WEST SUBURBAN HEALTH GROUP

BASIC FINANCIAL STATEMENTS AND
MANAGEMENT'S DISCUSSION AND ANALYSIS
WITH REQUIRED SUPPLEMENTARY INFORMATION
YEARS ENDED JUNE 30, 2013 AND JUNE 30, 2012
WITH INDEPENDENT AUDITOR'S REPORTS

MANAGEMENT'S DISCUSSION AND ANALYSIS

WEST SUBURBAN HEALTH GROUP
Management's Discussion & Analysis
June 30, 2013

The management of West Suburban Health Group (the Group) offers readers of our financial statements the following narrative overview and analysis of our financial activities for the years ended June 30, 2013 and 2012. Please read this discussion and analysis in conjunction with the Group's basic financial statements on the accompanying pages.

Basic Financial Statements

The basic financial statements are prepared using the accrual basis of accounting. Revenue is recorded when earned, and expenses are recorded when incurred. The basic financial statements include a statement of net position, a statement of revenues, expenses and changes in net position; a statement of cash flows and notes to the financial statements.

The statement of net position presents information on the assets and liabilities of the Group, with the difference being reported as net position.

The statement of revenues, expenses, and changes in net position reports the operating and non-operating revenues and expenses of the Group for the fiscal year. The net result of these activities combined with the beginning of the year net position reconciles to the net position at the end of the current fiscal year.

The statement of cash flows reports the changes in cash for the year resulting from operating and investing activities. The net result of the changes in cash for the year, when added to the balance of cash at the beginning of the year, equals cash at the end of the year.

The notes to the financial statements provide additional information that is essential to a full understanding of the data provided in the government-wide and fund financial statements. The notes to the financial statements follow the basic financial statements described above.

Financial Highlights

- Assets exceeded liabilities (net position) in 2013 and 2012 by $18,023,939 and $22,771,076 respectively, at the close of each fiscal year. Net position at June 30, 2013 represents 16.0% of fiscal year 2013 claims expense. At June 30, 2012 net position represents 20.2% of fiscal year 2012 claims expense.

- For the years ended June 30, 2013 and 2012, net position decreased by $4,747,137 and increased by $1,843,590, respectively.

- The statement of cash flows identifies the sources and uses of cash activity for the fiscal year and displays a net decrease in cash of $6,510,958 for 2013 and a net increase in cash of $1,696,092 for 2012.

Of the total claims liability $22,189 and $24,140 represents claims payable and $7,954,512 and $8,930,372 represents an estimate for claims incurred but not reported as of June 30, 2013 and 2012, respectively. The decrease in cash is a result of claims and other Group expenses exceeding member premiums during the fiscal year. Actuarial assumptions are used in projecting annual claims costs for each health plan on a per subscriber/per month basis and individual and Family plan rates, on a plan by plan basis, are set to fund the aggregate of the total

projected claims and other Group costs. The increase in plan rates for fiscal year 2013 range between 0.0% and 14.7% for active employee plans. All Rate Saver plans were assigned 0.0% increases. The Group reduced FY13 active employee plan rates from those recommended through the rate projection process in order to decrease the Group's Net Position which were deemed to be higher than required. The Group's self-funded Medicare supplement plans were moved to a calendar year renewal basis effective January 1, 2011. Fiscal year 2013 rates for these plans were set at the same level as for fiscal year 2012, i.e. 0% increase. Each Benchmark plan rate was set 3.5% lower than its respective Rate Saver plan rate.

Condensed Financial Information

A comparative summary of financial information is presented below:

	2013	2012	Amount of Change	% Change
Cash	$ 7,509,027	$ 14,019,985	$ (6,510,958)	(46.44)
Investments	15,421,837	15,178,227	243,610	1.6
Other current assets	3,151,984	2,668,870	463,114	17.22
Total assets	26,082,848	31,887,082	(5,804,234)	(18.20)
Claims liabilities	7,976,701	8,954,512	(977,811)	(10.92)
Other current liabilities	82,208	161,494	(79,286)	(49.10)
Total liabilities	8,058,909	9,116,006	(1,057,097)	(11.60)
unrestricted net position	$ 18,023,939	$ 22,771,076	(4,747,137)	(20.85)
Members' contributions	$ 122,211,081	$ 126,383,249	(4,172,168)	(3.30)
Medicare Part D subsidy	1,227,473	1,208,355	19,118	1.58
Total operating revenues	123,438,554	127,591,604	(4,153,050)	(3.25)
Claims expense	112,635,757	112,455,549	180,208	0.16
Claims administration expenses	5,207,928	5,537,046	(329,118)	(5.94)
Fixed premiums	7,070,860	6,246,125	824,735	13.20
Stop loss insurance premiums	697,092	644,784	52,308	8.11
Consulting and group administration	1,062,917	964,318	98,599	10.22
Other administrative services	414,854	139,632	275,222	197.11
Total operating expenses	127,089,408	125,987,454	1,101,954	0.87
Operating income (loss)	(3,650,854)	1,604,150	(5,255,004)	(327.59)
Investment income	257,502	239,440	18,062	7.54
Refund of Medicare part D to members	1,353,785	0	1,353,785	100.00
Change in net position	$ (4,747,137)	$ 1,843,590	$ (6,590,727)	(357.49)

Economic Factors Affecting the Subsequent Year

The Group is operating in an environment of escalating health care costs. Given this environment the Group's employers are participating in wellness programs to promote healthier lifestyles and ultimately to reduce health claim costs. The Group engages the health plan providers' Disease Management (DM) programs and engages Abacus Employer Health Solutions to provide the Good Health Gateway Diabetes Rewards Program® to reduce the risk level of the Group's diabetic members. Participation in DM programs is voluntary.

The Massachusetts Municipal Health Care Reform Law was enacted on July 1, 2011. The law provides municipal employers with an expedited collective bargaining process to make plan design changes provided the plan design changes do not go beyond the plan design of the Group Insurance Commission's (GIC) most popular plan. The law also gives joint purchase groups the authority to approve such plan design changes and then requires each participating employer to follow the expedited bargaining process or other approved bargaining process. The WSHG approved plan design changes for FY13 are similar to the plan design of the GIC benchmark plan. None of the WSHG participating employers have bargained in the Benchmark level of plan design changes to replace the Legacy and Rate Saver plans; however, most WSHG employers have bargained replacement of the Legacy plans with the Rate Saver plans that have higher member cost-sharing and lower monthly funding rates. These changes reduced the claims costs in WSHG's FY13 expenses beyond what they otherwise would have been had the installation of Rate Saver plans not been made. The revenues from rates was also reduced.

Request for information

This financial report is intended to provide an overview of the finances of the Group. Any questions concerning this report, or for additional information, please contact Marc Waldman, Chairman of the Board, or Ruth Hohenschau, Treasurer, 7 Snow Street, Sherborn, MA 01770.

BASIC FINANCIAL STATEMENTS

WEST SUBURBAN HEALTH GROUP
Statement of Net Position
June 30, 2013 and June 30, 2012

	2013 Total	2012 Total
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 7,509,027	$ 14,019,985
Investments	15,421,837	15,178,227
Receivables:		
Medicare Part D subsidy	645,511	349,000
Reinsurance claims	-	902,222
Due from members	621,988	221,343
Rebates from insurance carriers	741,212	374,904
Total receivables	2,008,711	1,847,469
Deposits with insurance carriers	1,143,273	841,401
Total assets	$ 26,082,848	$ 31,887,082
LIABILITIES AND FUND BALANCES		
Current Liabilities:		
Accounts payable	$ -	$ 65,545
Members' advance contributions	82,208	95,949
Claims liabilities (Note 5)	7,976,701	8,954,512
Total liabilities	8,058,909	9,116,006
Unrestricted/total net position	18,023,939	22,771,076
Total liabilities and net position	$ 26,082,848	$ 31,887,082

The accompanying notes are an integral part of these financial statements.

WEST SUBURBAN HEALTH GROUP

Statement of Revenues, Expenses, and Changes in Net Position

Years Ended June 30, 2013 and June 30, 2012

	2013 Total	2012 Total
Operating revenues:		
Members' contributions	$ 121,835,836	$ 125,964,029
Medicare Part D subsidy	1,227,473	1,208,355
COBRA contributions	375,245	419,220
Total operating revenues	123,438,554	127,591,604
Operating expenses:		
Claims expense	112,635,757	112,455,549
Claims administration fees	5,207,928	5,537,046
Fixed premiums	7,070,860	6,246,125
Stop loss insurance premiums	697,092	644,784
Consulting and group administration services	1,062,917	964,318
Other administrative services	414,854	139,632
Total operating expenses	127,089,408	125,987,454
Operating income (loss)	(3,650,854)	1,604,150
Nonoperating revenues(expenses):		
Investment income	257,502	239,440
Refund of medicare part D to members	(1,353,785)	
Change in net position	(4,747,137)	1,843,590
Net position, beginning of year	22,771,076	20,927,486
Net position, end of year	$ 18,023,939	$ 22,771,076

The accompanying notes are an integral part of these financial statements.

WEST SUBURBAN HEALTH GROUP
Statement of Cash Flows
Years Ended June 30, 2013 and June 30, 2012

	2013	2012
Cash flows from operating activities:		
Cash received from members	$ 121,796,695	$ 125,388,489
Cash received for Medicare Part D subsidy	930,962	1,373,355
Cash paid to insurance providers	(127,709,191)	(122,764,949)
Cash paid to other vendors	(1,543,316)	(1,038,405)
Net cash provided (used) by operating activities	(6,524,850)	2,958,490
Cash flows from investing activities:		
Change in investments, net	(243,610)	(1,501,838)
Interest on deposits	257,502	239,440
Net cash provided (used) by investing activities	13,892	(1,262,398)
Net increase (decrease) in cash and cash equivalents	(6,510,958)	1,696,092
Cash and cash equivalents, beginning of year	14,019,985	12,323,893
Cash and cash equivalents, end of year	$ 7,509,027	$ 14,019,985
Reconciliation of operating income to net cash provided by operating activities:		
Operating income (loss)	$ (3,650,854)	$ 1,604,150
Changes in operating assets and liabilities:		
Accounts receivable	(161,242)	3,427,036
Deposits with insurance carriers	(301,872)	112,151
Accounts payable	(65,545)	65,545
Medicare part D due to members	(1,353,785)	(1,355,815)
Members' advance contributions	(13,741)	(1,418,717)
Claims liabilities	(977,811)	524,140
Net cash provided (used) by operating activities	$ (6,524,850)	$ 2,958,490

The accompanying notes are an integral part of these financial statements.

Note 1. Description of Group

West Suburban Health Group (the Group) was organized in July 1990 under Chapter 32B, Section 12 of the Massachusetts General Laws to obtain health insurance for its member governments that have signed the Joint Negotiation and Purchase of Health Coverage governmental agreement. The Group is governed by the West Suburban Health Group Board (the Board), comprised of representatives from each of the member governmental units. The Board has elected a Steering Committee to oversee the business of the Group. As a governmental entity, the Group is not subject to the provisions of the Employee Retirement Income Security Act of 1974 nor is it subject to federal and state income taxes.

The Group offers health benefits to all eligible employees and retirees of its participating governmental units. At June 30, 2013, participants are the Towns of Ashland, Dedham, Dover, Holliston, Natick, Needham, Sherborn, Shrewsbury, Walpole, Wayland, Wellesley, Westwood, and Wrentham; the Dover-Sherborn School District; the ACCEPT Educational Collaborative and The Education Cooperative.

Governmental units may apply for membership and be added to the Group, commencing on a date mutually agreed upon, provided that no less than two-thirds of Board members representing the participating governmental units vote to accept such additional participants.

Any participating governmental unit may withdraw participation at its discretion, but withdrawal is only effective on June 30 of a given year. A governmental unit that elects to terminate participation in the Group must notify the Board in writing by March 31 in order to be effective for the following June 30. In addition, any participating governmental unit which is 60 days in arrears for payments may be terminated at the discretion of the Board. In lieu of termination, the Board may take other appropriate action.

There is no liability for premium or administrative expense following the effective date of termination of a participating governmental unit's coverage under a contract purchased through the Group except for the governmental unit's proportionate share of any deficit in the trust, as of its termination date, or of any premium expense or any subsequent expense for its covered individuals continued on the plan after termination, as well as for any unpaid contributions or assessments attributable to periods prior to the effective date of the participating governmental units termination. In the case of a certified surplus, the joint purchase agreement does not allow a withdrawing unit to receive any portion of the Group's surplus.

Contributions to the Group's trust fund from participating governmental units are on a monthly basis, based upon plan specific funding rates for coverage provided on individual and family enrollments for self-insured plans. The funding rates are determined by the Board based on recommendations from the health plans and its consultant and are determined to be 100% of the cost of coverage of the Group as a whole (including, but not limited to, anticipated incurred claims, retention risk, and Group administration expenses) as established through underwriting and/or actuarial estimates. Premiums for insured plans are set by the health plans.

Note 1. Description of Group (continued)

All refunds, surplus, and deficits are dealt with on a proportional and collective basis. In the case of a certified surplus, the Board determines whether the excess funds will remain in the trust fund for the purpose of reducing the participants' future premium cost or be distributed to the participating governmental units in proportion to the number of participating governmental unit's employees and retirees covered under the contract purchased at the time the surplus was incurred. In the case of a certified deficit, the Board will determine to resolve the deficit through increasing participant's future contributions or whether additional revenue will be raised through direct assessment and paid by the participating governmental units in proportion to the number of participating governmental unit's employees and retirees covered under the contract purchased at the time the deficit was incurred.

The Group offers the following self-insured plans: Blue Cross Blue Shield of MA (BCBSMA) Network Blue New England Exclusive Provider Organization (EPO) plan and Medex 3 with OBRA90 benefits; Fallon Health & Life Assurance Company's SelectCare and DirectCare EPOs; Harvard Pilgrim Health Care (HPHC) EPO plan, HPHC Preferred Provider Organization (PPO) plan, and HPHC Medicare Enhance; Tufts Health Plan EPO plan and Tufts Point of Service ((POS) plan.

These plans are administered by the respective insurance companies for a monthly administration fee based on the number of individual, single parent/single child, and family plan subscribers for a particular month.

The Group offers the following health plans on a fully insured basis: BCBSMA Managed Blue for Seniors, Fallon Senior Plan, Tufts Medicare Prime Supplement, and Tufts Medicare Preferred HMO.

The Group employs the services of John R. Sharry, Incorporated, d/b/a Group Benefits Strategies (GBS), as central benefit administrator to provide certain management, consulting, enrollment, COBRA and technical functions and to audit medical claims paid. The current agreement with GBS is for a three year term ending December 31, 2015, and provides for a monthly fee based upon the number of subscribers. The agreement may be terminated by either party, at any time with 60 days prior, written notice.

The Group employs the services Prescription Benefits Services, Inc. (PBS) as benefit administrator to provide certain management, consulting, and technical functions for the Group's alternative prescription drug program. The current agreement with PBS is for a three-year term ending September 30, 2016, and provides for a monthly fee based upon the number of subscribers, a one time set up fee and an annual incentive fee paid in monthly installments. The agreement may be terminated by the Group, at any time after the initial term the agreement with 90 days prior, written notice.

The Group appoints a Treasurer and an Assistant Treasurer who collects payment from member units, pay claims and vendor expenses, maintain the financial records of the Group, and oversee investments.

Note 2. Summary of Significant Accounting Policies

A. Basis of Presentation

The financial statements of the Group are prepared in accordance with accounting principles generally accepted in the United States of America, using the economic resources measurement focus and the accrual basis of accounting, and reflect transactions by and on behalf of the Group.

Member contributions include the monthly premiums charged to each participating governmental units and include costs for administrative services as well as insurance charges. Contributions are recorded as revenue during the period in which the Group is obligated to provide services to its members. The unearned portion of contributions for a coverage period is reported as advance collections.

Under Governmental Accounting Standards Boards (GASB) Statement No. 20, *Accounting and Reporting for Proprietary Funds and Other Governmental Entities that use Proprietary Fund Accounting*, the Group has elected to apply accounting standards applicable to the private sector issued on or before November 30, 1989, unless those standards conflict with or contradict pronouncements of the Governmental Accounting Standards Board. Operating revenues and expenses result from providing health insurance to its member governments. All other revenues and expenses are reported as non-operating.

B. Claims liabilities

The Group's obligations include estimated health claims incurred but not reported at June 30. The Group uses the latest reported claims to record the Group's payable of reported claims and to estimate health claims incurred but not reported as of that date. The Group pays self-funded claims weekly for Tufts Health Plan, Harvard Pilgrim Health Care (HPHC) and Fallon, for actual claims to be paid and the central benefits administrator, Group Benefits Strategies, is sent supporting detail for the funding requests. The Group pays Blue Cross/Blue Shield (BCBS) a level- monthly payment each month to cover the expected cost of claims for that month. The amount has been mutually agreed upon to represent approximately one month of projected claims for the BCBS plans. There is a quarterly reconciliation and settle-up against actual claims payments made by BCBS on behalf of the Group. Actual claims reported differ from claims estimated, but the Group's size and stop-loss coverage minimize the risk of a significant difference. Claims liabilities are reviewed periodically using claims data adjusted for the Group's current experience. Adjustments to claims liabilities are charged or credited to expense in the periods in which they are made.

C. Reinsurance

The Group has a specific excess medical and prescription drug claims reinsurance contract with an insurance carrier covering claims paid on all self-funded plans, except HPHC Medicare Enhance and Medex, in excess of $300,000 and $300,000 per individual to a lifetime maximum amount payable of $2,000,000 and $2,000,000, for each individual member within any one-policy period for the years ended June 30, 2013 and 2012, respectively.

Note 2. Summary of Significant Accounting Policies (continued)

C. Reinsurance (continued)

Additionally, each policy has an Aggregating Specific Deductible of $500,000 for the years ended June 30, 2013 and June 30, 2012. The Aggregating Specific Deductible is the amount of excess claims the Group must pay before the policy begins to pay.

The policy period covers claims incurred on a fiscal basis within 12 months and paid within 24 months.

The Group does not include reinsured risks as liabilities unless it is probable that those risks will not be covered by the re-insurer. Amounts recoverable through re-insurers on paid claims are classified as receivable and as a reduction of claims expense.

D. Cash, Cash Equivalents and Investments

The Group considers all highly liquid investments purchased with a maturity of three months or less to be cash equivalents.

Investments are stated at fair value. Where applicable, fair values are based on quotations from national securities exchanges.

E. Medicare Part D Prescription Drug Benefit Program

The Group acts as the Retiree Drug Subsidy (RDS) plan sponsor on behalf of its members for the purpose of applying for the subsidy payment provided for under The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (subpart R).

F Accounting Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, and disclosures of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the reporting period. Actual results will differ from those estimates.

Note 3. Cash, Cash equivalents and Investments

The Group maintains deposits in authorized financial institutions. Authorized deposits include demand deposits, term deposits, and certificates of deposit in trust companies, national banks, savings banks, and certain other financial institutions. Deposits may not exceed certain levels without collateralization of the excess by the financial institution involved. The Group may also invest in securities issued by or unconditionally guaranteed by the U.S. Government or an agency thereof, and having a maturity from date of purchase of one year or less. The Group may also invest in repurchase agreements guaranteed by such government securities with maturity dates of not more than ninety days from date of purchase. The Group may invest in units of the Massachusetts Municipal Depository Trust (MMDT), and external investment pool managed by the Treasurer of the Commonwealth of Massachusetts. Cash deposits are reported at carrying amount, which reasonably approximates fair value.

Note 3. Cash, Cash equivalents and Investments (continued)

In the case of deposits, custodial credit risk is the risk that in the event of a bank failure, the Group's deposits may not be returned. The Group does not have a formal deposit policy for custodial credit risk. At June 30, 2013 and June 30, 2012, deposits totaled $7,533,310 and $14,055,024, respectively. The carrying amounts of these deposits at June 30, 2013 and June 30, 2012, were $7,509,027 and $14,019,985, respectively. Of the deposit amounts $7,451,102 and $13,959,076 was exposed to custodial credit risk at June 30, 2013 and June 30, 2012, respectively because it was uninsured and uncollateralized. The difference between deposit amounts and carrying amounts generally represents outstanding checks and deposits in transit.

The Group maintains accounts for investment of funds.

Custodial credit risk for investments is the risk that, in the event of the failure of the counter party to a transaction, a government will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The Group does not have an investment policy covering custodial credit risk. Two of the Groups accounts are insured by Securities Investor Protection Corporation (SIPC) up to $500,000 and are otherwise uninsured and uncollateralized.

Interest rate risk is the risk that changes in market interest rates that will adversely affect the fair market value of an investment. Generally, the longer the maturity of an investment the greater the sensitivity of its fair market value to changes in market interest rates. The Group has an investment policy, included as part of its joint purchase agreement, which provides for the investment of funds in securities with a weighted average maturity not to exceed 2.5 years. The approximate maturities of the Group's debt investments are disclosed in the following table:

		Maturity			
Investment Type	**Fair Market Value**	**12 months or less**	**13 – 24 months**	**25 – 60 months**	**Thereafter**
As of June 30, 2013:					
Government securities	$ 150,436	$ -	$ -	$ 150,436	$ -
MMDT	8,062,171	8,062,171			
Asset backed securities	1,807,043	159	-	85,186	1,721,698
Money market funds	2,487,391	2,487,391			
Negotiable Certificates of Deposit	50,112	50,112			
Corporate notes	2,864,684	180,929	412,069	1,891,168	380,518
	$ 15,421,837	$ 10,780,762	$ 412,069	$ 2,126,790	$2,102,216
As of June 30, 2012:					
Government securities	$ 0	$	$ -	$	$ -
MMDT	8,044,729	8044,729			
Asset backed securities	1,503,472	965	4,295	17,058	1,481,154
Money market funds	792,788	792,788			
Negotiable Certificates of Deposit	106,087	106,087			
Corporate notes	4,731,151	424,822	251,354	4,054,975	0
	$ 15,178,227	$ 9,369,391	$ 255,649	$ 4,072,033	$1,481,154

Note 3. Cash, Cash equivalents and Investments (continued)

Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. Credit risk is measured by the assignment of a rating by a nationally recognized statistical rating organization. Obligations of the U.S. Government and certain of its agencies are not considered to have credit risk and therefore no rating is disclosed in the above table. Equity securities and equity mutual funds are not rated as to credit risk. The Group does not have an investment policy which would limit its investment choices. The following table discloses the approximate amount of debt investments in each rating classification using Standard & Poor's rating classifications:

		S&P Rating as of Year End					
Investment Type	**Fair Market Value**	**Exempt from Disclosure**	**AAA**	**AA to A**	**BBB**	**BB to B**	**Not Rated**
As of June 30, 2013:							
Government securities	$ 150,436	$ -	$ -	$ -	$ 150,436	$ -	$ -
MMDT	8,062,171	8,062,171					
Asset backed securities	1,807,043	1,807,043					
Money market funds	2,487,391						2,487,391
Negotiable Certificates of Deposit	50,112						50,112
Corporate notes	2,864,684	-	-	1,391,688	1,254,151	-	218,845
	$ 15,421,837	$9,869,214	$ -	$ 1,391,688	$ 1,404,587	-	$2,756,348
As of June 30, 2012:							
Government securities	$ -	$ -	$ -	$ -		$ -	$ -
MMDT	8,044,729	8,044,729					
Money market funds	792,788						792,788
Negotiable Certificates of Deposit	106,087						106,087
Asset backed securities	1,503,472	1,503,472					
Corporate notes	4,731,151	-	-	1,454,703	3,037,545	51,000	187,903
	$ 15,178,227	$ 9,548,201	$ -	$ 1,454,703	$ 3,037,545	$ 51,000	$ 1,086,778

Concentration of credit risk – The Group does not have an investment policy which limits the amount that can be invested in any one issuer or security. Excluding U.S. federal agency securities, and external investment pools, there are no securities or issuers which represent more than 5% of the total investments of the governmental activities.

Note 4. Plan Deposits

The Group has established deposits with certain insurers who draw upon these accounts to pay claims. Fallon, Tufts, and Harvard Pilgrim notify the Group of the funding required on a weekly basis, and the Group transfers that funding into the appropriate account. These deposits and other claim advance amounts at June 30, 2013 and 2012, are as follows:

Administrator	June 30, 2013	June 30, 2012
Fallon Health & Life	$ 60,611	$ 56,097
Abacus Diabetes program	195,794	
Harvard Pilgrim	494,897	491,222
Prescription drug plan	243,644	152,464
Tufts	148,327	141,618
Total deposits	$ 1,143,273	$ 841,401

Note 5. Health Claims Incurred but not Reported

The Group establishes a liability for both reported and unreported insured events, which include estimates of both future payments of losses and related adjustment expenses, if any. The following table represents changes in claims' liabilities for the years ended June 30, 2013 and June 30, 2012:

	2013	2012
Unpaid claims and claims' adjustment expenses—beginning of year	$ 8,954,512	$ 8,430,372
Incurred claims and claims' adjustment expenses:		
Provision for insured events of the current fiscal year	113,398,568	113,515,498
Increase (decrease) in provision for insured events of prior fiscal years	(762,811)	(1,059,949)
	112,635,757	112,455,549
Payments:		
Claims and claims' adjustment expenses attributable to insured events of the current fiscal year	(105,424,762)	(104,563,881)
Claims and claims' adjustment expenses attributable to insured events of prior fiscal years	(8,188,806)	(7,367,528)
	(113,613,568)	(111,931,409)
Total unpaid claims and claims' adjustment expenses—end of year	$ 7,976,701	$ 8,954,512

Note 6. GASB Pronouncements Recently Issued

The following are pronouncements issued by the Governmental Accounting Standards Board (GASB), which the Group believes are applicable to its financial statements.

Current pronouncements

The GASB issued Statement #61, *The Financial Reporting Entity: Omnibus-an amendment of GASB Statements No. 14 and No. 34*, which was required to be implemented in fiscal year 2013. This pronouncement modified requirements for the inclusion of component units in the financial reporting entity. This pronouncement had no effect on the Group's financial statements.

The GASB issued Statement #62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements*, which was required to be implemented in fiscal year 2013. This pronouncement continued the codification of all generally accepted accounting principles for state and local governments into a single source.

The GASB issued Statement #63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position*, which was required to be implemented in fiscal year 2013. This pronouncement standardized the financial reporting relating to the elements of a government's consumption of net assets, and an acquisition of net assets that is applicable to a future reporting period.

The GASB issued Statement #65, *Items Previously Reported as Assets and Liabilities*, which is required to be implemented in fiscal year 2014. This pronouncement will clarify the appropriate use of the financial statement elements deferred outflows of resources and deferred inflows of resources to ensure consistency in financial reporting. The Group doesn't believe this pronouncement will impact the Group's financial statements.

Future pronouncements

The GASB issued Statement #66, *Technical Corrections - 2012, an amendment of GASB Statements No. 10 and No.62*, which is required to be implemented in fiscal year 2014. This pronouncement will resolve conflicting accounting and financial reporting guidance that could diminish the consistency of financial reporting and thereby enhance the usefulness of the financial reports. The Group expects this pronouncement will require additional disclosure and impact the Group's financial statements.

The GASB issued Statement #69, *Government Combinations and Disposals of Government Operations*, which is required to be implemented in fiscal year 2014. The pronouncement addresses accounting and financial reporting issues associated with a variety of transactions, such as mergers, acquisitions, disposals and transfer of governmental operations. The Group does not anticipate this pronouncement will impact the Group's financial statements.

The GASB issued Statement #70, *Accounting and Financial Reporting for Nonexchange Financial Guarantees*, which is required to be implemented in fiscal year 2014. The pronouncement addresses accounting and financial reporting for financial guarantees extended by a government for the obligations of another government, not-for-profit, or private entity without directly receiving equal or approximately equal value in exchange for the guarantee. The Group does not anticipate the pronouncement will impact the Group's financial statements.

WEST SUBURBAN HEALTH GROUP
Required Supplementary Information
Ten-Year Claims' Development Information

The table on the next page illustrates how the Group's earned revenues and investment income compare to related costs of loss and other expenses assumed by the Group as of the end of each of the last ten years. The rows in the table are defined as follows: (1) This line shows the total of each fiscal year's earned contribution revenues and investment revenues. (2) This line shows each fiscal year's HMO fixed premiums paid and other operating costs of the Group including overhead and claims' expense not allocated to individual claims. (3) This line shows the Group's incurred self-insured claims and allocated claims' adjustment expense (both paid and accrued) as originally reported at the end of the first year in which the event triggered coverage under the contract occurred (called *policy year).* (4) This section of rows shows the cumulative amounts paid as of the end of successive years for each policy year. (5) This section of rows shows how each policy year's incurred claims increased or decreased as of the end of successive years. This annual re-estimation results from new information received on known claims, reevaluation of existing information on known claims, as well as emergence of new claims not previously known. (6) This line compares the latest re-estimated incurred claims' amount to the originally established (line 3) and shows whether this latest estimate of claims' cost is greater or less than originally thought. As data for individual policy years mature, the correlation between original estimates and re-estimated amounts is commonly used to evaluate the accuracy of incurred claims currently recognized in less mature policy years. The columns of the table show data for successive policy years.

WEST SUBURBAN HEALTH GROUP
REQUIRED SUPPLEMENTARY INFORMATION
Ten-Year Claims' Development Information
(Unaudited)

	6/30/2013	6/30/2012	6/30/2011	6/30/2010	6/30/2009	6/30/2008	6/30/2007	6/30/2006	6/30/2005	6/30/2004
1. Earned member assessments, other and investment revenues	$ 123,696,056	$ 127,831,044	$ 126,786,485	$ 121,573,836	$ 114,994,091	$ 110,744,575	$ 102,055,287	$ 90,244,549	$ 72,472,587	$ 56,966,086
2. HMO fixed premiums paid and other operating expenses	$ 14,453,651	$ 13,531,905	$ 13,755,106	$ 12,590,164	$ 11,521,971	$ 10,558,928	$ 9,308,954	$ 9,329,425	$ 10,039,714	$ 7,328,724
3. Estimated incurred, self-insured claims and expense, end of fiscal year	$ 113,398,568	$ 113,515,498	$ 112,640,161	$ 108,039,538	$ 99,860,561	$ 95,819,229	$ 89,205,017	$ 87,471,102	$ 66,464,025	$ 46,386,503
4. Paid (cumulative) as of:										
End of fiscal year	$ 105,424,762	$ 104,563,881	$ 104,212,684	$ 97,907,967	$ 89,602,981	$ 85,176,530	$ 78,904,946	$ 74,903,229	$ 58,381,021	$ 41,659,615
One year later		$ 112,720,084	$ 111,621,430	$ 106,474,559	$ 98,290,428	$ 95,733,731	$ 88,871,478	$ 83,118,800	$ 64,861,744	$ 46,404,704
Two years later			$ 111,682,108	$ 106,451,253	$ 98,277,910	$ 95,796,458	$ 88,761,224	$ 83,010,897	$ 65,120,834	$ 46,479,264
Three years later				$ 106,432,807	$ 98,263,634	$ 95,770,988	$ 88,786,385	$ 83,003,414	$ 65,099,507	$ 46,434,965
Four years later					$ 98,263,630	$ 95,768,763	$ 88,754,592	$ 82,977,736	$ 65,093,733	$ 46,419,966
						$ 95,763,671	$ 88,752,650	$ 82,976,885	$ 65,093,917	$ 46,417,491
							$ 88,748,601	$ 82,976,881	$ 65,094,103	$ 46,417,491
								$ 82,976,859	$ 65,094,639	$ 46,417,491
									$ 65,094,177	$ 46,417,491
5. Re-estimated incurred, self-insured claims and expense:										
End of fiscal year	$ 113,398,568	$ 113,515,498	$ 112,640,161	$ 108,039,538	$ 99,860,561	$ 95,819,229	$ 89,205,017	$ 87,471,102	$ 66,461,025	$ 46,386,503
One year later		$ 112,720,084	$ 111,621,430	$ 106,474,559	$ 98,290,428	$ 95,733,731	$ 88,871,478	$ 83,118,800	$ 64,861,744	$ 46,404,704
Two years later			$ 111,682,108	$ 106,451,253	$ 98,277,910	$ 95,796,458	$ 88,761,224	$ 83,010,897	$ 65,120,834	$ 46,479,264
Three years later				$ 106,432,807	$ 98,263,634	$ 95,770,988	$ 88,786,385	$ 83,003,414	$ 65,099,507	$ 46,434,965
Four years later					$ 98,263,630	$ 95,768,763	$ 88,754,592	$ 82,977,736	$ 65,093,733	$ 46,419,966
						$ 95,763,671	$ 88,752,650	$ 82,976,885	$ 65,093,917	$ 46,417,491
							$ 88,748,601	$ 82,976,881	$ 65,094,103	$ 46,417,491
								$ 82,976,859	$ 65,094,639	$ 46,417,491
									$ 65,094,177	$ 46,417,491
6. (Increase) decrease in estimated, incurred, self-insured claims and expense from the end of the original policy year.		$ 795,414	$ 958,053	$ 1,606,731	$ 1,596,931	$ 55,558	$ 456,416	$ 4,494,243	$ 1,366,848	$ (30,988)