inferent rato and economic environment. Tho prospective adjustment method is used to value all auch recurition.

Cash cauh equivalents, and thort-ferm irventments inchude cnuh balances and investupents which aro liquid and mature in one year or less when purchused, including finde mainteined under stahutory requirementa (deposits), and consist of nuonory market and certificaloe of deporit finds regiatered with the NAIC.
 reported net of taves in other charges in capitel and aurplus.

Realized capital goins and losyot are determined psing the specific identification bacis. Changea in the admitted unset carrying anyonnt of bands are credited or charged directy to unamigned arpulus.

Tho fir value of an asest in the amonat nt which that asset could be bought or sold in a curcnt transaction between willing partied, that is, other than in $n$ forced or liquidation swla. The fair yatue of a liability is the amount ot which that linbility could be cettled in - current transection between willing parties, that is, other than in a forced or liquidation setilemant.

Pair velues aro based an quoted market prices when available. When quoted market prices ase aot availabla, fair valua in geaerally ostimated uning dircounted carh flow analynes, incorporatiog current markot inputs for similar figancial intrumense with comparable terms and credit quality. In inntances whero theto is litile or no market sctivity for the same or similar inatramenta, the Compayy eatimatos fair vilua using methode, modols, and assumptions that managemeat believea market participeats would use to -devermine a curreat tranaction prica. These viluation techniquer involve some lovel- of manageonent entimation and judgment, which becomes ajprifiennt with increasingly complex instruments or pricing models. Where appropriato, adjustanente ave inchuded to roflect the risk inherent in a particular methodology, model or input used.

Financial ancots caried at fair vaho are classified, for disclonure parposes, based on a hietarchy defined by the Fair Vakue Mempurementa Disclosuze Topic of the Finsocial Accounsiag Standarda Board's Accounting Standards Codifieation (FASB ASC). Tho hierarchy gives the highest ranking to fhir values determined uaing bundjuted quoted prices in active markete for ideatical ancts and tiabilities (Lovel 1) and the lowent rankiag to fair vahues detennined using methodologies and modols wilh unobservable inpate (Lovel 3). An asset's or a linbility's clasmification is based on the loweat lovel input that is significant to ite mearurement. The tovels of the fair vatue hierarchy are is fallows:

Lavel 1 - Vahues are undjuated quoted prices for ideatical assets and linbilitien in active marketa accessiblo at the measurement date.
Lavol 2 - Inputs inchude quoted prices for similar asceta or linbilities in ective marketa, quated priess from thome willing to trade in markets that are not active, or other inpute that are observible or can be corrobarated by markat data for the term of the ingtument Sroh inputs inchude market interest rates and volatilition, spreado, und yiold curveak
Lovel 3 - Certain inputs are unobserviblo (mupported by littlo or no market activity) and significant to the firir value measurement. Unobservable inputs reflect the Company's beat eatimate of what hypothetical market participants would uso to determino a transaction price for tho atret or liability at the reporting dnte.

## NOTES TO FINANCIAL STATEMENTS

At December 31, 2011 the Company's inventments are all cleapified as Level 2 instruments.

## Minimum Capitilind Supplua Reguirementis

Purnant to Section 624.408(1a) of Florida Statutes, the Company is required to maintain a minimumanampas not less than the greates of $\$ 1,500.000$, or $4 \%$ of sotal himbilitien phes $6 \%$ of liabilities relative to heath inamenco. Purguat to Section 624.4095(1) and 4(c) of Florida Slatatos, the Company in atbo required to maintain a ratio of actual or projected armual premiuma, as dofined, to current or projected surplus as to policy holdets, as defined, of not ancer than $10: 1$ for grons writen preniume or 4:1 for net written premivme. For purposes of this requirement, annual ar projected preminma are limited to $80 \%$ for heath inrumace compenios auch as the Company. By Corivent Order fifed Jannery 5, 2011, the FL OR granted penminsion for tho Comptury to operato at a ratio of groses actull or projected annal preminoms to consent muphas as to policy haldons of not more then 16:1, anceeding the required sation pannant to Section 624.4095(1) and 4(c) of Forido Stututex. AB a condition to thit approval, the Company agreod to (1)
 holdert of $4: 1$ and RBC of $250 \%$ of tho zuthorized control level; (2) maintain compliance with minimum capital and maphr requiremante dofined by Section 624.408, Florida Statubes; (3) elect a $75 \%$ attachment point quota-shame reinsumance for 2011; (4) limit Medicure enrolleen for the 2011 plan yeor; and (5) defer any requent to pay dividende until ufter the September 30, 2011 quarterty ovverneat is filed with the ORR Additionally, according to the State of Georgis Consent Onder dated Aurgut 29, 2006, the Company must atso maintain capital and aurplus of not less than $250 \%$ of tho authosized controll lovel rink based capital. Ae of Desember 31, 2011, the Compary's capital and ruphus of $\$ \mathbf{\$ 4 , 6 2 3 , 8 2 0}$ med the reapective lovels preseribed by tio statutes and segulatory requirements deacribed abowa.

## Recomilion of Presmiyn Revenue and Medicat Expenser

The Company generally receives premiums in advence of providing services, and recogaizes premium rovemo during the period in which the Company ie obligated to provide aervices to its membera. Preminmu are tilled monthly for coverage in tha folloning month and ane recognired as revemio in tho month for which innurance covernge in provided. Accordingly, the portion of premivans applicable to future periods is inclinded in the accompanying statutory-basis balance shesto as promiuns received in advanced and in accounts payablo and accrued expentea.

The Compary reconciles the membership in its afministrative system to the earollunent data provided by CMS. Thero are timing differences between the addition of a member to the Compary's administrative syncem and the approvil, or scerotion, of the member by CMS. Additionslly, the monthly payments from CMS includo sdjustments to reflect changea in memborship as a reauli of rofrouctive terminations, additions or other changes. Curnent period memberthip, net preminume, and cisimen expenso are adjosted to roflect retronctive changes in mombership.

Premium and other health enro receivables consint of premiuns due from federal agencien and members based on enrolled membenkip and other related health care plan recerivabien. On an ongoing buais, manageneent eatimates the amount of premium billinge that may not be futly collectiblo based on hiatorical treads and other fictors. Amornts deemed uncollectible are written off ageinst prominm rovenua in the period the determination is made.

CMS uses risk-adjueted rates per member to determine tho monthly puyntente to the Conpany. CMS has implomeated a jiak adjutment model, which apportions premivins paid according to health diagnosea. The riak adjustment model uses health atatus iadieaton, or rink acoren, to improve the accuracy of payment. The CNS rist adjustment model pays more for mombers with increasiag health eeverity. Uader this risk Edjuatment methodology, diagrotia datu fromingatient and ansbulatory treatment wettioga are used by CMS to celculate the risk-edjusted premixm poyment to the Company. The monthly riak-adjusted premivm per meembor it determised by CMS based on normnlized rink teores of each member from the prior year. Anmully, CMS provides the updated riak scones to tho Company and revises premium ratise prospectively, beginoing with the July remithace for arrent plan yex members. CMS will alvo calculate the serroactive adjustanents to premium related to the revised risk icoren for the current year for current plan year mamben and for the prior year for prior plan year members.

All health beaefil orgnuizations must capture, collect, and aubmit tho necosary diagnosis code information to CMS within

 based upon the diagrosis data rubmitted to CMS and ultimataly accepted by CMS. Rink scores ars apdeted annally by CMS, and: the Company reconcilen the data to eatimated amonata recorded by tho Compmay with any adjustanests recorded in premium reverus.

Medical expences consist of cinimpayments, capilation payments, and phatmey conta, net of rebates, at well as astimutes of future prymonte of clairas provided for services readered prior to tho end of the reporting period Capitetion payments represent monthly contractual fees disbrised to physicinas and other providers who are responsiblo for providing medical care to members. Phamary conts (inchoding Medicaro Part D costa) reprenent payments for mewbest' prencription drug benofith, net of rebates from drug manufacturens. Rebntes aro recognized when the rebaten are enrned aceording to tho contrictual arrangements with the refpective vendore.

Premirums the Company payn to minsurens aro reported as medical expenses and rolabed reinnarance recoveriss are reported as iteductions of medical expenses.

Medicit einimp fiability represents the Company's paymuent reuponubility for gervicee that havo been readered by medical wervice providen to memben. There costa have not been settled as of tho balnoce aheet diter The liability concists of medical chims reported by the medical servico providery at well as ats ectuarillly determined estimate of claims that havo been incurred but not yet reported (IBNR) by the medical servico providers.
 projection methodologiss uning claim submission and paymeat pattems and cost trende Devistiona, whether positive or negative, between actual experience and estimstes used to establish tho linbility and recorded in the period of claim payment on a concitemt

## ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Unlversal Health Care insurance Co., Inc.

## NOTES TO FINANCIAL STATEMENTS

basia. The Conspany continually monitors the rownonshlenens of tho asmumptions used in prior estimates by comparison with actual claica patteras and considers thin information in firture estimates.

Medich and other benefita paid tan also be significanty impacted by oufcomes from eorrt decitions, interpmetationa by regulatory authorities, and logidntive changos irvolving henth enre mathers. As a rosult, amounte ultimately paid may differ from innitial eutimaten that did not comsider anch outcomes, interprotationg, and changes.

## Medicara Pat D

Tho Compeny's Medicare Advantagg plan offres prescriplion drug benofits under Part D of the Nediempe fedegil healih ingursince progrem to indlividuals eligible for bencfits under Pert A or Part B. As such, the Company receives additional preminm and cont reimblursement components.

For qualifying low-income rtatur (LIS), members, CMS paye the Company for wome or all of tho LSS memberb monthly premium The CMS pryment is dependent upon a member's incoma lovel, which is detommined by tha Social Secrrity Adminietration. Low income premsium is recognizod over the contract period nad reported as premium rovenua. Additionally, for qualifying LJS members, CMS will reimburso the Compeny for ill or a portion of the LIS mernbers deductible, coinnurance, and co-pmymont amounts above the ont-of-pocket threabold for low-incomo beneficiarios. Low-income cotk-abaring subsidies are paid by CMS psompectively as a fized amonnt per member per month, and aro dotemined baiced upon the plan year bid submitted to CMS. Aftor the close of the anutal plan year, CMS reconciles actual oxperience to low-income cost sharing subsidies paid to the plan and any differeness ars settled botween CMS and the Company.

Tha Company also receiven payments from CMS for catastrophic reinsurance for membens of its Medicare Advantage plan. CMS manke prospective monlhly catartrophic reinsurance payments to the Company based on entimatod average reinaurnace paymenta to other Medicare Advantage-Prescription Dive plans that provide Part D benefits. After the clove of the anoual plan year, CMS recopeilen attual experience compared to catartrophic seinsurance mabsidies paid to the Company and any fifferencer are setted between CNS and tho Company.

Low-incoane cost sbering and entastrophic reinsuranco rubsidies ropresent fundiag from CMS for which the Company assumen no risk end axisounta received from CMS are seported not of payments of the actual prescription drug coats selated to the low-income cost sharigg and catastrophic reinnurauce in the nccompanying atatutory-bmais balunce abeetn. The Company doee not recognize preminm reverso or medical claims expense for thin setivity.

Medicare Part D activity roaulted in a payable from CNS of $\mathbf{3 2 9 1 , 1 4 0}$ at Decomber 31, 2011, othich is inchoded in mapuats receivable relating to uninarared plans in the accompanying ctatutory-basis bnlance sheets Actual amounts of Medicare Part D rolated asseta and tiobilities could difier materially from amounts recorded.

Accoued Lowt Adiputment Expense
Chim processing expenses for unpuid claims, inchuding claims IBNR, are socrued based on ostimated oxpernor mecessary to prooces ruch chims.

## Adyretiving Expente

Marketing and advertising coste are anpensed as incurred For the year ended December 31. 2011, the Company incurred \$348,380 of advertixing expenca

## Income Taxet

On September 27, 2007, the Company olected to memorializa ita ter-sharing arrangement by participating in an Intercompany Tex Sharing Agreament (he Agreement) with Group, Universal Henth Care, Inc (UHC), and Amerietn Mathaped Care, LLC (AMC). UHC and AMC are entities owned $100 \%$ by Group. Beginning with the 2007 tary year, Group has filed a consolidened fedenal tax setmen that inctudea the opentions of the Company, Group, UHC, and AMC. On May 27, 2009, the Agreement was amexded to inchude pariticipation by Universal HMO of Tenss, Inc. (UHMOT). UHMOT was incerporated during the year ended December 31, 2009 and it wholly owned by Groupp. The Comppnny obtained final approval of the ampended Agreement frome the OIR in Oetober 2009. On July 27, 2010, the Agreement was amended to include purticipation by Univerral Health Caro of Neveda, Inc. (UHCNV). UHCNV war incorporated duriag the yenr ended December 31, 2010. and is wholly owned by Group. The Company obtinined finat epproval of the anveaded Agreement from the OIR in March 2011,

Under terma of the Agreament, each compnny shall be responsible for and shall reimburse Group for its separstely calculated sharo of the consolidated tax benefit or expense. Further, per tho Agreement, cach company shall pry prompthy to, or be reimbursed fiom. Group, on a quarterily batis not liber than the due dato for the estimated quateriy payment of taxea, ite ahace of auch paymams ostimuted in the samo nanner as epecified abova. Any final adjustmenta to payments chall bo made following the preparation of the consolidined federal income tax return.

## 2. Accounting Changee mad Corrections of Errory

NA
3. Bryiness Combinations and Goodwill N/A

## 4. Ditcontinued Onerations

N/A

## NOTES TO FINANCIAL STATEMENTS

5. Invetimenta

A-D. N/A
E. Repurchaso Agreemeata and/or Securities Lending Tyansactiona:

Thu Cospany entered into a sweep repurchase agreanent with a finmeial eervicea institution to increaso ith refura on invested assetr. The remeactions involve the transfer of excess cash to a regulated finmeinl instintion that in collateralized by menritios. On tho noxt businose day, the tronsferred caich, aloagg with any intereat thereon, is transfarred back to tho Company and the collatembizod securitiet are returned. Tho arrangement moets tho requirement to bo accounted for as secured borrowings. Tho Company requires that at all times, securities obtained as collateral aro urfficient to fund nubstantially all of tho cost of purchacing replacement sevolus. As of December 31, 2011, amonnts outitanding under repprechaso agreenuapts of $\$ 8,285,087$ are chasaified an cash in tho accompanying statement of asseta. As of December 31, 2011, wewritica with a fair mathot vahue of approximntely $\$ 8,450,800$ were held at coltsteral under this agreement.
F.G.NA
6. Ioint Yentrote Perpershipand Limited Iiabilite Comnanien

N/A
7. Invetment Income

N/A
8. Derivative Ingtrument!

N/A
9. Income Texes


NOTES TO FINANCIAL STATEMENTS

10. Information Concerning Parents Supbeidiaries and Affiliates

A - C. All outeranding shares of the Compary are owned by Group, an insurance holding compeny incorporated in she Stute of Dolaware wilh operations based in Florida. On Febraary 14, 2011, Group entered into a $\$ 37,500,000$ term-loan and a $\$ 2,500,000$ unfunded tovolving credit agreemont which placed additional minimum statutory cnpital requirements on its mbaidiaries, inchuding UHCLC. Under the credit agreement, the Compaoy nruat maintain curplus and capital equal to or greater than $\mathbf{1 2 5 \%}$ of the 8 tatutory minimum. Group pledged $100 \%$ of its equity interest in UHCIC as security uader Ho credit agreement:

Srophus rotes pagabte, nelated party:
 terme of the enuplus notes payable epecify that principal and intereat in payable only upon the prior approval of EL OR. The notes
 and received FL OR epproval for payment of iniereat. As of the year ended December 31, 2010. Note \#f's principnal and interent of $\$ 66,000,000$ and $\$ 4,295,202$, respectivoly had been paid in fuili. The Compnny paid down Noto \#3 in tho total amount of

## NOTES TO FINANCIAL STATEMENTS

$\$ 2,750,000$ on July 14, 2010. During tho period from May 25, 2006 (deto of inception) through Deceraber 31, 2011, UHCLIC did not obtrin approval from FL, OR for the Surphus Notes H1, W2 and H3; therefore UHCIC hat not recorded acconed intereat and intereat expense of $\$ 4,963,230$ ralated to those notes.

Dividand papmant
N/A
Other relotionships:
Tho Coanpany has a management agreemeat with American Mansged Caxa, ILC (AMC), offective through May 31. 2012 and antomatically renowed in ons year terma, whereby AMC providen aupervinory and management services, performs apecific
 Efiective December I. 2010, fees purnuant to this agreemens wero set at $9.0 \%$ of the total oollected prenriums on a monthly basin as approved by FL OR on November 5, 2010. Effective Jamury 1. 2011. for compenmation for services remdered, the Company shall pay AMC a pereentinge of total collected premiums on a monthly basis. The amount whall vary, matually agreed betreen AMC and the Company, but uader no circumatance shall the percentige of collected permiums gaid to AMC exceed $9 \%$, withoust obtaining prior approval from the FL ORR Further, no amounte paid by the Compary shill revult in tho Counpany being out of complimce with the minimum stathory requiremeats of the Flaridn Statates. Brpenses incurred under thie agreemont totaled $\$ 20,350,967$ for the period from Jamary 1. 2011 through December 31, 2011.
D. In addition to the above-seferenced managennent agreement, centain expenditures for the Company are paif by and reiminursed to Univernal Heath Care, Inc. (UHC). Univernal HMO of Texas, Ine. (UHMOT), Univeren Heath Cere of Novade, Inc. (UHICNV) asd AMC, companies under commion control by Group, as well at Group ituolf. The Company also pays for pud is seimbured by UHC, UHMOT, UHCNV and AMC for certain oxpenditures. At December 31, 2011; the Company owed UHC $\$ 30,747$ and was owed $\$ 14,888,053$ frosn ANC. All amountr will be settied per terma of tho Company's intercompany tranactioas policy which sequires the payment to be mide within 30 days.
E. $\mathbf{N} / \mathbf{A}$
F. The Company has a managenment agreement with AMC, effoctive through May 31, 2012 and automaticnlly senewed, whereby AMC providea mperviecry and management rervicen, performs specific fractions and contract servicos to and performe cartain prytoll function for the Company. AMC in owned $100 \%$ by Group

In eddition, tho Company Iminthins a provider agreemens with American Family \& Geriatric Care (AFGC), which is owned 100\% by a mujority shareholder of Group. Amsunts paid to AFGC under the provider agreement for the year ended December 31, 2011 were $\$ 2,271,190$.
G. - L. N/A

Under the Company'/ tax tharing agreement, \$546,550, included in curneat federal and foreign incomo tax rocoverable in the accompnnying Statement of Acters, Linbilivies, Capital nind Surphe, il due to the Company from Group and will be cettled per terms of the intorcompany trensactions policy.
11. Debit
12. Retiremens Pinns, Deferred Compansation Potemployment Benefits and Compencrated Absacen mi Othes Postrctivement Bynfapians
N/A
13. Capital end Surphe Shereholdert'Dividend Restrictions and Ohani-Regreanirationa

1. UHCIC has $10,000,000$ shares of $\$ 1.00$ par value common ctock authorived, $2,500,100$ shnres isqued and ourdsandiag an of

Decemiber 31. 2011.
2. NA
3. Prior appoval is needed by Floride OIR for dividend payments to Group and may not be presented for approval until niter the June 30,2011 quarterly statomenta are filed.
4. N/A
5. Within the linuitations of (3) above, there are no restrictione placed on the portion of compary profite that miry be paid an ordinary dividends to atockholders.
6. N/A

7, N/A
B. N/A
9. N/A
10. The portion of unnscigned fixads (gurghus) represented by comalative wrealized gring and losses is $\$ \mathbf{1 0 0 , 8 6 2}$.

|  | Dita bund | Trtereat Ente | $\begin{aligned} & \text { Pur Vatuo } \\ & \text { (Thee } \\ & \text { Amont of } \\ & \text { Noto) } \end{aligned}$ | Cuming Viloe of Note | Indocipni end/or Interest Puid Current yar |  | Uapproved Princtiplal radior interset | Datajoluntrity |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | 12Regans | 50\% | \$ 8.000 .000 | 380000000 | 0 | 0 |  | W/A |
| $\begin{aligned} & \text { Surphon } \\ & \text { lipte } 22 \end{aligned}$ | 91/137097 | 5,0\% | \$2000,000 | \$2.000000 | 0 | 0 | \$491.944 | N/ |
| $\begin{aligned} & -8 \mathrm{saph} \text { 保 } \\ & \text { Boto } 3 \end{aligned}$ | 02828007 | 5.0\% | \%11000.000 | \% 250009 | 0 | 32730,090 | \$2467.930 | w/A |

12. W/A
13. N/A

NOTES TO FINANCIAL STATEMENTS

achacivales

| Quartor | Estimated Rx <br> Rebates as <br> Reported on Financial Statements | RxRebratis Billed or Otherwise Confinned | Actual Rebaten Received within 90 days of Bitling | Actual Rebates Recrived within 91 to 180 Drys of billing | Actual Rebatos Received More Then 180 Daye After Billing |
| :---: | :---: | :---: | :---: | :---: | :---: |
| 3/31/2009 | \$929,951 | \$929,951 | S | \$ | \$929,951 |
| 6130/2009 | 977,292 | 977.292 | - | - | 977,292 |
| 9/302009 | 1,015,385 | 1,015,385 | - | 899,703 | 115,682 |
| 1231/2009 | 887,585 | 887,585 | - | - | 887,585 |
| $-3 / 31 / 2010^{-}$ | 653,467 | 653,467 | = | 36;875 | 596,592- |
| 630/2010 | 1,319,378 | 1,319,378 | - | 1,319,378 |  |
| 9/30/2010 | 1,021,724. | 1,021,724 | 144,746 | 876,978 |  |

ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Universal Healkh Care Ineurance Co., Inc.
NOTES TO FINANCIAL STATEMENTS

| $12 / 31 / 2010$ | $1,248,839$ | $1,248,839$ | 92,048 | 921,625 | 235,166 |
| ---: | ---: | ---: | ---: | ---: | ---: |
| $3 / 31 / 2011$ | $1,685,901$ | $1,685,901$ | - | $1,685,901$ | -1 |
| 63302011 | $2,148,552$ | $2,148,552$ | 354,189 | $1 ; 545,081$ | 249,282 |
| $9 / 302011$ | $1,873,665$ | $1,873,665$ | - | $1,601,843$ | - |
| $12 / 31 / 2011$ | $2,174,692$ | $2,174,692$ | $\cdots$ | - | - |

## 29. Puticipating Policies

N/A

## 30. PremitnnDeficiency Retecyen

N/A
31. Anticipated Siluage mid Surmogation N/A

## GENERAL INTERROGATORIES

## PART 1 - COMMON INTERROGATORIES

## GENERAL

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## GENERAL INTERROGATORIES


Yes [ \| M \| \| ]









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13. FOR UNITED 8TATES BRANGHES OP ALEN REPORTINO ENTITLES CNIY:






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- Acsenntibiliy for ed hamee to the coda.




## GENERAL INTERROGATORIES



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## GENERAL INTERROGATORIES





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| 25.20 |  | 1 |
| 25.24 |  | 1 |
| 2535 | Pludyed as eclutaril |  |
| 2824 | Plerad mader opplon mpoumelts |  |
| 2387 |  |  |
| 25.20 |  | 4.854,889 |
| 25.20 | Other | 4 |



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Yes [ ] No $|\boldsymbol{X}|$



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## GENERAL INTERROGATORIES



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## ANHUAL 8TATEMENT FOR THE YEAR 2011 OF THE Univereal Heabth Core Inaurance Ca, inc.

## GENERAL INTERROGATORIES

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## ASSETS



ANNUAL 8TATEMENT FOR THE YEAR 2014 OF THE Univerasi Health Care Insurance Co., Inc.
LIABILITIES, CAPITAL AND SURPLUS


ANNUAL STATEMENT FOR THE YEAR 2011 OF THE Univerad Hoalth Care Insurance Co., Inc.
STATEMENT OF REVENUE AND EXPENSES


STATEMENT OF REVENUE AND EXPENSES (Continued)

|  |  | GY:YMI | $\stackrel{2}{2}$ |
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| CAPITAL E BURPLUS ACCOUNT |  |  |  |
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## ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Univereal Health Care Inourance Co., Inc.

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 ANALYSIS OF OPERATIONS BY LNES OF BUSINESS $\pm$


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ANTLAL STATEMENT FOR THE YEAR 2011 OF THE Unlversal Hoalth Care msurance Co, me.
UNDERWRITING AND INVESTMENT EXHIBIT

ARNUAL STATEMENT FOR THE YEAR 2011 OF THE Untrersal Hoakt Care insurance Co, me. UNDERWRITING AND INVESTMENT EXHIBT


ANOMAL STATEMENT FOR THE YEAR 2011 OF THE Unversal Healk Cere lisariance Co, inc.
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ANRUAL STATEMENT FOR THE YEAR 2011 OF THE Unwerial Hoaith Cere Insurance Co, bric.
UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C - DEVELOPMENT OF PAED AND INCURRED HEALTH CLAMS

| Section A - Paid Heath Crums - Medicarg |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
|  |  |  |  |  | 2010 | 2018 |
|  |  | 5\%\%,06 | 48,49 | - 450102 | 10.204 | 46.80 |
|  |  | xix | \%.7\% | -m00,138 | 100,388 | 101.309 |
|  |  | - | 10 | 38.806 | 15, 73 | 16,50 |
|  |  | m | W | xar | ת, 04 | 80,93 |
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| Section B - Mncurted Heallh Claims - Mecicare |  |  |  |  |  |  |
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|  |  | 2007 | ${ }_{2}^{2008}$ | ${ }_{2}^{3}$ | 2040 | 2011 |
| 7. Pror |  |  |  |  |  |  |
| 22007 |  | 40,501 |  | M8.512 | 46,716 | 46.87 |
| ${ }^{3} 2000$ |  | -81 | 131,080 | 100,24 | - 100.40 | 101.39 |
| 4. 2009 |  | $\underline{10}$ |  | - ${ }^{40} 881$ | M, 010 | 6,530 |
| ${ }_{\text {c }}{ }^{\text {a }} 2011$ |  | ${ }_{80}$ | $x_{x}$ | 10 | cax ${ }^{\text {a }}$ | ${ }_{10} 98.94$ |


ANRUAL STATEMENT FOR THE YEAR 2011 OF THE Univercal Health Gare Insurance Co, he.

ANMLUL STATEMENT FOR THE YEAR 2011 OF THE Universal Hasth Care Insurance Co, the
UNDERNRITIG AND MNESTMENT EXHIBIT
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ANNUAL STATEMENT FOR THE YEAR 2041 OF THE Universal Health Care Insurance Co., Inc.
UNDERWRITING AND INVESTMENT EXHIBIT
PART 3 - ANALY8I8 OF EXPENBES

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EXHIBIT OF NET INVESTMENT INCOME


EXHIBIT OF CAPITAL GAINS (LOSSES)

|  |  |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: |
| i. U.E. Gowmment bonde - | 2,313.843 |  | $\frac{2,313,063}{}$ | -(310,35) |  |
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| 12 Otwer bonde (matilatiod) - -m. | 2,500.304 |  | -2,343,304 |  |  |
|  |  |  | $-0$ |  | - - 0 |
| 2.1 Proteried docks (manmicted) | 0 |  |  | 0 |  |
| 2.11 Probruad tocke of timetor. | 0 |  | --b | 0 |  |
| 22. |  |  | --9 | (100, 062) |  |
| 2.21 Connich stacta of mimitas. |  |  |  |  |  |
| 3. Mortases tome. |  |  |  |  | --_0 |
| 4, Reol entere. |  |  | -2 |  | -. 0 |
| 8. Contrat ione. |  |  |  |  |  |
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| 7. Denverve nethument ....m...-----...- |  |  |  |  |  |
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|  | 4,877,200 |  |  |  | . 0 |
| DETALS OF WMIETNS |  |  | 4, $0^{4}$ | (a112) |  |
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|  | 0 | 0 | 0 | ${ }^{0}$ |  |

dNNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Unkersal Health Care Ineurance Co., inc.
EXHIBIT OF NET INVESTMENT INCOME


EXHIBIT OF CAPITAL GAINS (LOSSES)

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| 1. US. Oowernment bonde. | 2,3i3,043 |  | 2.313,043 | -(310.34) |  |
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| 12 Othar bends (nevimeiedy | 3,30,34 |  | 2,309,584 |  |  |
| 1.8 fondr of atinetes | 0 | 0 |  | 0 | 0 |
| 21 Prulared atache (undifitud) | 0 | 0 | 0 | $t$ | 0 |
|  | 1 | 0 | 6, 6 | 0 | 0 |
|  | 0 | --10 | -10 | _-_(900, (307) | - 0 |
| 2.21 Common stocks of almedes. | 1 | -10 | - | 0 | -0 |
| 3. Morteres low | 1 | -1.9 | d | 0 | -. 0 |
| 4, Ruot metes.... | 0 | 0 | 0 |  | -m |
| 8. Contruethens |  |  | 0 |  |  |
|  |  |  | -. 0 | 0 | - 0 |
| 7. Dowlvive inefurwots |  |  | --0 |  |  |
| 8. Ofter invested mavition | 0 | $\rho$ | --10 | - 0 | 0 |
| 9. Aggregate witheine lor ceplut gata (loweoe) | 0 | 0 | -ummon | 0 | -0 |
|  | 4.027. 272 | 0 | 4.877.270 | (411.22) | 0 |
| OETME OF Whiteres |  |  |  |  |  |
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ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Unlversal Health Care Insurance Co., finc.

EXHIBIT OF NONADMITTED ASSETS

|  |  |  | Change in Totial Nonumited Aserte (Col, 2.CoI, () |
| :---: | :---: | :---: | :---: |
| 1. Bonde (Setroctula D) | . 9 |  |  |
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| 2.2 Commion |  | 0 |  |
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| 3.2 Other then |  | 0 |  |
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| 2501. Prषpaid Apemses. $\qquad$ <br> 2502. Accounts (impivabla. $\qquad$ <br> 2503. $\qquad$ <br>  $\qquad$ <br>  $\qquad$ |  | 208,807 | 151,013 |
|  | 1\%,60\% | .30,954 | (94.938) |
|  |  |  | 0 |
|  |  |  | 0 |
|  | 14.032 | 29,75 | 54,679 |



# NOTES TO FINANCIAL STATEMENTS 

## Univeral Health Care Insurance Company Inc.

Notes to Finmeial Statementa for the year eoded December 31, 2011
1A. Summa of Sigmificent Accounting Podicion.
The accompmying sintutory-bacis finmaiel statemente havo been prepared in conformity with tho thatory necounting practices prescribed or permittod by the State of Florida Department of Financial Services, Office of Inaurance Rogulation (OfR), which procticee differ from U.S. gepernlly accepted accounting principles (GAAP).

Promeribed athtutary secounting practices includs a variety of pablications of the National Ansociation of fosurance Commiasioners (NAIC), as well as thato lawa, segulations, apd general administrative rules. Permitted stabutory acconnting practices encompans all accounting practices not so proscribed The Company han no permitted atatutory accounting practicea. The more gignificant variancen from GAAP ero an follows:

Investmoiks: Investumenta in bonds ast reported at amortined cort or fair value baned on their National Asmociation of Insurance Consmistioners (NAIC) rating. For GAAP, such fixed maturity investments would be detignated at purchase as beld-to-mmturity, trading, or available for oale. Held-to-maturity fixed invertments would be reported at amortized coal, and treding anst availablo-for-saio fixed-msturity invertments would be reported at finir valuo with umrealized gaina and lowges reported in operations for those derigasted an trating and an a weparate component of other comprehencive income for those dosigarated as available-fir-mile. Fair value for slatutory porpocess in based on the prices publiched by the Securities Vahuation Office of tho NAIC (SVO), if wailable, whereas fair vahe for GAAP is based on quoted matcei pricea.
 changon in prepayment ascomptione on the related accretion of discopnt or amotization of premium of ruch eecurities vaing cither the retrospective or proppective methods. If it in delemined that a decline in fair value is other-han-remporery, the coas buris of the security in written down to the unditcounted estimated foture canh flowe. For GAAP puppower, sull secrritien, purchased or retioned that represent beneficinl interesta in securitized aseeto (ag. CMO. CBO, CDO, CIO, MBS, and ABS secritien), other than high-quality iecurities, are adjusted wing the prospective method when there is a chnoge in entimuted future canh flowe II it is detemined that a decline in fuir valve is othes-han-temporary, the cost besis of the recurity is written down to finir value. If high-credib-quality securities are adjusted, the retrospectivo ninethod is used.
 receivable, and other assets not specifically ideatified an ma adnitted asset with tho NATC Accounting Practices and Procedurea Mamal, are exchuded from the accompnaying atatutory-basis balanco aboets and are eharged directly to unnslgned surphus. Under GAAP, wurh ancote would be inchuded in the balnuce sheest to tho axtent that those assets aro not impained. The balances of nonadmitted nuveta are an follow:

| Non Admitted Asmeta | December 31. 2011 |  | December 31, 2010 |  |
| :---: | :---: | :---: | :---: | :---: |
| Pherrmacy Rebato Receivible | \$ | 2,446,514 | \$ | 2.122,947 |
| Accoume Receiviblo |  | 2,281,601 |  | 1,449,517 |
| Reinsuranco Recoivable |  | 134,934 |  | 59.230 |
| Prepaid Receivable |  | 57,194 |  | 208,807 |
| Total Mon Admitted Assots | \$ | 4,920,243 | \$ | 3,840,501 |

Reinumance: Any reingurtance balances devned to be uncollectiblo are witten off through a charge to operationn. Under GAAP, an allowance for amounta deemed uncollectihla would be eatablished through a charge to operations. Chims lisbilities ceded to reingmers have been reported as reductions of the related reserves mather than ass assets, as would be required under GAAP.

Shaphse notas payabie: Noten pryable issued by the Company to related pastien ase ciassified at capital and auphos on a statultory-barin, if approved by tho OR Under GAAP, anch noles payable are reconded as liabilivies (see Note 13).
 be recovesod through loss canry backs for exiuting temporary differences that reverse by tho and of the rabeequent calendar yens, plos (3) the lanear of the remniming grose doforred tax assets expected to bo realized within one your of the balenco sheet dete or $10 \%$ of net worth enctuding any yut defrried tax nasetn, electronic dats processing (EDP) equipment and operatings reftware, and any not positive goodwill, plus (3) the amownt of remsining pross dofared tax asebes that cen be offiot agringt existing groa doferred tax liabilitios. Any remaining doferred tax aspete ase nonadmitted. Doferred taxer do not inchade amounta for atate taxes. Parsuant to Statement of Statutory Accounting Principlea (SSAP) No. 10R, peragraph 10.a, the Company may elect to admit edditional doferred tax assets. The election is oubject to certain capital mpd auphus foquirements. If elected the abova is modified as follow: (a) the cary back period for ( 1 ) showe is modified to reflect avaitablo lons cany backs for both ordioncy and capital losses to bo the earry back time fraone correaponding with the RS tax loss carcy buck provisions, not to exceed threo yeurs; (b) the period of reatiantion and tha percentage of capital spod suphus mentioned in (2) abowa, ase increaped to three yenss and 15\%, reipectively. Under GAAP, state incomo taxee nre included in the comaratation of definged taxes, a doferred trx asset is recorded for the amount of gross deffrred tax assess axpected to ba realized in all future yeura, and a valuation allowance is eatablished for doferred tax assets net realizable.

Slanment of cash flows: Cash, cash equivilenty, and abort-term invettmeats ia the ztatements of cach flowe reprosent cash and investenent balancea with initial mansitios of ono year or leun-Under GAAP; the comresponding eaption includea cath and investments with initial maturities of thace nsonbs or less.

Tho. effects of the foregoing variacen from GAAP on the accomprrying elatutory-banis financial statements heve not been determined, but are presumed to be material.

## NOTES TO FINANCIAL STATEMENTS

## B. UsoofFtimatas

Thi prasentation of the fimancial chatements in confomity with statutory accounting prixciples requiros management to make estimatos and assumptions that offect reportod amounts of amens and linbilities and diecloaures of contingent ansen and liabilitiea at the dite of the financial etatements and the reported rovenues and expenser during the reporsing poriod. Significant accounts that
 reimburnement duo CMS, premiums receivable due from CMS rolated to reuro-premium adjastments and rink-sharing adjustroants; and unallocated promiumis reccived from CMS included in uneareed premium. Actual remalts could differ from thoso estimatiox, and thone differences eould be material. Such extimitee and essumptions could change in the firture as more information becomes koown, which could imprate the amounts reported berein.

## C. Significent Accounting Policies

Univeral Health Care Inrurnce Compeny, Inc. (UHCCIC' or "the Company"') is a Floridn domiciled inmurance company mad a wholly owned subsidiary of Univeral Health Chere Group. Inc. ("Group'). The Company whs iwcorporated an May 25, 2006 and formed as a beath insurance company that opernies a Medicaro Advantay Privato Fee for Service plan. The Company commenced reverne generating activities in January 2007.

Tho Company has a contrset with the Depurtment of Heallh and Fumm Services, Contes for Medicara \& Medienid Service: (CMS) to provido health care services to Medicare enoollees in the chates of Alabams, Arizonn, Atkamar, Florida, Georgis, Minois, Indiema, Loviminma. Maryland, Mispinaippi, Miesouri, Novadh, Now Jersoy. New York, North Carolins, Okio, Oklahoms, Pennrylvanis, South Carolina, South Daikoth, Taxas, Utah and Vigginia, at well an tho District of Columbia. This contrnet ecounted for $100 \%$ of the Componin's revemues in 2011. CMS awarded the Compnay the contract for the period begirning Jamuary 1, 2007 and ending December 31, 2007 and has renowed the connract through Decenber 31, 2011. The controct provides for anomgl exdensions rubject to agrement and appiovial by both partien

## Inveratimenta

Investmentis in bonds, cush, cach equivalents, and ahort-term investmionts are stated at values prescribed by tho NAIC, wathows:
Inventmende are reposted at amortized coat or fhir valus based an thoir NAIC rating. Boode not becked by ober Joana are principalty stated at amortized cost uning the interest method
 methad including enticipated prepnyments. Prepayment assumptions ase obtained Aram dealer murvoyr or internal or thirdparty erfimmes and are baved on the current interent rate and economic enviroument. The proepective adfustareat mothod in used to value all much weewitien.
Cash, ceah equivalents, and short-erm invetments include cash balences and invatments which ars liquid and matuse in one yoar or less when purchased, inchuding fiunde maintained under statutory requirements (deposits), and consist of money markek and certificates of depoeit funds registered with the NAIC.

Investments in common atoche are denignoted at availoble for salo and are reported at fair value with unrealized gains of losses reported not of taxen in other charget in copital and mophus.

Realized eapital gains and tossos are determined using the apecifie identification basis. Changes in tho admitted asset carrying amounts of boods ine credited or charged directly to unasajgied auplen.
Tho fhir value of an satot is the amount at which that assot contd be bought or mold in a current trangaction between willing parties, that is, other them in E forced of liquidation ule. The fir valvo of a liabdity is the amount at which that liability corld be setiled io a carrent tranaction between willing parties, that is, other than in a forced or liquidation seitiement.

Fuir viluen are based an quoted markes prices when available. When quoted market pricos ase not available, frir valuo is gemerally extionted wing discosuted cash flow analynes, incopporating corrent market inputs for samiler finapriel inctruments with comperable terms and credit quality. In ingtneess where there in little ar no ourket sclivity for tho shmo or similar inatnumenke, the Company eatimates fair value using methods, modeis, and asmumptions that managensent belioves market puticipants mould use to
 which beconots aignificant with increusingly complex instruments or pricing modols. Where approprinta, adjantmentia aro inchaded to reflect the rist inherent in a particular methodology, model or input ued.
Finnacial amets caniod at fiar vaho ase classified for disclosore papposes, based on a hienrchy definod by the Fair Vahue Mearosements Disclosure Topic of the Financial Accounting Standerds Board'a Accounting Soundards Codification (FASB ASC). The hierarchy gives the highest ranking to fair valucs determined uving unadjucted quoted prices in activo markets for iderticai ascets and liabilities (Lovel 1) and the lewest tanking to fair valuas determined using methodologies and modole with unobvervable inpuss (Leval 3). An asset's or a linbility's classification is based on the loweat lovel input that is aignificant to its meararement The lovels of the fir vilue hierarchy are as fallowr:

Laved 1 - Values ant unadjomted quoted prices for identical assets and linbitition in sctivo mankets accousiblo at the measurement date.
measorrement dato. 2 - Inputs inciode quoted prices for similar assets or liabribiot in active markets, quoted prices from those willing to trade in markets thet ere not ectiva; or othor inputs that are observable or can be corroborated by market deta for tha term of

Lewol 3 - Certain inpusto are unobeervable (aupported by bitle or no market activity) and sigaificant to tha fair valuo measurement Unobservable inputs refleat the Compary's bost eatimats of what hypothetical maricot participants would uso to deterning a tumatcion price for the actet or liability at the reporting dite.

## NOTES TO FINANCIAL STATEMENTS

At Decomber 31, 2011 the Compeny's inverpanats ent all chasified as Loved $\mathbf{2}$ instrumente.
Minimum Croital ead Surplon Reqpiryments
Purmant to Section 624.408(1a) of Flogida Statutete the Company is cequired to maintain a miosimasn surphes not loss than the ereater of $\$ 1,500,000$, or $4 \%$ of total lisbilibies phes $6 \%$ of liabilitien rolative to heelth incurance. Putnuant to Section 624.4093(1) and 4(c) of Florida Statuter, the Comprayy is also required to mintrin a ratio of actual or projected anmual premimes, an defined, to
 premiums. For purposen of this requirement, ennual or projected premiams aro limitod to $80 \%$ for healith insurance compenies such as the Compmy. By Conent Order filed January 5, 2011, the FL OR granted perminsion for tho Conipacy to operato at a ritio of grows actual or projected annvil premiums to curreas surphius an to policy holden of not more than 16:1. exceeding tha required ratios gurmant to Sactian 624.4095(1) and 4(c) of Flonida Statuter. As a condition to this approval, tho Company agreed to (1) maintain at all times complinnce with the ratio limitation of net ectan or projected armul premiums to current auplene as to policy bolders of $4: 1$ and RBC of $250 \%$ of tho authorized control toval; (2) msintain compliance with mantman capilal and aurphus requirements dofinod by Section 624.408, Flosida Statutos; (3) elect a $75 \%$ attachmeat point quoth-abere reingurance for 2011; (4) Limis Medicaro enrolleek for the 2011 plen year, and ( $)$ defer any requent to pay dividende until aftor the September 30,2011 quarterly statement in filed with the OIR. Additionally, according to the Sinbe of Georgin Conseat Order dated Augact 28, 2006, tha Compnay mant atoo maintain capital and saphus of not leen than $250 \%$ of the nanthoized control bevol risk based capital Ans of December 31, 2011, the Company's cagital and supflus of $\$ 36,579,328$ met the respective levels preveribed by the statutes sontrogalatory requiremente described abova

## Recomition of Premium Revepue and Medical Experneas

The Company genernlly receives premiums in adyance of providing eervices, and recognizes preminm rovenue daning the period in which the Company is obligated to provide services to its members. Promiums are billed monthly for coveruge in the following month and are recognized as reverms in the month for which insuranco coverage is provided. Accosdingly, the portion of premiums applicable to fubuce periods in incheded in the accompanying statutory-basis balnace shesta as premiums received in advanced and in eccorusts payable and accrued expenser.

The Compary reconcilos the membership in its administrative eyetem to the enrollment data provided by CMS. Thero ere timing difforences between the addition of a member to the Company': adrainistrative syetem and the approval, or accretion, of the niember by CMS. Additionslly, the monthly paynents from CMS inchudo adjustments to raflect changea in menbership as a resule of retronctivo terminations, addisions or othar changes. Current period membership, net premuiums, nud chaime expenve ato edjurted to reflect retrosetive changes in memberahip.

Preminm and other houlth cro receivables consiat of premiuma to flom Pederal agencies and members bued on enrolled membership and other rolated health care plan tectivabios. On an ongoing banis, mangement eatimates the amount of preminum billinga tha may not be fully collectiblo bared on historical treads and other fictors. Amounte deened meallectiblo are written off agrinst promium rovenue in tho period the determination is mada.
CMS uses risk-adjusted rates per member to detemine the moothly payouents to the Compreny. CMS has implemonted a sisk adjumanent model which apportions premiums paid atcording to healdh diagnoses. The rink adjustment model uree health tatuse indientors, oc risk meoros, to improve the securncy of payment. The CMS risk adjustraent model paya mare for membere with imcreaning heath severity. Under this rink adjustment methodology, diagnosis dupa from inpatient and ambulatory treatment setticge ase used by CMS to calculats the rixk-adjusted growivm payment to the Companay. The monihly risk-adjusted premium per member in determined by CMS based on normalized risk acones of each member from tho prim year. Annually, CMS providep the updnted riat scosea to the Compeny and sevises premium rates prospectively, beginning with the Jnly remittanco fur cerretit plan year members. CMS will also calculato tha reforactive adjuctments to premium reltied to the revised risla scones for the current year for ewreat plan year membere end for the prior year for prior plan year members.
 preacribed deadlines. Accordingly, the Company collects, captures, and submite the necensny end runitbble diegnosis data to CMS
 based upon the diagoonie data nubnittod to CMS and uhinantely socepped by CMS. Risk peorea are updated anmually by CMS, and tho Connpuny reconciles the data to ettimated amonata recorded by tho Compary with any adjustments reconded in promium rovensa

Medical expenses consint of claim payments, caqiation payments, and pharmacy costs, net of rebates, us well as entimates of future paymente of claims provided for services rendered prior to tho end of the reporting period Capitation payments represent momaly contrectual fese disbursed to physicians end other providers who are responsiblo for providing medical cerre to members. Pharmacy costs (including Medicese Part D conts) represent paynents for members' prescription drus besofith, net of rebates fuom drug manufacturers. Rebates aro recognized when the rebetes are earned aceording to the contrietual armangements with the reapective vendors.

Premiums the Company pays to reinsurers ero reported as medical expenses and related reinarance recoverien nre reported as redactions of ruedical expenses.

Medical cfaime liability seprecents the Company's payment reaponsibility for services that have been rendered by medical mervice providers to member. Theto coste hove not been setted as of the balance sheet dates. The liability consists of medical chaima reported by the medical service providers af well as ap acturially detamined estimnto of clsims thet have been inctured bat not yet reponted (IBNR) by the medical service providers.

Due to the aumerous fictorn influencing this lisbility, the Company dovalopa an estimato bosed upon genemilly arcepped actuarial projection methodologies uning claim submission and payment pallenns and cont treads. Doviations, wheher poritive or negatives, between ectual experience and estimatos used to establish the liabitity we reconded in the period of claim payment on a consietem

## NOTES TO FINANCIAL STATEMENTS

basia. The Company continunlly monitors the raconsbleness of the asturupptions used in prior estimates by courapatiton with actual cleim pattems and considere this information in future eatimates.

Medical and other benofits paid cas also be significnally inapected by ontcomea from court decisions, interprotations by regulatory authorities, and legindative changes involving helfth care matterk As a result, amounts ultimstety paid may differ from initial estimaten that did not consider moch ourcomens, interpretations, nod chmagos.

## MedicurePentD

The Companya Medicare Advantage plan offers preacription drug benofite under Part D of the Medicare federal health inaurance progran to individuals digible for beanfite under Part A or Part A. As such, the Company seceives additional premium and cost reimburmement components.

For qualifyiag low-iocome watue (LIS), members, CMS paye the Company for some or all of tho LIS member'a monthly premium. The CMS payment in dependent upon a member't income lovel, which is determined by the Social Secwity Administration. Lownincoms preminm is reciognized over the contruct period and reported as premium revenuse Additionally, for qualifying LIS members, CMS will roimburse tha Conpany for all or a partion of the LIS member's deductibla coinurrarce, and co-payment anounta above the cutiofpociket threshold for low-incoma benaficiaries Lowiscome cot-nharing aubsidien ars paid by CMS prospectively as a fixed amount per member per mooth, and are detemained based upon the plan year bid mbmilted to CMS. After the elone of the ansual pian year, CMS recomiles actanl experionce to low-income cost alhaing eubsidies paid to the plan and any differences are settled between CMS And the Company.

The Cosupany nleo receives payments from CMS for catatrophic reinerurance for members of its Medicaro Advantago plan CMS maken propective monthly catantrophic reinsuranco paymeuta to the Comprany betwd on oftimsted ayerago reinnurnace paymento to other Medicare Advratage-Prescription Drug plant that provide Part D benofits. Afler the close of the ammal plac yeter, CMS reconciles actual experience compared to catatrophic reinsurance subsidies paid to the Company and any differences aro eetted betwoen CMS and the Company.

Low-incoms cont sharing and catastophic Tinournice subsidies represent fanding from CMS for which the Company ansumes no risk and amonata received from CMS aro reported not of payments of the aclual prescription ding costa related to the low-income cont sharing and contastrophic reinsurance in the accotropatying atatutory-bania balence ebeets. The Company dose not recognizo premium rovence or inodical claims expenso for tais activily.

Medicare Pat D ectivity resulted in a payable froan CMS of \$391,140 at December 31, 2011. which is inchuded in amounts receivalo relating to uniagured plann in the actompanying etatutory-baris belnnce aheets. Actual amoounta of Medicare Paet D


## Accrued Lon Adjustment Expense

Claim processing oxpeames for unpaid claims, inchuding claims IBNR, are ncenved based on extimated expenses necosary to procenn nuch claims.

## Advertising Expemes

Marketing and advertining costs are expensed an incurred. For the year eured December 31, 2011. the Company incurred \$348,380 of advertining expense.

## Income Taxen

On September 27, 2007, the Conspany elected to memorialize ita tax-Ahering erengennent by particifuting in en Intercompuny Tax Shaing Agreement (tho Agreemont) with Group, Universal Health Care, Inc. (UHC), and Amarican Mamaged Cure, LUC (AMC). UHC and AMC are catities owned $100 \%$ by Group. Beginning with the 2007 tax year, Group has Gled a convolidited foderal tax setum that includes the opentions of the Compeny, Group. UHC, and AMC. On May 27, 2009, the Agrecunent wate emended to inclade participation by Univernal HMO of Tosat, Iac. (UHMOT), UHMOT was inconporated during the year ended Decensber 31. 2009 mod is wholly owned by Group. The Compnay obtained fmal approval of the amenied Agreement from the ORR in October 2009. On July 27, 2010, the Agreement whe amended to include participation by Universal Health Cars of Novad, lice. (UHCNV). UHCNV wa incorporated during tho your ended December 31, 2010, and is wholly owned by Group. The Compeny obtaited final approval of the umended Agreenient from the ORR in March 2011.

Under terms of the Agreement, each compriny shatl te reapousible for and shall xeimburse Group for its ceparraly calculated share of the consolidated tax benefit or eapenua. Further, per the Agreement, each company shill pay promply to, or be reimburred from,
 entimited in tho mame menser as apecified abova. Any final adjusunents to payments thall to made following the preparation of tho consolidated federal income taz return
2. Accosunting. Changes and Corrections of Enruch

Ampapl Byaternent for the Year 2011 of the Uhhresil Eealh Core Invermee Compary, Ine



ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE UnIveral Health Care insurance Co., inc.
NOTES TO FINANCIAL STATEMENTS


ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Universal Health Care insurance Co., Inc.
NOTES TO FINANCIAL STATEMENTS


ANNUAL STATEMENT FOR THE YEAR 2011 OF THE Univeraal Health Care Insurance Co., Inc.
NOTES TO FINANCIAL STATEMENTS


# ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Univarsal Health Care Insurance Co., Inc. 

## NOTES TO FINANCIAL STATEMENTS

## 10. Infomation Conscrming Parent, 8ubaidianiess and Affilinten

A - C. All outstanding sharee of the Company are owned by Group, an insuranco holaing compary incorperated in the Stato of Dolawnes with aperations based in Florida. On February 14, 2011, Group antered into a $\$ 37,500,000$ term-loan and a $\$ 2.500,000$ unflunded rovolving credit agreeanent which pinced additional minimun matutory capital requiremonts oa its subaidiniet, inclucing UHCIC. Under tho credit agreement, the Conipany must mainsin suaphas and capital equal to or eremter than $125 \%$ of tho Statutory minimum. Group pledged $100 \%$ of ite equity intoreat in UHCIC as security under tho credil agreement.

Sheplue motes parabla, raloted paroy:
The Compeny has recorded $\$ 18,250,000$ in muples notes payable to its partert, Group, at Deceniber 31, 2011 (ges note 13). The terms of the suppina notes paysblo nyecify that principal and interest it payable onsy upon the prior approvil of FL ORR The notes
 and received FL OR approval for peyment of intereat. As of the year taded December 31, 2010, Noto ${ }^{14} 4$ a principal and interent of $\$ 66,000,000$ and $34,205,202$, respectivoly had been paid in fill. Ths Company paid down Noto in in the total amonnt of $\$ 2,750,000$ oa July 14, 2010. During the period from May 25, 2006 (date of ineeption) throngh December 31, 2011, UHCIC did
 intersst expense of $\$ 4,963,230$ related to those notes.

## Dividend proment

N/A
Other ralationships:
The Company hat a management agreement with American Maraged Cura, LIC (AMC), effoctivo through May 31, 2012 and autometically renowed in one year terms, wharoby AMC provides supervisory and nungrement mervicos, perform specific
 Efiective December 1, 2010, feen purnuant to this agreement were bet at $9.0 \%$ of the total collected premiums on a monthly basis an approved by FL, OIR on November 5,2010 . Effective Junuary 1, 2011, for compensation for tervices readered, the Compary shall pry AMC a percendego of total collected premiusis on a monthly basis. The nomount thald vary, as mutadty agreed between AMC and the Company, bot under no citcountance ahnil the percentage of collected pratinmers paid to AMC onceed 9\%, withont obtrining paior approval from the FL, ORR. Further, no amounts plid by the Conmpany shall result in the Company being out of complimes with the minimum atatutory requirements of tho Flosida Stututes. Expenose incurred ander this agreement totaled $\$ 20,350,967$ for tho period from Jamary 1, 2011 throagh December 31, 2011.
D. In addition to the above-rofereaced menagement agreement, certain expendituran far tho Company aro paid by and reimbursed to Univenal Heith Care, Inc. (UHC). Univers HMO of Toxas, Inc. (UHMOT), Universal Hoath Core of Nevish, Inc. (UHCNV) and AMC, companies under common control by Group, me well al Group iteolf. Tbe Company nleo paye fir and in roimbursed by UHC, UHMOT, UHCNV and AMC for certain expendituree. At December 31, 2011, the Compeny owed UHC $\$ 30,747$ fud was owed $\$ 14,88$, 053 from AMC. All somounts will be settled per terms of the Company's intercompany traneaclions policy whirh requires the pryment to be made within 30 days.

## EN/A

F. The Compary has a mangemont agreement with AMC, offective through May 31, 2012 and automatically senowed, whereby AMC providea enpervisory and mangement nervices, perfonst specific functions and contract mervices to and peafomis certain peyioll functions for the Company. AMC is owned $100 \%$ by Groap.

In addition, the Company maintsins a provider ngreewent with American Family \& Geriatric Care (AFGC), which is owned 100\%\% by a majority dhareboldor of Grous Amounts paid to AFGC under tho provider sgreement for the year ended Decembex 31. 2011 wope \$2,271,190.

## G. -L. N/A

Under the Company'a tax aharing agreement, $\$ 0,906,053$, included in current federal and foreign incomo tax recoversblo in the encompadying Statement of Asseta, Lisbilivies. Cupital and Surphes, is due to the Company from Group and will be setiled per terms of the intercompany traneactions policy.
11. Deps

N/A
12. Retirement Pluns, Deferredi Compongation Postemoloyment Benefity and Commenated Absences and Other Postretirement Renofit Plans
N/A
13. Curital and Sprolus, Shateholdere' Dividend Rearictions mad Opai-Reorganizations
I. UHCTC hins $10,000,000$ vhares of $\$ 1.00$ par valoe common stock anthorized, $2,500,100$ sharea issued and outranaling as of December 31, 2011.
2. N/A
3. Prior approval is neseded by Florida ORR for dividend payments to Group and may not be presented for approval nontil after the Junc 30, 2011 quaterly statewients ase filed. 4. $N / A$
 ordinary dividende to stockbolders.
6. N/A
7. N/A
8. N/A

ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Unlvernal Health Care Insurance Co., Me.

## NOTES TO FINANCIAL STATEMENTS

9. N/A
10. Tho portion of unasaigned fimde (muphas) represented by cumulative unresized gains and loweas in $\$-100,862$.

|  | Duakned | Eneme |  | Curging Nota |  |  | $\begin{aligned} & \text { Unepporsed } \\ & \text { Prinecpol madoc } \\ & \text { inferest } \end{aligned}$ | Drapofmanity |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Supher | 17R\%2egs | 5.0\% | \$8000000 | \$8000,000 | 0 | 0 | 52003333 | NU |
| $\begin{aligned} & \begin{array}{l} \sin \sin ^{2} \\ \text { Noxta } \end{array} \end{aligned}$ | 01138507 | 2.8\% | \$2000000 | 58000000 | 0 | 0 | 401,94 | N/ |
| $\begin{aligned} & \text { Saphon } \\ & \text { Notan } \end{aligned}$ | 02222007 | 5.0\% | \$11,000,000 | 58250,000 | 0 | \$2,780,000 | 52,479,95 | N/ |

12. N/A
13. N/A
14. Contiagencies

N/A
15. Leaman

N/A
 Crodit Risk
N/A
17. Snla Tanafer and Servicing of Financial Aescla and Extingaishments of Liebilities N/A
 N/A
19. Diroct Premium Written/Pxoduced by Mangeing General Agentrihird Paty Administratofe

N/A
20. Fir.Vaha Mearmementa

N/A
21. Ohther Iteme

N/A
22. Eyentr Subrequent

NA
23. Reinsprapes
 Hamover Lifo Re and entered into a coded reinsunace agreemant with RGA Reinsurance Company (Barbadon) Limited (ROA) for indenvity raigeurance. Thin agreemsat does not roliove tho Company from its cbligatioss to ite memberst. Failure on the pert of RGA to honor its obligations could resoll in lowes to the Comppayy. Under terms of the agreement, the Comapany coded to RGA, and RGA neinnured, a $75 \%$ quota chars of the rointured riske subject to anousal maximmen seingurance premium and net of ary exicting reinsurance for the year eaded December 31, 2011. Thero nre no amonnts of seinamance credits.
B.N/A
C.NA
24. Retrospectively Roted Contracte \& Contancts Spbiect to Redetermination N/A.
25. Changein Incerred Claimss and Chim Adjurtpent Expenaer N/A
26. Inescrompany Pooling Arragements N/A
27. StructureciSetilementa

N/A
28. Hedth Caro Receivableas

| Quarter | Eatimated Rx <br> Refraten Aa | Rx Robater as <br> Ralled or | Actual <br> Rebates | Actuval Rebates <br> Received | Actunal <br> Rebuntee |
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ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Unlvareal Health Care Insurance Co., Inc.
NOTES TO FINANCIAL STATEMENTS

|  | Reported on Finascinal 8 Statementit | Onherwiso Confinned | Recerived within 90 days of Etiling | within 91 to 180 Days of Biling | Received More Than 180 Deys After Billing |
| :---: | :---: | :---: | :---: | :---: | :---: |
| 3/31/2009 | \$929,951 | \$929.951 | \$ - | \$ | \$929,951 |
| 6/30/2009 | 977,292 | 977,292 | - | - | 977,292 |
| 9/30/2009 | 1,015,385 | 1.015,385 | - | 899,703 | 115,682 |
| 12/31/2009 | 887,585 | 887,585 | - | - | 887,585 |
| 3/31/2010 | 653.467 | 653.467 | - | 36,873 | 596,592 |
| 6/30/2010 | 1,319,378 | 1,319,378 | - | 1,319,378 | $\cdots$ |
| 973012010 | 1,021,724 | 1,021,724 | 144,746 | 876.978 | - |
| 12/31/2010 | 1,248,839 | 1,248,839 | 92,048 | 921,625 | 235,166 |
| 3/31/2011 | 1.685.901 | 1,685,901 | - | 1,685,901 | $\square$ |
| 6/30/2011 | 2.148,552 | 2,148,552 | 354,189 | 1,545,081 | 249,282 |
| 930/2011 | 1,873,665 | 1,873,665 | $\cdots$ | 1,001,843 | - |
| 1231/2011 | 2,174,692 | 2,174,692 | - | - |  |

29. Paticipating Pelicies

N/A
30. Premium Deficiency Reserver

NA
31. Anticipated Sablake and Subrogntion

NA

## GENERAL INTERROGATORIES

## PART 1 - COMMON INTERROGATORIES

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annual statement for the year 20110 F THE Universal Hoalth Care Insurance Co．，Inc．

## GENERAL INTERROGATORIES




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## ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Unlverael Health Care Insurance Ca, inc.

## GENERAL INTERROGATORIES



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## GENERAL INTERROGATORIES





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| 25.35 | Preced under opeton agremmerts | 1 |
| 28.37 |  |  |
| 25.20 | On depopat eth atate or other regititary baity |  |
| 25.29 | Other |  |



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ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Univeraal Health Care insurance Co., Inc.

## GENERAL INTERROGATORIES




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## ANNUAL BTATEMENT FOR THE YEAR 2011 OF THE Universal Health Care Insurance Co., Inc.

## GENERAL INTERROGATORIES

OTHER





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## GENERAL INTERROGATORIES

## PART 2- HEALTH INTERROGATORIES



ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE Unvaranl Health Care Inaurance Co., Inc.

## GENERAL INTERROGATORIES

## PART 2 - HEALTH INTERROGATORIES



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ANNUAL 8TATEMENT FOR THE YEAR 2011 OF THE UnNversal Health Care Insurance Co., Inc.
SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS






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# Universal Health Care Insurance Company, Inc. Financial Statements - Statutory-Basis <br> Years Ended December 31, 2011 and 2010 

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## Ernst \& Young LLP

## Report of Independent Certified Public Accountants

The Board of Directors Universal Health Care Group, Inc.

We have audited the accompanying statutory-basis balance sheets of Universal Health Care Insurance Company, Inc. (the Company), a wholly owned subsidiary of Universal Health Care Group, Inc., as of December 31, 2011 and 2010, and the related statutory-basis statements of operations, changes in capital and surplus, and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Company's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's intemal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As described in Note 1 to the financial statements, the Company presents its financial statements in conformity with accounting practices prescribed or permitted by the State of Florida Department of Financial Services, Office of Insurance Regulation, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles also are described in Note 1. The effects on the financial statements of these variances are not reasonably determinable but are presumed to be material.

In our opinion, because of the effects of the matter described in the preceding paragraph, the financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of Universal Health Care Insurance Company, Inc. at December 31, 2011 and 2010, or the results of its operations or its cash flows for the years then ended.

## 케 ERNST\& Young

However, in our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Universal Health Care Insurance Company, Inc. at December 31, 2011 and 2010, and the results of its operations and its cash flows for the years then ended, in conformity with accounting practices prescribed or permitted by the Florida Department of Financial Services, Office of Insurance Regulation.

June 1, 2012
Emit + Young LLP

# Universal Health Care Insurance Company, Inc. 

Balance Sheets - Statutory-Basis

|  | December 31 |  |
| :---: | :---: | :---: |
|  | 2011 | 2010 |
| Admitted assets |  |  |
| Admitted assets: |  |  |
| Cash, cash equivalents, and short-term investments | \$ 89,407,582 | \$ - |
| Due from financial services institution | 8,285,087 | 9,110,604 |
| Investments in bonds | 7,302,115 | 49,143,349 |
| Investments in equity securities | 2,030,520 | - |
| Premiums and other health care receivables | 11,604,760 | 9,389,429 |
| Other current assets | 832,535 | 494,448 |
| Due from affiliates | 24,794,107 | 4,661,373 |
| Deferred tax assets | - - | 2,517,226 |
| Total admitted assets | \$144,256,706 | \$ 75,316,429 |
| Liabilities and capital and surplus |  |  |
| Liabilities: |  |  |
| Checks drawn in excess of bank balance | \$ | \$ 4,425,505 |
| Medical claims payable | 26,082,000 | 10,139,809 |
| Accounts payable and accrued expenses | 80,634,304 | 2,889,934 |
| Accrued loss-adjustment expense | 930,330 | 274,454 |
| Due to affiliates | 30,744 | 2,070,769 |
| Total liabilities | 107,677,378 | 19,800,47I |
| Capital and surplus: |  |  |
| Common stock, $\$ 1.00$ par value; $10,000,000$ shares authorized, $2,500,100$ shares |  |  |
| issued and outstanding | 2,500,100 | 2,500,100 |
| Gross paid-in and contributed surplus | 12,499,900 | 12,499,900 |
| Unassigned surplus | 3,329,328 | 22,265,958 |
| Surplus note payable, related party | 18,250,000 | 18,250,000 |
| Total capital and surplus | 36,579,328 | 55,515,958 |
| Total liabilities and capital and surplus | \$ 144,256,706 | \$ 75,316,429 |

See accompanying notes.

## Universal Health Care Insurance Company, Inc.

Balance Sheets - Statutory-Basis

|  | December 31 |  |  |  |
| :---: | :---: | :---: | :---: | :---: |
|  | 2011 |  | 2010 |  |
| Admitted assets |  |  |  |  |
| Admitted assets: |  |  |  |  |
| Cash, cash equivalents, and short-term investments | \$ | 89,407,582 | \$ | - |
| Due from financial services institution |  | 8,285,087 |  | 9,110,604 |
| Investments in bonds |  | 7,302,115 |  | 49,143,349 |
| Investments in equity securities |  | 2,030,520. |  | - |
| Premiums and other health care receivables |  | 11,604,760 |  | 9,389,429 |
| Other current assets |  | 832,535 |  | 494,448 |
| Due from affiliates |  | 24,794,107 |  | 4,661,373 |
| Deferred tax assets |  | - |  | 2,517,226 |
| Total admitted assets |  | 144,256,706 | \$ | 75,316,429 |
| Liabilities and capital and surplus |  |  |  |  |
| Liabilities: |  |  |  |  |
| Checks drawn in excess of bank balance | \$ | - | \$ | 4,425,505 |
| Medical claims payable |  | 26,082,000 |  | 10,139,809 |
| Accounts payable and accrued expenses |  | 80,634,304 |  | 2,889,934 |
| Accrued loss-adjustment expense |  | 930,330 |  | 274,454 |
| Due to affiliates |  | 30,744 |  | 2,070,769 |
| Total liabilities |  | 107,677,378 |  | 19,800,471 |
| Capital and surplus: |  |  |  |  |
| Common stock, $\$ 1.00$ par value; $10,000,000$ shares authorized, $2,500,100$ shares |  |  |  |  |
| issued and outstanding |  | 2,500,100 |  | 2,500,100 |
| Gross paid-in and contributed surplus |  | 12,499,900 |  | 12,499,900 |
| Unassigned surplus |  | 3,329,328 |  | 22,265,958 |
| Surplus note payable, related party |  | 18,250,000 |  | 18,250,000 |
| Total capital and surplus |  | 36,579,328 |  | 55,515,958 |
| Total liabilities and capital and surplus |  | 144,256,706 | \$ | 75,316,429 |

See accompanying notes.

Universal Health Care Insurance Company, Inc.
Statements of Operations - Statutory-Basis


See accompanying notes.

Universal Health Care Insurance Company, Inc.
Statements of Changes in Capital and Surplus - Statutory-Basis

|  | Common Stock |  | $\begin{gathered} \text { Gross Paid-In } \\ \text { and } \\ \text { Contributed } \\ \text { Surplus } \\ \hline \end{gathered}$ | Unassigned Surplus | Surplus Note Payable, Related Party | Total |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Capital and surplus at January 1,2010 | 2,500,100 | \$2,500,100 | \$ 12,499,900 | \$ 24,714,208 | \$ 23,750,000 | \$ 63,464,208 |
| Change in surplus notes | - | - | - | - - | $(5,500,000)$ | (5,500,000) |
| Net loss | - | - | - | $(3,151,623)$ | - | $(3,151,623)$ |
| Clange in deferred income tax | - | - | - | 1,008,143 | - | 1,008,143 |
| Change in nonedmitted assets | - | - | - | $(382,274)$ | - | (382,274) |
| Clange in unrealized gains and losses | - | - | - | 71,504 | - | 71,504 |
| Capital and surplus at Decomber 31, 2010 | 2,500,100 | 2,500,100 | 12,499,900 | 22,265,958 | 18,250,000 | 55,515,958 |
| Net loss | - | - | - | $(15,332,304)$ | - | (15,332,304) |
| Change in deforred income tax | - | - | - | $(2,517,226)$ | - | $(2,517,226)$ |
| Change in nenedmitted assels | - | - | - | $(856,074)$ | - | $(856,074)$ |
| Chango in uncealized gains and losses | - | - - | - - | $(231,026)$ | - - | (231,026) |
| Capital und surplus at December 31, 2011 | 2,500,100 | \$2,500,100 | \$ 12,4929000 | \$ 3.329 .328 | \$ 18,250,000 | \$ $36.572,328$ |

## See accompranting notes.

## Universal Health Care Insurance Company, Inc.

## Statements of Cash Flows - Statutory-Basis

|  | Year Ended December 31 |  |  |  |
| :---: | :---: | :---: | :---: | :---: |
|  | 2011 |  | 2010 |  |
| Operating activities |  |  |  |  |
| Premiums and revenues collected, net of Part B reimbursement and reinsurance | \$ | 205,930,505 | \$ | 128,244,544 |
| Claims and loss-adjustment expenses paid, net of reinsurance |  | $(99,093,684)$ |  | (82,914,054) |
| General and administrative expenses |  | (32,827,606) |  | $(46,381,798)$ |
| Net investment income |  | 2,021,951 |  | 1,484,216 |
| Net cash flows provided by operating activities |  | 76,031,166 |  | 432,908 |
| Investing activities |  |  |  |  |
| Cost of investments purchased |  | $(20,933,441)$ |  | $(25,462,533)$ |
| Costs of investments in common stock purchased |  | $(2,131,382)$ |  | - |
| Proceeds from the sale of investments |  | 62,213,985 |  | 28,072,718 |
| Change in due from financial services institution |  | 825,517 |  | 992,536 |
| Net cash flows provided by investing activities |  | 39,974,679 |  | 3,602,721 |
| Financing activities |  |  |  |  |
| Change in checks drawn in excess of bank balance |  | $(4,425,505)$ |  | 4,425,505 |
| Net amounts paid and received on deposit-type contracts |  | - |  | $(752,318)$ |
| Payment on surplus notes |  | - |  | $(5,500,000)$ |
| Change in due to affiliates |  | $(22,172,758)$ |  | $(4,503,060)$ |
| Net cash flows used in financing activities |  | $(26,598,263)$ |  | (6,329,873) |
| Net change in cash, cash equivalents, and short-term investments |  | 89,407,582 |  | (2,294,244) |
| Cash, cash equivalents, and short-term investments at beginning of year |  | - |  | 2,294,244 |
| Cash, cash equivalents, and short-term investments at end of year |  | 89,407,582 | \$ | - |

See accompanying notes.

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis 

December 31, 2011 and 2010

## 1. Organization and Basis of Presentation

## Organization

Universal Health Care Insurance Company, Inc. (the Company) is a Florida domiciled insurance company and a wholly owned subsidiary of Universal Health Care Group, Inc. (Group). The Company was incorporated on May 25, 2006, and formed to operate a Medicare Advantage private fee-for-service plan. The Company commenced revenue-generating activities in January 2007.

The Company has a contract with the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to provide health care services to Medicare enrollees in the states of Arizona, Florida, Georgia, Louisiana, Maryland, Mississippi, Nevada, Pennsylvania, South Carolina, Texas, and Utah. CMS initially awarded the Company the contract for the period beginning January 1, 2007 and ending December 31, 2007, and has renewed the contract through December 31, 2012. The contract provides for annual extensions, subject to agreement and approval by both parties. In 2012, the Company was approved to provide health care services to Medicare enrollees in the states of Alabama, North Carolina, Ohio, and Virginia, as well as the District of Columbia.

## Basis of Presentation

The accompanying statutory-basis financial statements have been prepared in conformity with the statutory accounting practices prescribed or permitted by the State of Florida Department of Financial Services, Office of Insurance Regulation (OIR), which practices differ from U.S. generally accepted accounting principles (GAAP). The more significant variances from GAAP are as follows:

Investments: Investments in bonds are reported at amortized cost or fair value based on their National Association of Insurance Commissioners (NAIC) rating. For GAAP, such fixedmaturity investments would be designated at purchase as held-to-maturity, trading, or available for sale. Held-to-maturity fixed investments would be reported at amortized cost, and trading and available-for-sale fixed-maturity investments would be reported at fair value with unrealized gains and losses reported in operations for those designated as trading and as a separate component of other comprehensive income for those designated as available-for-sale.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 1. Organization and Basis of Presentation (continued)

Fair value for statutory purposes is based on the prices published by the Securities Valuation Office of the NAIC (SVO), if available, whereas fair value for GAAP is based on quoted market prices.

All single-class and multi-class mortgage-backed and asset-backed securities (e.g., CMOs) are adjusted for the effects of changes in prepayment assumptions on the related accretion of discount or amortization of premium of such securities using either the retrospective or prospective methods. If it is determined that a decline in fair value is other-than-temporary, the cost basis of the security is written down to the undiscounted estimated future cash flows. For GAAP purposes, all securities, purchased or retained, that represent beneficial interests in securitized assets (e.g., CMO, CBO, CDO, CLO, MBS, and ABS securities), other than high-quality securities, are adjusted using the prospective method when there is a change in estimated future cash flows. If it is determined that a decline in fair value is other-thantemporary, the cost basis of the security is written down to fair value. If high-credit-quality securities are adjusted, the retrospective method is used.

Nonadmilted assets: Certain assets designated as "nonadmitted," principally furniture and equipment, certain amounts receivable, and other assets not specifically identified as an admitted asset with the NAIC Accounting Practices and Procedures Manual, are excluded from the accompanying statutory-basis balance sheets and are charged directly to unassigned surplus. Under GAAP, such assets would be included in the balance sheets to the extent that those assets are not impaired. The balances of nonadmitted assets are as follows:

|  | December 31 |  |  |
| :--- | ---: | ---: | ---: |
|  | $\mathbf{2 0 1 1}$ |  | $\mathbf{2 0 1 0}$ |
|  |  |  |  |
| Pharmacy rebates receivable | $\mathbf{\$ 2 , 4 4 6 , 5 1 4}$ | $\$ 1,156,791$ |  |
| Prepaid expenses | $\mathbf{5 7 , 1 9 4}$ | 208,807 |  |
| Accounts receivable | $\mathbf{2 , 4 1 6 , 5 3 4}$ | $2,698,570$ |  |
| Total | $\mathbf{\$ 4 , 9 2 0 , 2 4 2}$ | $\$ 4,064,168$ |  |

Reinsurance: Any reinsurance balances deemed to be uncollectible are written off through a charge to operations. Under GAAP, an allowance for amounts deemed uncollectible would be established through a charge to operations. Claims liabilities ceded to reinsurers have been reported as reductions of the related reserves rather than as assets, as would be required under GAAP.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 1. Organization and Basis of Presentation (continued)

Surplus notes payable: Notes payable issued by the Company to related parties are classified as capital and surplus on a statutory-basis, if approved by the OIR. Under GAAP, such notes payable are recorded as liabilities (see Note 7).

Deferred income taxes: Deferred tax assets are limited to: (1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year, plus (2) the lesser of the remaining gross deferred tax assets expected to be realized within one year of the balance sheet date or $10 \%$ of net worth, excluding any net deferred tax assets, electronic data processing (EDP) equipment and operating software, and any net positive goodwill, plus (3) the amount of remaining gross deferred tax assets that can be offset against existing gross deferred tax liabilities. Any remaining deferred tax assets are nonadmitted. Deferred taxes do not include amounts for state taxes. Pursuant to Statement of Statutory Accounting Principles (SSAP) No. 10R, paragraph 10.e, the Company may elect to admit additional deferred tax assets. The election is subject to certain capital and surplus requirements. If elected, the above is modified as follows: (a) the carryback period for (1) above is modified to reflect available loss carrybacks for both ordinary and capital losses to be the carryback time frame corresponding with the IRS tax loss carryback provisions, not to exceed three years; (b) the period of realization and the percentage of capital and surplus mentioned in (2) above, are increased to three years and $15 \%$, respectively. Under GAAP, state income taxes are included in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in all future years, and a valuation allowance is established for deferred tax assets not realizable.

Statement of cash flows: Cash, cash equivalents, and short-term investments in the statements of cash flows represent cash and investment balances with initial maturities of one year or less. Under GAAP, the corresponding caption includes cash and investments with initial maturities of three months or less.

The effects of the foregoing variances from GAAP on the accompanying statutory-basis financial statements have not been determined, but are presumed to be material.

# Universal Health Care Insurance Company, Inc. 

# Notes to Financial Statements - Statutory-Basis (continued) 

## 2. Significant Accounting Policies

Significant accounting practices are as follows:

## Investments in Bonds and Securities

Investments in bonds, securities, cash, cash equivalents, and short-term investments are stated at values prescribed by the NAIC, as follows:

Investments are reported at amortized cost or fair value based on their NAIC rating. Bonds not backed by other loans are principally stated at amortized cost using the interest method. Investments in equity securities are stated at fair value.

Single-class and multi-class mortgage-backed and asset-backed securities are valued at amortized cost using the interest method, including anticipated prepayments. Prepayment assumptions are obtained from dealer surveys or internal or third-party estimates and are based on the current interest rate and economic environment. The prospective adjustment method is used to value all such securities.

Cash; cash equivalents, and short-term investments include cash balances and investments that are liquid and mature in one year or less when purchased, including funds maintained under statutory requirements (deposits), and consist of money market funds and bank bonds registered with the NAIC.

Realized capital gains and losses are determined using the specific-identification basis. Changes in the admitted asset carrying amounts of bonds and securities are credited or charged directly to unassigned surplus.

The fair value of an asset is the amount at which that asset could be bought or sold in a current transaction between willing parties, that is, other than in a forced or liquidation sale. The fair value of a liability is the amount at which that liability could be settled in a current transaction between willing parties, that is, other than in a forced or liquidation settlement.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 2. Significant Accounting Policies (continued)

Fair values are based on quoted market prices when available. When quoted market prices are not available, fair value is generally estimated using discounted cash flow analyses, incorporating current market inputs for similar financial instruments with comparable terms and credit quality. In instances where there is little or no market activity for the same or similar instruments, the Company estimates fair value using methods, models, and assumptions that management believes market participants would use to determine a current transaction price. These valuation techniques involve some level of management estimation and judgment, which becomes significant with increasingly complex instruments or pricing models. Where appropriate, adjustments are included to reflect the risk inherent in a particular methodology, model, or input used.

Financial assets carried at fair value are classified, for disclosure purposes, based on a hierarchy defined by the Fair Value Measurements Disclosure Topic of the Financial Accounting Standards Board's Accounting Standards Codification. The hierarchy gives the highest ranking to fair values determined using unadjusted quoted prices in active markets for identical assets and liabilities (Level 1) and the lowest ranking to fair values determined using methodologies and models with unobservable inputs (Level 3). An asset's or a liability's classification is based on the lowest level input that is significant to its measurement.

The levels of the fair value hierarchy are as follows:
Level 1 - Values are unadjusted quoted prices for identical assets and liabilities in active markets accessible at the measurement date.

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. Unobservable inputs reflect the Company's best estimate of what hypothetical market participants would use to determine a transaction price for the asset or liability at the reporting date.

At December 31, 2011, the Company's investments in equity securities are classified as Level I instruments. At December 31, 2011 and 2010, the Company's investments in bonds are classified as Level 2 insistruments.

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 2. Significant Accounting Policies (continued)

## Minimum Capital and Surplus Requirements

Pursuant to Section 624.4095(1) and 4(c) of Florida Statutes, the Company is required to maintain a ratio of actual or projected annual premiums, as defined, to current or projected surplus as to policy holders, as defined, of not more than $16: 1$ for gross written premiums. As a condition to this approval, the Company agreed to (1) maintain at all times compliance with the ratio limitation of net actual or projected annual premiums to current surplus as to policy holders of $4: 1$ and RBC of $250 \%$ of the authorized control level; (2) maintain compliance with minimum capital and surplus requirements defined by Section 624.408, Florida Statutes; (3) elect a $75 \%$ attachment point quota-share reinsurance for 2011; (4) limit Medicare enrollees for the 2011 plan year; and (5) defer any request to pay dividends until after the June 30,2011 quarterly statement is filed with the OIR. Pursuant to Section 624.408(1a) of Florida Statutes, the Company is also required to maintain surplus as to policyholders not less than the greater of $\$ 1,500,000$ or $4 \%$ of total liabilities plus $6 \%$ of the liabilities relative to health insurance. Additionally, according to the State of Georgia Consent Order dated August 28, 2006, the Company must also maintain capital and surplus of not less than $250 \%$ of the authorized control level risk-based capital (RBC).

As of December 31, 2011, the Company's capital and surplus of $\$ 36,579,328$ exceeded the $\$ 27,314,049$ minimum level prescribed by the statutes, NAIC guidelines, and the regulatory requirements described above by $\$ 9,265,279$ (hereinafter referred to as the "excess minimum capital and surplus level").

The Company may receive premiums in advance of providing services. However, the Company recognizes premium revenue during the period in which the Company is obligated to provide services to its members. Premiums are billed monthly for coverage in the following month and are recognized as revenue in the month for which insurance coverage is provided. Accordingly, the portion of premiums applicable to future periods is recorded as unearned premiums in accounts payable and accrued expenses.

The Company reconciles the membership in its administrative system to the enrollment data provided by CMS. There are timing differences between the addition of a member to the Company's administrative system and the approval, or accretion, of the member by CMS. Additionally, the monthly payments from CMS include adjustments to reflect changes in membership as a result of retroactive terminations, additions, or other changes. Current period membership, net premiums, and claims expense are adjusted to reflect retroactive changes in membership.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 2. Significant Accounting Policies (continued)

## Recognition of Premium Revenue and Medical Expenses

Premium and other health care receivables consist of premiums due from federal agencies and members, based on enrolled membership and other related health care plan receivables. On an ongoing basis, management estimates the amount of premium billings that may not be fully collectible, based on historical trends and other factors. Amounts deemed uncollectible are written off against premium revenue in the period the determination is made.

CMS uses risk-adjusted rates per member to determine the monthly payments to the Company. CMS has implemented a risk-adjustment model, which apportions premiums paid according to health diagnoses. The risk-adjustment model uses health-status indicators, or risk scores, to improve the accuracy of payment. The CMS risk-adjustment model pays more for members with increasing health severity. Under this risk-adjustment methodology, diagnosis data from inpatient and ambulatory treatment settings are used by CMS to calculate the risk-adjusted premium payment to the Company. The monthly risk-adjusted premium per member is determined by CMS based on normalized risk scores of each member from the prior year. Annually, CMS provides the updated risk scores to the Company and revises premium rates prospectively, beginning with the July remittance for current plan-year members. CMS will also calculate the retroactive adjustments to premium related to the revised risk scores for the current year for current plan-year members and for the prior year for prior plan-year members.

All health benefit organizations must capture, collect, and submit the necessary diagnosis code information to CMS within prescribed deadlines. Accordingly, the Company collects, captures, and submits the necessary and available diagnosis data to CMS within prescribed deadlines for its HMO plan. The Company estimates changes in CMS premiums related to revenue adjustments based upon the diagnosis data submitted to CMS and ultimately accepted by CMS. Risk scores are updated annually by CMS, and the Company reconciles the data to estimated amounts recorded by the Company with any adjustments recorded in premium revenue.

Medical expenses consist of claim payments, capitation payments, and pharmacy costs, net of rebates, as well as estimates of future payments of claims provided for services rendered prior to the end of the reporting period. Capitation payments represent monthly contractual fees disbursed to physicians and other providers who are responsible for providing medical care to members. Pharmacy costs (including Medicare Part D costs) represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Rebates are recognized when the rebates are earned according to the contractual arrangements with the respective vendors.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 2. Significant Accounting Policies (continued)

Premiums the Company pays to reinsurers are reported as medical expenses and related reinsurance recoveries are reported as reductions of medical expenses.

Medical claims liability represents the Company's payment responsibility for services that have been rendered by medical service providers to members. These costs have not been settled as of the balance sheet dates. The liability consists of medical claims reported by the medical service providers, as well as an actuarially determined estimate of claims that have been incurred but not yet reported (IBNR) by the medical service providers.

Due to the numerous factors influencing this liability, the Company develops an estimate based upon generally accepted actuarial projection methodologies using claim submission and payment patterns and cost trends. Deviations, whether positive or negative, between actual experience and estimates used to establish the liability are recorded in the period of claim payment on a consistent basis. The Company continually monitors the reasonableness of the assumptions used in prior estimates by comparison with actual claim patterns and considers this information in future estimates.

Medical and other benefits paid can also be significantly impacted by outcomes from court decisions, interpretations by regulatory authorities, and legislative changes involving health care matters. As a result, amounts ultimately paid may differ from initial estimates that did not consider such outcomes, interpretations, and changes.

## Medicare Part D

The Company's Medicare Advantage plan offers prescription drug benefits under Part D of the Medicare federal health insurance program to individuals eligible for benefits under Part A or Part B. As such, the Company receives additional premium and cost-reimbursement components as described below.

For qualifying low-income status (LIS), members, CMS pays the Company for some or all of the LIS member's monthly premium. The CMS payment is dependent upon a member's income level, which is determined by the Social Security Administration. Low-income premium is recognized over the contract period and reported as premium revenue. Additionally, for qualifying LIS members, CMS will reimburse the Company for all or a portion of the LIS member's deductible, coinsurance, and co-payment amounts above the out-of-pocket threshold

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 2. Significant Accounting Policies (continued)

for low-income beneficiaries. Low-income cost-sharing subsidies are paid by CMS prospectively as a fixed amount per member per month, and are determined based upon the plan-year bid submitted to CMS. After the close of the annual plan year, CMS reconciles actual experience to low-income cost-sharing subsidies paid to the plan, and any differences are settled between CMS and the Company.

The Company also receives payments from CMS for catastrophic reinsurance for members of its Medicare Advantage plan. CMS makes prospective monthly catastrophic reinsurance payments to the Company based on estimated average reinsurance payments to other Medicare Advantage-Prescription Drug plans that provide Part D benefits. After the close of the annual plan year, CMS reconciles actual experience compared to catastrophic reinsurance subsidies paid to the Company, and any differences are settled between CMS and the Company.

Effective January 1, 2011, CMS began providing the Medicare Coverage Gap Discount Program, where CMS provides monthly prospective payments for pharmaceutical manufacturer discounts made available to members. The prospective discount payments are determined based upon the plan-year bid submitted by plan sponsors to CMS and current plan enrollment. Following the plan-year, CMS performs an annual reconciliation of the prospective discount payments received by the plan sponsor to the cost of actual manufacturer discounts made available to each plan sponsor's enrollees under the program.

Low-income cost-sharing, catastrophic reinsurance subsidies and coverage gap discount subsidies represent funding from CMS for which the Company assumes no risk and amounts received from CMS are reported net of payments of the actual prescription drug costs related to the low-income cost-sharing, catastrophic reinsurance and coverage gap discounts in the accompanying statutory-basis balance sheets. The Company does not recognize premium revenue or medical claims expense for these activities.

Medicare Part D activity resulted in a payable to CMS of $\$ 291,140$ at December 31, 2011, which is included in accounts payable and accrued expenses in the accompanying statutory-basis balance sheets. Such activity resulted in a receivable from CMS of $\$ 498,858$ at December 31, 2010, which is included in premiums and other health care receivables in the accompanying statutory-basis balance sheets. Actual amounts of Medicare Part D related assets and liabilities could differ materially from amounts recorded.

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 2. Significant Accounting Policies (continued)

## Accrued Loss-Adjustment Expense

Claim processing expenses for unpaid claims, including claims IBNR, are accrued based on estimated expenses necessary to process such claims. Claims processing expenses are included in general and administrative expenses in the accompanying statutory-basis statements of operations.

## Advertising Expense

Advertising costs are expensed as incurred. For the years ended December 31, 2011 and 2010, the Company incurred $\$ 959,801$ and $\$ 47,219$, respectively, of advertising expense.

## Reinsurance

Certain premiums and medical benefits are ceded to other insurance companies under various reinsurance agreements. The ceded reinsurance agreements provide the Company with increased capacity to write larger risks and maintain exposure to loss within capital resources. The Company is contingentiy liable in the event that the reinsurers do not meet their contractual obligations and, thus, evaluates the financial condition of these reinsurers on a regular basis. The reinsurers are well-known and are well-established, as indicated by their strong financial ratings.

Reinsurance premiums and medical expense recoveries are accounted for consistently with the accounting for the underlying contract and other terms of the reinsurance contracts (see Note 10).

## Income Taxes

On September 27, 2007, the Company elected to memorialize its tax-sharing arrangement by participating in an Intercompany Tax-Sharing Agreement (the Agreement) with Group, Universal Health Care, Inc. (UHC), and American Managed Care, LLC (AMC). UHC and AMC are entities wholly owned by Group. Beginning with the 2007 tax year, Group has filed a consolidated federal tax return that includes the operations of the Company, Group, UHC, and AMC. On May 27, 2009, the Agreement was amended to include participation by Universal HMO of Texas, Inc. (UHMOT). UHMOT was incorporated during the year ended December 31, 2009, and is wholly owned by Group. The Company obtained final approval of the amended

# Universal Health Care Insurance Company, Inc. 

## Notes to Financial Statements - Statutory-Basis (continued)

## 2. Significant Accounting Policies (continued)

Agreement from the OIR in October 2009. On July 27, 2010, the Agreement was amended to include participation by Universal Health Care of Nevada, Inc. (UHCNV). UHCNV was incorporated during the year ended December 31, 2010, and is wholly owned by Group. The Company obtained final approval of the amended Agreement from the OIR in March 2011.

Under terms of the Agreement, each company shall be responsible for and shall reimburse Group for its separately calculated share of the consolidated tax benefit or expense. Further, per the Agreement, each company shall pay promptly to, or be reimbursed from, Group, on a quarterly basis not later than the due date for the estimated quarterly payment of taxes, its share of such payment, estimated in the same manner as specified above. Any final adjustments to payments shall be made following the preparation of the consolidated federal income tax return.

## Use of Estimates

The presentation of the financial statements in conformity with statutory accounting principles requires management to make estimates and assumptions that affect reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported revenues and expenses during the reporting period. Significant accounts that are largely determined based on management's estimates and assumptions include IBNR claims payable, accrued pharmacy reimbursement due CMS, premiums receivable due from CMS related to retro-premium adjustments and risk-sharing adjustments, and unallocated premiums received from CMS included in unearned premium. Actual results could differ from those estimates, and those differences could be material. Such estimates and assumptions could change in the future as more information becomes known, which could impact the amounts reported herein.

## Reclassifications

Certain prior year amounts have been reclassified to conform with current year presentation. Such reclassifications had no effect on capital and surplus or net loss.

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 3. Invested Assets

Included in cash, cash equivalents, and short-term investments at December 31, 2011 and 2010, is $\$ 1,100,000$ of minimum deposits required to be maintained under statutory requirements. At December 31, 2011 and 2010, investments with an admitted asset value of $\$ 3,454,869$ and $\$ 2,593,025$, respectively, were required to be maintained to satisfy regulatory requirements.

The Company entered into a sweep repurchase agreement with a financial services institution to increase its return on invested assets. The transactions involve the transfer of excess cash to a regulated financial institution that is collateralized by securities. On the next business day, the transferred cash, along with any interest thereon, is transferred back to the Company and the collateralized securities are returned. The arrangements meet the requirements to be accounted for as secured borrowings under SSAP No. 91R. The Company requires that, at all times, securities obtained as collateral are sufficient to fund substantially all of the cost of purchasing replacement assets.

As of December 31, 2011 and 2010, the amounts outstanding under repurchase agreement of $\$ 8,285,087$ and $\$ 9,110,604$, respectively, are classified as due from financial services institution in the accompanying statutory-basis balance sheets. At December 31, 2011 and 2010, securities with a fair market value of approximately $\$ 8,450,789$ and $\$ 9,292,816$, respectively, were held as collateral under this agreement.

The carrying value and fair value of investments in bonds and securities at December 31, 2011, are summarized as follows:

|  | Carrying Value | Gross Unrealized Gains |  | Gross Unrealized Losses |  | Fair <br> Value |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| U.S. government and agencies | \$ 4,598,348 | \$ | 6,315 | \$ | 1,661 | \$ | 4,603,002 |
| States, territories, and possessions and political subdivisions | 848,800 |  | 4,832 |  | - |  | 853,632 |
| Mortgage-backed and assetbacked securities | 1,134,967 |  | 7,116 |  | 3,411 |  | 1,138,672 |
| Bank bonds | 720,000 |  | 3 |  | 576 |  | 719,427 |
| Equity securities | 2,131,382 |  | 635 |  | 101,497 |  | 2,030,520 |
| Total bonds and securities | \$9,433,497 | \$ | 18,901 | \$ | 107,145 | \$ | 9,345,253 |

## 3. Invested Assets (continued)

The carrying value and fair value of investments in bonds at December 31, 2010, are summarized as follows:

|  | Carrying <br> Value | Gross <br> Unrealized Gains |  | Gross <br> Unrealized Losses |  | Fair <br> Value |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| U.S. government and agencies | \$ 15,766,987 | \$ | 623,641 | \$ | 1,329 | \$16,389,299 |
| States, territories, and possessions and political subdivisions | 16,915,636 |  | 120,990 |  | 349,608 | 16,687,018 |
| Mortgage-backed and assetbacked securities | 10,485,436 |  | 383,676 |  | 153 | 10,868,959 |
| Corporate debt securities | 5,015,290 |  | 153,624 |  | 4,908 | 5,164,006 |
| Bank bonds | 960,000 |  | 220 |  | 172 | 960,048 |
| Total bonds | \$49,143,349 |  | ,282,151 | \$ | 356,170 | \$50,069,330 |

The following table shows gross unrealized losses and fair values of bonds and securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position at December 31, 2011.


Universal Health Care Insurance Company, Inc.
Notes to Financial Statements - Statutory-Basis (continued)

## 3. Invested Assets (continued)

The Company reviews its investment securities at least quarterly to determine if an other-thantemporary impairment is present, based on certain quantitative and qualitative factors. The primary factors considered in evaluating whether a decline in value is other-than-temporary include (a).the length of time and the extent to which the fair value has been or is expected to be less than cost or amortized cost, (b) the financial condition, credit rating, and near-term prospects of the issuer, (c) whether the debtor is current on contractually obligated interest and principal payments, and (d) the intent and ability of the Company to retain the investment for a period of time sufficient to allow for recovery. In addition, the Company compares the carrying amount of securities with potential other-than-temporary impairment with undiscounted anticipated cash flows on the security. There is no impairment unless the undiscounted anticipated cash flows are less than the carrying amount.

Each quarter, during this analysis, the Company asserts its intent and ability to retain until recovery those securities judged to be temporarily impaired. Once identified, the Company will only authorize the sale of these securities based on criteria that relate to events that could not have been foreseen. Examples of the criteria include, but are not limited to, the deterioration in the issuer's creditworthiness, a change in regulatory requirements, or a major business combination or major disposition.

Based on that analysis, management makes a judgment as to whether the loss is other-thantemporary. If the loss is other-than-temporary, an impairment charge is recorded within net realized investment gains (losses) in the statutory-basis statements of operations in the period the determination is made. The Company has reviewed its investment portfolio and there were no other-than-temporary impairments during the years ended December 31, 2011 and 2010.

## Universal Health Care Insurance Company, Inc.

Notes to Financial Statements - Statutory-Basis (continued)

## 3. Invested Assets (continued)

A summary of the amortized cost and fair value of the Company's investments in bonds and securities at December 31, 2011, by contractual maturity, is as follows:

|  | Carrying Value |  | Fair <br> Value |
| :---: | :---: | :---: | :---: |
| Years to maturity: |  |  |  |
| One or less | \$ 1,304,212 | \$ | 1,305,879 |
| After one through five | 4,014,136 |  | 4,016,550 |
| After five through ten | - |  | - |
| After ten | 848,800 |  | 853,632 |
| Mortgage-backed and asset-backed securities | 1,134,967 |  | 1,138,672 |
| Equity securities | 2,131,382 |  | 2,030,520 |
| Total | \$ 9,433,497 | \$ | 9,345,253 |

The expected maturities in the foregoing table may differ from the contractual maturities because certain borrowers have the right to call or prepay obligations with or without call or prepayment penalties.

At December 31, 2011 and 2010, there were no bonds or securities carried at market value because their NAIC rating required a reduction in carrying value (market value lower than amortized cost).

Major categories of net investment income are summarized as follows:

|  | $\begin{gathered} \text { Year Ended } \\ 2011 \\ \hline \end{gathered}$ | $\begin{gathered} \text { December } 31 \\ 2010 \end{gathered}$ |
| :---: | :---: | :---: |
| 1ncome: |  |  |
| Cash, cash equivalents, and short-term investments | \$ 102,273 | \$ 70,875 |
| Bonds | 1,217,711 | 1,310,707 |
| Total investment income | 1,319,984 | 1,381,582 |
| Investment expenses | $(120,689)$ | $(103,066)$ |
| Net investment income | \$ 1,199,295 | \$ 1,278,516 |

All accrued investment income was included in admitted assets at December 31, 2011 and 2010.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 3. Invested Assets (continued)

Gross gains of $\$ 4,682,548$ and $\$ 274,473$ were realized on sales of investments during the years ended December 31, 2011 and 2010, respectively. Gross losses of $\$ 5,320$ and $\$ 23,928$ were realized on sales of investments during the years ended December 31, 2011 and 2010.

## 4. Fair Values

The following methods and assumptions were used by the Company in estimating the fair value of financial instruments in the accompanying statutory-basis financial statements and notes thereto:

Cash, cash equivalents, and short-term investments: The carrying amounts reported in the accompanying statutory-basis balance sheets for these financial instruments approximate their fair values.

Investments: Fair values for investment securities are based on unit prices published by the SVO or, in the absence of SVO published unit prices or when amortized cost is used by the ISVO as the unit price, quoted market prices by other third-party organizations, where available. For certain mortgage-backed and asset-backed securities, inputs used in the determination of fair value include, but are not limited to, reported trades, benchmark yields, issuer spreads, bids, offers, and/or estimated cash flows and prepayments speeds. Based on the typical trading volumes and the lack of quoted market prices for certain fixed-maturities, third-party pricing services will normally derive the security prices through recent reported trades for identical or similar securities, making adjustments through the reporting date based upon available market observable information as outlined above. If there are no recent reported trades, the third-party pricing services may use matrix or model processes to develop a security price where future cash flow expectations are developed based upon collateral performance and discounted at an estimated market rate. Included in the pricing for mortgage-backed and asset-backed securities are estimates of the rate of future prepayments of principal over the remaining life of the securities. Such estimates are derived based on the characteristics of the underlying structure and prepayment speeds previously experienced at the interest rate levels projected for the underlying collateral. Actual prepayment experience may vary from these estimates.

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 4. Fair Values (continued)

Financial Assets Measured at Fair Value on a Recurring Basis: Financial assets measured at fair value on a recurring basis would include actively traded public and private equity securities. Fair values of equity securities reported in this category are provided by external sources. The fair value of equity securities held by the Company at December 31, 2011, was $\$ 2,030,520$. The Company did not have any equity securities recorded at fair value on a recurring basis at December 31, 2010.

Financial Assets Measured at Fair Value on a Nonrecurring Basis: Certain financial assets are measured at fair value on a nonrecurring basis, such as certain fixed-income securities valued at cost, that are other-than-temporarily impaired or designated as an NAIC Level 6 security by the SVO during the reporting period and recorded at fair value on the accompanying statutory-basis balance sheets. The Company does not have any financial assets measured at fair value on a nonrecurring basis at December 31, 2011 and 2010.

Due from affliates and due to affliates: The carrying amounts reported in the accompanying statutory-basis balance sheets approximate the fair value of amounts due to and due from affiliates due to the short-term settlement of those amounts.

The carrying amounts and fair values of the Company's admitted financial instruments are as follows:


# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 5. Medical Claims Payable and Accrued Loss-Adjustment Expense

The liability for medical claims payable as of December 31, 2011 and 2010, was $\$ 26,082,000$ and $\$ 10,139,809$, respectively, net of ceded medical claims payable of $\$ 72,536,794$ and $\$ 12,582,192$, respectively (see Note 10 ). The liabilities include claims received and in process, as well as management's estimate of the cost of claims incurred but not reported, totaling $\$ 14,475,800$ and $\$ 11,606,200$, respectively, for 2011 and totaling $\$ 3,545,342$ and $\$ 6,594,467$, respectively, for 2010. The liabilities for accrued loss-adjustment expense as of December 31, 2011 and 2010 , were $\$ 930,330$ and $\$ 274,454$, respectively.

The following table provides a reconciliation of the beginning and ending balances of medical claims payable:

Year Ended December 31 20112010

Medical claims payable at beginning of year
Add provision for claims related to:
The current year
Prior years
Total benefits paid or provided during the current year
Deduct payments for claims related to:
The current year
Prior years
Total benefits paid
Medical claims payable at end of year
$\$ 10,139,809 \quad \$ 8,985,001$

| $110,265,141$ | $90,020,226$ |
| ---: | ---: |
| $\mathbf{4 , 3 0 2 , 7 6 8}$ | $(5,951,364)$ |
| $\mathbf{1 1 4 , 5 6 7 , 9 0 9}$ | $84,068,862$ |


| $\mathbf{8 4 , 8 8 3 , 1 4 1}$ | $\mathbf{7 7 , 4 3 7 , 4 1 7}$ |
| ---: | ---: |
| $\mathbf{1 3 , 7 4 2 , 5 7 7}$ | $5,476,637$ |
| $\mathbf{9 8 , 6 2 5 , 7 1 8}$ | $\mathbf{8 2 , 9 1 4 , 0 5 4}$ |
| $\mathbf{\$ 2 6 , 0 8 2 , 0 0 0}$ | $\$ 10,139,809$ |

The provision for claims incurred but not yet reported is actuarially determined based on historical claims payment experience, current enrollment, member statistics, and other statistics. This liability is subject to the impact of changes in claim severity and frequency, as well as numerous other factors. The liability for medical claims payable also includes management's best estimate for amounts due to providers for disputed and denied claims. These accruals are continually monitored and reviewed, and, as settlements are made or accruals adjusted, differences are reflected in current operations. Management believes that the recorded liability is adequate, but the variance between the estimate and the ultimate net cost of settling this liability could be material.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 6. Income Taxes

The Company adopted SSAP No. 10R, Income Taxes, which was effective beginning January 1, 2009. The application of SSAP No. 10R requires the Company to evaluate the recoverability of deferred tax assets and to establish a valuation allowance, if necessary, to reduce the deferred tax asset to an amount that is more likely than not to be realized. Considerable judgment is required in determining whether a valuation allowance is necessary and, if so, the amount of such valuation allowance. In evaluating the need for valuation allowance, the Company considers many factors, including: (1) the nature of the deferred tax assets and liabilities; (2) whether they are ordinary or capital; (3) the timing of their reversal; (4) taxable income in prior carryback years as well as projected taxable earnings exclusive of reversing temporary differences and carryforwards; (5) the length of time that carryovers can be utilized; (6) unique tax rules that would impact the utilization of the deferred tax assets; and (7) any tax planning strategies that the Company would employ to prevent a tax benefit from expiring unused.

Management has determined that recorded deferred tax assets may not be realizable and has recorded a valuation allowance at December 31, 2011. No valuation allowance was recorded at December 31, 2010.

The components of deferred tax assets are as follows:
(a) Oross deferred tax
assets
(b) Stelutory valuation allowtnce adjustment

| December 31, 2011 |  |  | December 31, 2010 |  |  | Change |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) |
|  |  | $(\mathrm{Coll}+2)$ |  |  | (Col 4+5) | ( Coll 1 -4) | ( $\mathrm{COL} 2-5$ ) | $(\mathrm{Col} \mathrm{7}+8)$ |
| Ordinary | Capital | Total | Ordinnry | Capital | Total | Ordinary | Capital | Total |

$$
\begin{array}{lll}
1,818,311 & 39,202 & 1,853,513 \\
\hline
\end{array}
$$

(c) Adjusted gross deferred lax assets (a-b)

$$
\begin{array}{lllllllll}
\hline & & & & & \\
\hline
\end{array}
$$

(d) Doferred tax liabilities
(e) Subtolal (net deferred tax essels) ( $\mathrm{c}-\mathrm{d}$ )
(f) Deferied tax assets nonsdmitted
(g) Net adinitted deferred tax assets (o-f)

\$ $(698,915)$ \$ 35,202 ( 663,713$)$

|  | -5 | - |
| :--- | :--- | :--- | :--- |

$\$(2,517,226) \$$
$-\quad \$(2,317,226)$

## Universal Health Care Insurance Company, Inc.

## Notes to Financial Statements - Statutory-Basis (continued)

## 6. Income Taxes (continued)

The amount of admitted gross deferred tax assets under each component of SSAP No. 10R is as follows:


The Company had no admitted deferred tax assets resulting from tax planning strategies.

## Universal Health Care Insurance Company, Inc.

Notes to Financial Statements - Statutory-Basis (continued)

## 6. Income Taxes (continued)

The components of incurred income taxes are as follows:

|  | (1) <br> Year Ended De 2011 | (2) cember 31 2010 | (3) <br> (Col 1-2) Change |
| :---: | :---: | :---: | :---: |
| (a) Federal | \$(11,696,397) \$ | $(652,321)$ | \$(11,044,076) |
| (b) Foreign | - | - | - |
| (c) Subtotal | (11,696,397) | (652,321) | (11,044,076) |
| (d) Federal income tax on net capital gains | 1,637,030 | 87,691 | 1,549,339 |
| (e) Utilization of capital loss carryforwards | . - | - | . -- |
| (f) Other | - | - | - |
| (g) Federal and foreign income taxes incurred | \$(10,059,367) \$ | $(564,630)$ | \$ $(9,494,737)$ |

## Universal Health Care Insurance Company, Inc.

Notes to Financial Statements - Statutory-Basis (continued)

## 6. Income Taxes (continued)

The components of deferred tax assets are as follows:

|  | $\text { December } 31_{(2)}^{(1)}$ |  | (3) <br> (Col 1-2) <br> Change |
| :---: | :---: | :---: | :---: |
|  | 2011 | 2010 |  |
| (a) Ordinary: |  |  |  |
| 1. Discounting of unpaid losses | \$ | \$ 67,513 | \$ (67,513) |
| 2. Unearned premium reserve | 64,328 | 41,334 | 22,994 |
| 3. Compensation and benefits accrual | 2,175 | 3,059 | (884) |
| 4. Nonadmitted assets - receivables | 1,702,067 | 1,349,376 | 352,691 |
| 5. Allowance for uncollectible accounts | 31,306 | 1,057,280 | $(1,025,974)$ |
| 6. Prepaid expenses | 20,018 | 29,567 | $(9,549)$ |
| 7. Net operating loss carryforward | - | - | . - |
| 8. Tax credit carryforward | - | - | - |
| 9. Other (including items $<5 \%$ of total ordinary tax assets) | $(1,583)$ | $(30,903)$ | 29,320 |
| 10. Subtotal | 1,818,311 | 2,517,226 | $(698,915)$ |
| (b) Statutory valuation allowance adjustment | 1,818,311 | - | 1,818,311 |
| (c) Nonadmitted | - | - | - |
| (d) Admitted ordinary deferred tax assets (a10-b-c) | - | 2,517,226 | (2,517,226) |
| (e) Capital | - | - | - |
| (f) Statutory valuation allowance adjustment | - | - | - |
| (g) Nonadmitted | - | - | - |
| Subtotal | - | - | - |
| (h) Admitted capital deferred tax assets (e-f-g) | - | - | - - |
| (i) Admitted deferred tax assets ( $\mathrm{d}+\mathrm{h}$ ) | \$ | \$ 2,517,226 | \$ $2,517,226$ ) |

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 6. Income Taxes (continued)

At December 31, 2011 and 2010, the Company had no deferred tax liabilities.
The Company's federal income taxes incurred differs from the amount that would be obtained by applying the statutory federal income tax rate of $35 \%$ to pretax net income for the year ended December 31, 2011, for the following reasons:

| Provision computed at statutory rate | $\$(8,918,168)$ | $35.0 \%$ |
| :--- | :---: | :---: |
| Change in nonadmitted assets | $(299,626)$ | 1.2 |
| Nontaxable investment income | $(169,786)$ | 0.7 |
| Nondeductible expense | 7,141 | $(0.0)$ |
| State taxes | 28,386 | $(0.1)$ |
| Change in deferred tax valuation allowance | $1,818,311$ | $(7.1)$ |
| Other | $(8,399)$ | 0.0 |
|  | $\$(7,542,141)$ | $29.7 \%$ |
|  |  |  |
| Federal and foreign income taxes incurred | $\$(11,696,397)$ | $46.1 \%$ |
| Realized capital gains (losses) tax | $1,637,030$ | $(6.5)$ |
| Change in deferred income taxes |  | $2,517,226$ |
|  | $\$(7,542,141)$ | $29.9)$ |

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 6. Income Taxes (continued)

At December 31, 2011 and 2010, no operating loss or tax credit carryforwards were available for tax purposes.

At December 31, 2011 and 2010, the Company had no federal income taxes that were available for recoupment in the event of future net losses.

The Company has an intercompany tax balance due from Group of $\$ 9,906,054$ and $\$ 4,661,373$ as of December 31, 2011 and 2010, respectively (see Note 7).

At December 31, 2011 and 2010, the Company did not record any gross unrecognized tax benefits. The Company recognizes interest and penalties related to unrecognized tax benefits in income tax expense when incurred. No interest and penalties related to unrecognized tax benefits were incurred for the years ended December 31, 2011 and 2010, or accrued as of those dates.

In the normal course of business, the Company is subject to examination by federal and state income tax authorities. During 2010, an amended 2008 consolidated federal income tax return was filed requesting a federal tax refund of $\$ 2,250,855$. This request prompted an audit by the Internal Revenue Service which was concluded in 2011 and a refund of $\$ 2,250,855$ was issued. The consolidated federal income tax returns for the years ended December 31, 2010 and 2009, are still open for federal income tax examination. The Company is not currently under any federal or state income tax examinations. Although the statute of limitations can vary by state, in general, years prior to 2008 are closed for state income tax examination.

## 7. Related-Party and Affiliated Transactions

A summary of transactions between the Company and affiliated companies is as follows:

## Surplus Note Payable, Related Party

On December 31, 2007, the Company received cash proceeds for a surplus note payable issued to Group, amounting to $\$ 66,000,000$. During the years ended December $31,2010,2009$, and 2008, the Company made principal and interest payments to Group of $\$ 2,750,000, \$ 3,250,000$, and $\$ 60,000,000$ and $\$ 215,202, \$ 540,000$, and $\$ 3,540,000$, respectively, upon approval by the OIR. This surplus note and all related interest were fully paid as of December 31, 2010.

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 7. Related-Party and Affiliated Transactions (continued)

On February 22, 2007, the Company received cash proceeds for a surplus note payable issued to Group amounting to $\$ 11,000,000$. The terms of the note payable specify that principal and interest on the note are payable only upon the prior approval from OIR. The note payable bears interest at $5 \%$ per annum upon OIR approval. Any repayment of the principal or of any interest accrued is subordinate to the prior payment in full of all other liabilities of the Company, and no payment of any kind shall be made until all claims of subscribers or general creditors of the Company have been paid or otherwise discharged. The Company has not pledged any assets or other collateral to support the repayment of the note. The liquidation preference to the Company's common shareholders is paid in accordance with Florida Statute 631.271. During the year ended December 31, 2010, the Company made $\$ 2,750,000$ in principal payments to Group upon approval by the OIR. During the period covered by these financial statements, the Company has not received approval from the OIR to pay interest. As of December 31, 2011 and 2010 , unpaid interest related to this surplus note totaled $\$ 2,467,952$ and $\$ 2,055,452$, respectively.

On. January 31, 2007, the Company received cash proceeds for a surplus note payable issued to Group, amounting to $\$ 2,000,000$. The terms of the note payable specify that principal and interest on the note are payable only upon the prior approval from OIR. The note payable bears interest at 5\% per annum upon OIR approval. Any repayment of the principal or of any interest accrued is subordinate to the prior payment in full of all other liabilities of the Company, and no payment of any kind shall be made until all claims of subscribers or general creditors of the Company have been paid or otherwise discharged. The Company has not pledged any assets or other collateral to support the repayment of the note. The liquidation preference to the Company's common shareholders is paid in accordance with Florida Statute 631.271. During the period covered by these financial statements, the Company has not received approval from the OIR to pay interest. As of December 31, 2011 and 2010, unpaid interest related to this surplus note totaled $\$ 491,944$ and $\$ 391,944$, respectively.

Universal Health Care Insurance Company, Inc.
Notes to Financial Statements - Statutory-Basis (continued)

## 7. Related-Party and Affiliated Transactions (continued)

On December 29, 2006, the Company received cash proceeds for a surplus note payable issued to Group, amounting to $\$ 8,000,000$. The terms of the note payable specify that principal and interest on the note are payable only upon the prior approval from OIR. The note payable bears interest at $5 \%$ per annum upon OIR approval. Any repayment of the principal or of any interest accrued is subordinate to the prior payment in full of all other liabilities of the Company, and no payment of any kind shall be made until all claims of subscribers or general creditors of the Company have been paid or otherwise discharged. The Company has not pledged any assets or other collateral to support the repayment of the note. The liquidation preference to the Company's common shareholders is paid in accordance with Florida Statute 631.271. During the period covered by these financial statements, the Company has not received approval from the OIR to pay interest. As of December 31, 2011 and 2010, unpaid interest related to this surplus note totaled $\$ 2,033,333$ and $\$ 1,603,333$, respectively.

## Other Relationships

The Company has a management agreement with AMC, which automatically renews on an annual basis, whereby AMC provides supervisory and management services, performs specific functions, and contract services to and performs certain payroll functions for the Company. Effective December 1, 2010, as compensation for services rendered, the Company shall pay AMC a percentage of total collected premiums on a monthly basis. The amount shall vary, as mutually agreed between AMC and the Company, but under no circumstance shall the percentage of collected premiums paid to AMC exceed $9.0 \%$, without obtaining prior approval from the FL OIR. Fee percentages incurred under this agreement approximated $4.0 \%$ and $8.1 \%$ for the years ended December 31, 2011 and 2010, respectively. Expenses incurred under this agreement totaled $\$ 20,350,967$ and $\$ 20,963,454$, for the years ended December 31, 2011 and 2010 , respectively. Additionally, AMC allocated certain expenses directly to the Company. Allocated expenses include selling and marketing, telesales, grievance and appeals, compliance, Medicare risk-adjustment, and executive costs. Allocated costs totaled $\$ 13,392,791$ and $\$ 4,434,340$ for the years ended December 31, 2011 and 2010, respectively.

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 7. Related-Party and Affiliated Transactions (continued)

The Company also pays and is reimbursed for certain expenditures by AMC, UHC, UHMOT, UHCNV, and Group. The Company adopted an intercompany transactions policy on November 1, 2009, which establishes prompt cash settlement of intercompany balances that meet the criteria for admitted assets (see Note 1). At December 31, 2011, in addition to the intercompany tax balance due from Group of $\$ 9,906,054$, amounts unreimbursed from AMC totaled $\$ 14,888,053$. At December 31, 2010, all amounts were reimbursed by such affiliates. These amounts, along with any intercompany tax balance due from Group (see Note 6), are included in due from affiliates in admitted assets in the accompanying statutory-basis balance sheets.

In addition to the above-referenced management agreement, certain expenditures for the Company are paid by and reimbursed to AMC, UHC, UHMOT, UHCNV, and Group. At December 31, 2011 and 2010, these transactions resulted in a net payable to affiliates as follows:

|  | December 31 |  |  |  |
| :---: | :---: | :---: | :---: | :---: |
|  | 2011 |  |  | 2010 |
| AMC | \$ | - | \$ | 1,557,039 |
| UHC |  | 30,744 |  | 476,230 |
| UHMOT |  | - |  | 25,000 |
| UHCNV |  | - |  | 12,500 |
| Group |  | - |  | - - |
|  | \$ | 30,744 |  | 2,070,769 |

The December 31, 2011 and 2010, amounts above were included in due to affiliates in the accompanying statutory-basis balance sheets.

During March 2011, the Company entered into a management services agreement with American Family \& Geriatric Care (AFGC), which is owned $100 \%$ by a majority shareholder of Group. Amounts paid to AFGC under this agreement totaled $\$ 2,271,190$ for the year ended December 31, 2011.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 8. Concentrations of Credit Risk and Revenues

## Cash, Cash Equivalents, and Short-Term Investments

Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of cash, money market accounts, and short-term investments. The Company maintains its cash and money market accounts in several different financial institutions, each of which is insured by the Federal Deposit Insurance Corporation up to $\$ 250,000$. The Company has deposits of more than $\$ 250,000$ in certain financial institutions with which it maintains depository relationships.

## Revenue

The Company received $99 \%$ of its revenue from the Medicare program for the years ended December 31, 2011 and 2010, under a contract that has been renewed through December 31, 2012. The loss of this contract or significant changes in the program as a result of legislative action, including reduction of premium payments to the Company, or increases in member benefits without corresponding increases in premiums to the Company, may have a material adverse effect on the Company's financial position, results of operations, and cash flows.

## 9. Employee Benefit Plan

The Company's employees are eligible to participate in the American Family and Geriatric Care (AFGC) Savings Plan (the Plan), a 401(k) plan sponsored by AFGC. The Plan was established for the benefit of substantially all employees (and the employees of related companies) who have completed one year of service. The Company matches up to $4 \%$ of employees' contributions as follows: $100 \%$ of the first $3 \%$ of gross earnings and $50 \%$ of the next $2 \%$ of gross earnings. The Company's matching contributions to the Plan were $\$ 833$ and $\$ 6,665$ for the years ended December 31, 2011 and 2010, respectively.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 10. Commitments and Contingencies

## Regulatory

The Company is subject to extensive federal and state health care and insurance regulations designed primarily to protect enrollees, particularly with respect to government-sponsored enrollees. Such regulations govern many aspects of the Company's business affairs and typically empower state agencies to review management agreements with health care plans for, among other things, reasonableness of charges. Among the other areas regulated by federal and state law are licensure requirements, premium rate increases, new product offerings, procedures for quality assurance, and the financial condition, including cash reserve requirements. Legislation mandating managed care for Medicare recipients is often subject to change and may not initially be accompanied by administrative rules and guidelines. Changes in federal or state governmental regulation could affect the Company's operations, cash flows, and business prospects. There can be no assurances that the Company will maintain federal qualifications or state licensure.

By Consent Order filed with the OIR on December 21, 2007 (Consent Order), the Company agreed to take the corrective actions set forth therein. Under the terms of the Consent Order, the Company agreed to file monthly financial statements until further notice from the OIR, correct any significant deficiencies or material weaknesses within 45 days of receipt of notice of such deficiencies, and reimburse the State for its examination expenses. Effective October 7, 2010, the OIR notified the Company that it was no longer required to file monthly financial statements but must report enrollment, including pending enrollments, on a monthly basis. Currently, the Company remains in full compliance with the Consent Order and has no restrictions on its ability to market new business. There can be no assurances that the Company will maintain compliance with the Consent Order.

## Reinsurance

Effective January 1, 2011, the Company entered into a reinsurance agreement with HCC Life Insurance Company (HCC Life) to reduce the risk of loss that may arise from excessive medical claims. These agreements do not relieve the Company from its obligations to its members. Failure on the part of HCC Life to honor its obligations could result in losses to the Company. Under terms of the agreement to reinsure Medicare private fee-for-service members, HCC Life reinsures a percentage of eligible expenses, as defined, that exceeds the applicable attachment point, as defined, limited to a lifetime maximum reimbursement per individual. For the year ended December 31, 2011, the per-member per-month factor, attachment point, and lifetime maximum reimbursement per individual were $\$ 1.39, \$ 250,000$, and $\$ 2,000,000$, respectively.

# Universal Health Care Insurance Company, Inc. 

Notes to Financial Statements - Statutory-Basis (continued)

## 10. Commitments and Contingencies (continued)

Under terms of the previous reinsurance agreement to reinsure Medicare private fee-for-service members, with HCC Life, effective January 1, 2008 through December 31, 2010, HCC Life reinsures a percentage of eligible expenses, as defined, that exceeds the applicable attachment point, as defined, limited to a lifetime maximum reimbursement per individual. Additionally, the agreement includes a minimum aggregate specific deductible that is the greater of the amount calculated using a formula based on the number of members enrolled and a per-member permonth factor or the defined minimum aggregate specific deductible. For the year ended December 31, 2010, the per-member per-month factor, minimum aggregate specific deductible, and lifetime maximum reimbursement per individual were $\$ 1.21, \$ 250,000$, and $\$ 2,000,000$, respectively.

During the years ended December 31, 2011 and 2010, premiums paid to HCC Life for reinsurance amounted to $\$ 1,009,162$ and $\$ 350,380$, respectively.

Effective January 1, 2011, the Company entered into a ceded reinsurance agreement with RGA Reinsurance Company LTD (RGA) for indemnity reinsurance. This agreement does not relieve the Company from its obligations to its members. Failure on the part of RGA to honor its obligations could result in losses to the Company. Under terms of the agreement, the Company ceded to RGA, and RGA reinsured, a $75 \%$ quota share of the reinsured risks, subject to annual maximum reinsurance premium and net of any existing reinsurance for the year ended December 31, 2011. RGA is not an authorized reinsurer; accordingly the ultimate responsibility for payment of claims remains with the Company. At December 31, 2011, reserves of $\$ 72,536,794$ and amounts payable to RGA of $\$ 2,085,938$ are included in accounts payable and accrued expenses in the accompanying statutory-basis balance sheets. Net amounts paid to RGA were $\$ 6,026,399$ during the year ended December 31, 2011.

Effective January 1, 2010, the Company entered into a ceded reinsurance agreement with Hannover Life Reassurance Company of America (HLR) for indemnity reinsurance. This agreement does not relieve the Company from its obligations to its members. Failure on the part of HLR to honor its obligations could result in losses to the Company. Under terms of the agreement, the Company ceded to HLR, and HLR reinsured, a $50 \%$ quota share of the reinsured risks, subject to annual maximum reinsurance premium and net of any existing reinsurance. Net amounts paid to HLR were $\$ 19,946,304$ during the year ended December 31, 2010.

# Universal Health Care Insurance Company, Inc. <br> Notes to Financial Statements - Statutory-Basis (continued) 

## 10. Commitments and Contingencies (continued)

At December 31, 2010, additional net receivables of $\$ 3,778,796$ were due to the Company from HLR and are included in premiums and other health care receivables in the accompanying statutory-basis balance sheet. This amount includes $\$ 7,483,524$ due from HLR related to the experience refund settlement, less $\$ 3,698,524$ due to HLR for the settlement of ceded claims and premiums, adjusted for administrative expenses, at December $31,2010$.

## Litigation

In the normal course of its operations, the Company is engaged in various litigation, none of which is currently considered material to the Company's results of operations or financial position. Where appropriate, the Company has accrued the anticipated costs of loss or settlement of such litigation in the accompanying statutory-basis financial statements, in accordance with statutory accounting principles.

## 11. Subsequent Events

On April 6, 2012, Group entered into a $\$ 60,000,000$ senior revolving line of credit, which placed additional minimum statutory capital requirements on its subsidiaries, including the Company. Group pledged $100 \%$ of its equity interest in the Company as security under the credit revolver.

Subsequent events have been evaluated by management through June 1, 2012, the date that the financial statements were available for issuance.

## Supplementary Information



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## Report of Independent Certified Public Accountants on Supplementary Information

The Board of Directors
Universal Health Care Insurance Company, Inc.
Our audits were conducted for the purpose of forming an opinion on the statutory-basis financial statements as a whole. The accompanying supplemental investment disclosures are presented to comply with the National Association of Insurance Commissioners' Annual Statement Instructions and the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and for purposes of additional analysis and are not a required part of the statutory-basis financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in our audit of the statutory-basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures, in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the statutory-basis financial statements as a whole.

This report is intended solely for the information and use of the Company and state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.
Knot + Young LLP

June 1, 2012

# Universal Health Care Insurance Company, Inc. <br> Supplemental Schedule of Investment Risk Interrogatories 

December 31, 2011

## Investment Risks Interrogatories

1. Universal Health Care Insurance Company, Inc.'s (the Company) total admitted assets as reported on page three of the Company's amended Annual Statement for the year ended December 31,2011 , is $\$ 144,256,706$.
2. Following are the 10 largest exposures to a single issuer/borrower/investment, excluding (i) U.S: government, U.S. government agency securities, and those U.S. government money market funds listed in the Appendix to the SVO Practices and Procedures Manual as exempt, (ii) property occupied by the Company, and (iii) policy loans.

|  | Issuer | Description of <br> Exposure | Percentage <br> of Total <br> Admitted |
| :--- | :--- | :--- | :--- | :--- |
| Assets |  |  |  |

## Universal Health Care Insurance Company, Inc.

## Supplemental Schedule of Investment Risks Interrogatories (continued)

## Investment Risks Interrogatories (continued)

3. The Company's total admitted assets held in bonds and securities, by NAIC rating, are:

| Bonds |  |  | Preferred Stocks |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: |
| NAIC Rating | Amount | Percentage of Total Admitted Assets | NAIC Rating | Amount | Percentage of Total Admitted Assets |
| NAIC-1 | \$ 97,228,602 | 67.4\% | P/RP-1 \$ | - | - \% |
| NAIC-2 | - | - | P/RP-2 | - | - |
| NAIC-3 | - | - | P/RP-3 | - | - |
| NAIC-4 | - | - | P/RP-4 | - | - |
| NAIC-5 | - | - | P/RP-5 | - | - |
| NAIC-6 | - | - | P/RP-6 | - | - |
|  | \$97,228,602 | 67.4\% | \$ | - - | -\% |

4. Assets held in foreign investments with contractual sales restrictions are less than $2.5 \%$ of the Company's total admitted assets.
5. Assets held in Canadian investments are less than $2.5 \%$ of the Company's total admitted assets.
6. Assets held in investments with contractual sales restrictions are less than $2.5 \%$ of the Company's total admitted assets.
7. Assets held in equity interest are less than $2.5 \%$ of the Company's total admitted assets.
8. Assets held in nonaffiliated, privately placed equities are less than $2.5 \%$ of the Company's total admitted assets.
9. Assets held in general partnership interest are less than $2.5 \%$ of the Company's total admitted assets.
10. Mortgage loans reported in Schedule B are less than $2.5 \%$ of the Company's total admitted assets.

# Supplemental Schedule of Investment Risks Interrogatories (continued) 

## Investment Risks Interrogatories (continued)

11. Assets held in each of the five largest investments in one parcel or group of contiguous parcels of real estate reported in Schedule A are less than $2.5 \%$ of the Company's total admitted assets.
12. The Company had $\$ 8,285,087$ at December 31, 2011, included in admitted assets that is subject to overnight repurchase agreements. The Company had no other admitted assets subject to securities lending (excluding assets held as collateral for such transaction), repurchase agreements, reverse repurchase agreements, dollar repurchase agreements, or dollar reverse repurchase agreements during the year ended December 31, 2011.
13. The Company had no warrants not attached to other financial instruments, options, caps, and floors at December 31, 2011.
14. The Company had no potential exposure for collars, swaps, and forwards at any time during the year ended December 31, 2011.
15. The Company had no potential exposure for futures contracts at any time during the year ended December 31, 2011.
16. The Company had no investments included in the write-ins for the invested assets category included on the summary investment schedule at December 31, 2011.

# Universal Health Care Insurance Company, Inc. 

## Summary Investment Schedule

December 31, 2011

| Investment Categories | Gross Investment Holdings ${ }^{\star}$ |  |  | Admitted Assets as Reported in the Annual Statement |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | Amount |  | Percentage of Gross Investment Holdings | Amount |  | Percentage of Admitted Invested Assets |
| Bonds: |  |  |  |  |  |  |
| U.S. treasury securities | \$ | 4,598,348 | 4.3\% | \$ | 4,598,348 | 4.3\% |
| U.S. government agency and corporate obligations (excluding mortgage-backed securities): |  |  |  |  |  |  |
| - Issued by U.S. government agencies |  | - | - |  | - | - |
| Issued by U.S. government-sponsored agencies |  | . - | - |  | - | - |
| Foreign government (including Canada, excluding mortgage-backed securities) |  | - | - |  | - | - |
| Securities issued by states, teritories, and possessions and political subdivisions in the US. |  |  |  |  |  |  |
| State, teritory, and possessions - general obligations |  | - | - |  | - | - |
| Political subdivisions of states, territories, and possessions - general obligations |  | 848,800 | 0.8 |  | 848,800 | 0.8 |
| Revenue and assessment obligations |  | - | - |  | - | - |
| Industrial development and similar obligations |  | - | - |  | - | - |
| Mortgage-backed securities (includes residential and commercial MBS): |  |  |  |  |  |  |
| Pass-through securities: |  | - | - |  | - | - |
| Issued or guaranteed by GNMA |  | - | - |  | - | - |
| Issued or guaranteed by FNMA and FHLMC . |  | 56,146 | 0.0 |  | 56,146 | 0.0 |
| All other |  | - | - |  | - | - |
| CMOs and REMICs: Issued or guaranteed by GNMA, FNMA, - FHLMC, or VA |  | 612,204 | 0.6 |  | 612,204 | 0.6 |
| Issued by U.S. government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies |  | _ | - |  | - | - |
| All other. |  | - | - |  | - | - - |
| Other dibt and other fixed-income securities (excluding short term): |  |  |  |  |  |  |
| Unaffiliated domestic securities (includes credit tenant loans rated by the SVO) |  | 1,186,617 | 1.1 |  | 1,186,617 | 1.1 |
| Unaffiliated foreign securities |  | - | - |  | - | - - |
| Certificates of deposit |  | - | - |  | - | - - |

## Universal Health Care Insurance Company, Inc.

## Summary Investment Schedule (continued)

| Investment Categories | Gross Investment Holdings* |  |  | Admitted Assets as Reported in the Annual Statement |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | Amount |  | Percentage of Gross Investment Holdings | Amount |  | Percentage of Admitted Invested Assets |
| Equity interests: <br> Investments in mutual funds | \$ | 1,301,565 | 1.2\% | \$ | 1,301,565 | 1.2\% |
| Preferred stocks: |  |  |  |  |  |  |
| Affiliated |  | - | - |  |  | - |
| Unaffiliated |  | - | - |  | - | - |
| Publicly traded equity securities (excluding preferred stocks): |  |  |  |  |  |  |
| Affiliated |  | - | - |  | - | - |
| Unaffiliated |  | 728,955 | 0.7 |  | 728,955 | 0.7 |
| Other equity securitics |  | - | . - |  | - | - |
| Mortgage loans |  | - | - |  | . | - |
| Real estate investments |  | - | - |  |  | - |
| Contract loans |  | - | $\cdots$ |  |  | - |
| Receivables for securities |  | - ${ }^{-}$ | - |  | 97,502 - | - |
| Cash and cash equivalents |  | 97,692,669 | 91.3 |  | 97,692,669 | 91.3 |
| Total invested assets | \$ | 107,025,304 | 100.0\% | \$ | .107,025,304 | 100.0\% |

*Gross investment holdings as valued in compliance with NAIC Accounting Practices and Procedures Manual,

# Universal Health Care Insurance Company, Inc. 

Note to Supplementary Information
December 31, 2011

## 1. Basis of Presentation

The accompanying supplemental schedules present selected statutory-basis financial data as of December 31, 2011, and for the year then ended, for purposes of complying with the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual and agree to or are included in the amounts reported in the Company's 2011 Statutory Annual Statement as amended and filed with the Office of Insurance Regulation of the State of Florida.

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## AFFIDAVIT OF TOMA L. WILKERSON

BEFORE ME, the undersigned authority, personally appeared Toma L. Wilkerson, Director of Life \& Health Financial Oversight, Office of Insurance Regulation, who after being duly sworn, deposes and says:

1. I, Toma L. Wilkerson, am over the age of eighteen (18), sui juris, and I am competent to testify to and have personal knowledge of the facts contained herein.
2. I, Toma L. Wilkerson, currently hold the position of Director with Life \& Health Financial Oversight, Office of Insurance Regulation (hereinafter referred to as the "Office"). I graduated from the University of West Florida in 1995 with a Bachelor of Science degree in Management. I have been employed by the Office for approximately 15 years.
3. Universal Health Care Group, Inc. (UHCG) is the sole owner of Universal Health Care, Inc. ("UHC"), an HMO, and Universal Health Care Insurance Company, Inc. ("UHCIC"), an insurance company. UHCG also owns American Managed Care ("AMC") which is the management company and third party administrator for UHC and UHCIC. AMC employs the corporate officers and the majority of the employees of both UHC and UHCIC. UHCG, UHC and UHCIC have identical corporate officers. (Exhibits $\mathrm{A}, \mathrm{B}$, and C ).
4. UHCIC was licensed on May 26, 2006 in the State of Florida as a Life and Health Insurance Company and was authorized to sell the Health line of business. UHCIC has only sold Medicare business since it began writing business in 2007.
5. The Office has determined that grounds exist for the Department of Financial Services (hereinafter referred to as the "Department") to petition for an order, under Section 631.051(1), (3), and (13) Florida Statutes, directing the Department to initiate delinquency proceedings against UHCIC. The basis for this determination is summarized as follows:
(a) On January 14, 2013, the Office received a copy of UHCG's Management Presentation, which was presented by the management of UHCG to potential buyers of UHCIC and UHC. This presentation shows, by its own admission, that UHCIC is impaired by $\$ 0.4$ million. (Exhibit D).
(b) On January 15, 2013, UHCIC requested that CMS allow the company to implement enrollment capacity limits on UHCIC's Network PFFS (Contract No. H8090), Non-Network PFFS (Contract No. H5820), and PPO (Contract No. H5096). (Exhibit E). On January 17, 2013, UHCIC again requested that CMS allow the company to implement enrollment capacity limits, and requested that the decision be expedited.

By its own admission, UHCIC stated that the reason for this request is that the company "has reason to believe that Universal is financially impaired." (Exhibit F).
(c) UHCIC has a pattern of mismanagement, which has resulted in UHCIC operating in such a condition as to render its further transaction of insurance hazardous to its policyholders, creditors, stockholders, and the public.
i. There has been frequent turnover in the position of Chief Financial Officer. UHCIC has had five Chief Financial Officers within a period of six years. UHCIC was without a Chief Financial Officer between May 2011 and October 2012.
ii. The Report on Significant Deficiencies in Internal Controls that accompanied the 2011 audited financial statements included a list of issues that the auditor considered material weakness involving internal control over financial reporting. (Exhibit G).
iii. The claim system is compromised and previous attempts to convert to a new claim system have been unsuccessful. (Exhibit H).
(d) The Office has determined that UHCIC is operating in an unsound financial condition.
i. The Office has concerns over the company recording retrospective management fees as receivables from AMC. AMC does not have the ability to pay such receivables. AMC has filed multiple insolvent financial statements, most recently September 30, 2012. (Exhibit I).
ii. Section 624.4095, Florida Statutes, limits an insurer's ratio of annual net written accident and health premium to surplus as to policyholders to a maximum of $4: 1$ and annual gross written accident and health premium to a maximum of $10: 1$. UHCIC has a history, beginning in 2007, of noncompliance with one or both of the accident and health writing ratios. This ratio measures the insurance company's cushion of capital and surplus available to absorb losses resulting from unexpected variances from expected operating results, and is an important indicator of financial solvency. UHCIC's violations of Section 624.4095, Florida Statutes, has resulted in Corrective Action Plans, Consent Orders and a Consent Order For Public Administrative Supervision And Contingent Order Of Liquidation since UHCIC's licensure during 2006. UHCIC's writing ratios remain out of compliance today.
(e) The Office has determined that UHCIC is engaging in methods or practices which render the continuance of business hazardous to the public or insureds.
i. During 2012, UHCG entered into a credit agreement with Bank United for a total of $\$ 60$ million. On three separate occasions since October 29, 2012, Bank United has notified UHCG of certain events of default. These events include an allegation that the financial statements provided at the time the Credit Agreement was entered into were incorrect, false, and/or misleading. (Exhibits J, K, and L). UHCG, UHC and UHCIC have identical corporate officers.
ii. The Office has concluded that some of UHC's assets, as reported on previously filed financial statements, have been materially overstated, causing UHC to be in worse financial condition than its filed financial statements make it appear.
iii. UHCIC has had multiple adverse findings related to the financial condition of UHCIC, which includes material financial adjustments made to the 2011 annual statement, the March 31, 2012, and June 30, 2012, financial statements. (Exhibit M).
iv. The Office has concluded that several receivables reported on UHCIC's previous financial statements will not be able to be collected.
v. Management of UHCIC has filed misleading financial statements and has omitted an entry of material amounts on the books of the insurer. (Exhibit M).
vi. The Office believes that there will be future problems with insurer solvency because of a lack of access to additional capital.
(f) Two other states in which UHCIC operates have issued Consent Orders stating that UHCIC shall not enroll any new customers in that state, due to UHCIC's unsound financial condition.
i. The Georgia Office of Insurance issued a Consent Order dated November 15, 2012, stating that UHCIC "shall cease writing new business" in the State of Georgia. (Exhibit N).
ii. The Ohio Department of Insurance issued a Consent Order dated December 18, 2012, affirming that UHCIC "will not solicit, issue, or otherwise write any new policies or contracts of insurance, nor shall it assume any new risk in the State of Ohio". (Exhibit O).
6. Based on the above admissions from UHCIC and other conclusions of the Office, the Office has determined that UHCIC is impaired or insolvent, is in an unsound financial condition, and is in such a condition and is using such methods and practices as to render its further transaction of insurance hazardous to it policyholders, creditors, stockholders, or the public. Thus, grounds for issuing an Order for entry into receivership exist under Sections 631.0517(1), (3), and (13), Florida Statutes.

## FURTHER AFFIANT SAYETH NOT.



Toma L. Wilkerson, Director
Life \& Health Financial Oversight
Office of Insurance Regulation

## STATE OF Florida <br> COUNTY OF Leon

The foregoing instrument was acknowledged before me this 31 day of January 2013, by Toma wilkerson as birector of LtH Financial Onersight (name of person)
..... e.g. officer, trustee attorney in fact)
for $F L O I R$
(company name)


Personally Known $\qquad$ OR Produced Identification $\qquad$
Type of Identification Produced

# America's $1^{\text {st }}$ ChoIce Holdings of Florida, LLC Dr. Kiran Patel Chairman 

# Letter Agreement 

January 31, 2013

Dr. Akshay M. Desai
Chairman, Chief Executive Officer Universal Health Care Group, Inc. 100 Central Avenue, Suite 200
St. Petersburg, FL 33701

Dear Dr. Desai:
The purpose of this Letter Agreement ("Agreement") is to set forth certain agreements reached through discussions to date among Universal Health Care Group, Inc., ("UHCG or Seller"), America's First Choice Holdings of Florida, LLC ("AFCH"), Universal Health Care, Inc., Universal HMO of Texas, Inc., and Universal Health Care of Nevada, Inc., ("UHC" or the "Company") with respect to the proposed acquisition by AFCH or one or more of its subsidiaries and affiliates ("Buyer") of One Hundred Percent ( $100 \%$ ) of the issued and outstanding shares of UHC (or $100 \%$ of its assets), subject to the terms of a more definitive purchase agreement ("Purchase Agreement") to be entered into between the parties.

## 1. The Acquisition

Buyer shall acquire One Hundred Percent ( $100 \%$ ) of the issued and outstanding shares and all the equity interests of UHC (or $100 \%$ of its assets) at closing, free and clear of all liens, claims, encumbrances and security interests.

## 2. The Consideration

(i). Equity Interests

In exchange for One Hundred Percent of the outstanding shares of UHC or of its assets, AFCH shall grant UHCG, Twelve and One Half Percent (12.5\%) of the total issued and outstanding ownership interests in AFCH ("Equity Interests"). The Equity Interests shall not be diluted except in cases of where AFCH is raising capital or in the event of recapitalizations, reorganizations, acquisitions, or mergers wherein all equity holders are diluted on a pro-rata basis.

## (ii). Cash Consideration

In addition to the Equity Interests, Buyer shall infuse up to Thirty Million Dollars (\$30M) in additional capital as needed for UHC to meet statutory requirements in the state of Florida. Further additional capital as needed will be raised from the disposition of certain assets of UHC including the potential sale of its Medicaid line of business. All capital infused in accordance herein shall be in the form of subordinated notes.

## 3. Non Assumption of Certain Liabilities

AFCH shall not assume and UHCG shall indemnify against any and all liabilities relating to UHC's employees, leases, equipment, software agreements and any and all other liabilities, including contingent liabilities which existed prior to the date of Closing or which arises from any action or inaction of Seller taken prior to Closing.

## 4. Management Company

With effect from Closing, UHC and all its affiliated health plans shall enter into a general and administrative services agreement with a management company affiliated, owned or operated by Dr . Patel to provide general and administrative management services to UHC and its affiliates for a $10 \%$ monthly management fee. With effect upon Closing UHC and all its affiliated health plans shall terminate all existing third party administrator ("TPA") or management agreements.

## 5. Due Diligence

From the date of this Agreement, UHCG, UHC and related parties shall cooperate fully and assist AFCH and its advisors to conduct an investigation of the business, financial and legal affairs of the Company (the "Due Diligence"). For this purpose, with appropriate notice from AFCH, you will permit the management of AFCH to gain access to the premises of UHC and to the books, records, and contracts of UHC. You shall also permit the appropriate management employees and the accountants/advisors of UHCG and UHC to be available to give explanations and provide information, as reasonably requested. The parties agree to negotiate, execute, and deliver within a reasonable time from the execution hereof but no later than the end of the exclusivity period (as defined below), a mutually acceptable Purchase Agreement containing such covenants (including a 5 -year noncompete and non-solicitation agreement), representations and warranties as are customary in transactions of this kind (including, without limitation, representations and warranties by seller, and related indemnification obligations, as to the financial statements of UHC for the past three years and as to assets, liabilities, title, litigation, taxes, and other customary matters).

## 6. Conditions

The understandings set forth in this Agreement and the Closing of the transactions contemplated hereby are conditional upon, among other things:
6.1 Receipt of all required governmental and regulatory approvals, including the approval from all regulatory agencies with which UHC holds contracts and the reasonable assurance that such contracts will continue post Closing without any' impositions of any material conditions ("Regulatory Approval");

6.2 Lender approval of the proposed transaction and agreement to accept the Equity Interests as substituted collateral.

## 7. PPO/PFFS Entities

As part of the transaction contemplated hereby, Buyer shall assist Seller to raise up to an additional Fifteen Million Dollars ( $\$ 15 \mathrm{M}$ ) to be infused as additional capital into the PPO and PFFS entities (owned by Seller) as needed to meet statutory capital surplus requirements. Dr. Patel or Buyer shall be granted 20\% (non-dilutive) ownership in all such PPO/PFFS entities owned by UHCG. All capital infused may be in the form of subordinated notes or if in the form of direct paid in capital, provided that Dr. Patel's or Buyer's ownership interests shall never be diluted below 20\%.

## 8. Closing

All parties shall cooperate with each other and shall use reasonable endeavours to enter into a Purchase Agreement, execute closing documents, and complete the transactions contemplated by the end of the exclusivity period but in no event shall Closing occur prior to the receipt of all Regulatory Approvals.

## 9. Exclusivity and Non-Solicitation

You hereby agree that, during the exclusivity period, unless the parties mutually agree or unless AFCH notifies you in writing of its decision not to proceed with the proposed transaction due to failure of a condition, you will not solicit any offer from, or negotiate or have any discussions with, any party other than AFCH with respect to any sale, transfer or disposal of assets or shareholdings of UHCG or UHC or any sale, merger, or other business combination involving UHCG or any of its subsidiaries or assets, except that during the exclusivity period, UHCG, UHC and AFCH shall continue to market UHC's Medicaid and Nursing Home Diversion lines of business to potential third party buyers.

AFCH's willingness to proceed with this transaction is subject to the Company's willingness to negotiate in good faith and on an exclusive basis. Accordingly, during the period beginning upon execution of this Letter Agreement and ending at midnight (Eastern time) on February 28, 2013 (the "exclusivity period"), UHCG and UHC (a) shall cease, and shall cause their affiliates to cease, any negotiations with any other party regarding the potential acquisition, directly or indirectly, of all or any substantial portion of their assets (whether by way of an asset purchase, stock purchase, merger, consolidation, business combination or otherwise) and (b) shall not, and shall not permit their affiliates directly or indirectly, through any officer, director, manager, employee, agent or representative, to initiate, solicit or encourage (including by way of furnishing any information or assistance), or enter into negotiations of any type, directly or indirectly, or enter into a confidentiality agreement, letter of intent or purchase agreement, merger agreement or other similar agreement with any person other than AFCH or its affiliates with respect to a sale or transfer of all or any substantial portion of the assets, merger, consolidation, business combination, sale or transfer of any of the capital stock of the UHCG or UHC or the liquidation or similar transaction with respect to the Company. The Company or its representative shall notify AFCH orally and in writing (as promptly as practicable) of all relevant terms of any inquiry or proposal that are material and bonafide to acquire the Company by a third party to do any of the foregoing that the Company or any of their affiliates or officers, directors, partners, managers, employees, investment bankers, financial advisors, attorneys, accountants or
other representatives may receive relating to any such matters. In the event such inquiry or proposal is in writing, the Company shall immediately deliver to AFCH a copy of such inquiry or proposal together with such written notice.

## 10. Continuing Operations

From the date of this Agreement through and including actual completion of the transaction or the date AFCH notifies you in writing that it does not intend to proceed with the proposed transaction, or the date that the conditions to the transaction are unable to be met, you shall ensure that the business of UHC and its affiliates is conducted only in the ordinary course, customer contracts are renewed as usual as in the ordinary course of business and that none of the assets of UHC or its affiliates are disposed of without the consent of AFCH. In addition, you shall ensure that during such period, UHCG shall not, without AFCH's prior written consent:
10.1 Declare any dividend or issue any form of cash outside the normal course of business, except as agreed in this Letter Agreement, or as agreed to by written permission of AFCH .
10.2 Make any distribution of its assets in any form without the written permission of AFCH;
10.3 Award any salary increase or approve any bonus payments, except those consistent with prior practice in the ordinary course of business; or as agreed to by written consent of AFCH;
10.4 Take any other action of any kind, which can be reasonably anticipated to impair or to reduce the value of the assets of UHC or its affiliates.

## 11. Servicing of UHCG Bank Debt

Upon Closing, Buyer on behalf of Seller shall be responsible to make all regular payments as they become due to Bank United on the outstanding loan made to UHCG by Bank United Syndication ("Lender") and standing on the books of UHCG in the principal amount of approximately Thirty Eight Million Dollars (\$38M) (the "Loan"). Provided however that any and all payments made or arranged by Buyer that are applied to the principal balance of the Loan (as such may be refinanced) shall be treated as a loan to Seller from Buyer and shall be offset against any proceeds due to Seller from the sale of AFCH.

## 12. Confidentiality / Non-disclosure

Except for such disclosure to the parties' professional advisors as may be necessary or appropriate and such disclosure as may be required by court order or by any law or regulation to which a party is subject or in order to defend litigation, the parties hereto agree that the parties shall use all reasonable efforts to maintain in confidence the existence and terms of this Agreement and the fact that the proposed transaction is under consideration and no party will issue any press release or public statement concerning this Agreement or any of the transactions contemplated hereby without the prior written consent of the other parties. Provided, however, that AFCH and UHC may make such disclosure as is required by law.


## 13. Costs

Whether or not the transaction contemplated by this Agreement is consummated, each of the parties (AFCH and UHC) shall bear their own costs arising out of and in connection with the preparation of this Agreement, the contract negotiations and closing the proposed transaction, including the fees and expenses of any accountants, lawyers, or other advisors retained by such party; provided however that the parties shall equally share the cost of the Form A filing to the Florida Office of Insurance Regulation and the HSR filing (if required).

## 14. Notices

Any notice or other communication required or permitted by this Agreement shall be in writing and shall be hand delivered or sent by facsimile transmission or by registered airmail, postage prepaid (provided that a copy of any notice sent by facsimile transmission shall also be sent by registered mail, postage prepaid) to the relevant party or parties at the address specified below or to such other address as such party may specify by notice to the other parties in accordance with this clause. All such notices shall be effective upon receipt.

If to AFCH :

Dr. Kiran C. Patel<br>President \& CEO<br>America's $1^{\text {st }}$ Choice Holdings of Flonida, LLC<br>5600 Mariner Street, Suite 200<br>Tampa, FL 33609<br>Facsimile Number: 813.506.6250

## If to you:

Dr. Akshay M. Desai
Chairman, Chief Executlve Officer Universal Health Care Group, Inc. 100 Central Avenue, Suite 200

St. Petersburg, FL 33701
Facsimile Number:

## 15. Governing Law

This Letter of Intent shall be governed by the laws of the State of Florida. Any action or proceeding against any party relating to this Agreement shall be brought in the courts of State of Florida.

## 16. Prior Agreements

This Agreement supersedes all prior written and oral understandings or agreements between the parties relating to the subject matter hereof.


## 17. Representations

Each of Buyer and Seller represents and warrants that each has all requisite power and authority to execute and deliver this Agreement. The Seller represents and warrants that the Company is not a party to or bound by any written or oral agreement or understanding with respect to a transaction involving the sale of the stock or assets of the Company other than this Agreement and the execution and delivery hereof will not breach any written or oral agreement to which the Company is a party.

If the foregoing is in accordance with your understanding, please so indicate by signing the enclosed copy of this Agreement where indicated and returning it to the undersigned no later than January 31, 2013.


Dr. Kiran C. Patel
President
America's $1^{\text {st }}$ Choice Holdings of Florida, LLC

The above terms correctly set forth our understanding with respect to the matters indicated above.
$\square$
Dr. Akshay.M. Desai
Chairman, CEO
Universal Health Care Group, Inc.
Universal Health Care, Inc
Universal HMO of Texas, Inc
Universal Health Care of Nevada, Inc
Dated: $\qquad$

## N THE CIRCUIT COURT OF THE SECOND JUDICIAL CIRCUIT, IN AND FOR LEON COUNTY, FLORIDA

State of Florida, ex rel., the Department of Financial Services of the State of Florida,

Relator,
v.

CASE NO: $\qquad$
Universal Health Care Insurance
Company, Inc.,
Respondent,

## ORDER APPOINTING THE FLORIDA DEPARTMENT OF

FINANCIAL SERVICES AS RECEIVER FOR PURPOSES OF LIQUIDATION, INJUNCTION AND NOTICE OF AUTOMATIC STAY

THIS CAUSE was considered on the Application of the State of Florida, Department of Financial Services (hereinafter the "Department") for an Order to Show Cause on the appointment of a Receiver of Universal Health Care, Inc. (hereinafter the "Respondent" or "UHCIC") for Purposes of Liquidation and Request for Expedited Hearing filed on February 4, 2013 (hereinafter, "Application"). After consideration, this Court entered its Order to Show Cause, Injunction and Automatic Stay, on $\qquad$ ——, 2013. A hearing was conducted on the Order to Show Cause on $\qquad$ , 2013, wherein the Department and Respondent appeared and presented evidence and argument related to the Department's allegations contained in its Application.

The Court, having reviewed and considered the pleadings of record, heard the evidence of the parties and arguments of counsel, and otherwise being fully informed in the premises, finds:

1. This Court has jurisdiction pursuant to Section 631.021(1), Florida Statutes, and venue is proper pursuant to Section 631.021 (2), Florida Statutes.
2. Respondent is a corporation authorized pursuant to the Florida Insurance Code to transact business in the state of Florida as a domestic life and health insurer since May 26, 2006. Respondent's principal place of business is located at 100 Central Avenue, Suite 200, St. Petersburg, Florida 33701.
3. Section 631.021(3), Florida Statutes, provides that a delinquency proceeding pursuant to Chapter 631, Florida Statutes, constitutes the sole and exclusive method of liquidating, rehabilitating, reorganizing, or conserving a Florida domiciled insurer.
4. Sections 631.031 and 631.061, Florida Statutes, authorize the Department to apply to this Court for an Order directing it to liquidate a domestic insurer upon the existence of any grounds specified in Section 631.051, Florida Statutes, or if an insurer is or is about to become insolvent.
5. Section 631.031 directs the Department to initiate such delinquency proceedings after receiving notification from the Director of the Office of Insurance Regulation as to the existing grounds for the initiation of such proceedings.
6. On February 1, 2013, pursuant to Section 631.031(1), Florida Statutes, Kevin McCarty, Commissioner of the Florida Office of Insurance Regulation ("Office"), advised by letter to Florida's Chief Financial Officer, Jeff Atwater, that the Office determined grounds existed for the initiation of delinquency proceedings against Respondent.
7. Respondent is found by the office to be in such condition as to render its further transaction of insurance hazardous to its policyholders, creditors, stockholders, or the public. Section $631.051(3)$, Florida Statutes. Accordingly, grounds exist pursuant to Sections $631.051(3)$ and 631.061 for entry of an Order appointing the Department as receiver of Respondent for purposes of Liquidation.
8. Pursuant to Sections 631.051 and 631.061 , Florida Statutes, this Court finds that it is in the best interests of Respondent, its creditors and its members that the relief requested in the Department's Application be granted. The Court further finds the Respondent to be insolvent pursuant to Section 631.061(1), Florida Statutes.

THEREFORE, IT IS ORDERED AND ADJUDGED as follows:
9. The Department of Financial Services of the State of Florida shall be and is hereby appointed Receiver of Respondent for purposes of liquidation effective immediately.
10. The Receiver shall be authorized and directed to:
A. Take immediate possession of all the property, assets, and estate, and all other property of every kind whatsoever and wherever located belonging to Respondent pursuant to Sections 631.111 and 631.141 , Florida Statutes, including but not limited to: offices maintained by Respondent, rights of action, books, papers, electronic records, evidences of debt, bank accounts, savings accounts, certificates of deposit, stocks, bonds, debentures and other securities, mortgages, furniture, fixtures, office supplies and equipment, wherever situate and however titled, whether in the possession of Respondent or its officers, directors, shareholders, trustees, employees, consultants, attorneys, agents or affiliates and all real property of Respondent, wherever
situate, whether in the possession of Respondent or its officers, directors, shareholders, trustees, employees, consultants, attorneys, agents or affiliates or other persons.
B. Liquidate the assets of Respondent, including but not limited to, funds held by Respondent's agents, subagents, producing agents, brokers, solicitors, service representatives or others under agency contracts or otherwise which are due and unpaid to Respondent, including premiums, unearned commissions, agents' balances, agents' reserve funds, and subrogation recoveries.
C. Employ and authorize the compensation of legal counsel, actuaries, accountants, clerks, consultants, and such assistants as it deems necessary, purchase or lease personal or real property as it deems necessary, and authorize the payment of the expenses of these proceedings and the necessary incidents thereof, as approved by the Court, to be paid out of the funds or assets of the Respondent in the possession of the Receiver or coming into its possession.
D. Reimburse such employees, from the funds of this receivership, for their actual necessary and reasonable expenses incurred while traveling on the business of this receivership.
E. Not defend or accept service of process on legal actions wherein Respondent, the Receiver, or the insured is a party defendant, commenced either prior to or subsequent to the order, without authorization of this Court; except, however, in actions where Respondent is a nominal party, as in certain foreclosure actions, and the action does not affect a claim against or adversely affect the assets of Respondent, the Receiver may file appropriate pleadings in its discretion.
F. Commence and maintain all legal actions necessary, wherever
necessary, for the proper administration of this receivership proceeding.
G. Collect all debts which are economically feasible to collect which are due and owing to Respondent.
H. Deposit funds and maintain bank accounts in accordance with Section 631.221, Florida Statutes.
I. Take possession of all of Respondent's securities and certificates of deposit on deposit with the Chief Financial Officer of Florida or any similar official of any other state, if any, and convert to cash as much as may be necessary, in its judgment, to pay the expenses of administration of this receivership.
J. Publish notice specifying the time and place fixed for the filing of claims with the Receiver once each week for three consecutive weeks in the Florida Administrative Weekly published by the Secretary of State, and at least once in the Florida Bar News and to publish notice by similar methods in all states where Respondents may have issued insurance policies.
K. Negotiate and settle subrogation claims and Final Judgments without further order of this Court.
L. Sell any salvage recovered property without further order of this Court.
M. Coordinate the operation of the Receivership with the Florida Health and Life Insurance Guaranty Association ("FLHIGA") pursuant to Part III, Chapter 631, Florida Statutes, as may be necessary. The Receiver may in its discretion, contract with the FLHIGA or other relevant guaranty associations to provide services as are necessary to carry out the purposes of Chapter 631.
N. Give notice of this proceeding to Respondent's agents pursuant to Section 631.341, Florida Statutes, and to its insureds, if any.
O. For purposes of this Order, the term "affiliate" shall be defined in accordance with Section 631.011(1), Florida Statutes and includes but is not limited to Universal Health Care, Inc., Universal Health Care Group, Inc., and American Managed Care, LLC.
P. The Receiver is granted all of the powers of the Respondent's directors, officers, and managers, whose authority is hereby suspended, except as such powers are re-delegated in writing by the Receiver. The Receiver has full power to direct and manage the affairs of Respondent, to hire and discharge employees, and to deal with the property and business of the Respondent.
Q. Apply to this Court for further instructions in the discharge of its duties as the Receiver deems necessary.

## IT IS FURTHER ORDERED AND DIRECTED:

11. Any officer, director, manager, trustee, administrator, attorney, agent, accountant, actuary, broker, employee, adjuster, independent contractor, or affiliate of Respondent and any other person who possesses or possessed any executive authority over, or who exercises or exercised any control over, any segment of Respondent's affairs or the affairs of its affiliates shall be required to fully cooperate with the Receiver, pursuant to Section 631.391, Florida Statutes, notwithstanding the provisions of the above paragraph. Any person who fails to cooperate with the Receiver, interferes with the Receiver, or fails to follow the instructions of the Receiver, may, at the Receiver's
discretion, be excluded from Respondent's business premises.
12. Title to all property, real or personal, all contracts, rights of action and all books and records of Respondent, wherever located, is vested in the Receiver pursuant to Sections 631.111 and 631.141, Florida Statutes.
13. All officers, directors, trustees, administrators, agents and employees and all other persons representing Respondent or currently employed or utilized by Respondent in connection with the Conduct of its business are discharged forthwith; provided, however, the Receiver may retain such persons in the Receiver's discretion.
14. All attorneys employed by Respondent as of the date of the Order, within 10 days notice of the Order, are required to report to the Receiver on the name, company claim number and status of each file they are handling on behalf of the Respondent. Said report shall also include an accounting of any funds received from or on behalf of the Respondent. All attorneys employed by Respondent shall be discharged as of the date of the Order unless their services are retained by the Receiver. All attorneys employed by Respondent shall be advised that pursuant to Section 631.011(21), Florida Statutes, a claim based on mere possession does not create a secured claim and all attorneys employed by Respondent, pursuant to $\ln \mathrm{Re}$ the Receivership of Syndicate Two, Inc., 538 So.2d 945 (Fla. $1^{\text {st }}$ DCA 1989), who are in possession of litigation files or other material, documents or records belonging to or relating to work performed by the attorney on behalf of Respondent shall be required to deliver such litigation files, material, documents or records intact and without purging to the Receiver, on request, notwithstanding any claim of a retaining lien which, if otherwise valid, shall not be extinguished by the delivery of these documents.
15. All agents, brokers or other persons having sold policies of insurance and/or collected premiums on behalf of the Respondent shall be required to account for and pay all premiums and commissions unearned due to cancellation of policies by the Order or in the normal course of business owed to the Respondent directly to Receiver within 30 days of demand by the Receiver or appear before this Court to show cause, if any they may have, as to why they shall not be required to account to the Receiver or be held in contempt of Court for violation of the provisions of the Order. No agent, broker, premium finance company or other person shall use premium monies owed to the Respondent for refund of unearned premium or for any purpose other than payment to the Receiver.
16. Any premium finance company which has entered into a contract to finance a premium for a policy which has been issued by the Respondent shall be required to pay any premium owed to the Respondent directly to the Receiver.
17. Reinsurance premiums due to or payable by Respondent shall be remitted to, or disbursed by, the Receiver. Reinsurance losses recoverable or payable by Respondent shall be handled by the Receiver. All correspondence concerning reinsurance shall be between the Receiver and the reinsuring company or intermediary.
18. Upon request by the Receiver, any company providing telephonic services to Respondent shall be required to provide a reference of calls from the number presently assigned to Respondent to any such number designated by the Receiver or perform any other services or changes necessary to the conduct of the receivership.
19. Any bank, savings and loan association, or other financial institution which
has on deposit, in its possession, custody or control any funds, accounts and any other assets of Respondent, shall be required to immediately transfer title, custody and control of all such funds, accounts and other assets to the Receiver. The Receiver shall be authorized to change the name of such accounts and other assets, withdraw them from such bank, savings and loan association or other financial institution, or take any lesser action necessary for the proper conduct of this receivership. No bank, savings and loan association or other financial institution shall be permitted to exercise any form of set-off, alleged set-off, lien, any form of self-help whatsoever, or refuse to transfer any funds or assets to the Receiver's control without the permission of this Court.
20. Any entity furnishing telephone, water, electric, sewage, garbage or trash removal services to Respondent shall be required to maintain such service and transfer any such accounts to the Receiver as of the date of the Order, unless instructed to the contrary by the Receiver.
21. Any data processing service, which has custody or control of any data processing information and records including but not limited to source documents, data processing cards, input tapes, all types of storage information, master tapes or any other recorded information relating to Respondent is directed to transfer custody and control of such records to the Receiver. The Receiver shall be authorized to compensate any such entity for the actual use of hardware and software which the Receiver finds to be necessary to this proceeding. Compensation should be based upon the monthly rate provided for in contracts or leases with Respondent which was in effect when this proceeding was instituted, or based upon such contract as may be negotiated by the Receiver, for the actual time such equipment and software is used by the

Receiver.
22. The United States Postal Service shall be directed to provide any information requested by the Receiver regarding Respondent and to handle future deliveries of Respondent's mail as directed by the Receiver.
23. All claims shall be filed with the Receiver on or before 11:59:59 p.m. EST, on the date of one year following the entry of this Order, or be forever barred, and all such claims shall be filed on proof of claim forms prepared by the Receiver.
24. In order to assure the validity of claim assignments, to assure that the processing of assignments does not create an undue burden on estate resources, and to assure that assignment decisions are made using the best information available, the Receiver shall not recognize or accept any assignment of claim by the claimant of record unless the following criteria are met:
A. A distribution petition has not been filed with this Court;
B. The Receiver has been provided with a properly executed and notarized assignment of claim agreement entered into between the parties; and
C. The Receiver has been provided with a properly executed and notarized Receiver's Assignment of Claim Change Form and required supporting documentation.
D. The Receiver's Assignment of Claim Change Form shall contain an acknowledgement by the claimant, or someone authorized to act on behalf of the claimant, that:

1. The claimant is aware that financial information regarding
claims distributions and payments published on the Receiver's website or otherwise available can assist the claimant in making an independent and informed decision regarding the sale of the claim;
2. The claimant understands that the purchase price being offered in exchange for the assignment may differ from the amount ultimately distributed in the receivership proceeding with respect to the claim;
3. It is the claimant's intent to sell their claim and have the Receiver's records be permanently changed to reflect the new owner; and
4. The claimant understands that that they will no longer have any title, interest, or rights to the claim including future mailings and distributions if they occur.
5. All executory contracts to which the Respondent was a party shall be cancelled and stand cancelled unless specifically adopted by the Receiver within ninety (90) days of the date of this Order or from the date of the Receiver's actual knowledge of the existence of such contract, whichever is later. "Actual Knowledge" means the Receiver has in its possession a written contract to which the Respondent is a party, and the Receiver has notified the vendor in writing acknowledging the existence of the contract.

Further, the Receiver shall have the authority to do the following:

1) Pay for services provided by any of Respondent's vendors, in the ninety (90) day period prior to assuming or rejecting the contract, which are necessary to administer the Receivership estate;
2) Once the Receiver determines Respondent's vendor is necessary in the continued administration of the Receivership estate for a period to exceed the ninety (90) days from the date of this order, or form the date of Receiver's actual knowledge of such contract, whichever is later, the Receiver may make minimal modifications to the terms of the contract, including, but not limited to, the expiration date of the agreement, the scope of the services to be provide, and/or the compensation to be paid to Respondent's vendor pursuant to the contract. "Minimal Modifications" shall mean any minimum alteration made to the contract in order to adapt to the new circumstances of the Receivership estate. In no event will any minimal modification be construed as the receiver entering into a new contract with Respondent's vendor.

Any vendor, including but not limited to, any and all employees / contractors of insurer, claiming the existence of a contractual relationship with the insurer shall provide notice to the Receiver of such relationship. This notice shall include any and all documents and information regarding the terms and conditions of the contract, including a copy of the written contract between the vendor and the insurer, if any, what services or goods were provided pursuant to the contract, any current, future and/or past due amounts owing under the contract, and any supporting documentation for third party services or goods provided. Failure to provide the required information may result in vendors' contractual rights not being recognized by the Receiver. The rights of the parties to any such contracts are fixed as of the date of the Order and any cancellation under this provision shall not be treated as an anticipatory breach of such contracts.
26. All affiliated companies and associations, including but not limited to Universal Health Care, Inc., Universal Health Care Group, Inc., and American Managed Care, LLC., shall make their books and records available to the Receiver (including electronic records), to include all records located in any premises occupied by said affiliate, whether corporate records or not, and to provide copies of any records requested by the Receiver whether or not such records are related to Respondent. The Receiver shall have title to all policy files and other records of, and relating to Respondent, whether such documents are kept in offices occupied by an affiliate company or any other person, corporation, or association. The Receiver shall be authorized to take possession of any such records, files, and documents, and to remove them to any location in the Receiver's discretion. Any disputed records shall not be withheld from the Receiver's review, but shall be safeguarded and presented to this Court for review prior to copying by the Receiver.
27. The Receiver shall have complete access to and administrative control of all information technology resources of the Respondent and its affiliates at all times including, but not limited to, Respondent's computer hardware, software and peripherals. Each affiliate shall be given reasonable access to such records for the purpose of carrying out its business operations.
28. Any person, firm, corporation or other entity having notice of the Order that fails to abide by its terms is directed to appear before this Court to show good cause, if any they may have, as to why they shall not be held in contempt of Court for violation of the provisions of this Order.
29. Except as noted in the following paragraph, pursuant to the provisions of
631.252, Florida Statutes, all policies of insurance or similar contracts of coverage that have not expired are cancelled effective 12:01 a.m. EST on the date of liquidation. Policies or contracts of coverage with normal expiration dates prior to the dates otherwise applicable under this paragraph, or which are terminated by insureds or lawfully cancelled by the Receiver or insurer before such date, shall stand cancelled as of the earlier date.
30. Pursuant to Sections $631.041(3)$ and (4), Florida Statutes, all persons, firms, corporations and associations within the jurisdiction of this Court, including, but not limited to, Respondent and its officers, directors, stockholders, members, subscribers, agents and employees, are enjoined and restrained from the further transaction of the insurance business of the Respondent; from doing, doing through omission, or permitting to be done any action which might waste or dispose of the books, records, including but not limited to electronic records, and assets of the Respondent; from in any means interfering with the Receiver or these proceedings; from the transfer of property and assets of Respondent without the consent of the Receiver; from the removal, concealment, or other disposition of Respondent's property, books, records, and accounts; from the commencement or prosecution of any actions against the Respondent or the Receiver together with its agents or employees, the service of process and subpoenas, or the obtaining of preferences, judgments, writs of attachment or garnishment or other liens; and, from the making of any levy or execution against Respondent or any of its property or assets. Notwithstanding the provisions of this paragraph, the Receivers should be permitted to accept and be subpoenaed for non-party production of claims files in its possession, including medical records, which
may be contained therein. In such cases, the requesting party must submit an affidavit to the Receiver stating that notice of the non-party production was appropriately issued and provided to the patient and that the patient was given the opportunity to object and either did not object to the non-party production, or objected and the Court overruled the objection, in which case a copy of the Court's ruling must be attached to the affidavit. The Receiver should be authorized to impose a charge for copies of such claim files pursuant to the provisions of Sections 119.07(1)(a), and 624.501, Florida Statutes.
31. All subsidiaries, affiliates, parent corporations, ultimate parent corporations, and any other business entity affiliated with Respondent shall fully cooperate with the Receiver in the effort to liquidate Respondent.
32. All subsidiaries, affiliates, parent corporations, ultimate parent corporations, and any other business entity affiliated with Respondent having any interest in the building located at 100 Central Avenue, Suite 200, St. Petersburg, Florida, 33701, or any other facility in which Respondent may operate, shall make available, at that location and at no charge to the Receiver or to Respondent, office space, and related facilities (telephone service, copiers, computer equipment and software, office supplies, parking, etc.) to the extent deemed necessary by the Receiver in its sole discretion.
33. All subsidiaries, affiliates, parent corporations, ultimate parent corporations, and any other business entity affiliated with Respondent having any interest in the computer equipment and software currently used by or for Respondent shall make such computer equipment and software available to the Receiver at no
charge to the Receiver or Respondent to the extent deemed necessary by the Receiver in its sole discretion.

## CONTINUATION OF INVESTIGATION

34. The Receiver shall be authorized to conduct an investigation as authorized by Section 631.391, Florida Statutes, of Respondent and its affiliates, as defined above, to uncover and make fully available to the Court the true state of Respondent's financial affairs. In furtherance of this investigation, Respondent and its affiliate shall be required to make all books, documents, accounts, records, and affairs, which either belong to or pertain to Respondent, available for full, free and unhindered inspection and examination by the Receiver during normal business hours (8:00 a.m. to 5:00 p.m.) Monday through Friday, from the date of the Order. Respondent and the above specified entities shall be required to cooperate with the Receiver to the fullest extent required by Section 631.391, Florida Statutes. Such cooperation shall include, but not be limited to, the taking of oral testimony under oath of Respondent's officers, directors, managers, trustees, agents, adjusters, employees, or independent contractors of Respondent, its affiliates and any other person who possesses any executive authority over, or who exercises any control over, any segment of the affairs of Respondent in both their official, representative and individual capacities and the production of all documents that are calculated to disclose the true state of Respondent's affairs.
35. Any officer, director, manager, trustee, administrator, attorney, agent, accountant, actuary, broker, employee, adjuster, independent contractor, or affiliate of Respondent and any other person who possesses or possessed any executive authority
over, or who exercises or exercised any control over, any segment of the affairs of Respondent or its affiliates shall be required to fully cooperate with the Receiver as required by Section 631.391, Florida Statutes, and as set out in the preceding paragraph. Upon receipt of a certified copy of the Order, any bank or financial institution shall be required to immediately disclose to the Receiver the existence of any accounts of Respondent and any funds contained therein and any and all documents in its possession relating to Respondent for the Receiver's inspection and copying.
36. All Sheriffs and all law enforcement officials of this state shall cooperate with and assist the Receiver in the implementation of this Order.
37. In the event the Receiver determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the Respondent is appropriate, the Receiver shall prepare a plan to effect such changes and submit the plan to this Court for consideration.

## NOTICE OF AUTOMATIC STAY

38. Notice is hereby given that, pursuant to Section 631.041(1), Florida Statutes, the filing of the Department's initial petition herein operates as an automatic stay applicable to all persons and entities, other than the Receiver, which shall be permanent and survive the entry of this order, and which prohibits:
A. The commencement or continuation of judicial, administrative or other action or proceeding against the insurer or against its assets or any part thereof;
B. The enforcement of judgment against the insurer or an affiliate, provided that such affiliate is owned by or constitutes an asset of Respondent, obtained either before or after the commencement of the delinquency proceeding;
C. Any act to obtain possession of property of the insurer;
D. Any act to create, perfect or enforce a lien against property of the insurer, except a secured claim as defined in Section 631.011(21), Florida Statutes;
E. Any action to collect, assess or recover a claim against the insurer, except claims as provided for under Chapter 631;
F. The set-off or offset of any debt owing to the insurer except offsets as provided in Section 631.281, Florida Statutes.
39. This Court retains jurisdiction of this cause for the purpose of granting such other and further relief as from time to time shall be deemed appropriate.

DONE and ORDERED in Chambers at the Leon County Courthouse in Tallahassee, Florida this $\qquad$ day of $\qquad$ 2013.

Copies furnished to:
Robert V. Elias, Esq.
Timothy Newhall, Esq.
Lourdes Calzadilla, Esq.
Jody E. Collins, Esq.


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