REPORT ON EXAMINATION

OF

CATHOLIC SPECIAL NEEDS PLAN, LLC

AS OF

DECEMBER 31, 2010

DATE OF REPORT	**SEPTEMBER 12, 2013**
EXAMINER	**KAIWEN K. GUO**

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September 12, 2013

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Number 30651, dated January 26, 2011, attached hereto, I have made an examination into the condition and affairs of Catholic Special Needs Plan, LLC, d/b/a ArchCare Advantage, a not-for-profit health maintenance organization ("HMO") licensed under the provisions of Article 44 of the New York Public Health Law, as of December 31, 2010, and submit the following report thereon.

The examination was conducted at the home office of Catholic Special Needs Plan, LLC located at 205 Lexington Avenue, New York, New York.

Wherever the designations "the Plan" or "ArchCare" appear herein, without qualification, they should be understood to indicate Catholic Special Needs Plan, LLC.

Wherever the designation "the Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF THE EXAMINATION

Catholic Special Needs Plan, LLC began writing business in January of 2008. This is the first examination that has been performed on the Plan. This examination was a combined (financial and market conduct) examination and covers the three-year period January 1, 2008, through December 31, 2010. The financial component of the examination was conducted as a financial examination, as defined in the National Association of Insurance Commissioners ("NAIC") *Financial Condition Examiners Handbook, 2011 Edition* ("the Handbook"). The examination was conducted observing the guidelines and procedures in the Handbook and where deemed appropriate by the examiner, transactions occurring subsequent to December 31, 2010, were reviewed.

The financial portion of the examination was conducted on a risk-focused basis, in accordance with the provisions of the Handbook, which provides guidance for the establishment of an examination plan based on the examiner's assessment of risk in the Plan's operations, and utilizes that evaluation in formulating the nature and extent of the examination. The risk-focused examination approach was included in the Handbook for the first time in 2007. The examiner planned and performed the examination to evaluate the Plan's current financial condition, as well as identify prospective risks that may threaten the future solvency of the Plan.

The examiner identified key processes, assessed the risks within those processes and assessed the internal control systems and procedures used to mitigate those risks. The examination also included an assessment of the principles used and significant estimates made by

management, an evaluation of the overall financial statement presentation, and determined management's compliance with the Department's statutes and guidelines and annual statement instructions.

Information concerning the Plan's organizational structure, business approach and control environment were utilized to develop the examination approach. The examination evaluated the Plan's risks and management activities in accordance with the NAIC's nine branded risk categories.

These categories are as follows:

- Pricing/Underwriting
- Reserving
- Operational
- Strategic
- Credit
- Market
- Liquidity
- Legal
- Reputation

The Plan was audited annually for the years 2008 through 2010, by the accounting firm O'Connor, Davis, Munns & Dobbins, LLP. The Plan received an unqualified opinion in each of those years. Certain audit workpapers of O'Connor, Davis, Munns & Dobbins, LLP were reviewed and relied upon in conjunction with this examination. The guidelines and procedures in the Handbook require a review of insurers' internal audit function and Enterprise Risk Management program. However, the Plan did not have an internal audit function and it has not adopted an Enterprise Risk Management program. Additionally, it was noted that the Plan also

did not have an Audit Committee. The entire Board (known as the "Management Committee"), among their other duties, also acts in the capacity of an Audit Committee for the Plan. The Plan's audit function is solely relied on the aforementioned external accounting firm.

This report on examination is confined to financial statements and comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

2. DESCRIPTION OF THE PLAN

Catholic Special Needs Plan, LLC d/b/a ArchCare Advantage is a Medicare Advantage Special Needs Plan. Under the Medicare Modernization Act ("MMA") of 2003, Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. Special needs plans ("SNP") were allowed to target enrollment to one or more types of specials needs individuals identified by Congress as: 1) institutionalized; 2) dually eligible for both Medicare and Medicaid; and 3) individuals with severe or disabling chronic conditions.

The Plan was incorporated under the laws of New York State as an Article 44 Health Maintenance Organization on March 6, 2007, and commenced business on January 1, 2008. The Plan enrolls Medicare eligible individuals who are eligible for nursing homes and senior needs facilities for more than 90 days. The Plan is exempt from income tax.

The Plan is a wholly owned subsidiary of Catholic Health Care System, Inc. ("CHCS"), which was established principally to provide support services and coordination of managed care,

medical affairs, management information systems and other services to CHCS, under which, CHCS provides finance, information systems, human resources, and legal services to the Plan.

The Plan is incorporated as a not-for-profit organization and is exempt from income tax under Section 501(c)(3) of the Internal Revenue Code. In June 2007, the Plan received two separate loans under Section 1307 of the New York Insurance Law; one from its Parent, CHCS and the other from its affiliate, Kateri Residence, in the amounts of $4,000,000 and $750,000, respectively.

On July 7, 2007, the Department of Health issued a Certificate of Authority authorizing the Plan to operate in Bronx, New York and Richmond counties. Medicare Advantage Plan ("MAP") is the only line of business of the Plan. Total written for the MAP line of business was $28,244,994 for calendar year 2010.

A. Management and Controls

Section 5.1 of the Plan's Operating Agreement ("the Agreement") provides that management of the Plan shall be vested in a Management Committee. The number of directors comprising the Management Committee shall be fixed from time to time by the Parent company, Catholic Health Care System, Inc. ("CHCS"). The Agreement stated that there shall be three directors. It should be noted that no less than one third of the directors shall be residents of New York State, as required by Part 98-1.11(g)(1) of the Administrative Rules and Regulations of the Health Department (10 NYCRR 98-1.11), and within one year of the Plan becoming operational no less than twenty percent (20%) of the directors shall be enrollees of the Plan. However, in lieu of such requirement, the Management Committee may establish an Enrollee Advisory

Council which is representative of the Plan's enrollment. As of December 31, 2010, the Enrollee Advisory Council consisted of five (5) enrollee members.

The members of the Plan's Management Committee as of December 31, 2010 were as follows:

Name and Residence	Principal Business Affiliation
Karl P. Adler, MD New York, NY	President and Chief Executive Officer New York Medical College
Frank A. Calamari Pelham Manor, NY	President and Chief Executive Officer Calvary Hospital
Francis J. Serbaroli, Esq Greenwich, CT	Shareholder Greenberg Trauring, LLP
Gerald Sweeney New York, NY	Senior Director CIGNA

A review of the attendance records of the Management Committee's meetings held during the period under examination revealed that the meetings were generally well attended, with all of the members attending at least one-half of the meetings they were eligible to attend.

The principal officers of the Plan as of December 31, 2010 were as follows:

Name	Title
James Introne	Chief Executive Officer
Annmarie Covone	Chief Financial Officer

B. Corporate Governance

Exhibit M of the Handbook (Understanding the Corporate Governance Structure) was utilized by the examiners as guidance for assessing corporate governance. Overall, it was determined that the Plan's corporate governance structure was adequate, sets an appropriate

"tone at the top", supports a proactive approach to operational risk management, and contributes

to an effective system of internal controls. It was found that the Plan's Management Committee and key executives encourage integrity and ethical behavior throughout the Plan, and that senior management promotes a corporate culture that acknowledges, understands and maintains an effective control environment.

The Plan's management has an adequate approach to identifying and mitigating risks across the organization, including prospective business risks. The Plan deals proactively with its areas of risk, and its management is knowledgeable about mitigation strategies. Through risk discussions and other measures, the Plan's management discusses significant issues and reacts to changes in the environment with a clear commitment to address risk factors and manage the business accordingly. The Plan's overall risk management process takes a proactive approach to identifying, tracking, and dealing with significant current and emerging risk factors.

C. Territory and Plan of Operation

The New York State Department of Health ("NYSDOH") issued a Certificate of Authority to Catholic Special Needs Plan, LLC, d/b/a ArchCare Advantage, effective June 5, 2007, pursuant to Article 44 of the New York Public Health Law. The certificate authorized the Plan to offer Medicare products in Bronx, New York and Richmond counties. Two amendments to the Certificate of Authority were issued on November 12, 2007 and May 1, 2009, respectively, to reflect the NYSDOH's approval of the Plan's expansion application to serve the Medicare population in the following additional five (5) counties: Dutchess, Kings, Orange, Queens and Westchester.

The certificate contained the following conditions and limitations:

> "*Catholic Special Needs Plan is limited to enrolling and offering only Medicare products in these counties. All aspects of operation in these Medicare only counties will be governed primarily by the Center for Medicare and Medicaid Services ("CMS"), and implementation is contingent upon securing a Medicare contract with the Federal government."*

D. Enrollment

The Medicare Advantage Plan is the only line of business written by the Plan. During the examination period January 1, 2008 through December 31, 2010, the Plan experienced a net increase in enrollment of 778 members. An analysis of the enrollment is set forth below:

	2008	**2009**	**2010**
Enrollment at January 1,	138	410	580
Net gain	272	170	336
Enrollment at December 31,	410	580	916

E. Reinsurance

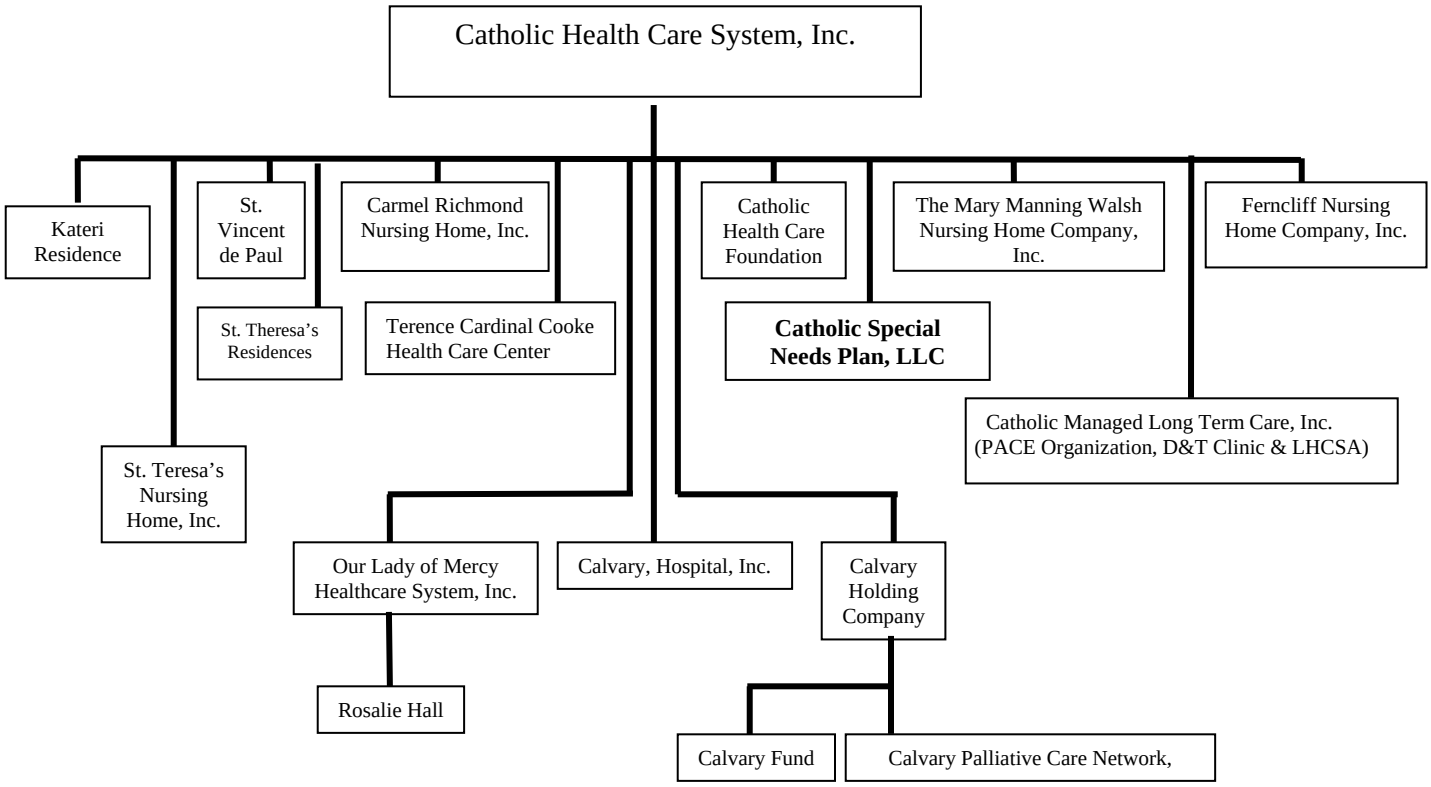
As of December 31, 2010, the Plan had an excess-of-loss reinsurance contract in effect with HCC Life Insurance Company, an authorized reinsurer. The contract's effective date was January 1, 2010 to December 31, 2010. Additionally, the Plan had excess-of-loss reinsurance contracts with HCC Life Insurance Company covering the periods January 1, 2008 to December 31, 2008 and January 1, 2009 to December 31, 2009.

The reinsurance coverage in effect as of December 31, 2010, was as follows:

Covered member type:	Medicare
Excess-of-loss retention:	$75,000 per member per agreement period
Policy limit:	$1,000,000 per member per agreement period

F. Holding Company System

The Plan is a wholly-owned subsidiary of Catholic Health Care System, Inc. The following chart depicts the Plan's holding company system as of December 31, 2010:



The Plan is a member of a holding company system. However, it was noted that the Plan answered "No" in the General Interrogatories page of its filed 2010 annual statement when asked

whether the reporting entity is a member of an insurance holding company system consisting of two or more affiliated persons, one or more of which is an insurer.

It is recommended that the Plan accurately report all information in its filed annual statement.

G. Disaster Response and Business Continuity Plans

Department Circular Letter No. 2 (2010) states in part (Circular Letters with similar requirements are issued by the Department annually):

> "…By June 1, 2011, each company must submit a Disaster Response Plan to the Insurance Department. Entities may provide their completed disaster response plans to the Insurance Department via the Insurance Department Portal Application or by hard copy…
>
> …By June 1, 2011, the Disaster Response Questionnaire must be submitted to the Insurance Department via the Insurance Department Portal Application or in hard copy…
>
> …By June 1, 2011, the Business Continuity Plan Questionnaire must be submitted to the Insurance Department via the Insurance Department Portal Application or in hard copy…"

The examination revealed that the Plan did not file its Disaster Response Plan, Disaster Response Questionnaire or its Business Continuity Plan Questionnaire during the period under examination.

It is recommended that the Plan comply with the requirements of Circular Letter No. 2 (2010) and file its Disaster Response Plan, Disaster Response Questionnaire, and Business Continuity Plan Questionnaire on an annual basis with the Department.

H. Conflict of Interest Policy

The examination included a review of how the Plan handles conflicts of interest. The Plan's Board and Officer Conflict of Interest Policy provides that each manager, Officer, and member of the senior staff sign a statement within thirty (30) days of assuming such responsibility. The examination revealed that during December 2009, the company changed the signature requirement by adopting an electronic signature format which required disclosure through email rather than the original requirement of signed hard copy. However, it should be noted that the Plan's Conflict of Interest Policy was never updated to reflect such change.

It is recommended that the Plan revise its Conflict of Interest Policy to reflect its adoption of using electronic signatures for conflict of interest disclosures.

I. Department Regulation No. 118 (11 NYCRR 89.0)

The Plan is subject to the requirements of Department Regulation No. 118 (11 NYCRR 89.0) – *Audited Financial Statements,* which is patterned after the NAIC's Annual Financial Reporting Model Regulation, otherwise known as the Model Audit Rule ("MAR"). Department Regulation No. 118 (11 NYCRR 89.0), which became effective January 1, 2010, applies certain requirements to the Department's regulated entities with regard to CPA qualifications and duties.

Part 5(e)(2) of Department Regulation No. 118 (11 NYCRR 89.0) states:

> *"(5)(e)(2) The company shall attach a statement to its audited financial statement, when filed, that the CPA does not function in the role of management, does not audit his or her own work, and does not serve in an advocacy role for the company."*

The examination revealed that no such statement was attached to the Plan's annual filings for the examination period.

It is recommended that the Plan comply with Part 5(e)(2) of Department Regulation No. 118 and attach the required statement with its annual filings.

J. Accounts and Records

During the course of the examination, it was noted that the Plan's treatment of certain items was not in accordance with annual statement instructions and/or Department guidelines. A description of such items is as follows:

1. As noted previously in Item 2 of this Report, since inception, the Plan obtained two (2) capital infusions in the form of Section 1307 loans. The initial capital infusion of $750,000 was followed by a subsequent capital infusion of $4,000,000. These capital infusions were made on June 8, 2007 and June 11, 2007, respectively.

Section 1307(c) of the New York Insurance Law states:

> "Any sum so advanced or borrowed shall not be part of the legal liabilities of such insurer and shall not be a basis of any set-off but until repaid all statements published by such insurer or filed with the superintendent shall show, as a footnote, the amount then remaining unpaid."

During the examination period, it was noted that the Plan's financial statement failed to include a footnote regarding the two outstanding Section 1307 loans and their respective interest, as required by Section 1307(c) of the New York Insurance Law.

It is recommended that the Plan comply with the requirements of Section 1307(c) of the New York Insurance Law and include a footnote for all outstanding Section 1307 loans and their respective interest amounts in its filed annual statements.

2. The 2010 *NAIC Annual Statement Instructions* for health insurance companies states in part:

> *"There is to be included on or attached to Page 1 of the annual statement, the statement of the appointed actuary setting forth his her opinion relating to claim reserves and any other actuarial items. The appointed actuary must be a qualified health actuary appointed by the board of directors, or its equivalent, or by a committee of the board… "Qualified health actuary", as used herein means a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation."*

The examination revealed that during the examination period, all Statements of Actuarial Opinion were prepared and signed by the Director of Financial Services of the Plan. According to management of the Plan, the Plan does not have an actuary on staff to review the reserve calculation. It did, however, have an external actuary performed the reserve calculation for credibility.

It is recommended that the Plan implement procedures to have the Statement of Actuarial Opinion prepared and signed by a qualified health actuary as defined in the NAIC Annual Statement Instructions.

3. Reporting entities are required to file a supplement to the annual statement titled "Management Discussion and Analysis" ("MD&A"). A review of the MD&A indicated that it was not prepared in accordance with the NAIC Annual Statement Instructions.

The *2010 NAIC Annual Statement Instructions* for health insurance companies provides detailed requirements for what should be included in the Plan's filed Management's Discussion & Analysis. The *2010 NAIC Annual Statement Instructions* for health insurance companies states in part:

> *"…The discussion shall provide information as specified in paragraphs that follow and also shall provide such other information that the reporting entity believes to be necessary for an understanding of its financial condition, changes in financial condition and results of operations…*
>
> *The MD&A requirements are intended to provide, in one section, material historical and prospective textual disclosure enabling regulators to assess the financial condition and results of operations of the reporting entity…*
>
> *Generally, the discussion shall cover the two year period covered by the financial statements and shall use year-to-year comparisons or any other formats that in the reporting entity's judgment enhance a regulator's understanding…*
>
> *Disclosure of known trends or uncertainties that the reporting entity reasonably expects will have a material impact on premium, net income or other gains/losses in surplus is also encouraged…"*

Upon review of the Plan's MD&A for calendar year 2010, it was noted that the above-mentioned required items were not included. Such required information is needed in order to provide an accurate historical and prospective assessment of the financial condition of the Plan.

It is recommended that the Plan, when filing its Management's Discussion and Analysis, comply with the requirements of the NAIC Annual Statement Instructions.

4. As noted previously in "Item F" of this report, the Plan is a wholly-owned subsidiary of Catholic Health Care System, Inc. It should be noted that several other affiliated entities ("affiliates") of the Plan also have business transactions with the Plan. These affiliates are participating providers functioning as nursing homes located in the Plan's service area. The Plan makes claim payments on behalf of these nursing homes. Claim payments to these nursing homes during 2010 were in the range from $22,740 to $1,441,665.

The *2010 NAIC Annual Statement Instructions* for health companies states:

> *"PART 1- ORGANIZATION CHART…Attach a chart or listing presenting the identities of and interrelationships between the parent, all affiliated insurers and reporting entities; and other affiliates…*
>
> *PART 2- SUMMARY OF INSURER'S TRNSACTIONS WITH ANY AFFILIATES – This schedule was designed to provide an overview of transactions among insurance holding company system members. It is intended to demonstrate the scope and direction of major fund and/or surplus flows throughout the system… All insurer and reporting entity members of the holding company system shall prepare a common schedule for inclusion in each of the individual annual statement…*
>
> *Include transactions between insurers; and between insurers and non-insurers within the holding company system…"*

The examiner's review of the Plan's filed Schedule Y- *Information Concerning Activities of Insurer Members of a Holding Company Group* - for calendar year 2010 revealed that the Plan filed an incomplete organization chart; the Schedule only listed transactions of the Parent and itself and did not list any transactions with any of the other affiliates that were listed in Schedule Y, Part 2 – *Summary of Insurer's Transactions with any Affiliates*.

It is recommended that the Plan prepare and file Schedule Y- *Information Concerning Activities of Insurer Members of a Holding Company Group* - in accordance with the requirements of the NAIC Annual Statement Instructions.

It is also recommended that the Plan exercise greater care when preparing its annual statements and schedules thereof.

FINANCIAL STATEMENTS

A. Balance Sheet

The following compares the assets, liabilities and capital and surplus as determined by this examination with those reported by the Plan in its filed annual statement as of December 31, 2010:

Assets	Examination	Plan
Cash, cash equivalents and short-term investments	$ 10,314,897	$ 10,314,897
Investment income due and accrued	4,598	4,598
Uncollected premiums and agents balance in the course of collection	688,474	688,474
Receivables from parent, subsidiaries and affiliates	259,805	259,805
Total assets	$ 11,267,774	$ 11,267,774
Liabilities		
Unpaid claims	$ 5,146,316	$ 5,146,316
General expenses due or accrued	1,826,783	1,826,783
Total liabilities	$ 6,973,099	$ 6,973,099
Capital and surplus		
NYS escrow account	$ 1,334,223	$ 1,334,223
NYS contingent reserve	802,351	802,351
Surplus notes	4,750,000	4,750,000
Unassigned funds (surplus)	(2,591,899)	(2,591,899)
Total capital and surplus	4 ,294,675	4 ,294,675
Total liabilities, capital and surplus	$ 11,267,774	$ 11,267,774

Note 1: The Plan is incorporated as a not-for-profit organization and is exempt from income tax under Section 501(c)(3) of the Internal Revenue Code.

Note 2: Pursuant to Section 1307 of the New York Insurance Law, no liability appears in the statement for loans in the amount of $4,750,000. The principal and interest may be repaid only with the permission of the Superintendent of Insurance.

B. Statement of Revenue, Expenses and Capital and Surplus

Capital and Surplus decreased by $ 455,325 during the examination period, January 1, 2008 through December 31, 2010, detailed as follows:

Revenue		
Net premium income		$ 56,302,252
Hospital and medical expenses		
Hospital/medical benefits	$ 21,310,262	
Other professional services	14,866,451	
Emergency room and out-of-area	1,239	
Prescription drugs	6,771,827	
Net reinsurance recoveries	(328,559)	
Total medical and hospital expenses	$ 42,621,220	
Administrative expenses		
General administrative expenses	12,856,706	
Total underwriting expenses		55,477,926
Net underwriting gain		$ 824,326
Net investment income earned		84,290
Net income		$ 908,616

Changes in Capital and Surplus

Capital and surplus at date of certificate of authority - July 7, 2007*			$ 4,750,000
	Gains in Surplus	Losses in Surplus	
Net gain in surplus	$ 908,616		
Change in non-admitted assets		518,709	
Aggregate write-ins for loss in surplus		845,232	
Net decrease in capital and surplus			(455,325)
Capital and surplus, per report on examination, as of December 31, 2010			$ 4,294,675

*Note: The Plan acquired its certificate of authority on July 7, 2007, five months prior to the period under examination, but did not commence business until January 1, 2008. In June 2007, the Plan received two separate loans under Section 1307 of the New York Insurance Law; one from its Parent, CHCS and the other from its affiliate, Kateri Residence, in the amounts of $4,000,000 and $750,000, respectively. It should be noted that the Plan did report pre-operational losses (losses occurring prior to January 1, 2008) and such losses are reflected in the statement above.

4. UNPAID CLAIMS

The examination liability of $5,146,316 is the same the amount reported by the Plan in its filed annual statement as of December 31, 2010.

The examination analysis of the accrued other medical liability was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination. The examination reserve was based upon actual payments made through December 31, 2010, with an estimate for claims remaining unpaid at that date. Such estimate was calculated based on actuarial principles, which utilized the Plan's past experience in projecting the ultimate cost of claims incurred.

5 UNPAID CLAIMS ADJUSTMENT EXPENSES

The examination liability of unpaid claims adjustment expense is $89,000 more than the amount reported by the Plan in its filed annual statement as of December 31, 2010. Upon the review of the Department's actuaries, it was noted that the Plan did not account for the expenses associated with the payment of its claims by CHCS. Such payments are based on service agreements the Plan has with CHCS. An insurance industry percentage was utilized to determine the estimated amount of the captioned liability.

The examination analysis of the unpaid claims adjustment expenses liability was conducted in accordance with generally accepted actuarial principles and practices and was based on statistical information contained in the Plan's internal records and in its filed annual statements as verified during the examination.

It should be noted that no change was made to the account due to the immateriality (less than 5% of surplus) of the amount, however a reserve for the liability should be established for future payment of administrative expenses associated with the payment of claims.

It is recommended that the Plan establish a reserve for the liability of expenses associated with the administrative expenses for processing claims.

6. MARKET CONDUCT ACTIVITIES

In the course of this examination, a review was made of the manner in which the Plan conducts its business and fulfills its contractual obligations to enrollees and claimants. The review was general in nature and is not to be construed to encompass the more precise scope of a market conduct examination. The review was directed at the practices of the Plan relative to agents' licensing and terminations. In determining the scope of this review, the examiner took into consideration that the Plan writes only Medicare Advantage and therefore most of its market conduct activities are under the regulatory purview of CMS rather than under the purview of the Department of Financial Services. Thus, the market conduct review was limited to:

- Agents' licensing and terminations

A. Agents' licensing and terminations

Sections 2112(a) and (d) of the New York Insurance Law state in part:

> "(a) Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization…
>
> (d) Every insurer, fraternal benefit society or health maintenance organization or insurance producer or the authorized representative of the insurer, fraternal benefit society, health maintenance organization or insurance producer doing business in this state shall, upon termination of the certificate of appointment as set forth in subsection (a) of this section of any insurance agent licensed in this state, or upon termination for cause for activities as set forth in subsection (a) of section two thousand one hundred ten of this article, of the certificate of appointment, of employment, of a contract or other insurance business relationship with any insurance producer, file with the superintendent within

> thirty days a statement, in such form as the superintendent may prescribe, of the facts relative to such termination for cause..."

The examination included a review of how the Plan licenses and terminates its sales agents. During the examination period, the Plan hired three sales agents whom were all salaried employees of the Plan. One of agents was terminated after several months of employment. However, the Department's licensing records shows that no appointment or termination was filed by the Plan with the Department.

It is recommended that the Plan comply with the requirements of Section 2112(a) of the New York Insurance Law and file the required certificate of appointments with the Department for all employed sales agents.

It is further recommended that the Plan comply with the requirements of Section 2112(d) of the New York Insurance Law and file the required statement regarding agent termination with the Department within thirty days of termination.

7. SUBSEQUENT EVENTS

The Plan, in its June 30, 2013 quarterly statement filing and subsequent the examination date, reported itself as being impaired in the amount of $92,554. It should be noted that the impairment was cured on August 17, 2013 when the Plan received a reimbursement of expenses from its Parent, CHCS in the amount of $190,190.

8. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____/S/_____
Kaiwen K. Guo
Senior Insurance Examiner

STATE OF NEW YORK)
) SS.
)
COUNTY OF NEW YORK)

Kaiwen K. Guo, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

_____/S/_____
Kaiwen K. Guo

Subscribed and sworn to before me
this __ day of _____ 2013.

Appointment No. **30651**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Kaiwen Guo

as a proper person to examine into the affairs of the

Catholic Special Needs Plan, LLC.

and to make a report to me in writing of the condition of the said

HMO

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by name and affixed the official Seal of this Department, at the City of New York.

This 26th day of January, 2011

James J. Wrynn
Superintendent of Insurance

STATE OF NEW YORK
SUPERINTENDENT OF INSURANCE
EXCELSIOR